

Department of Mental Health  
**TRANSMITTAL LETTER**

**SUBJECT:**

**MHRS Provider Authorization and Billing Manual**

**POLICY NUMBER**

**Manual 1000.2A**

**DATE**

**AUG 07 2013**

**TL# 192**

**Purpose.** The manual was updated to incorporate the new CBI level IV and Supported Employment reimbursement rates, 3<sup>rd</sup> party liability, mental health peer specialists, billing code for ACT group rate, child choice providers flexible spending local funds program, elimination of ISSP and extension of treatment plan updates to 180 days with corresponding authorization timeframes where applicable, eligibility rules for Medicaid-funded MHRS and locally funded MHRS, new codes for community providers to use when they visit a consumer in a hospital or other institutional setting, new Medication/Somatic treatment rates and codes, changes in Rehabilitation Day Services, descriptions of place of service (POS) billing codes, revised Appendix A, Service Code/Modifier/POS Table with Medicaid rates, as well as other general updates.

**Applicability.** Applies to DMH staff responsible for service authorization and billing processes and certified Mental Health Rehabilitation Services (MHRS) providers.

**Policy Clearance.** Reviewed by affected responsible staff and cleared through appropriate MHA offices.

**Implementation Plans.** Specific staff should be designated to carry out the implementation and training as needed, and program managers are responsible for following through to ensure compliance.

**Policy Dissemination and Filing Instructions.** Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed with the DMH Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

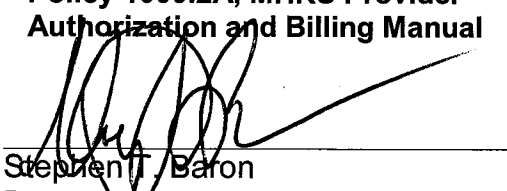
**ACTION**

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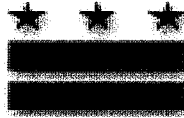
**Policy 1000.2, MHRS Provider Authorization and Billing Manual, dated March 30, 2010, in its entirety.**

**FILE**

**Policy 1000.2A, MHRS Provider Authorization and Billing Manual**

  
\_\_\_\_\_  
Stephen J. Baron  
Director, DMH

District of Columbia  
Department of Mental Health  
Mental Health Rehabilitation Services

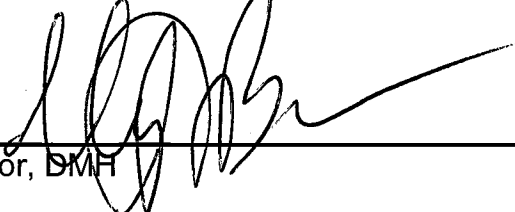


## Provider Authorization and Billing Manual

**Reviewed and Approved By:**

  
Deputy Director, Office of Administrative Operations 7/24/13 Date

  
DMH Senior Deputy Director for Office of Programs and Policy July 24, 2013 Date

  
Director, DMH 8/1/13 Date

July 2013

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**DISTRICT OF COLUMBIA**  
**DEPARTMENT OF MENTAL HEALTH**  
**MENTAL HEALTH REHABILITATION SERVICES**  
**PROVIDER AUTHORIZATION AND BILLING MANUAL**

## **1.0 GENERAL INFORMATION**

---

This section presents a general overview of the purpose, organization, maintenance, and distribution of the manual.

### **1.1 Purpose of the Manual**

This manual's purpose is to document the authorization and billing processes for certified mental health providers who participate in the District of Columbia (DC) Mental Health Rehabilitation Services (MHRS) Program. The procedures include specific instructions on the authorization of MHRS services, filing claims for reimbursement, and documenting clinical records.

### **1.2 Policy**

Providers are responsible for adhering to the requirements set forth in this manual. The requirements are generated from federal regulations and the interpretation of the regulations that are specific to the District.

### **1.3 Maintenance**

The Department of Mental Health (DMH) will maintain this manual with information based on DMH policies and rules established in coordination with the Department of Health Care Finance (DHCF).

Billing and authorization updates will be announced by MHRS bulletins. Providers are responsible for updating their manual and for checking the website for posted changes. When revisions are extensive, the entire manual will be revised and reissued by DMH electronically.



## **1.4 Distribution**

This manual will be distributed electronically to certified providers who participate in the MHRS Program by DMH Provider Relations. A link to this manual will also be available on the DMH website.

## **1.5 Organization**

This manual is organized into sections that address various authorization and billing issues.

Other information that might be helpful when using this manual includes:

- Terms used throughout this manual are defined in Section 3.0, Glossary.
- Contact numbers referenced throughout this manual are included in Section 12.

## **2.0 INTRODUCTION**

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The following subsections provide information regarding the MHRS Program.

### **2.1 District of Columbia MHRS Program**

The MHRS Program is a federally assisted program operated by DMH. The MHRS Program is designed to provide comprehensive rehabilitative mental health services of a high quality at public expense to all eligible residents of the District of Columbia. The MHRS Program permits eligible individuals (see Section 7 for eligibility requirements) the freedom of choice in the selection of a provider of mental health rehabilitative services who has agreed to the conditions of participation by applying and being certified as a provider of services.

### **2.2 Legal Authority**

The Department of Mental Health Establishment Amendment Act of 2001 (D.C. Official Code, Section 7-1131 *et al*); Title 22 DCMR Chapter A34, MHRS Provider Certification Standards as amended, and Title 29 DCMR Chapter 52, Medicaid Reimbursement for Mental Health Rehabilitative Services.

### **2.3 Administration**

The MHRS Program payment system is administrated by DMH for the Department of Health Care Finance (DHCF). DHCF is the District agency that administers the Medicaid Program.

### **2.4 Medicaid Funded MHRS Services**

The following basic core services, when rendered by certified MHRS providers to Medicaid eligible consumers, are covered by MHRS, authorized by DMH, and paid by DHCF:

- Community Support
- Medication/Somatic Treatment
- Diagnostic/Assessment
- Counseling

The following specialty services, when rendered by certified MHRS providers to Medicaid eligible consumers and authorized by DMH, are covered by MHRS, and paid by DHCF:

- Assertive Community Treatment
- Community Based Intervention

- Rehabilitation Day Services
- Intensive Day Treatment Services
- Crisis Emergency

Community support MHRS includes the following activities:

Supported Employment. DMH provides an evidence-based supported employment program that involves helping adult consumers find and maintain a job. Supported Employment can be rendered by a certified MHRS provider who has also been certified by DMH to provide supported employment pursuant to 22 DCMR Chapter A51. Only supported employment (therapeutic) can be reimbursed by Medicaid.

- Supported employment (therapeutic) activities such as assessment, benefits counseling, follow-along supports, and on-going individual job coaching shall be billed as community support (H2023 - supported employment therapeutic).
- Supported employment (non MHRS - vocational) is paid for by DMH local funds under procedure code H2025 (see Section 2.5 below).

Self-Help Peer Support. Individuals who are certified by DMH as certified mental health peer specialists pursuant to 22 DCMR Chapter A73, will be authorized to provide Medicaid-reimbursable mental health rehabilitation services to consumers, when working under the supervision of a qualified practitioner. Medicaid-reimbursable MHRS shall be provided in accordance with the requirements of the District's State Medicaid Plan, Title 22 DCMR Chapter A34, and federal guidelines governing the provision of services by certified mental health peer specialists, and billed as Self-Help Peer Support (H0038).

DMH pays for covered services rendered out-of-the-District to eligible District consumers, if any of the following circumstances exist:

- The services were rendered by a certified provider in the DC MHRS Program who is eligible to provide services in that jurisdiction,
- The consumer requires emergency mental health care while temporarily away from his home,
- The consumer would be risking his health if he waited for the service until he returned home, or
- The consumer is under the custody of a District agency and has DC Medicaid.

More detailed information regarding the MHRS program, its policies and regulations is available at the DMH website at [www.dmh.dc.gov](http://www.dmh.dc.gov) or by contacting the DMH Office of Provider Relations at 202-671-3155.

## 2.5 Non-Medicaid Reimbursable Services Paid by Local Funds

The following services are authorized and paid by DMH Local Funds in accordance with a provider's contract or Human Care Agreement:

- Residential Crisis Stabilization
- Criminal Justice System (CJS) Jail Diversion
- FLEXN-code services – Services and supports provided by Child Choice Provider (see below).
- Team Meeting
- Integrated Community Care Project (ICCP)
- Supported Employment (non-MHRS vocational)
- Supported Employment Group (non-MHRS Job Club)
- Mental Health Service – COC Treatment Planning, Institution (MHS-CTPI)
- Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)
- MHS-DTPI (ACT) and MHS-DTPI (CBI)
- Community Psychiatric Supportive Treatment Program – Rehab/Day Services (CPS-Rehab/Day)

Supported Employment (non-MHRS vocational). DMH provides an evidence-based supported employment program that involves helping adult consumers find and maintain a job. Supported Employment can be rendered by a certified MHRS provider who has also been certified by DMH to provide supported employment pursuant to 22 DCMR Chapter A51.

- The following services shall be billed as supported employment (non-MHRS vocational) H2025: intake, supported employment job club (individual), treatment team coordination, job development (if not able to be billed to the Department of Disability Services, Rehabilitation Services Agency [RSA]); and time limited job coaching (if not able to be billed to RSA).
- Supported Employment Group (non-MHRS Job Club) is billed under H2025HQ.

Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) is a service to develop a mental health service plan for treating a consumer who is not enrolled in ACT or CBI in preparation for discharge from the hospital or other institutional setting (Institutes for Mental Disease (IMD) such as Saint Elizabeths Hospital or Psychiatric Institute of Washington (PIW); hospitals; nursing facilities (nursing homes or skilled nursing facilities); rehabilitation centers; residential treatment centers (RTCs); psychiatric residential treatment facilities (PRTFs); or correctional facilities for defendants or juveniles). It includes modifying goals, assessing progress, planning transitions, and addressing other needs after discharge to the community, as appropriate. MHS-DTPI is provided by an MHRS provider through a mental health professional or credentialed staff to a DMH consumer who is in a hospital or other institutional setting. Requires prior authorization from DMH.

Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – ACT is provided by a member of an MHRS Assertive Community Treatment (ACT) provider to a consumer who is enrolled in ACT services, and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer in preparation for discharge from the hospital or other institutional setting. Requires prior authorization from DMH.

Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI) – CBI is provided by a member of an MHRS Community Based Intervention (CBI) provider to a consumer who is enrolled in CBI services, and is in a hospital or other institutional setting to develop a mental health service plan for treating a consumer in preparation for discharge from the hospital or other institutional setting. Requires prior authorization from DMH.

Community Psychiatric Supportive Treatment Program – Rehab/Day Services (CPS-Rehab/Day) is a day treatment program provided in the community to consumers who are in a hospital or other institutional setting, and is designed to acclimate the consumer to community living. Requires prior authorization from DMH.

Mental Health Service – Continuity of Care Treatment Planning, Institution (MHS-CTPI)  
This code should be used for all continuity of care (non-discharge planning) services for consumers (including ACT and CBI consumers) in institutional settings.

Code	Service	Rate	Unit	Units Authorized
H0032HK	Mental Health Service – COC Treatment Planning, Institution (MHS-CTPI)	\$19.19	15 minutes	Up to 24 units within 180 days without prior authorization for COC
H0032	Mental Health Service – Discharge Treatment Planning, Institution (MHS-DTPI)	\$19.19	15 minutes	Based on medical necessity at time of authorization for discharge planning.
H0046HT	MHS-DTPI (ACT)	\$31.57	15 minutes	Based on medical necessity at time of authorization for discharge planning.
H0046HTHA	MHS-DTPI (CBI)	\$31.35	15 minutes	Based on medical necessity at time of authorization for discharge planning.
H0037	Community Psychiatric Supportive	\$144.77	Per Day, at least 3	Based on medical necessity at time of authorization only

	Treatment Program – Rehab/Day Services (CPS-Rehab/Day)		hours	within 60 days of discharge unless pursuant to court order.
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Flexible Spending Local Funds Program for Child Choice Providers. Providers who have contracts with DMH as Child Choice Providers are eligible to bill DMH up to the monthly ceiling that is provided in their contracts. These locally-funded services and supports are intended to augment the clinical services and increase the therapeutic benefit to consumers. Child Choice Providers will submit claims for flexible spending reimbursement through the eCura system under the billing code FLEXN. Eligibility for reimbursement for FLEXN-code services is determined solely by the contract between DMH and the Child Choice Provider and is subject to the availability of appropriated funds. The FLEXN code and rate are as follows:

SERVICE	CODE	RATE
Flexible Spending-Child Choice, Local Funds	FLEXN	\$0.01

**In addition, covered Medicaid services that are rendered to non-Medicaid eligible consumers enrolled in the MHRS program are covered by MHRS and authorized and paid by DMH Local Funds. Also see Section 7.2.2 and 7.2.5 for Consumer Medicaid Certification.**

## 2.6 Inquiries

More detailed information regarding the MHRS program, its policies and regulations is available at the DMH website at [www.dmh.dc.gov](http://www.dmh.dc.gov) or by contacting the DMH Office of Provider Relations at 202-671-3155.

## 3.0 GLOSSARY

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The following terms are used throughout this manual:

<b>3.0 GLOSSARY</b>	
ANSI	The American National Standards Institute
Approved	A term that describes a claim that will be, or has been, paid.
Authorization (or service authorization)	Service authorization is a process within the Division of Care Coordination whereby clinical staff (Care Coordinators) determine if the clinical justification meets the need for medical necessity for services that require prior authorization or re-authorization.
Automated Client Eligibility Determination System (ACEDS)	The combined eligibility determination system providing integrated automated support for several District of Columbia programs, including Medicaid.
Child Choice Provider	A MHRS CSA with demonstrated ability to provide quality, evidence-based, innovative services and interventions to meet the most complex and changing needs of children, youth, and their families in the District, particularly those who have histories of abuse or neglect, and has a contract with the Department to provide these services as a Child Choice Provider.
Claim	A request for reimbursement of services that have been rendered.
Claim Type	A classification of claim origin or type of service provided to a recipient.
Claim Status	The determined status of a claim; approved, denied or pended.
Clinical Home	The MHRS Provider that is responsible for coordinating the treatment plan and providing MHRS services for the consumer.
CMS	Centers for Medicaid and Medicare Services
CPT	Current Procedural Terminology code
Consumer	A person who is a recipient of MHRS services after enrollment into the Mental Health Rehabilitation Services (MHRS) Program.
Core Services Agency (CSA)	"Core Services Agency" or "CSA" - a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified

<b>3.0 GLOSSARY</b>	
	MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with specialty providers.
Covered Services	All services which providers enrolled in the DC Medicaid Program are either required to provide, or are required to arrange to have provided to eligible consumers.
DHCF	Department of Health Care Finance - is the District agency which administers the Medicaid program.
DCMMIS	District of Columbia Medicaid Management Information System.
District	The District of Columbia
DMH	Department of Mental Health
eCura	The enrollment, authorization and claims management system for the Department of Mental Health.
eCura ID	Department of Mental Health consumer enrollment ID number for MHRS.
EDI	Electronic Data Interchange
Enrollment	The initial process by which new enrollees apply for DMH services.
ESA (formally known as Income Maintenance Administration)	Economic Security Administration – the unit within the D.C. Department of Human Services that determines eligibility for medical assistance programs for District residents.
Exception Claims	During the front-end import, the DMH claims process rejects claims that are missing key data elements, or have formatting that is not consistent with HIPAA 837. These rejected claims are returned to the billing provider as Exception claims.
FLEXN-code Services	Non-Medicaid services and supports provided by a Child Choice Provider pursuant to a contract with the Department that are intended to augment and thereby increase the therapeutic benefit of clinical services provided to the consumers.
HMO	Health Maintenance Organization
ICD-CM	International Classification of Diseases – Clinical



<b>3.0 GLOSSARY</b>	
	Modification
Individualized Plan of Care (IPC)	The individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment, as described in Title 22 DCMR Chapter A34. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving qualified practitioner.
Individualized Recovery Plan (IRP)	The individualized recovery plan for adult consumers, which is the result of the Diagnostic/Assessment, as described in Title 22 DCMR Chapter A34. The IRP is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving qualified practitioner.
Medicaid	The District of Columbia Medical Assistance Program provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.
Medically Necessary	Those services contained in an approved IRP/IPC reasonably calculated to prevent the worsening of, alleviate, correct, cure, or ameliorate an identified mental health condition that endangers life, causes suffering or pain, causes physical deformity or bodily malfunction, threatens to cause or aggravate a disability, or results in an illness or infirmity. For children through age twenty (20), services reasonably calculated to promote the development or maintenance of age-appropriate functioning are also considered medically necessary.
MHRS Provider (also referred to as provider in this document)	An organization certified by DMH to provide MHRS services. MHRS Provider includes CSAs, sub-providers, and specialty providers.
Parent	A child's natural or adoptive parent or legal guardian.
Prior Authorization	The approval of a service before it is provided.
ProviderConnect	An application that allows an organization's providers to access information from eCura, and perform certain functions, depending on the security access an organization grants to its providers.
Qualified Practitioner	(i) a psychiatrist; (ii) a psychologist; (iii) a licensed independent clinical social worker; (iv) an advance practice registered nurse; (v) a registered nurse; (vi) a licensed professional counselor; (vii) a licensed independent social

<b>3.0 GLOSSARY</b>	
	worker; and (viii) an addiction counselor.
RA	Remittance Advice. A document, or electronic file, sent to providers to report the status of submitted claims – paid, denied and pended. The DMH electronic RA is also known as an 835.
Rejected	A term that describes a claim that has not met processing requirements.
Service Area	The area within the city limits of the District of Columbia.
Specialty Provider	A community-based MHRS provider certified by DMH to provide specialty services either directly or through contract.
State Plan Amendment (SPA)	The District's plan of mental health rehabilitative services which describes the eligibility criteria, covered services, payment methodology and/or rates and any limitations approved by the Center for Medicare and Medicaid Services for coverage under the District of Columbia's Medicaid Program.
TCN	The unique transaction control number that is assigned by DHCF to each claim for identification.
Void	A claim which has been paid and is later refunded because the original reimbursement was made erroneously.
Waiver	A situation where CMS allows the District to provide services that are outside the scope of the approved State Plan services, in non-traditional settings, and/or to consumers not generally covered by Medicaid.
837P	The HIPAA format for billing outpatient electronic claims is 837P (professional)

## **4.0 PROVIDER PARTICIPATION INFORMATION**

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This section of the manual provides information regarding enrollment and certification of providers to participate in the MHRS Program.

### **4.1 Provider Eligibility Requirements**

Providers shall meet the DMH certification requirements as outlined in Title 22 DCMR Chapter A34, Mental Health Rehabilitation Services Provider Certification Standards, in order to be considered for participation in the MHRS Program.

### **4.2 Participating Provider**

In order to participate in the MHRS Program, providers must be certified by DMH and adhere to the guidelines established by DMH and outlined in the MHRS Provider Certification Standards and their individual Human Care Agreements. At a minimum, certified providers must adhere to the following requirements:

- All conditions specified in the Human Care Agreement, signed by the provider and DMH;
- All policies and procedures established by DHCF in regard to practice and procedures and in compliance with Title XIX;
- All required DMH policies and procedures;
- Notification to DMH of any change in the information supplied to enroll in the program, i.e., address, affiliations, additional licenses acquired, etc.;
- Assurance of freedom of choice to all consumers of mental health rehabilitation services; and
- All applicable federal and District laws and regulations.

Failure to comply with requirements may lead to a Corrective Action Plan, Notice to Cure, fines, penalties, or other actions in accordance with District and federal laws and regulations.

## **5.0 REGULATIONS**

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The laws and regulations that govern the DC Medicaid Program are contained in 42 CFR Sections 401 *et seq.* and Title XIX of the Social Security Act, 42 U.S.C. Section 1396, (*et seq.*) and authorized by enabling legislation P.I. 90-227, 12/27/67. DMH is the District's agency responsible for administering payment for the MHRS Program for the Department of Health Care Finance (DHCF). DHCF is the District agency that administers the Medicaid Program.

An overview of the regulations governing provider activities follows. This overview is to be helpful, but does not substitute for the provider's own responsibility to know and comply with all applicable laws and regulations, etc.

### **5.1 Consumer Freedom of Choice of Providers**

A consumer may obtain services from any certified MHRS Provider that has a Human Care Agreement with DMH to provide specified services.

The agency assigned as the consumer's clinical home is responsible for coordinating treatment and obtaining authorization for services provided to the consumer.

### **5.2 Discrimination**

Federal and District of Columbia regulations require that all programs receiving federal and local assistance comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of The Rehabilitation Act of 1973 and the regulation at 45 CFR Parts 80 and 84. DMH ensures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or handicap.

### **5.3 Interrelationship of Providers**

Providers are prohibited from referring or soliciting consumers directly or indirectly to other providers for financial consideration. Providers are also prohibited from soliciting, receiving or offering kickbacks; payments, gifts, bribes, or rebates for purchasing; leasing, ordering, arranging for or recommending purchasing or leasing; ordering for goods, facilities, or items for which payment is made through the DC Medicaid Program. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services such as laboratory and X-ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner, as allowed by federal law and regulations.

## **5.4 Record Keeping**

Providers shall retain for a minimum of six (6) years (unless otherwise specified), medical and fiscal records that fully disclose the nature and extent of the services rendered to consumers. These records must meet all of the criteria established. Providers shall make such records readily available for review and copying by District and federal officials or their duly authorized agents. The term “readily available” means that the records must be made available at the provider’s place of business. If it is impractical to review records at the provider’s place of business, upon written request, the provider must forward without charge, the original records or facsimiles.

### **5.4.1 Medical Records**

Providers who have examined, diagnosed, and treated a consumer, shall maintain individual consumer records in accordance with 22 DCMR § A3410.16, MHRS Provider Certification Standards on clinical record documentation.

### **5.4.2 Fiscal Records**

Providers shall retain for a minimum of six (6) years, all fiscal records relating to services rendered to DC MHRS consumers. This may include, but is not necessarily limited to, the pricing system used for services rendered to consumers who are Medicaid eligible, and payments made by third-party payors.

### **5.4.3 Disclosure of Information**

Title XIX is part of the Federal Social Security Act. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulation of the Department of Health and Human Services or upon the express authorization of the Secretary of Health and Human Services.

A provider may only disclose records or information acquired under the DC MHRS Program in accordance with the DMH Privacy Manual and Procedures; Health Insurance Portability and Accountability Act (HIPAA) (45 CFR 164.512 and Public Law 104-191); and the Mental Health Information Act (MHIA) (DC Code 7-1201.01 et seq.).

### **5.4.4. Penalties for Non-Compliance**

Among other possible penalties, DMH may terminate agreements with providers who fail to maintain and provide medical and fiscal records. Providers may also be subject to

recoupment of payments, decertification as a DMH provider or District Medicaid provider, and federal and District civil and criminal prosecution.

## **6.0 ADMINISTRATIVE ACTION FOR FAILED CLAIMS**

### **6.1 Restitution**

The DMH Office of Accountability will audit claims and recoup funds for failed claims as necessary in accordance with DMH Policy 911.1C, Claims Audits.

DMH policies are available via the internet on the DMH website. To access the DMH policy on Claims Audits, type the following address in the browser box of a computer:  
[www.dmh.dc.gov](http://www.dmh.dc.gov)

1. Click on "Policies, Procedures and Rules" located under "About DMH"
2. Select DMH Policies
3. Select 911.1C, Claims Audits.

### **6.2 Notice of Infractions and Fines**

The DMH Office of Accountability may issue Notice of Infractions and corresponding fines for failed claims per 16 DCMR § 3502.

## **7.0 CONSUMER ELIGIBILITY**

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This subsection provides an overview of consumer eligibility in the Medicaid funded MHRS Program and locally funded MHRS (MHRS not reimbursed through Medicaid).

### **7.1 Eligibility Determination**

The Bureau of Eligibility Determination, Economic Security Administration (ESA), determines recipient eligibility for all publicly funded programs. The Medicaid eligibility records are shared with the Department of Health Care Finance (DHCF), and DMH uploads eligibility updates for the MHRS consumer population from DHCF.

### **7.2 Eligibility**

**7.2.1 Consumers eligible for Medicaid-funded MHRS** must meet the following requirements:

- (a) Be enrolled in Medicaid, or be eligible for enrollment and have an application pending;
- (b) Be a bona fide resident of the District, as defined in D.C. Official Code § 7-1131.02(29) (2008 Repl.);
- (c) Be a child or youth with mental health problems, as defined in D.C. Official Code § 7-1131.02(1), or an adult with mental illness as defined in D.C. Official Code § 7-1131.02(24); and
- (d) Be certified as requiring MHRS by a qualified practitioner.

Eligible consumers of MHRS shall have a primary diagnosis on either Axis I or II of the current edition of the DSM.

Persons with a primary substance abuse diagnosis only are not eligible consumers of MHRS.

**7.2.2 Consumers eligible for locally-funded MHRS** are those individuals who have been assigned a non reimbursable Medicaid program code from ESA. These individuals are not eligible for Medicaid funded MHRS or are not enrolled in any other third-party insurance program except the D.C. HealthCare Alliance, and who meet the following requirements:



- (a) Be a bona fide resident of the District, as defined in D.C. Official Code § 7-1131.02(29);
- (b) Be a child or youth with mental health problems, as defined in D.C. Official Code § 7-1131.02(1), or an adult with mental illness as defined in D.C. Official Code § 7-1131.02(24);
- (c) Be certified as requiring MHRS by a qualified practitioner; and
- (d) For individuals nineteen (19) years of age and older, live in households with a countable income of less than two hundred percent (200%) of the federal poverty level, and for individuals under nineteen (19) years of age, live in households with a countable income of less than three hundred percent (300%) of the federal poverty level.

**7.2.3 Consumers eligible for Medicare** remain eligible for the following locally-funded MHRS only to the extent these services are not otherwise covered by Medicare:

- (a) Community Support, and
- (b) Specialized services in 3414.3 of the MHRS Provider Certification Standards.

**7.2.4 Providers shall not bill Medicaid or DMH for MHRS provided to any consumer that does not meet the eligibility requirements set forth above.**

**7.2.5 For new enrollees and those enrollees whose Medicaid certification has lapsed**, there is an eligibility grace period of 90 days from the date of first service for new enrollees, or from the date of eligibility expiration for enrollees who have a lapse in coverage, until the date the Economic Security Administration (ESA) makes an eligibility or recertification determination. In the event the consumer appeals a denial of eligibility or recertification by the ESA, the Director may extend the 90 day eligibility grace period until the appeal has been exhausted.

The 90 day eligibility grace period may also be extended at the discretion of the Director for other good cause shown. Upon expiration of the eligibility grace period, MHRS services provided to the consumer are no longer reimbursable by DMH. Nothing in this section alters DMH's timely-filing requirements for claim submissions.

## **8.0 SERVICE AUTHORIZATION**

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### **8.1 Introduction and Care Coordination/Service Authorization Overview**

The Department of Mental Health (DMH) reimburses Mental Health Rehabilitation Service (MHRS) claims for the provision of medically necessary services to eligible consumers.

This manual details the prior authorization and re-authorization processes of MHRS for DMH. The Division of Care Coordination is responsible for the prior authorization/re-authorization process.

#### **8.1.1 Eligible Consumers**

Eligible consumers of MHRS include District of Columbia children and youth with mental health problems and adults with mental illness as described in the District of Columbia Department of Mental Health Establishment Act of 2001 (D.C. ACT 14-101), and Section 7 of this Manual. A qualified practitioner must certify the consumer as requiring *MHRS*. Eligible consumers must have a primary mental health diagnosis on either Axis I or II of the current edition of the DSM. Persons with a primary substance abuse diagnosis only are not eligible consumers of MHRS.

#### **8.1.2 Prior Authorization and Re-authorization of MHRS**

All MHRS require an authorization number for claims submission.

Most MHRS do not require clinical review by DMH prior to approval of the authorization request. However, if the request is submitted more than thirty (30) days after the date of service, the request will be denied for untimely submission.

When clinical prior authorization or re-authorization is required, the Division of Care Coordination determines if the clinical justification meets the need for medical necessity based upon information submitted electronically by the MHRS provider. As part of the service authorization process, DMH may request and review the consumer's Individualized Recovery Plan/Individualized Plan of Care (IRP/IPC) or other clinical material in order to evaluate the consumer's level of care needs.

It is the responsibility of the MHRS provider to request authorization for MHRS services that require prior authorization or re-authorization from DMH. **The CSA/Specialty Provider shall:**

- a. On or before the delivery of any service for which prior or re-authorization is required, create an electronic authorization request in ProviderConnect by selecting the appropriate service line with the correct Authorization Event Screen.
- b. Be responsible for ensuring the correct data entry of the electronic request, to include thoroughness of written clinical information.

### **8.1.3 Care Coordination**

Care Coordination is a set of functions within DMH performed by the Division of Care Coordination, Access Helpline (AHL). Care Coordinators are clinical staff responsible for facilitating enrollees' access to care and ensuring that authorization requests are reviewed daily. For most services, authorization requests process automatically. Some services require submission of specific clinical information for consideration by a Care Coordinator before the authorization request is processed. Also see Section 8.2.0 below on prior authorization or reauthorization.

### **8.1.4 Service Authorization**

Service authorization is a process within the Division of Care Coordination whereby clinical staff (Care Coordinators) determine if the clinical justification meets the need for medical necessity for services that require prior authorization or re-authorization. Prior authorizations/re-authorizations require electronic and sometimes "hard copy" submission of specific clinical information in order to be processed. All prior authorizations/re-authorizations are processed routinely by Care Coordinators or designated staff within the Office of Programs and Policy. Some decisions require more in-depth review by the Care Coordinators.

