

# The Addictive & Mental Disorders Division

Adult Mental Health Services

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# This presentation covers:

- Mental Health Services Plan
- Medicaid Mental Health
- MHSP Basic Medicaid Waiver
- SDMI HCBS Waiver
- Submitting Claims
- Forcing Claims



# The Mental Health Services Plan



# Enrollment in MHSP is limited to individuals who meet:

- Financial criteria (falling within 150% of Federal Poverty Level)
- Meet Severe Disabling Mental Illness (SDMI) criteria
- Individuals applying for MHSP must first apply for Medicaid
  - **ARM 37.89.106 MENTAL HEALTH SERVICES PLAN, MEMBER ELIGIBILITY**
- *MHSP eligibility is valid for one year*
- *A clinical assessment is not required for renewal*



# MHSP Contracts

AMDD contracts with six licensed mental health centers that provide services to adults with severe disabling mental illnesses who have been determined eligible for the Mental Health Services Plan.

# MHSP Eligibility Enrollments

- Regional mental health centers make the MHSP determinations and enrollments.
- Other mental health facilities make the determination of eligibility, but notify the Benefit Management Team for enrollments.

# Submitting MHSP Claims

- Regional mental health centers will submit encounter claims through the Medicaid Management Information System (MMIS) claims payment system.



# MHSP Fee-for-Service

- Reimbursement to providers who have **prescriptive authority** or **who provide medication management** will continue to be reimbursed on a fee-for-service model.
- The provider types include:
  - physicians,
  - psychiatrists,
  - mid-level practitioners,
  - labs,
  - rural health clinics, and
  - federally qualified clinics.

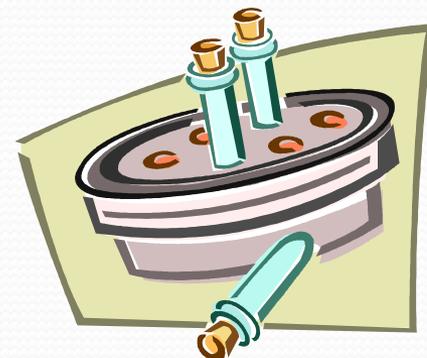


## PLEASE check for Medicare eligibility

- If an individual is receiving a Social Security check and does not have Medicaid, they are probably eligible for Medicare.
- Medicare eligible individuals should enroll in Parts B and D before applying for MHSP and Medicaid.

# MHSP Laboratory Fees

- Laboratory services for management of medications prescribed for mental illness are covered.
- Laboratory providers submit these claims to Xerox on a CMS 1500 form.
- Hospitals must submit these claims to the AMDD Benefits Management Team on a UB-04 form.





*Adult  
Medicaid  
Mental  
Health  
Services*

# Medicaid Mental Health Services

- Psychiatric Diagnostic Interview
- Individual, Family, and Group psychotherapy
- Psychological testing
- MH Group Home
- Adult Foster Care
- Day Treatment
- Community Based Psychiatric Rehabilitation Aid (CBPRS)
- Crisis Intervention Facility
- Illness Management and Recovery (IMR)
- Program for Assertive Community Treatment (PACT)
- Targeted Case Management
- Acute Partial Hospitalization
- Intensive Outpatient Services
- Dialectical Behavior Therapy (DBT)

# Prior Authorization\Service Limits

- Prior authorization services are provided by Magellan
  - 1-888-411-6343
- Outpatient Therapy
  - 24 sessions in a fiscal year
- Inpatient Services
  - Requires a prior-authorization before billing
- DBT
  - Requires a prior-authorization before services rendered
- Crisis Intervention Facilities
  - Requires a prior-authorization before billing

# Remember...

- The individual cannot be billed for services when Montana Medicaid was accepted as the payment source.
  - ARM 37.85.406(11)
- Services rendered must be documented and medically necessary.
  - ARM 37.85.414



*MHSP  
Basic  
Medicaid  
Waiver*

# MHSP Basic Medicaid Waiver

- Implemented December 1, 2010
- Renewed January 1, 2014
  - Additional 1200 slots added to the initial 800
- Eligibility
  - 18 years of age and no older than 64 years of age
  - Must be MHSP eligible
  - Have primary diagnosis of Schizophrenia, Bipolar Disorder, or Major Depressive Disorder
- Persons are randomly selected with priority given to those with Schizophrenia, then Bipolar, last Major Depression
- 2000 slots total; almost 1100 persons have been drawn

# MHSP Basic Medicaid Waiver

- Basic Medicaid Coverage
- Coverage is for one continuous year
- Can be re-enrolled after the one year provided the individual meets all eligibility criteria for MHSP

*SDMI  
Home and  
Community  
Based  
Waiver*



# SDMI HCBS Waiver

- Goal for the program is to keep individuals in their own community and to live as independently as possible.
- The waiver is recovery oriented.

