

FREQUENTLY ASKED QUESTIONS

SUPERVISED BILLING FOR BEHAVIORAL HEALTH SERVICES

1. Does Emergency Care and Assessment Services fall under Medicaid's policy on supervised billing for mental health providers?

Response: No, the supervised billing requirements as described in the policy apply only to clinical services, and are not applicable to case management, specialized rehabilitation or emergency care and assessment services. This has been clarified in the policy.

The appropriate code for emergency care and assessment services is H2011.

2. Moving to the supervised billing, each provider needs to bill under their own NPI number, if a staff is on a waiver, do they need to get their own NPI number?

Response: Only licensed providers are eligible for an NPI number. All non-licensed providers will bill under their supervisor's NPI number using the appropriate modifier (HO or HN).

For non-clinical services not subject to this policy, services may continue to be billed under the agency ID.

3. Do LADCs qualify to supervise non-licensed staff?

Response: The policy allows for any behavioral health provider enrolled in Medicaid and supervising within their scope of practice to provide supervision.

Further clarification: Only licensed mental health clinicians may provide supervision to a non-licensed rostered mental health clinician for purposes of supervised billing and sign-off on IPCs. An LADC who does not additionally have a clinical mental health license may not provide supervision to a non-licensed mental health clinician for Supervised Billing or IPC sign-off.

Note: Unlicensed providers who are seeking licensure from the Office of Professional Regulation (OPR) will need to obtain supervised hours from a supervisor meeting the requirements outlined by OPR in order to apply for licensure. For Licensed Alcohol and Drug Abuse Counselors, supervisors must meet requirements outlined by the Vermont Alcohol and Drug Addiction Certification Board.

4. Can non-licensed crisis clinicians do work in the field where there may be poor cell phone reception or access to land lines and thus significant time could go by prior to receiving "supervision"?

Response: A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.

5. Do DAIL DS Needs Assessments fall under this supervised billing policy?

Response: The DAIL DS needs assessment is not considered a clinical service for the purposes of the supervised billing policy and DAIL DS needs assessment providers do not need to meet the requirements set by this policy.

6. When providing Clinical services that are funded either through a Medicaid Waiver (e.g. CRT) or a bundled rate reimbursement (e.g. School Social Work bundle), does the requirement that supervision of a rostered clinician be provided by a licensed provider still apply, or can the clinical supervision of an unlicensed provider continue to be by a non-licensed supervisor? These individual treatment encounters will not be billed to Medicaid as a FFS claim, but included as part of the bundled payment model.

Response: When providing clinical services that are billed to Vermont Medicaid, the supervised billing policy applies and requires that a rostered unlicensed clinician be supervised by a licensed provider. This includes clinical services that are funded through fee-for-service, a Medicaid waiver (e.g. CRT), or a bundled rate reimbursement (e.g. School Social Work bundle). The supervised billing requirements do not apply to non-clinical services funded through fee-for-service, a Medicaid waiver, or a bundled rate.

7. Are DMH and DAIL using the same requirements or is this just DVHA?

Response: This policy applies to all Medicaid supervised billing, including DVHA, DMH, DAIL and ADAP. Medicaid is in active discussions with Developmental Services to equally apply the policy to the daily waiver rate.

8. What is the modifier when not licensed?

Response: Supervising provider must use their unique provider number for services provided by unlicensed providers.

- a. Modifier "HO" must be used to indicate the service was performed by a master's level non-licensed provider.*
- b. Modifier "HN" must be used to indicate the service was performed by a bachelor's level non-licensed intern engaged in a graduate-level mental health master's program.*

9. Are the AJ and HO/HN pricing modifiers the same for DMH?

Response: No, AJ and HO/HN modifiers should not be used for DMH services. They are DVHA-specific.

10. We are concerned about the length of time for credentialing and re-credentialing. We received a newsletter from the state that stated it can take up to 12 weeks for credentialing of new staff to occur. This puts us at financial and clinical risk for the period of time before we receive their Medicaid/NPI numbers. What if they do not get approved? We will lose out on the services they have provided for that 12 week period. It is our understanding that since they are licensed they cannot go up under the supervisor's license. We need the support of the state to make this process efficient now that this expectation is in place. Also if we need to hold billing until the credential practice is in place, this causes a cash flow issue for the agency.

Response: Presently, it may take up to 12 weeks to complete the credentialing process due to the high volume of new enrollments Medicaid is receiving, along with the revalidations that are necessary to come into compliance with the ACA provider screening requirements. Medicaid is working to shorten this time frame to no more than 60 days.

11. We also need direction on how to bill case management services. We understand the supervised billing rule only applies to therapy based services, but how do we bill for case management services as of January 1? Do we continue to use our facility number for those services? We have heard the facility number will not be allowed anymore.

Response: For non-clinical services, continue to bill with facility provider number as both the billing provider and the attending provider.

12. Can BCBA's be considered to be a "billing supervisor" for our school services program.

Response: Unless otherwise credentialed, Board Certified Behavior Analyst's may only provide supervision over behavioral services.

13. In order to Waiver someone, does the two years need to be consecutive? We have a Masters Level staff that was with our agency for many years, left and has recently come back.

Response: Yes, waivers to the Five Year Licensure rule are only available to current Designated Agency staff who have been employed by that Vermont Designated Agency for more than two consecutive years as of January 1, 2016. This has been clarified in the policy.

14. Is there a distinction between "board eligible" physicians and "board certified" physicians?

Response: Yes. Board eligible signifies a physician who has completed the residency in a specialty or subspecialty but has not yet been passed the board exams. Board certified physicians have passed the board exams and are certified.

Medicaid contracted providers who are licensed physicians certified in psychiatry by the American Board of Medical Specialties may bill for supervised services.

15. What if Medicare or Third Party is primary, do we follow their incident to supervisory rules?

Response: Providers are required to follow the rules of the primary insurance when submitting claims.

16. I have a question about the 5 year rule. I understand you to be saying that someone cannot bill for therapy after 5 years on the roster – not that the OPR rules will change so that there is a 5 year limit to BE on the roster? Is this correct?

Response: Correct. OPR does not have any rules limiting time on the roster, but an individual provider will no longer be permitted to bill Medicaid after 5 years on the roster, effective 1/1/2016.