# SDMI HCBS Waiver

- Designed to provide an individual with SDMI a choice:
  - Receiving long term services in a community, or
  - Receiving long term services in a nursing home setting.
- Individual must meet nursing home level of care and reside in an area of the state where the Waiver is available.
- Waiver providers are enrolled as Montana Medicaid providers.

# SDMI HCBS Waiver – Location and Counties Covered

- **Billings** (46 slots): Big Horn, Carbon, Stillwater, Sweet Grass, Yellowstone
- **Butte** (43 slots): Beaverhead, Deer Lodge, Granite, Jefferson, Powell, Silver Bow
- **Great Falls** (39 slots): Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Phillips, Pondera, Teton, Toole
- **Helena** (30 slots): Jefferson, Lewis & Clark
- **Missoula** (40 slots): Missoula

# SDMI HCBS Waiver – Services Included

- case management
- residential habilitation
- supported living
- adult day health
- personal assistance
- habilitation
- homemaking
- respite
- outpatient OT
- chemical dependency counseling
- dietetic and nutrition counseling
- nursing services
- personal emergency response systems
- durable medical equipment and supplies
- non-medical transportation
- IMR and WRAP
- community transition
- pain and symptom management
- health and wellness

# SUBMITTING CLAIMS



# Before submitting claims...

- Check eligibility
- Use correct member ID





- Do not submit claims without the proper Medicare or TPL documentation.
- Do not resubmit a denied claim without fixing it.
- If you don't understand why it denied:
  - **First**, call Xerox Provider Relations for help, and if it is not resolved, then
  - Send ICN to AMDD for assistance.



# When an individual has Medicare...

- Check Medicare enrollment on the Web Portal prior to submitting claims.
- Claims are denied when the MMIS (Web Portal) does not show Medicare enrollment and the claim includes Medicare information.
- Providers should notify the Benefit Management Team of Medicare coverage if enrollment does not show in the Web Portal and that information can be added.
- If individuals are Medicare eligible, then they should be enrolled in Medicare.

## Common Issues Resulting in Denials

- The individual has Medicare on file and no Medicare information is present on the claim
- Medicare denied the services as not medically necessary
- Medicare denial reasons are not attached
- Medicare EOB and claim information do not match
  - Check individual name, ID, date of service, billed amount, procedure code(s)

# Forcing Claims



# Claims we will force:

- Retroactive Medicaid eligibility.
- Claims that denied due to errors that were caused by Xerox or AMDD.
- MHSP lab claims for hospitals.
- Medicaid claims with a suspension span.

# Claims we will not force:

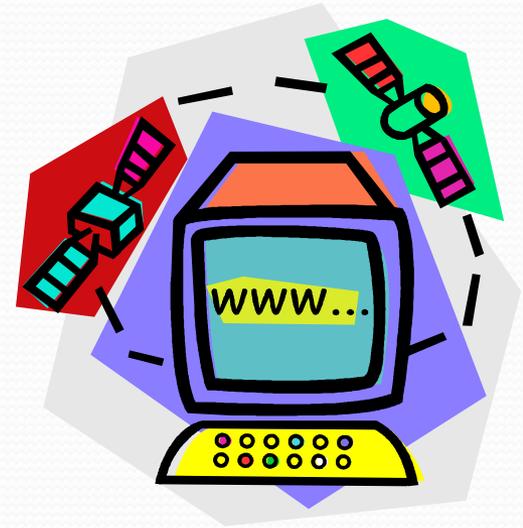
- Claims that are past timely due to billing errors.
- Claims that do not have required documentation of TPL attached.
- Claims for services that exceed the unit limit on the code or the authorized units.
- Claims for non-participating Medicare providers.

# Benefit Management Team Contacts

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# Helpful Websites

- AMDD
  - <http://www.dphhs.mt.gov/amdd>
- Montana Medicaid
  - <http://medicaidprovider.hhs.mt.gov>
- Montana Access to Health Web Portal
  - <https://mtaccesstohealth.acs-shc.com/mt/general/home.do>



# Any Questions?