### **8.1.5 Key Care Coordination Contacts**

The following **QUICK REFERENCE GUIDE** identifies the Division of Care Coordination key points of contact for providers:

<b>DIVISION OF CARE COORDINATION</b>	<b>PHONE</b>
Director , Division of Care Coordination	(202) 671-3105
Clinical Supervisor	(202) 671-3066
General Information (Access Helpline)	1-888-7WE-HELP
Crisis Intervention, 24/7	1-888-7WE-HELP
Information and Referral (Access)	1-888-7WE-HELP
Service Authorization	(202) 671-3070
Eligibility and Enrollment	1-888-7WE-HELP

## **8.2.0 Prior Authorization or Re-authorization**

### **8.2.1 Services Requiring Prior Authorization**

Due to the intensity of certain levels of care, and the resulting increased need for continuity of care, some services require clinical review for justification of medical necessity and authorization prior to the service delivery. Services requiring medical necessity review and authorization prior to their delivery include:

- Assertive Community Treatment (ACT)
- Community Based Intervention (CBI)
- \*Residential Crisis Stabilization
- Intensive Day Treatment Service

### **8.2.2 Services Requiring Re-Authorization**

“Re-authorization” is required for services once a benefit level has been reached **OR** to continue providing a prior authorized service after an initial authorized period expires.

The following services fall in this category:

- a. ACT
- b. CBI
- c. \*Residential Crisis Stabilization
- d. Counseling (reauthorize once benefit level is reached)
- e. Diagnostic/Assessment (reauthorize once benefit level is reached)
- f. Intensive Day Treatment Service
- g. Rehabilitation Day Services (required after first 90 units)

\*Residential crisis stabilization is not a specific MHRS service; however, it is included in this manual because it is authorized by the Division of Care Coordination and is billed through eCura.

### 8.2.3 Prior Authorization and/or Re-authorization Table

<b>SERVICE</b>	<b>LIMITATIONS AND AUTHORIZATION REQUIREMENTS</b>
<b>ACT</b>	Prior authorization from DMH required for enrollment Re-authorization required for continued treatment beyond the initial prior authorized period.
<b>CBI</b>	Prior authorization from DMH required for enrollment Re-authorization required for continued treatment beyond the initial prior authorized period.
<b>Counseling</b>	One hundred and sixty (160) units per year Additional units allowable with re-authorization by DMH.
<b>Residential Crisis Stabilization</b>	Prior authorization for enrollment after initial 2 days, for a period of up to seven (7) days. Provision for reauthorization not to extend beyond seven (7) days as clinically indicated (for a maximum of 14 days total).
<b>Diagnostic/ Assessment</b>	One (1) unit every six (6) months (180 days). Additional units allowable if reauthorized by DMH for periodic assessment, pre-hospitalization screening, neuropsychological assessments, and readmission to Rehabilitation Day Services or Intensive Day Treatment, or prior to 2 <sup>nd</sup> unit within 6 calendar months if re-authorized by DMH.
<b>Intensive Day Treatment</b>	Prior authorization from DMH required for enrollment per DMH. Additional units allowable after seven (7) days or for the second and any additional episodes of care up to a maximum of 14 days within a twelve (12) month period with re-authorization by DMH.
<b>Rehabilitation Day Service</b>	Re-authorization required after first 90 units.

### 8.3.0 Processing Prior Authorizations/Re-authorizations

Service authorization requests submitted electronically via ProviderConnect are processed by eCura on a daily basis. Most services will process automatically. Service requests that cannot be processed automatically will pend for review by DMH Care Coordinators. These requests are reviewed daily.

Services may pend for several reasons. These include limitations set in the MHRS Provider Certification Standards, service combinations, documentation of medical necessity, and level of care protocols, which set clinical best practice guidelines for some services. Information on the status of authorizations is available in ProviderConnect under "Authorizations". Providers may review the status of their submitted Authorization Plans electronically. Further information is available by calling the Access HelpLine (AHL).

#### 8.3.1 Service Authorization Documentation Tables

**The following table lists the documentation required for review of services requiring prior authorization or re-authorization by the Division of Care Coordination:**

<b>Service</b>	<b>Care Coordination Review</b>	<b>Documentation Required for Review (in addition to Authorization Plan)</b>
<b>ACT</b>	Required prior to any unit of service being authorized.	Electronic submission of the correct Event Screen including a thorough and complete clinical presentation. LOCUS /CALOCUS screening score is required as required by DMH ACT Policy 340.6A.
<b>CBI</b>	Required prior to any unit of service being authorized.	Electronic submission of the correct Event Screen including a thorough and complete clinical presentation. LOCUS/CALOCUS screening score is required as required by DMH CBI Policy 340.9.
<b>Counseling</b>	Required prior to the 161 <sup>st</sup> unit of any type of Counseling	Electronic submission of the Counseling Event Screen including a thorough and complete clinical presentation. Faxed case notes or other "hard copy" documents upon request of the Division of Care Coordination.
<b>Residential Crisis Stabilization</b>	Required prior to unit of service being authorized after initial 2 days	Faxed psychiatrist's evaluation of consumer within twenty-four (24) hours of request. Faxed clinical presentation with antecedents and goals of treatment. LOCUS/CALOCUS score is required
<b>Diagnostic/Assessment</b>	Required prior to 2nd unit within six (6) calendar months	IRP/IPC and most recent diagnostic/assessment must be faxed to the Division of Care Coordination. The Authorization Plan must be submitted electronically through ProviderConnect.
<b>Intensive Day Treatment</b>	Required prior to enrollment per DMH and required prior to the 8 <sup>th</sup> day of service or for the 2nd and additional episodes of care up to a max of 14 days within 12 months.	Electronic submission of the Intensive Day Treatment Event screen including a thorough and complete clinical presentation. LOCUS/CALOCUS screening score is required. Faxed case notes or other "hard copy" documents upon request of the Division of Care Coordination.

Service	Care Coordination Review	Documentation Required for Review (in addition to Authorization Plan)
Rehabilitation Day Services	Required after first 90 units.	Electronic submission of complete clinical presentation, LOCUS/CALOCUS screening score, diagnostic assessment, and IRP to the Division of Care Coordination.

The following table describes the correct Event Screen to select for specific prior and re-authorization requests:

Service	Request Type	Event Screen to Use	Folder Location in ProviderConnect
ACT	Very first request	Initial ACT Authorization Event	Provider Folder
	Continued treatment after the first request	ACT Continued Stay Event	Care Coordination Folder
	Planning return to core services	ACT Discharge/Transfer Event	For use by DMH only
CBI	All Requests for CBI Level I, MST; Level II, IHCBS; Level III, IHCBS short-term; and Level IV, FFT	CBI Authorization Event	Provider Folder
Counseling	For any unit(s) past one-hundred sixty (160)	Counseling 161 <sup>st</sup> Unit Reauthorization Event	Care Coordination Folder
IDT	Prior to enrollment per DMH	Intensive Day Treatment Services Authorization Event	Care Coordination Folder
	For any unit(s) past seven (7) or any exposure to treatment beyond the initial seven (7) days		
Residential Crisis Stabilization	Requests up to 7 days.	Crisis Stabilization Services Reauthorization Event	Care Coordination Folder
	For any unit past 7 days up to maximum of 14 days.	Crisis Stabilization Services Reauthorization Event	Care Coordination Folder

Incomplete submission or lack of submission of required event screen(s) and/or documentation noted above will result in a denial of the request for authorization.

The Division of Care Coordination will notify providers via email of denials due to lack of appropriate documentation.

Providers will have three (3) business days from the date of notification to submit the needed documentation for reconsideration of the initial request.

See Section 8.9.0 for appeals of denials.



## 8.4.0 Insurance and Service Line Unit Settings

### 8.4.1 Insurance Definitions for Authorization

Services are authorized by and claimed against one (1) of three (3) insurance types in eCura as follows:

- a. DC DMHRS – DC DMHRS
- b. DC DMHRS – LocMed Supplemental
- c. Medicaid – Medicaid

#### **Definitions:**

- a. DC DMHRS – DC DMHRS is local dollar coverage for consumers who DO NOT have Medicaid.
- b. DC DMHRS – LocMed Supplemental is local dollar coverage for consumers who have Medicaid. It is used to pay for non-Medicaid reimbursable services.
- c. Medicaid – Medicaid is for consumers who have Medicaid. It is Medicaid dollars used to pay for DMH services that ARE paid by Medicaid.

### 8.4.2 Selecting the Correct Insurance

IF a consumer has Medicaid, all services should be authorized to Medicaid **EXCEPT** Residential Crisis Stabilization. For consumers who have Medicaid, Residential Crisis Stabilization is authorized to DC DMHRS-LocMed Supplemental.

IF a consumer has DC-DMHRS insurance all services are authorized to DC-DMHRS insurance.

In order for the process to work providers **must** confirm and select the correct insurance for the service being authorized. Failure to select the correct insurance will result in system generated denials.

### 8.4.3 Coordination of Benefits

If a consumer has private insurance, the claim is denied and returned to the CSA for submission to the consumer's private insurance.

### 8.4.4 Service Line Unit Settings

Services on authorization plans have two (2) important unit settings, one the provider can change, and the other providers cannot change.

a. Units for services on the authorization plan will “default” (meaning this is what the provider and Access Helpline (AHL) will see for units when opening a new service line) to the following:

Community Support	96 units per 180 days
Supported Employment	96 units per 180 days
CBI	500 units per 180 days
ACT	500 units per 180 days
Medication/Somatic	24 units per 180 days
Rehabilitation Day Services	90 units
Crisis Emergency	60 units per 180 days
Diagnostic/Assessment	1 unit per 180 days (6 months)
Brief Assessment	1 unit per 180 days
Counseling	40 units per 180 days
Team Meeting	8 units per 180 days
IDT	7 units

b. Providers can change the “default” units up to the maximum setting for a selected service to be approved by AHL. The maximum number of units that can be placed on a service line by a provider are indicated below.

Community Support	600 units per 180 days
Supported Employment	600 units per 180 days
CBI	500 units per 180 days
ACT	500 units per 180 days
Medication/Somatic	64 units per 180 days
Rehabilitation Day Services	90 units
Crisis Emergency	60 units per 180 days
Diagnostic/Assessment	2 units (evaluations) per 180 days
Brief Assessment	2 units per 180 days
Counseling	160 units per 180 days
Team Meeting	16 units per 180 days
IDT	7 units

IF a provider needs to request more units than the maximum for any given service, they will need to contact an AHL Care Coordinator to make the request. ONLY AHL can add units beyond the service maximum setting.

**See Section 8.8.0 below for procedural details on supplemental unit requests.**

## 8.5.0 LOCUS and CALOCUS

Per DMH Policy 300.1D, Level of Care Utilization System (LOCUS/CALOCUS) Evaluation, DMH requires the CSA (Core Service Agency) to complete a LOCUS (for adults) or CALOCUS (for child youth) evaluation for each consumer. The Division of Care Coordination uses the LOCUS or CALOCUS evaluation to assist in making level of care determinations for services requiring prior or re-authorization. Submission of the results of a web-based application LOCUS or CALOCUS evaluation is required.

DMH policies are available via the internet on the DMH website. To access the DMH policy on LOCUS/CALOCUS, type the following address in the browser box of a computer: [www.dmh.dc.gov](http://www.dmh.dc.gov)

1. Click on "Policies, Procedures and Rules" located under "About DMH"
2. Select DMH Policies
3. Select 300.1D, Level of Care Utilization System (LOCUS/CALOCUS) Evaluation policy.

To locate LOCUS/CALOCUS provider training information, please see the following link: <http://dmh1.dc.gov/node/216512>.

Documents you can obtain from this site include:

- ["Steps to Complete the LOCUS/CALOCUS" \[PDF\]](#) (also available as a PowerPoint presentation)
- [CALOCUS/LOCUS Training and User Account Request Form Instructions \[PDF\]](#)
- [CALOCUS/LOCUS Training Request Form \[PDF\]](#)
- [CALOCUS/LOCUS User Account Request Form \[PDF\]](#)
- [DMH Policy for LOCUS/CALOCUS \[PDF\]](#)
- [LOCUS/CALOCUS Electronic Report Descriptions \[PDF\]](#)
- [Applied Research and Evaluation \(ARE\) Unit LOCUS/CALOCUS Utilization and Reporting Plan \[DOC\]](#)

Questions about training should be directed to the DMH Training Institute: [dmh.training@dc.gov](mailto:dmh.training@dc.gov)

General questions about use of the LOCUS/CALOCUS should be directed to the Applied Research and Evaluation Unit: [ARE.DMH@dc.gov](mailto:ARE.DMH@dc.gov)

## 8.6.0 Prior Authorization and Re-Authorization Clinical Protocols

Requests for services requiring prior and/or re-authorization are reviewed by the Division of Care Coordination using specific clinical protocols to determine medical necessity. This sections details the clinical criteria that when met, substantiates medical necessity for that level of care.

### 8.6.1 Level of Care Authorization Protocol – Assertive Community Treatment (ACT)

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators to prior authorize/re-authorize ACT services requests:

ACT LEVEL OF CARE AUTHORIZATION PROTOCOL	
<b>Choice</b>	1) The individual and/or the individual's legal guardian are willing to accept and participate in intensive and assertive treatment team services, and/or 2) The individual is unwilling or unable to accept and participate in the services offered by the team, but meets all other criteria.
<b>Diagnosis</b>	Serious Mental Illness (SMI), with diagnostic criteria for Axis I or II psychiatric disorder as defined in the current DSM criteria and intractable, persistent or recurrent severe major symptoms that interfere with the consumer's ability to function in two or more life domains and the consumer is experiencing disengagement and decreased stability. Exclusions: Individuals with a primary substance abuse or mental retardation/dementia diagnosis, brain trauma, neurological impairment, or who are severely medically compromised. The DMH Chief Clinical Officer may approve individuals otherwise excluded when the DMH referring physician deems the service medically necessary.
<b>History</b>	1) Recent history of multiple admissions to a psychiatric or substance abuse inpatient treatment facility related to the diagnosed disorder in the last twelve (12) months; and 2) The individual is homeless or is at imminent risk of becoming homeless or does not have adequate family/care giver/significant other support and therefore is in need of activities of daily living support in order to remain stable at a less intensive level of care; or 3) The individual is residing in an inpatient bed or a supervised community residence but clinically assessed to be able to live in more independent living if intensive services are provided or to prevent admission to a more intensive level of care.
<b>Service Need Indicators</b>	1) The individual is at high risk or has a recent history of reoccurring use of facility-based crisis services, emergency room or criminal justice involvement related to the diagnosed disorder(s) in the last twelve (12) months; and 2) The individual has a documented inability to sustain involvement with or remain engaged in or respond to traditional office-based services and there is evidence that a comprehensive integrated program of psychiatric, case management, psychosocial, vocational, and rehabilitation/habilitation services are needed to support improved functioning to remain stable in a less intensive level of care.
<b>Functioning</b>	A functional assessment is required to determine the level of care for each consumer. Use the LOCUS evaluation to support the level of care determination.
<b>Risk/Support Factors</b>	High risk with few supports, substance abuse and/or medical support needed.

### 8.6.2 Level of Care Authorization Protocol – Community Based Intervention (CBI)

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in the prior authorization and re-authorization for CBI:

CBI LEVEL OF CARE AUTHORIZATION PROTOCOL– 6 month maximum authorization period	
<b>Choice</b>	1) The individual and/or the individual's legal guardian are willing to accept and participate in intensive and assertive treatment team services.
<b>Diagnosis</b>	Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), with diagnostic criteria for Axis I or II psychiatric disorder as defined in the current DSM criteria and intractable, persistent or recurrent severe major symptoms that interfere with the consumer's ability to function in two or more life domains and the consumer is experiencing disengagement and decreased stability that places them at high risk of out-of-home placement.
<b>History</b>	1) History of unsuccessful involvement in other services, with recent unsuccessful history within the last twelve (12) months; and 2) The individual is at risk of out-of-home placement and does not have adequate family/care giver/significant other support and therefore is in need of activities of daily living support in order to remain stable at a less intensive level of care; or 3) The individual is residing in an inpatient bed or a supervised community residence but clinically assessed to be able to live in more independent living if intensive services are provided; or 4) The individual needs intensive services to prevent admission to a more intensive level of care.
<b>Service Need Indicators</b>	1) A clear, current threat to the individual's ability to remain in their home, placing them at risk or meeting the criteria for a higher level of care, e.g., inpatient or supervised residential care. The individual is out of their home presently or their family is unable to maintain them in the home with current supports; and 2) A clear, current threat to the individual's ability to be employed or attend school; and 3) Evidence of emerging/impending risk to the safety or property of the individual or of others.
<b>Functioning</b>	A functional assessment is required to determine the level of care for each consumer. Use the LOCUS/CALOCUS evaluation to support the level of care determination.
<b>Risk/Support Factors</b>	Moderate risk with some supports. Needed medical supports are in place.

## CBI LEVEL OF CARE AUTHORIZATION PROTOCOL– 6 month maximum authorization period

<p><b>Level Distinctions</b></p>	<p><b>CBI Level I</b> - A documented behavioral concern with externalizing (aggressive or violent) behaviors; a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system, have a permanent caregiver who is willing to participate with service providers for the duration of CBI Level I treatment. <b>Exclusions:</b> Child/youth is <b>not eligible</b> for CBI services if at least one of the following applies: C/Youth does not have a primary Axis I or II mental health diagnosis; in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; in full-service group home; is in need of crisis psychiatric hospitalization or stabilization; has moderate/severe/profound mental retardation or any moderate/ severe/profound disorder on the autism spectrum; substance abuse or sex offending behavior is the <b>primary</b> reason for referral; in an emergency or respite placement/ independent living or not returning to their biological home or long term placement within 30 days of referral; or is actively suicidal, homicidal, or psychotic w/o medication stabilization. The DMH Chief Clinical Officer may approve individuals otherwise excluded when the DMH referring physician deems the service medically necessary.</p> <p><b>CBI Level II</b> - Have any one or combination of the following: A history of involvement with the Child and Family Services Agency (CFSA), Court Social Services (CSS), or the Department of Youth Rehabilitation Services (DYRS); a history of negative involvement with schools for behavioral-related issues; or a history of either chronic or recurrent episodes of negative behavior that have or may result in out-of-home placement. <b>Exclusions:</b> Child/youth is <b>not eligible</b> for CBI services if at least one of the following applies: C/Youth does not have a primary Axis I or II mental health diagnosis; in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; in full-service group home; is in need of crisis psychiatric hospitalization or stabilization; has moderate/severe/ profound mental retardation or any moderate/ severe/profound disorder on the autism spectrum; substance abuse or sex offending behavior is the <b>primary</b> reason for referral; or is actively suicidal, homicidal, or psychotic w/o medication stabilization. The DMH Chief Clinical Officer may approve individuals otherwise excluded when the DMH referring physician deems the service medically necessary.</p> <p><b>CBI Level III</b> - Has situational behavioral problems that require short-term, intensive treatment. Is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills. Recently experienced out of home placement and requires development of communication and coping skills to manage the placement change. Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition. Has recently been discharged from an inpatient setting; i.e., acute hospitalization or psychiatric residential treatment facility. Is an adult parent or caregiver with a clinically significant mental health concern and the parent or caregiver will be parenting a child or youth returning from a residential</p>
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## CBI LEVEL OF CARE AUTHORIZATION PROTOCOL– 6 month maximum authorization period

<p><b>Level Distinctions (continued)</b></p>	<p>treatment center within the next ninety (90) days. <b>Exclusions:</b> Child/youth is <u>not eligible</u> for CBI services if at least one of the following applies: C/Youth does not have a primary Axis I or II mental health diagnosis; in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; in full-service group home; is in need of crisis psychiatric hospitalization or stabilization; has moderate/ severe/ profound mental retardation or any moderate/severe/profound disorder on the autism spectrum; substance abuse or sex offending behavior is the <u>primary</u> reason for referral; or is actively suicidal, homicidal, or psychotic w/o medication stabilization. The DMH Chief Clinical Officer may approve individuals otherwise excluded when the DMH referring physician deems the service medically necessary.</p> <p><b>CBI Level IV</b> – have a documented history of moderate to serious behavioral problems which impair functioning in at least one area (such as school or home); exhibit significant externalizing behavior which impairs functioning in at least one area (such as school or home); or be a risk of a disruption in placement; and be willing to participate with service providers for the duration of CBI Level IV treatment services; and or involved with a caregiver who is willing to participate with service providers for the duration of CBI Level IV treatment services <b>Exclusions:</b> Child/youth is <u>not eligible</u> for CBI services if at least one of the following applies: C/Youth does not have a primary Axis I or II mental health diagnosis; in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; in full-service group home; in need of crisis psychiatric hospitalization or stabilization; has moderate/severe/ profound mental retardation or any moderate/ severe/ profound disorder on the autism spectrum; substance abuse or sex offending behavior is the <u>primary</u> reason for referral; in an emergency or respite placement/ independent living or not returning to their biological home or long term placement within 30 days of referral; or is actively suicidal, homicidal, or psychotic w/o medication stabilization. The DMH Chief Clinical Officer may approve individuals otherwise excluded when the DMH referring physician deems the service medically necessary.</p>
<p><b>Concurrent Review for CBI</b></p>	<p>CBI is designed to be a time-limited service, NTE 180 days. If a consumer needs CBI beyond the maximum 6 month authorization period, the provider must contact AHL to provide additional clinical information to support the request.</p> <p>The AHL Care Coordinator will submit information provided to the Associate Chief Clinical Officer for determination.</p>

### 8.6.3 Level of Care Authorization Protocol – Intensive Day Treatment (IDT)

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in prior authorizing and re-authorizing IDT:

IDT LEVEL OF CARE AUTHORIZATION PROTOCOL	
<b>Choice</b>	<p>1) The individual and/or the individual's legal guardian are willing to accept and participate in intensive and assertive treatment team services, and/or</p> <p>2) The individual is unwilling or unable to accept and participate in the services offered by the team, but meets all other criteria and is under outpatient commitment.</p>
<b>Diagnosis</b>	Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), with diagnostic criteria for Axis I or II psychiatric disorder as defined in the current DSM criteria and intractable, persistent or recurrent severe major symptoms that interfere with the consumer's ability to function in two or more life domains and the consumer is experiencing disengagement and decreased stability.
<b>History</b>	<p>1) Present evidence that the individual would be at risk to self or others if he were not in an Intensive Day Treatment program; or</p> <p>2) There is an inability to adequately care for one's physical needs, representing potential serious harm to self; and</p> <p>3) The individual can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or</p> <p>4) The individual can contract to control his or her behavior and/or is receiving professional assistance or other support when not in the partial hospital setting.</p>
<b>Service Need Indicators</b>	<p>1) Some supports, either professional and/or social supports are identified and available outside of program hours, and</p> <p>2) Symptoms or functioning require a structured program with intervention and/or treatment for a minimum of five (5) hours per day, and</p> <p>3) The IRP includes specific treatment goals of this service to improve symptoms and level of functioning enough to return the consumer to a lesser level of care, and</p> <p>4) A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in admission with timely evaluations of post-Intensive Day Treatment needs.</p>
<b>Functioning</b>	A functional assessment is required to determine the level of care for each consumer. Use the LOCUS/CALOCUS evaluation to support the level of care determination.
<b>Risk/Support Factors</b>	High risks with some supports. Supports are in place outside of IDT hours.



#### 8.6.4 Level of Care Authorization Protocol - Rehabilitation/Day Services

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in authorizing Rehabilitation/Day Services after first 90 units:

REHABILITATION SERVICES (DAY SERVICES) LEVEL OF CARE AUTHORIZATION PROTOCOL	
<b>Choice</b>	1) The individual and/or the individual's legal guardian are willing to accept and participate in intensive and assertive treatment team services, and/or 2) The individual is unwilling or unable to accept and participate in the services offered by the team, but meets all other criteria and is under outpatient commitment.
<b>Diagnosis</b>	Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), with diagnostic criteria for Axis I or II psychiatric disorder as defined in the current DSM criteria and intractable, persistent or recurrent severe major symptoms that interfere with the consumer's ability to function in three (3) or more life domains, and the consumer is experiencing disengagement and decreased stability.
<b>History</b>	1) Present evidence that the individual is presently not operating at his or her optimal level (baseline), and/or 2) There is an inability to adequately care for one's physical needs or symptoms or loss of support that could result in a more restricted level of care, and/or 3) The individual can reasonably be expected to evidence improvement in recovery rehabilitation services that would result in his or her functioning in a less restrictive environment, and/or 4) The individual cannot be sustained at his or her present level of functioning without the facility-based, structured, clinical program of rehabilitation services.
<b>Service Need Indicators</b>	1) The consumer needs development of independent living and social skills, including the ability to make decisions regarding self care, management of illness, life work, and community participation; and/or 2) Symptoms or functioning require a structured program with intervention and/or treatment for a minimum of three (3) hours per day; and 3) The IRP includes specific treatment goals of this service to improve symptoms and level of functioning enough to return the consumer to a lesser level of care, and/or a higher level of recovery, and must include clinical documentation to support medical necessity; and/or 4) The consumer is in need of resource development to integrate him or her into the community; and/or 5) The consumer is in need of education on self-management of symptoms, medications and side effects, the identification of rehabilitation preferences, the setting of rehabilitation goals, and skill teaching and development.
<b>Functioning</b>	A functional assessment is required to determine the level of care for each consumer. Use the LOCUS/CALOCUS evaluation to support the level of care determination.
<b>Risk/Support Factors</b>	Moderate risks with some supports.

### 8.6.5 Level of Care Authorization Protocol - Diagnostic/Assessments

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in re-authorizing Diagnostic/Assessments:

DIAGNOSTIC/ASSESSMENT LEVEL OF CARE AUTHORIZATION PROTOCOL (re-authorization after 1 unit per 6 months)	
<b>Choice</b>	1) The individual and or the individual's legal guardian are willing to accept and participate in a diagnostic/assessment, and or 2) the individual is unwilling to accept and participate in the service offered by the team, but meets criteria for a diagnostic/assessment and is under an outpatient commitment or court order.
<b>Diagnosis</b>	Evidence of a Serious Mental Illness (SMI) or Seriously Emotional Disturbed (SED), with diagnostic criteria for Axis I or Axis II psychiatric disorder as defined in the current DSM.
<b>History</b>	Multiple CSA Changes Multiple Placements Multiple Hospitalizations Change in functioning that has impacted level of treatment Crisis Situation Level of Care evaluation
<b>Service Need Indicators</b>	The individual is a high risk or has recent history of reoccurring use of crisis services, emergency room contacts, or criminal justice involvement related to a diagnosed disorder, or exacerbation to a disorder in the last twelve (12) months, and the individual has a documented inability to sustain involvement with or remain engaged in treatment.
<b>Functioning</b>	Evidence of instability, changes, exacerbation of illness, or lack of progress towards recovery.
<b>Risk/Support Factors</b>	High risk with few supports.

### 8.6.6 Level of Care Authorization Protocol - Counseling

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in re-authorizing Counseling:

COUNSELING UNITS LEVEL OF CARE AUTHORIZATION PROTOCOL	
<b>Choice</b>	The individual and or the individual's legal guardian are willing to accept and participate in additional counseling units; or the individual is unwilling to accept and participate in the service offered by the team, but meets all criteria and is under an outpatient commitment or court order to participate.
<b>Diagnosis</b>	Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), with diagnostic criteria for Axis I or Axis II psychiatric disorder as defined in the current DSM.
<b>History</b>	The individual has been participating in counseling, has exhausted the initial time-line benefit, and continues to need counseling to obtain recovery.
<b>Service Need Indicators</b>	The service involves a standard set appointment, and should identify if the service is rendered for an individual, group, or family. This service is a face-to-face service and clear goals need to be identified that are specific to counseling.
<b>Functioning</b>	Able to tolerate counseling sessions.
<b>Risk/Support Factors</b>	Moderate risk with some supports.

### 8.6.7 Level of Care Authorization Protocol – Residential Crisis Stabilization

The following table contains the Level of Care Authorization Protocol that is used by Care Coordinators in prior authorizing and re-authorizing Residential Crisis Stabilization:

RESIDENTIAL CRISIS STABILIZATION LEVEL OF CARE AUTHORIZATION PROTOCOL	
<b>Choice</b>	The individual and/or the individual's legal guardian are willing to accept and participate in intensive and assertive treatment team services.
<b>Diagnosis</b>	Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED), with diagnostic criteria for Axis I or II psychiatric disorder as defined in the current DSM criteria and intractable persistent or recurrent severe major symptoms that interfere with the consumer's ability to function in two or more life domains and the consumer is experiencing disengagement and decreased stability (persons with a primary substance abuse diagnosis only are not eligible).
<b>History</b>	1) Consumer has been evaluated and assessed by a psychiatrist, and requires immediate twenty-four (24) hour supervision in other than the consumer's own residence (if the consumer has one). 2) Consumer may be actively suicidal or homicidal but able to contract for safety.
<b>Service Need Indicators</b>	1) The consumer is experiencing a psychiatric emergency that does not necessitate an inpatient admission to a hospital; and 2) The individual does not require extended observation, but is not able to be treated in a less restrictive environment; and 3) After initial 2 days, prior authorization must be obtained through the DMH Access Helpline for service for a total period of up to seven (7) days (which includes the initial 2 days); and 4) There will be a provision for reauthorization that should not extend beyond 7 days if clinically indicated (for a total of 14 days). 5) Community support staff/case managers are required to visit the consumer within twenty-four (24) hours (this includes weekends and holidays). 6) Discharge Planning begins upon admission into the crisis stabilization bed. 7) Outcomes to be achieved by needing this level of care are clearly defined and identified in consumer's IRP/IPC.
<b>Functioning</b>	A functional assessment is required to determine the level of care for each consumer. Use the LOCUS/CALOCUS evaluation to support the level of care determination.
<b>Risk/Support Factors</b>	High risk with few supports, substance abuse and/or medical support needed.

## 8.7.0 Service Request Dispositions

Services on an authorization plan are approved, denied, or pended independently of one another. The authorization plan number is used to submit claims for any approved service on the authorization plan.

If the authorization plan has a number, but a service on the plan is denied, the provider will not be able to claim for the denied service irrespective of the authorization plan number. Both an authorization plan number and an approved service line on the authorization plan are required for successful claims submission.

### 8.7.1 Approved Services

Claims for services that are approved on the authorization plan can be forwarded to DMH for processing. Providers can review the status of approved service authorization requests in ProviderConnect.

### 8.7.2 Pended Services

Service requests that fail the automatic review in eCura may pend for review by DMH Care Coordinators. Pended requests are reviewed daily. Authorization requests may be pended for several reasons. These include limitations set in the **MHRS** Standards, service combinations, documentation of medical necessity, and level of care protocols, which set clinical best practice guidelines for some services. Information on the status of authorizations is available in ProviderConnect under "Authorizations". Providers may review the status of their submitted authorization plans electronically. Further information is available by calling the Access HelpLine.

In cases of pended authorizations, a DMH Care Coordinator will:

- a. Conduct a telephone review within two (2) business days with the requesting clinician/qualified practitioner.
- b. Request the provider to forward additional required clinical information to DMH within three (3) business days to facilitate processing.
- c. Deny the request five (5) business days after requesting additional information if additional information is not submitted.

### 8.7.3 Denied Services

Service requests may be denied for the following reasons:

- a. **Administrative Denials:** Determined by the Division of Care Coordination.
  - Ineligible diagnosis/consumer
  - Non-compliance with authorization requirements

- Incomplete documentation to support the request
- Untimely submission of the request
- Failure to submit requested documentation within three (3) business days

**b. Clinical Denials:** Determined by the Division of Care Coordination.

- Lack of clinical justification

**c. eCura System Denials:** Determined by the eCura system.

- Invalid Rate Profile for a Provider
- Expired Insurance (and other insurance related denial reasons)
- Multiple Open Treatments
- Overlapping Authorizations
- Units exceeds provider's agreement limit.

**To decrease eCura System denials the provider must only enter one authorization plan for any specific date span. Any errors that are created on that plan need to be remedied since adding another plan will create more errors.**

In cases where the request for authorization was denied because the authorization request was not within thirty (30) business days of service, the provider shall forward the appeal request in writing to the Director, Division of Care Coordination. The appeal request shall include the consumer's complete name, the eCura number, and the date of the request.

#### **8.7.4 Adverse Determination**

An adverse determination at Level I occurs when the AHL Clinical Supervisor determines that the clinical documentation supporting the requested service does not meet medical necessity criteria. If the provider disagrees with the decision, the Level II appeal process outlined in section 8.9.2 may be initiated within twenty-four (24) hours of notification of this denial type.

#### **8.7.5 Untimely Submission Denials**

All administrative service authorization denials for untimely submission shall be forwarded to the Director of Care Coordination by email. The Director of Care Coordination shall forward all authorization requests post thirty (30) days to the Deputy Director, Office of Programs and Policy, for disposition.

## **8.8.0 Supplemental Units Requests**

Consumers may need more units than the authorization plan's maximum settings. Providers can request supplemental units for ACT, CBI, Community Support, Medication/Somatic, Diagnostic/Assessment, Counseling Services, Intensive Day Treatment, and Crisis Emergency. There are no event screens for completion by the provider for these requests. All requests are managed over the phone and AHL documents the request in eCura.

### **8.8.1 Supplemental Unit Requests for Assertive Community Treatment:**

If a consumer needs more than 500 units of Assertive Community Treatment (ACT) in any given 180 day authorization period, the following steps should be taken to process a request for more ACT units:

- A. ACT provider calls DMH ACT Coordinator to request more than 500 units of ACT on an existing authorization plan.
- B. The DMH ACT Coordinator locates the eCura record and opens a "supplemental units request" event screen.
- C. The DMH ACT Coordinator may ask the ACT provider to fax the following documents: A copy of the IRP/IPC, the 6 most recent case notes, and the most recent LOCUS evaluation for review of medical necessity at the proposed level of care.
- D. If the DMH ACT Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA/ACT provider will be notified of the outcome.
- E. If the DMH ACT Coordinator determines that medical necessity is not met, the case will be referred to the DMH Chief Clinical Officer for review.
- F. If the DMH Chief Clinical Officer approves, the units will be added.
- G. If the DMH Chief Clinical Officer denies, the units will not be added.
- H. The CSA/ACT provider will be notified of the outcome, including information on how to appeal the decision.
- I. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. ACT provider may request additional units for the current existing authorization plan only.
- b. The ACT provider has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the request will be denied.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

### **8.8.2 Supplemental Unit Requests for Community Based Intervention (CBI):**

Consumers may need more than the maximum units of Community Based Intervention (CBI) (500 units in any given 180 day authorization period). The following steps should be taken to process a request for more CBI units:

- A. CBI provider calls AHL to request more than the maximum units of CBI on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CBI provider to fax the following documents: A copy of the D&A, the IRP/IPC, the most recent treatment notes, and the most recent LOCUS/CALOCUS for review of medical necessity at the proposed level of care.
- D. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA/CBI provider will be notified of the outcome.
- E. If the Care Coordinator determines that medical necessity is not met, the case will be referred to the DMH Chief Clinical Officer/designee for review.
- F. If the DMH Chief Clinical Officer/designee approves, the units will be added.
- G. If the DMH Chief Clinical Officer/designee denies, the units will not be added.
- H. The CSA/CBI provider will be notified of the outcome, including information on how to appeal the decision.
- I. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CBI providers may request additional units for the current existing authorization plan only.
- b. The CBI provider has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the request will be denied.
- d. The DMH Chief Clinical Officer/designee has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.



### **8.8.3 Supplemental Unit Requests for Community Support:**

Consumers may need more than 600 units of Community Support in any given 180 day authorization period. The following steps should be taken to process a request for more community support units:

- A. CSA representative calls AHL to request more than 600 units of Community Support on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA representative the following questions:
  - a. Does the consumer participate in a specialized program where the intensity of community support is expected for a time-limited period? If so describe?
  - b. Has there been a recent (within the past 30 days) and significant change in treatment (examples listed below) that supports a request for additional units?
    - i. Decomposition as evidenced by:
    - ii. Substance abuse relapse as evidenced by:
    - iii. Change in case manager
    - iv. Housing status change
- D. If the answer is “yes” to either question, and there has not been a request for additional services in the past six (6) months, the Care Coordinator will add the requested Community Support units to the existing authorization plan.
- E. If the answer is “no” to either question, and/or:
  - a. The request is the second request for more than 600 units in a six (6) month period, or
  - b. The consumer is seen face to face exclusively in the Provider’s office the Care Coordinator will ask the CSA to fax a copy of the IRP/IPC for review of medical necessity at the proposed level of care.
- F. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA will be notified of the outcome.
- G. If the Care Coordinator determines that medical necessity is not met, the CSA will be notified of the outcome, including information on how to appeal the decision.
- H. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CSA’s may request additional units for the current existing authorization plan only.

- b. The CSA has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the Care Coordinator will deny the request.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

#### **8.8.4 Supplemental Unit Requests for Counseling:**

Consumers may need to use more than 160 units of Counseling in any given 180 day authorization period. The following steps should be taken to process a request for more counseling units:

- A. CSA representative calls AHL to request more than 160 units of Counseling on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA representative the following questions:
  - a. Does the consumer participate in a specialized program where the intensity of Counseling is expected for a time-limited period? If so describe?
  - b. Has there been a recent (within the past 30 days) and significant change in treatment (examples listed below) that supports a request for additional units?
    - i. Significant new psycho-social issues in counseling that require time limited intensive intervention as evidenced by:
    - ii. Substance Abuse relapse as evidenced by:
    - iii. Change in therapist/case manager
- D. If the answer is “yes” to either question, and there has not been a request for additional services in the past six (6) months, the Care Coordinator will add the requested Counseling units to the existing authorization plan.
- E. If the answer is “no” to either question, the Care Coordinator will ask the CSA to fax a copy of the IRP/IPC and the most recent (last 30 days) of Counseling notes for review of medical necessity at the proposed level of care.
- F. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA will be notified of the outcome.
- G. If the Care Coordinator determines that medical necessity is not met, the CSA will be notified of the outcome, including information on how to appeal the decision.
- H. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CSA’s may request additional units for the current existing authorization plan only.
- b. The CSA has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the Care Coordinator will deny the request.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

### 8.8.5 Supplemental Unit Requests for Crisis Emergency:

Consumers may need more than 60 units of Crisis Emergency in any given 180 day authorization period. The following steps should be taken to process a request for more Crisis Emergency units:

- A. CSA or Crisis Emergency Provider (CEP) calls AHL to request more than 60 units of Crisis Emergency on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA/CEP the following questions:
  - a. Is the consumer currently, or have they recently (within the past 30 days) received crisis stabilization services with a CEP for more than twenty-four (24) hours?
  - b. Has there been a recent (within the past 30 days) and significant change in treatment (examples listed below) that supports a request for additional units?
    - i. Decompensation as evidenced by:
    - ii. Substance abuse relapse as evidenced by:
    - iii. Change in housing or living arrangement
- D. If the answer is “yes” to either question, and there has not been a request for additional services in the past six (6) months, the Care Coordinator will add Crisis Emergency units to the existing authorization plan, as clinically indicated.
- E. If the answer is “no” to either question, and/or:  
the request is the second request for supplemental units in a six (6) month period, the Care Coordinator will ask the CSA to fax a copy of the IRP/IPC and the most recent LOCUS/CALOCUS screening or ask the CEP to fax a copy of the progress notes/crisis plan for review of medical necessity at the proposed level of care.
- F. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA/CEP will be notified of the outcome.
- G. If the Care Coordinator determines that medical necessity is not met, the case will be referred to the DMH Chief Clinical Officer for review.
- H. If the DMH Chief Clinical Officer approves, the units will be added, if the DMH Chief Clinical Officer denies the units will not be added.
- I. The CSA/CEP will be notified of the outcome, including information on how to appeal the decision.
- J. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CSA/CEP may request additional units for the current existing authorization plan only.
- b. The CSA/CEP has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the Care Coordinator will deny the request.

- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

### **8.8.6 Supplemental Unit Requests for Diagnostic and Assessment (D&A):**

Consumers may need more than 2 units of Diagnostic Assessment in any given 180 day authorization period. The following steps should be taken to process a request for more D&A units:

- A. CSA/clinical home representative calls AHL to request more than 2 units of D&A on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA/clinical home representative the following question:
  - Has there been a recent (within the past 30 days) significant and novel change in treatment (examples listed below) that supports a request for an additional unit?
    - i. Decompensation as evidenced by:
    - ii. Substance abuse relapse as evidenced by:
    - iii. Significant change in somatic health as evidenced by:
    - iv. Change in legal status
    - v. Change in case manager
    - vi. Housing status change
- D. If the answer is “yes”, and there has not been a request for additional services in the past 6 months, the Care Coordinator may add 1 D&A unit to the existing authorization plan.
- E. If the answer is “no”, the case will be referred to the DMH Chief Clinical Officer for review.
- F. If the DMH Chief Clinical Officer approves, the unit will be added, if the DMH Chief Clinical Officer denies, the unit will not be added.
- G. The CSA will be notified of the outcome, including information on how to appeal the decision.
- H. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CSA’s may request additional units for the current existing authorization plan only.
- b. The CSA has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the Care Coordinator will deny the request.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

### 8.8.7 Supplemental Unit Requests for Medication/Somatic:

Consumers may need more than 64 units of Medication/Somatic in any given 180 day authorization period. The following steps should be taken to process a request for more Medication/Somatic units:

- A. CSA representative calls AHL to request more than 64 units of Medication/Somatic on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA representative the following questions:
  - a. Has there been a change in somatic health status/condition within the past thirty (30) days that necessitates more intensive nursing supervision? If so describe?
  - b. Has there been a recent (within the past 30 days) and significant change in treatment (examples listed below) that supports a request for additional units?
    - i. Decompensation as evidenced by:
    - ii. Discharge from an acute care setting (including crisis beds) within the past thirty (30) days.
    - iii. Significant medication regimen change in the past thirty (30) days.
    - iv. Change in psychiatrist in the past thirty (30) days
- D. If the answer is “yes” to either question, and there has not been a request for additional services in the past six (6) months, the Care Coordinator will add the requested units of Medication/Somatic to the existing authorization plan.
- E. If the answer is “no” to either question, and/or:
  - a. The request is the second request for more than 64 units in a six (6) month period; or
  - b. The request is for more than 64 units total, the Care Coordinator will ask the CSA to fax a copy of the D&A, the IRP/IPC, and the most recent (past 3 visits) medication notes for review of medical necessity at the proposed level of care.
- F. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA will be notified of the outcome.
- G. If the Care Coordinator determines that medical necessity is not met, the case will be referred to the DMH Chief Clinical Officer for review.
- H. If the DMH Chief Clinical Officer approves, the units will be added; If the DMH Chief Clinical Officer denies the units will not be added.
- I. The CSA will be notified of the outcome, including information on how to appeal the decision.
- J. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### Timelines:

- a. CSA’s may request additional units for the current existing authorization plan only.

- b. The CSA has up to seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the Care Coordinator will deny the request.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.



### **8.8.8 Supplemental Unit Requests for Intensive Day Treatment (IDT):**

Consumers may need more than 7 units of Intensive Day Treatment (IDT). The following steps should be taken to process a request for more IDT units:

- A. CSA representative calls AHL to request more than 7 units of IDT on an existing authorization plan.
- B. The Care Coordinator locates the eCura record and opens a “supplemental units request” event screen.
- C. The Care Coordinator asks the CSA representative to fax the following documents: A copy of the D&A, the IRP/IPC, the most recent case notes, and the most recent LOCUS/CALOCUS for review of medical necessity at the proposed level of care.
- D. If the Care Coordinator determines that sufficient clinical justification for medical necessity is provided, the additional units will be added to the existing plan, and the CSA will be notified of the outcome.
- E. If the Care Coordinator determines that medical necessity is not met, the case will be referred to the DMH Chief Clinical Officer for review.
- F. If the DMH Chief Clinical Officer approves, the units will be added.  
If the DMH Chief Clinical Officer denies, the units will not be added.
- G. The CSA will be notified of the outcome, including information on how to appeal the decision.
- H. Appeals will follow the predetermined guidelines in Section 8.9 of this manual.

#### **Timelines:**

- a. CSA’s may request additional units for the current existing authorization plan only.
- b. The CSA has seven (7) business days to fax the Care Coordinator the requested information.
- c. If the information is not submitted by COB on the 7th business day, the request will be denied.
- d. The DMH Chief Clinical Officer has up to thirty (30) days to make a determination based on documents submitted and may request further documentation to make a decision.

## 8.9.0 Appeal Process

There are three (3) types of appeals. They are: Reconsideration, a Level I Appeal, and a Level II Appeal. The Reconsideration Appeal is a provider's opportunity to provide information after an administrative denial in which the Division of Care Coordination did not have sufficient clinical justification to render a medical necessity determination. A Level I Appeal is reviewed at the Division of Care Coordination/service authorization level. A Level II Appeal is reviewed by a DMH Appeal Board.

### 8.9.1 Reconsiderations and LEVEL I Appeals – Service Authorization:

Reconsiderations are made after a denial for administrative or eCura system reasons. The Division of Care Coordination notifies the provider of the administrative denial for prior and re-authorized requests. Providers monitor authorization status results in ProviderConnect for eCura system denials. In the case of an administrative denial, additional information is often requested. Additional information for the reconsideration should be submitted within three (3) business days to the Care Coordinator requesting the information. Requests in which additional information is not received within five (5) business days will remain denied, and the provider will need to request a Level I Appeal.

Level I Appeal Process	
Provider Responsibility	<p>Submit a request for appeal within fifteen (15) days from the date of initial denial by:</p> <p>Contacting the Director, Division of Care Coordination/designee, at (202) 671-3105 for email address or fax a request for an appeal to (202) 671-2972.</p> <p>The request is to include the date of filing, the first initial and last name of the consumer, the eCura number, the specific reason for the denial, date of the denial, and the reason (s) for which the denial occurred.</p>
DMH Division of Care Coordination Responsibility	<p>The Director, Division of Care Coordination/designee, will review the request and within twenty-four (24) hours (weekends and holidays excluded) notify the Provider of the disposition of the appeal. This will be in the form of an email and telephone call.</p>
Action/ Disposition	<p>If the denial of the authorization is supported at the Level I Appeal, the Provider may submit a request for a Level II Appeal.</p>

### 8.9.2 LEVEL II Appeals– DMH Service Authorization Appeal Board:

When an adverse determination is made by DMH, the provider may appeal this decision by requesting a Level II Appeal.

Level II Appeal Process	
Provider Responsibility	<p>The Provider must submit a request for a Level II appeal within twenty-four (24) hours of notification of an adverse determination by:</p> <p>Contacting the DMH Chief Clinical Officer or designee or by Faxing a request for an appeal to (202) 671-2972.</p> <p>The request includes the date of original filing, the first initial and last name of the consumer, the eCura number, the denial reason, date of the denial, and the reason(s) for which the denial occurred.</p> <p>The Provider shall submit the consumer's most recent treatment plan, and any relevant clinical information within the past year that supports the authorization request.</p> <p>The Qualified Practitioner or designated representative may be required to appear before the Appeal Board.</p>
DMH Chief Clinical Officer Responsibility	<p>The DMH Chief Clinical Officer or designee shall notify the Provider by email of receipt of the request for a Level II Appeal within twenty-four (24) hours (excluding weekends and holidays). This notification shall include the date of the Appeal Board Hearing. The Appeal Board is to convene within five (5) days (weekends and holidays excluded).</p>
Action/ Disposition	<p>If the denial of the authorization is supported at the Level II Appeal, the Provider shall receive written notification within five (5) business days stating the specific clinical reasons for the denial of the authorization.</p>
D.C. Office of Administrative Hearings (OAH)	<p>The consumer has the right to request a hearing from OAH to appeal a denial of Medicaid benefit.</p>

## 9.0 BILLING INFORMATION

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This chapter outlines the information required for proper claims billing. All billing is subject to claims auditing in accordance with DMH Policy 911.1C, Claims Audits.

### 9.1 Electronic Billing

The Department of Mental Health (DMH) only accepts claims in the Health Insurance Portability and Accountability Act (HIPAA) compliant American National Standards Institute (ANSI) 837 5010 format. **Claims billed on paper claim forms will not be accepted, but returned to the provider to be resubmitted in an electronic format.**

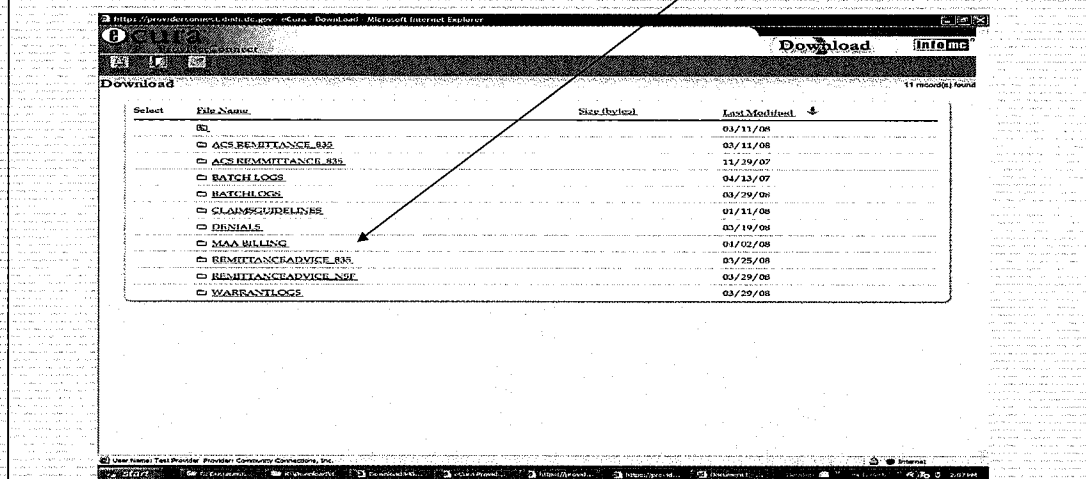
Providers will upload claim files to DMH via Secure File Upload (SFU) of the DMH web-based system application.

#### 9.1.1 ProviderConnect Download

DMH supplies each MHRS provider with a web-based application, ProviderConnect, that allows provider-specific access to membership and clinical data, as well as data download functionality for authorization, enrollment, and claims reports and documents.

# Download Option

## ☐ Claims Reports



## 9.1.2 File Naming Convention

All claims submitted to the Department of Mental Health (DMH) must include the following information:

File Name Components	Component Values	Example File Name
Provider Type	C=CSA, S=Specialty, P=Sub-Provider	C
Provider ID	2-3 Digit Number	01 - 999
Provider Site Number	2-3 Digit Number	01 - 999
Submission Number	2 Digit Number	01
Submission Date	Date (MMDDYYYY)	05012010
File Name Extension	.txt	.txt (extension must always be .txt)
Example		C27110105012003.txt

- Provider Type** is the character typically used to specify the provider type and can be represented by C, S, or P (C = CSA, S= Specialty, and P = Sub-provider).

- **Provider ID** is a two or three - character system generated value that is provided to a provider when they enroll with Mental Health Rehabilitation Services (MHRS) program.
- **Site ID** is a two or three - character system generated value that indicates the provider's site number. Providers may have multiple locations from which they operate. A site number is assigned to each physical location. This site number is required on the claim file and is provided when a provider enrolls with the MHRS program.
- **Submission Number** is the sequential number of claim files submitted by a provider on a given day (01-99), i.e., first submission =01, second submission =02, up to 99. We don't anticipate a provider submitting more than 99 times a day.
- **Submission Date** is the date a file is submitted and has the following format MMDDYYYY
- **Extension:** All claim file names must conclude with an extension of *.txt*.

## 9.2 File Acknowledgement

DMH uses HIPAA 999 functional acknowledgement transactions.

## 9.3 Modifier Codes

The following modifiers will be used to further identify services that are covered under MHRS.

Face to Face contact with Consumer	No Modifier
Face to Face Contact with Collateral Source	<b>UK</b>
Specified Service to Individual/Age 0-21	<b>HA</b>
Mental Health Service	<b>HE</b>
Family/Couple with consumer present	<b>HR</b>
Family/Couple without consumer present	<b>HS</b>
Group Setting	<b>HQ</b>
Community Residential Facility (CRF) Billing	<b>U1</b>
Funded by Child Welfare Agency – Used by DMH for Functional Family Therapy (FFT) CBI Level IV	<b>HU</b>
Multi-disciplinary Team – Used by DMH for MH Service Discharge Treatment Planning, Institution (MHS-DTP) - ACT	<b>HT</b>
Specialized Mental Health Program for High Risk Population	<b>HK</b>
Physician Team Member	<b>AM</b>

When a modifier is applicable to a specific service, the modifier code must be used as specified in Appendix A, Service Code/Modifier/Place of Service Table, in order to be accurately processed. **Do not create combinations other than what is reflected in**

**Appendix A.** The all inclusive codes for CBI and ACT allow for collateral, family, and telephone contacts to be provided and billed without using modifier codes UK, HR, and HS modifiers.

### **9.3.1 Services Provided to Collateral Care Givers and Other Professionals that do not include Significant Others or Family When the Consumer is Present, and When the Consumer is NOT Present**

Modifier “UK – Face to Face Services provided on behalf of the consumer to someone other than the consumer” (collateral relationship) should be used to capture services provided to Collateral Care Givers and other Professionals. Only face to face contact with collateral source is allowable when using the UK modifier.

### **9.3.2 Services Provided to Significant Others or Family When the Consumer is Present, and When the Consumer is NOT Present**

Modifier HR indicates Family/Couple contact when the consumer is present.

Modifier HS indicates Family/Couple contact when the consumer is NOT present.

## **9.4 Procedure Codes**

### **9.4.1 Procedure/Levels of Care Codes:**

The MHRS service taxonomy is broken down into levels of care in ProviderConnect. These levels of care are code and rate specific and must be accurately submitted in order for claims to process.

### **9.4.2 MHRS Service Limitations:**

The table in Appendix B, MHRS Service Limitations, provides a list of MHRS billable services along with the limitations on each.

## **9.5 Diagnosis Codes**

HIPAA requires use of the most current published version of the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM) diagnosis codes for professional claims submission. DMH will consider for payment claims containing only those diagnosis codes outlined in section 9.5.1 below:

### **9.5.1 MHRS ICD-9-CM Code List**

The following ICD-9 CM codes are currently valid for MHRS claims submission:

- 293 to 294.9 inclusive are behavioral health conditions related to organic psychoses.
- 295.0 to 302.9 inclusive, or 306 to 315.99 inclusive are mental psychoses related conditions.

## 9.6 Place of Services Codes

Place of Service Codes shall be used on professional claims to specify the entity where services(s) were rendered. Listed below are place of service code descriptions from the 2012 HCPCS Level II code book:

03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.



31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
99	Other place of service	Other place of service not identified above.

Providers must include the "place" in the narrative of the progress note whenever "other" (99) is used on a claim. Claims may be denied during a claims audit if "other" (99) is used on a claim as the place of service code, and the "place" is not identified in the narrative of the progress note.

### 9.6.1 Type of Service Codes

DMH previously used proprietary codes for Type of Service. Under HIPAA, these codes have now been incorporated into the modifier table.

## 9.7 Same Day Service Reporting

Legitimate “multiple” services (i.e., same services provided to the same consumer on the same day by the same provider) must be rolled up to one (1) service line on the claim before submitting to DMH. **Consequently, DMH will deny a non-rolled up service with a “duplicate” reason code.**

The following data elements are validated during duplicate checking:  
Provider, Consumer, Date of Service, Procedure Code, and Modifier 1.

**Important Note:** It is important to understand the implications of including the Modifier 1 in the duplicate claim validation. **If a procedure code is billed with a modifier on the same day as another service that uses the same procedure code without a modifier or with a different modifier, the services will be considered separate services. They should be submitted on the claim as separate service lines and should not be “rolled up”.**

Modifier 2 is not incorporated in duplicate checking. Claims for multiple services on the same day that can be validated as non-duplicate by information in Modifier 2 will be adjusted and released through the manual adjudication process.

### 9.7.1 Same Day Service Combination Billing Limitations

Certain same day core service combinations will not be billed, and same day prior authorization service combinations will not be authorized due to limitations. The table in Appendix C, Same Day Service Combination Billing Limitations, lists the limitations on combining MHRs Services on the same day.

The term “same day” is determined by the same start and end date, or the same ‘date from’ and ‘date to’ of the services.

## 9.8 Service Units

If the same service, meaning the same HCPCS code and modifier combination, is legitimately provided multiple times, on the same day to the same consumer, the service units must be summed for the date of service, then rounded according to the table as noted below and submitted as one service line on the claim. See Appendix A for procedure codes with Medicaid rates.

The actual minutes of the service must be accurately recorded in the consumer’s clinical record. Each encounter for the day should be recorded separately in the clinical record including the start and end time of the encounter. Documentation time is not billable.

### 9.8.1 Services Based on 15 Minute Units (1 unit = 15 minutes)

Applies to the following services:

- Medication/Somatic Treatment (H0034)
- Community Support (H0036)
- Physician Team Member (H0036AM)
- Crisis/Emergency (H2011)
- Multi-Systemic Community Based Intervention CBI Level I (H2033)
- Intensive Home and Community Based Services CBI Level II & III (H2022)
- Functional Family Therapy (FFT) CBI Level IV (H2033HU)
- Assertive Community Treatment (H0039)
- Counseling (H0004)
- Team Meeting (DMH20)
- Supported Employment - therapeutic (H2023)
- Supported Employment – non-MHRS vocational (H2025)
- Supported Employment Group (non-MHRS – Job Club) (H2025HQ)
- Self-help/Peer Support (H0038)
- Mental Health Service Discharge Treatment Planning, Institution (H0032)
- Mental Health Service Discharge Treatment Planning, Institution ACT (H0046HT)
- Mental Health Service Discharge Treatment Planning, Institution CBI (H0046HTHA)
- Mental Health Service COC Treatment Planning, Institution (H0032HK)

Services exceeding seven (7) minutes must be rounded to the nearest whole unit in accordance with the following table:

Time Service Provided	Units to bill
0 minutes to 7 minutes	Not billable
8 minutes to 22 minutes	1
23 minutes to 37 minutes	2
38 minutes to 52 minutes	3
53 minutes to 67 minutes	4
68 minutes to 82 minutes	5
83 minutes to 97 minutes	6

### 9.8.2 Rounding Example

#### Sample Scenario

A consumer is provided face to face community support by the same agency three (3) times during a single day. Community Support Individual is billed at \$50 per unit for a 15-minute service. Since the consumer was seen for a total of 33 minutes, the provider can bill for

two (2) fifteen (15) minute intervals of community support individual (H0036) at \$50 per unit, for a total of \$100.

When the “sum and round” methodology is used, the units of service on the bill would be calculated as follows:

Clinician (Staff)	Date of Service	Consumer	Duration	Start Time	Billable Service	Billable Units	Billable Rate
Clinician A	11/5/03	Joe Consumer	7 min.	9:00 am	H0036	---	---
Clinician B	11/5/03	Joe Consumer	23 min.	11:00 am	H0036	---	---
Clinician C	11/5/03	Joe Consumer	3 min.	4:00 pm	H0036	---	---
<b><i>TOTAL BILLED as one line item</i></b>	<b><i>11/5/03</i></b>	<b><i>Joe Consumer</i></b>	<b><i>33 min</i></b>	<b><i>---</i></b>	<b><i>H0036</i></b>	<b><i>2</i></b>	<b><i>\$100</i></b>

### 9.8.3 Per Encounter- Based Services

Applies to the following service:

- Diagnostic Assessment (T1023-HE) [An assessment, which is at least three (3) hours in duration]
- Behavioral Health Screening (H0002) [A brief diagnostic assessment which is 40-50 minutes in duration] to determine eligibility for admission to a mental health treatment program. This code should not be used for routine, on-going assessments.
- Transitional Service (DMH26) - allows a one-time occurrence fee, per consumer, to a closing Core Services Agency (CSA), for assistance with the transitioning and documentation of its consumers to other CSAs.

### 9.8.4 Per Diem- Based Services

Applies to the following services:

- Rehabilitation Day Services (H0025) [One (1) day, which shall consist of at least three (3) hours]
- Community Psychiatric Supportive Treatment Program - Rehab/Day Services (CPS-Rehab Day) H0037 - [One (1) day, which shall consist of at least three (3) hours]. This code should be used when a consumer who is in a hospital or other institutional setting receives rehab day services 30-60 days prior to discharge as part of the community integration plan.
- Intensive Day Treatment (H2012) [One (1) day, which shall consist of at least five (5) hours]
- Residential Crisis Stabilization – no auth (DMH23) for first two (2) days
- Residential Crisis Stabilization – (DMH14) for subsequent days

## **9.9 Billing for Multiple Sites**

Claims for services provided must use each appropriate billing provider's National Provider Identifier (NPI) number for the billed procedure code(s).

## **9.10 Reporting Other Carrier Information**

Other carrier (i.e., payor) information is required on the current 837P format, if other payors are known to potentially be involved in the paying of the claim. Providers are required by Medicaid to check for applicable insurance for a consumer. Please refer to the national standard HIPAA 837P implementation guide for further information regarding all of the other payor data that is required. DMH will only retrieve certain data elements from the required data set for adjudication purposes as noted in the DMH 837 Professional Claim Informational Guide. The DMH 837 Claims Guide Map is a 20 page spreadsheet and is located in the Claims/Claims Guidelines section in the download folder in ProviderConnect.

Medicaid will continue to be payor of last resort for Medicaid covered services, and DMH will be the payor of last resort for local funds. Other payor information required on the 837P format is informational only for DMH at this time.

## **9.11 Testing of Billing Format**

### **9.11.1 Introduction**

This test plan details the process of approving a provider agency to submit live HIPAA compliant claims electronically to the DMH Information System (DMHIS). DMHIS will be using a three-tiered approach to test 837Ps received from providers. This approach allows the staff to identify basic 837P format problems in Tier 1, then focus on basic content problems in Tier 2, and more complex issues that may only manifest themselves in a large, production-simulation environment in Tier 3.

The following are the three levels that must be completed successfully before approval is granted to submit electronic claims in the production system:

Tier 1 – Basic Form, Structure, Syntax Testing

Tier 2 – Segment, Field and Components with Dummy data provided by DMH

Tier 3 – Submission of live claims against live DMHIS Production consumer service data

All Core Services Agencies (CSAs), specialty providers and sub-providers will need to provide test 837Ps since each provider agency will be submitting claims to DMH as trading partners. For the remainder of this section, CSAs, specialty providers, sub-providers, and trading partners will all be referred to as "providers".

Each test transmission is inspected for correct format and accurate codes and other data format integrity. Assistance from the DMHIS HIPAA Compliance Testing Coordinator (HTC) is available throughout this process.

## **9.11.2 Preparation for Testing**

### **9.11.2.1 ProviderConnect Account**

Tier 1 and Tier 2 testing will be accomplished using dummy provider accounts, which will be provided by the DMHIS HTC when testing begins. 837Ps will be transmitted via email in the first two Tiers, which does not require a ProviderConnect account.

Since Tier 3 testing uses live client information, it will require ProviderConnect to transmit the 837Ps securely. Each provider who does not already have a ProviderConnect account will need to go through the appropriate steps to obtain an account.

## **9.11.3 DMHIS Testing and Approval Process**

### **9.11.3.1 General Information**

When submitting test 837Ps, providers must initiate the “DMHIS Claims Testing Form”. In an effort to identify common problems across software vendors, providers will be asked to provide information about the software used to create the 837P on this form. The completed request form should be sent to [DMH.Applications@dc.gov](mailto:DMH.Applications@dc.gov) or faxed to 202-671-3511 prior to each tier of testing.

**Important note:** the test 837P file name should comply with the 837P file naming conventions as outlined in section 9.11.3.2 of this section. Please note that test 837P file names should begin with the character “T” instead of “C”, “S”, “P”, so they can easily be distinguished as test 837Ps.

The DMHIS HTC will be responsible for initiating the testing and approval process for each provider through DMHIS. The DMHIS HTC will communicate the approval status related to a provider using the DMHIS Claims Testing Form(s). It is the DMHIS HTC’s responsibility to share the status with the provider as well as with the DMH Provider Relations office. If approved, these entities will receive a faxed copy of the DMHIS Claims Testing Form approving the provider to submit the next level of testing. If rejected, these entities will be notified via the same form of the reason for the rejection, which could be one of the following:

- HIPAA-Mandated and/or ASC X12N requirements are not met
- DMHIS-specific billing requirements are not met
- Fatal errors occur on the DMHIS Edit Reports

- Less than 90% of the claims pass DMHIS Edits
- Duplicate claims contained on the 837P violate the Duplicate Claim Check Policy under HIPAA

Please note subsequent re-testing and approval for production claim submission will be required if the provider or their respective software vendor or clearinghouse changes their file creation program.

### 9.11.3.2 Claims File Naming Conventions - Test Files Only

Providers must comply with the following naming conventions when naming test 837Ps:

Filename Components	Component Values	Example File Name
Provider Type	<i>T</i> = Test File	<i>T</i>
Provider ID	2-3 digit number	01 - 999
Provider Site Number	2-3 digit number	01 - 999
Submission Number	2 digit number	09
Submission Date	Date (MMDDYYYY)	07172010
File Name Extension	<i>.txt</i>	txt (extension must always be .txt)
Resulting Test File Name		T56750107172003.txt

- **Provider Type:** is the character typically used to specify the provider type and can be represented by C, S, or P. C = CSA, S= Specialty, and P = Sub-provider. During the Test phase each 837P file name should begin with T to indicate a Test 837P is in receipt.
- **Provider ID** is a two or three - character system generated value that is provided to a provider when they enroll with DMHRS program. For Tiers 1 and 2 testing a fictitious provider number is given to the testing provider to complete the testing process. In Tier 3 testing the actual provider ID is used. Only MHRs enrolled providers may participate in Tier 3 testing.
- **Site ID** is a two or three - character system generated value that indicates the provider's site number. Providers may have multiple locations from which they operate. A site number is assigned to each physical location. This site number is required on the 837P and is provided when a provider enrolls with the DMHRS program. For Tiers 1 and 2 testing a fictitious Site ID number is given to the testing provider to complete the testing process. In Tier 3 testing the actual Site ID(s) is used. Only MHRs enrolled providers may participate in Tier 3 testing.

- **Submission Number** is the sequential number of 837Ps submitted by a provider on a given day (01-99), i.e., first submission =01, second submission =02, up to 99. We don't anticipate a provider submitting more than 99 times a day.
- **Submission Date** is the date an 837P is submitted and has the following format MMDDYYYY
- **Extension:** all 837P file names must conclude with an extension of .txt, i.e. T56750107172003.txt

### 9.11.3.3 Testing Procedure Overview

The DMH Provider Relations office provides existing and new providers with a companion guide via email or regular mail.

The provider submits the testing request form, along with the specified 837Ps to initiate the desired level of testing via email to the DMHIS HTC.

Once the initial 837P is received the DMHIS HTC will submit it to a current HIPAA Compliance testing tool. This tool validates HIPAA mandated EDI transactions for compliance with the HIPAA Implementation Guides. It validates transactions for all 7 types of testing defined by WEDI/SNIP.

Following successful HIPAA compliance testing, the DMHIS HTC will complete Tier 1 testing to ensure proper format structure.

Following successful completion of Tier I testing, the DMHIS HTC will notify the provider of the status of the 837P.

The provider will complete and submit a Tier 2 test request form and the DMH will provide the provider with a dataset of five (5) consumers, for which the provider will create and submit HIPAA compliant claims via email.

The DMHIS HTC will process these claims, checking for content and adherence to business rules. The DMHIS HTC will notify the provider of the outcome of the testing and forward any output to the provider so they may review any errors and ensure that business rules were followed.

When Tier 2 testing is successfully completed, the provider will complete and submit the final test request form for Tier 3 testing along with an 837P(s) comprised of a representative number of claims against their own existing live data resident in the DMHIS database. Upon successful completion of Tier 3 testing the provider will be approved to submit live HIPAA compliant claims to the DMHIS database.

If a tier is failed, testing will continue on that tier until the test cases are successfully completed, reaching a 90% success rate.



#### **9.11.3.4 Tier 1 – Basic Form, Structure, Syntax Testing**

The primary purpose of Tier 1 testing is to evaluate the form, structure and syntax of the claims EDI test file as it pertains to DMHIS specific guidelines. The type of review includes but is not limited to:

- Conformance to 837P naming conventions
- Envelope Structure and Control Numbers

Tier 1 testing does not require information related to “real” clients. These 837Ps can contain fictitious names, dates of birth, DMH Ids, insurance policy numbers, etc.). Segment, field and component usage will be examined, but no comparisons will be made between the 837P and the DMHIS database content at this point in the testing process.

The first part of Tier 1 testing will include pre-testing the submitted ASC X12N 837 Version 5010 Professional Claim files in HIPAA Desk to minimize the number of problem 837Ps in the test DMHIS database. Pre-testing will include testing for basic HIPAA-compliant form, structure and syntax requirements at a minimum.

Providers should ensure at a minimum that the same system parameters; software versions are used to create the test 837Ps as established in the provider’s current production environment.

#### **Submitting Tier 1 Test 837Ps to DMHIS Testing and Approval**

Tier 1 test 837Ps should include:

- A maximum of 25 claims per initial test 837P file
- The test 837P must contain appropriate segment, field and component usage
- The test 837P should not use actual client or service data

#### **9.11.3.5 Tier 2 – Segment, Field and Components with Dummy data provided by DMH**

Tier 2 testing is the stage where providers submit claims in response to five (5) authorization plans sent to them by the DMHIS HTC for five (5) pseudo consumers in the DMHIS test database. All 837Ps must be created by the provider’s software and contain valid HIPAA compliant DMHIS codes. This level of testing will process the test 837P in a copy of the DMHIS production environment to simulate, as closely as possible, how claims will be processed in a live environment. Every effort should be made to emulate standard operating procedures.

All output generated from this processing including denial letters, exception reports, warrants, and 835 electronic remittances will be returned along with the Request Form indicating the status of the claims submitted. This data will help providers to determine why records created critical errors, why warnings were created, if the procedures were priced as expected, and if all benefit rules were applied appropriately.

The primary goal is to ensure that the provider software has created a standard, DMHIS compliant ANSI X12 837P V5010; that provider data and format is HIPAA compliant and accurate for specified lines of business and services; and that all procedures that are expected to result in claims being denied or held as specified in the benefit rules are applied as intended. The type of review includes but is not limited to:

- Appropriate segment terminator, data element delimiter and other control character usage
- Appropriate use of sender and receiver identification numbers
- Appropriate use of provider identification numbers
- One-To-Many relationship of the 837P and Loop 2300 (i.e. multiple claims per transaction set)
- One-To-Many relationship of Loops 2300 and 2400 (i.e. multiple service lines per claim)
- Appropriate segment usage for DMHIS adjudication purposes as outlined in the DMHIS Claims Processing Guide

### **Submitting Tier 2 Test 837Ps to DMHIS Testing and Approval**

Tier 2 test 837Ps should include:

- A maximum of 25 claims
- At least 1 claim for each service (HCPCS code with modifier(s)) for each test consumer in the test package

#### **9.11.3.6 Tier 3 – Submission of live claims against live DMHIS Production consumer service data**

Tier 3 testing is the final stage before approval is granted to submit claims into the HIPAA-compliant DMHIS Production environment. All 837Ps must be created by the provider's software with no manual (or other) corrections or adjustments performed by provider or DMHIS staff. This phase of testing uses ProviderConnect to transfer the 837Ps for the respective provider. This level of testing will process the 837Ps in a copy of the DMHIS production environment against the submitting providers own consumer data to ensure that no unforeseen issues present with the actual data. After successful processing in the test database, this same 837P will be run against the providers' own data in the DMHIS Production database. Any payable claims resulting from this submission will be paid based on the DMH payment schedule.

All output from adjudication of this submission will be returned to the provider for review along with the Request Form.

The primary goal is to ensure that the provider software has created a standard, DMHIS-compliant ANSI X12 837P V5010; that provider agreements are in place (in the HIPAA compliant DMHIS database) and are accurate; and that all system edits that result in claims being denied or pended, are applied as intended.

The Tier 3 test 837P should be large enough to approximate at least one week's data with all possible funded procedure codes from the provider before Tier 3 Approval will be granted.

Providers will have the option to request a simulated 835 Health Care Claim Payment/Advice file in return, if the final test 837P is processed successfully into the DMHIS test environment.

### **Submitting Final Test 837Ps to DMHIS Testing and Approval (Tier 3)**

Tier 3 test 837Ps should include:

- The volume of claims representative of a typical production 837P submission for that agency up to a maximum of 1,000 claims.
- Real client data.
- Clients for whom claims are submitted must have consumer records in the HIPAA-compliant DMHIS Production database.

## **10.0 CLAIMS PROCESSING**

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### **Claims**

- MHRS providers must submit all claims for MHRS services to the Department of Mental Health (DMH).
- Claims adjudicated for Local Funds (non-Medicaid) determination are processed only in the DMH claims system.
- Claims identified as Medicaid-eligible are first processed in the DMH claims system for consumer eligibility and authorization. If authorized, DMH extracts Medicaid eligible claims, generates an 837 claim file, and exports the claim file to the Department of Health Care Finance (DHCF) to be adjudicated for payment determination.

Claims go through several stages before final determination is made. They are received, imported and matched to eligibility and authorizations at DMH; adjudicated for non-Medicaid payment determination at DMH, or adjudicated for Medicaid payment determination at DHCF.

When a claim file is received by DMH, the following will occur:

- (1) If the file meets 5010 format requirements, the provider will receive a 999 acknowledgement stating that the file is accepted.
- (2) If the file does not meet 5010 format requirements, the provider will receive a 999 acknowledgement indicating either:
  - (a) The file was rejected and needs to be resubmitted, or
  - (b) The file was accepted with errors. In this case, the file will be processed; however, the claims that have errors will not be paid.

Once the file is successfully imported, the following claims processing will occur:

- (1) If a claim is denied during DMH adjudication, the provider must correct the claim and re-bill electronically to DMH.
- (2) If a claim is denied by DHCF, the provider must correct the claim and re-bill on paper health insurance claim form (HCFA 1500) to DHCF. See Appendix C sample.

### **10.1 Receive and Record**

After claims batch files have been received from providers, DMH imports and transfers provider's claims batch files to data tables in the DMH claims system. Claims data is

reviewed for required data during the transfer process. Examples of required data element validation:

- Valid Authorization Plan
- Enrolled Consumer
- Participating Provider
- MHRS Service Code, Modifier and Place of Service
- Date of Service
- Proper Diagnosis

## 10.2 Rejected Claims

If required data is missing, the claim is listed on an exception (reject) report that is made available to the submitting provider in the ProviderConnect module named 'Exception Reports'. The module can be accessed at any time. **A claim will be rejected if any of the following situations occur:**

- Unspecified Exception – system unable to identify any consumer information as submitted.
- Unable to Match Member – possible member match identified, but does not match submitted information, or more than one match found, and system cannot determine.
- No Authorization Plan on Claim
- Unable to Match Authorization – a) Date of service billed does not fall within authorization date range; b) Service code billed is not included on authorization plan; or c) Billing provider is not included on authorization plan.
- No match for the given CPT Code – a) Service code/modifier combination is not recognized by the system; b) Service code billed is not included on authorization plan; or c) Authorization plan date span does not cover date of service.

**Rejected claims should always be corrected and resubmitted to DMH.** (Also see Section 10.4.7 on timely filing).

## 10.3 Adjudication by DMH – Non-Medicaid Claims

Claims, received and recorded, that pass the validations for essential data elements, and have an eligibility status of 'non-Medicaid', are adjudicated by DMH for payment to the provider from Local District funds.

Adjudication by the DMH Claims department calculates the validated claims to determine the proper payable amount, and produces a warrant by provider. The warrant represents the

amount that the DMH Claims department has processed and approved to be submitted for payment. The payable amount is determined by:

- Service code rate
- Modifier rate
- Number of units of service provided
- Authorization limits
- Eligibility coverage

The status that is assigned to each claim is dependent on compliance with the requirements. The assigned status of each claim will be paid, denied or pended.

### 10.3.1 Approval Notification

The electronic Remittance Advice (RA) document for each warrant placed in each provider's 'Remittance Advice 835' download folder shows the status of each claim.

### 10.3.2 Denied Claims

**Claims that do not meet the DMH edit requirements will not be paid.** All denied claims are listed in the local 835 Remittance File that DMH places in each provider's Local Remittance 835 download folder. The following is a list of DMH Denial Reason Codes, explanations, and resolutions:

#	Reason Code	Explanation / Action	Action By:
16	Dates of Service Not Authorized	DMH insurance and/or auth plan does not cover date(s) of service.	Provider
40	Service is Not Authorized	Consumer is enrolled, but authorization on file does not cover billed charges.	Provider
55	Frequency of Authorization Exceeded	Frequency was changed to insufficient units when Auth Plan was requested. Correct Auth Plan and resubmit.	Provider
61	Number of Authorized Units/Sessions Exceeded	Units for this claim exceed Authorized units on Auth Plan or Unmatched Auth. (See additional notes below)	Provider
62	Exceeded Amount	Contractual Reduction of the portion of the charge(s) that exceed(s) the established Medicaid rate.	N/A
65	Duplicate Claim	Duplicate service. (LOCAL Duplicates are returned to provider)	Provider
70	Exceeded Provider Agreement Limit	System monitored Purchase Order limit has been reached. (See additional notes below)	N/A
83	Primary Diagnosis Must Be Axis I	Diagnosis submitted in primary position (1) is not on the Axis I table. Resubmit with Axis I as primary.	Provider

88	Invalid LOC/Modifier/Place of Service combination	Modifier/Place or Service combination is not on DMH approved Code/Mod/POS list. Correct and resubmit	Provider
89	Invalid Units	Billed units cannot be zero (0). Correct and resubmit claim.	Provider
95	Missing Modifier Code for Bill Type	Service billed requires specific Modifier code. Re-bill service with proper modifier.	Provider
112	Diagnosis Code Is Not Valid or Missing	Claim received without diagnosis, or with non-DSM diagnosis. Add diagnosis and resubmit.	Provider

#### **ADDITIONAL NOTES:**

61	Number of Authorized Units/Sessions Exceeded	DMH will pay up to the authorized remaining units.  Add enough units to Auth Plan to cover claims not covered and resubmit.
70	Exceeded Provider Agreement Limit	Applies to local claims only. Submit request for additional funds on Purchase Order.

### **10.3.3 Pended Claims**

Claims that require additional review by DMH cannot be made payable until discrepancies have been resolved.

In order to verify that the claim is in error, the adjudication process assigns a status of "Pend" to indicate the need for review.

#### **DMH MHRs Claims**

#### **Pend Reason Codes for Re-work by DMH Staff**

#	Pend Reason Code	Action
13	Incomplete Claim Insurance	Manual Pend code. Revert and approve charge(s).
15	Terminated	Insurance not aligned with Auth plan. Verify enrollment; re-align Auth plan; then, revert & approve.
16	Dates of Service Not Authorized	DMH enrollment does not cover date(s) of service. Re-link claim to valid Auth plan if available. Revert & approve.
21	Claim Received After Billable Period	Date of service on claim is greater than ninety (90) days from adjudication date. Review.
56	Authorization Ended	Manually assigned reason code. Review before reverting.
62	Exceeded Amount	Contractual Reduction of the portion of the charge(s) that exceed(s) the established Medicaid rate.
65	Duplicate Claim	Duplicate service (Medicaid claims are pre-processed and forwarded to DHCF).
67	Benefits Exhausted	Units for this claim exceed Authorized units on Auth Plan or Unmatched Auth. (See below).

70	Exceeded Provider Agreement Limit	System monitored Purchase Order limit has been reached (See below).
75	Service Not in Provider's Profile	Caused by systems bug that has been corrected. Revert and approve charge(s).
94	Bill Type Missing	Manually assigned reason code. Review before reverting.

## 10.4 Payment Adjudication by DHCF – Medicaid Claims

In order to ensure that a DC Medicaid claim is processed according to DC Medicaid policy, an advanced Medicaid Management Information System (MMIS) has been developed to adjudicate and price claims. This section outlines the claims process.

### 10.4.1 Receive and Record

Claims that are determined to be Medicaid eligible by the Department of Mental Health (DMH) are submitted by DMH on behalf of MHRS Provider to DHCF for Medicaid payment adjudication.

DMH submits claims to DHCF on a weekly basis, in the HIPAA-compliant electronic 837 format.

DMH submits electronic claims to DHCF through an Electronic Data Interchange (EDI) process to validate proper file format. Format errors detected by EDI are reported back to DMH, and the DMH Claims and IT staff correct and resubmit the claims file(s) to DHCF until the file is accepted on behalf of the MHRS providers.

### 10.4.2 Transaction Control Number

Claims that are accepted by DHCF receive a tracking control number (TCN). This is a unique tracking number assigned to each claim. The TCN consists of seventeen (17) numeric digits.

- The first digit designates the document input medium indicator.
- The next five (5) digits indicate the year and Julian date.
- The next two (2) digits designate the image machine number.
- Followed by the next three (3) digits, which designate the batch number.
- The following three (3) digits designate the type of document (i.e., new document, credit or adjustment), followed by the document number digit.
- The last two (2) digits designate the line number.

Claims that have been accepted and have received a TCN are then entered into the Medicaid Management Information System (MMIS) for processing.



### 10.4.3 Edits

When the claims data has been loaded, it is edited to ensure compliance with the following DC Medicaid requirements:

- Provider eligibility
- Recipient eligibility
- Valid and appropriate procedure and diagnosis
- Reasonable charges
- Duplicate claims
- Conflicting services
- Valid dates
- Other Medicaid requirements

The status that is assigned to each claim is dependent on compliance with all the requirements. The assigned status of each claim will be paid, denied, or pended.

The Remittance Advice (RA) electronic file in HIPAA-compliant 835 format, is sorted by provider and a RA file for each provider is uploaded to DMH from DHCF for each processing period. DMH places a copy of each provider's RA file in each provider's 'Medicaid Remittance Advice 835' download folder.

A RA summary document is sent to providers. The claims information is sorted on the RA summary in the following order:

•	Paid original claims
•	Paid adjustment claims
•	Denied original claims
•	Denied adjustment claims
•	Pended claims (in process)
•	Paid claims MTD
•	Denied claims MTD
•	Adjusted claims MTD
•	Paid claims YTD
•	Denied claims YTD
•	Adjusted claims YTD
•	Check amount

### 10.4.4 Approval Notification

Medicaid claims that meet all requirements are paid directly to MHRS providers by DHCF during the next payment cycle. The provider will receive a Remittance Advice (RA) report listing all paid, denied and pended claims in the system.

Claims previously paid incorrectly may be adjusted or voided. Voids will appear as credits; adjustments will appear as two (2) transactions – debit and credit.

Adjustments/voids need to be initiated by the provider since errors can only be corrected by the provider *after* the claim has been paid and appears on the RA report. ***It is the responsibility of the provider to make corrections when errors are made.***

Adjustments/voids must be submitted by the provider directly to DHCF via hard copy (paper) claim (See Appendix C). ***Do not submit these transactions electronically through DMH.***

#### **10.4.5 Denied Medicaid Claims**

Claims that do not meet DC Medicaid edit requirements will not be paid. All denied claims are listed on the RA report in alphabetical order by recipient last name. Denial reasons are listed on the RA report as well. Listed below are some examples of denial reasons:

- Recipient not eligible on date of service
- Provider not eligible on date of service
- Duplicate claim
- Claims submitted more than six (6) months from date of service (See timely filing in Section 10.4.7 below)

#### **10.4.6 Pended Medicaid Claims**

Claims that do not meet the edit requirements cannot be paid until discrepancies have been resolved. In order to verify that the claim is in error, the MMIS assigns a status of “Pend” which will outline the problem to resolve the issue.

DHCF resolves all pended Medicaid claims. The RA report will only state that the claim is suspended and will not give a reason.

#### **10.4.7 Timely Filing**

##### **10.4.7.1 Local Claims**

**MHRS Providers must submit local claims to DMH within ninety (90) days of the date of service** in order to be considered for payment processing. See pages 6-8 of Appendix A for further explanation of non-Medicaid reimbursable services paid by local funds.

#### **10.4.7.2 Medicaid Claims**

Medicaid claims must be submitted in a timely manner to avoid timely filing denial.

**MHRS Providers must submit Medicaid claims to DMH within ninety (90) days of the date of service** in order for DMH to pre-process the claim for eligibility and authorization before forwarding the claim to DHCF.

DMH guarantees that clean claims will be forwarded to DHCF for processing within five (5) business days of receipt.

#### **10.4.8 Remittance Advice**

The Remittance Advice (RA) report is the vehicle used by DHCF to communicate with the providers on the status of Medicaid claims. DHCF is responsible for creating RA reports following the adjudication cycles. The RA report provides pertinent information relevant to the claim, the errors that have been detected, and the payment amount.

## **11.0 REIMBURSEMENT**

### **11.1 Medicaid Reimbursement**

The Department of Health Care Finance (DHCF) pays for compensable services and items in accordance with established Federal and District Medicaid regulations and fee schedules.

#### **11.1.1 Medicaid Maximum Fees or Rates**

The maximum fees or rates shall be the lower of either the provider's charge to the general public or the fees/rates established by DHCF.

#### **11.1.2 Medicaid Payment Inquiries**

Providers may inquire regarding payment of claims. Inquiries must include the Tracking Control Number (TCN), the Remittance Advice (RA) payment date, and the provider's DC Medicaid identification number (this information appears on the provider's RA report). Providers should address payment inquiries to the address or phone contacts listed in the 'Inquiries' section of this manual.

#### **11.1.3 Medicaid Coordination of Benefits**

The DC Medicaid Program is the payor of last resort for Medicaid covered services. DC Medicaid benefits will be reduced to the extent that benefits may be available through other Federal, State, or local programs or third-party liability to which the recipient may otherwise be entitled.

Providers must make reasonable efforts to obtain sufficient information from the recipient regarding primary coverage. Medical resources which are primary third parties to DC Medicaid include Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Blue Cross & Blue Shield, commercial insurance, VA benefits and Workman's Compensation. If a potentially liable third party exists, providers must attempt to ensure that the mental health provider bills the third party first before sending the claim for Medicaid reimbursement. Whenever the existence of a liable third party is discovered, the provider shall attempt to recover the money from the liable third party.

The provider must obtain the following information to bill a third party:

- Insurer's name and address
- Policy or Group identification number
- Patient and/or patient's employer's address

If the District of Columbia fee rate is more than the third-party fee or rate, the provider can bill DC Medicaid for the difference by submitting a paper claim and attaching all documentation relating to the payment.

Also refer to DMH Policy 913.1, Third Party Liability (TPL) for more information regarding third party liability.

#### **11.1.4 Medicaid Method of Payment**

The DC Medicaid Program makes direct payments to eligible providers for compensable mental health care and related items dispensed to eligible recipients. In order to be reimbursed for a service, the provider must be eligible to provide the service on the date it is rendered, and the recipient must be eligible to receive the service on the date the service is rendered.

Medicaid claims are processed for payment adjudication by the Department of Health Care Finance (DHCF) each Friday evening. Remittance reports outlining the adjudication results are made available to DMH on the DHCF web portal each Monday morning. Electronic remittances in the 835 format are made available to DMH by DHCF within a week of adjudication processing. Upon receipt, on a weekly basis, DMH places the electronic file 835 remittances in each provider's individual ProviderConnect download folder.

DHCF presents a warrant of payable charges to DC Treasury which issues the check, or electronic funds transfer (EFT) to the provider within twenty-one (21) days of the payment adjudication process.

### **11.2 Non-Medicaid Reimbursement**

DMH pays for compensable non-Medicaid services and items in accordance with established Federal and District regulations and fee schedules.

#### **11.2.1 Non-Medicaid Method of Payment**

The DC Department of Mental Health (DMH) makes direct payments to providers for mental health rehabilitation services that are not Medicaid compensable, or if a consumer is not eligible for Medicaid and receives a Medicaid-eligible service.

Non-Medicaid determined service charges are processed for payment adjudication by DMH on a weekly basis, and are warranted by DMH to be paid from local DC funds. Remittance reports outlining the adjudication results are made available to providers by DMH in each provider's individual ProviderConnect download folder.

Warrants are forwarded to the DMH Accounts Payable division, which processes the warrant, and submits the payment request for a tentative due date from the DC Treasury.

The tentative payment date generally represents fourteen (14) days from the date that the Accounts Payable manager completes the processing of the warrant and submits the request for payment to the DC Treasury.

**Appendix A: Service Code/Modifier/Place-of-Service Table with Medicaid Rates and Local Rates**

Reference Section 9.3 and 10.4.7.1

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
<b>Diagnostic / Assessment</b>	T1023	HE	11-Office	Y	240.00 / Occurrence
	Diagnostic Assessment		12-Home	Y	
	(at least 3 hours)		14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0002		11-Office	Y	85.00 / Occurrence
	Brief Diagnostic		12-Home	Y	
	Assessment		14-Group Home	Y	
	(40-50 minutes in duration to determine eligibility for admission to a mental health treatment program)		53-Community MH center	Y	
			99-POS not identified	Y	
<b>Medication Somatic Treatment</b>	H0034	HQ	11-Office	Y	21.26 / 15-min Unit
	Med Somatic	Group	12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0034	HA	04-Homeless Shelter	Y	42.86 / 15-min Unit
	Med Somatic	Age 0-21	11-Office	Y	
		Individual	12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0034	Age 22 +	04-Homeless Shelter	Y	39.29 / 15-min Unit
	Med Somatic	Individual	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
<b>Community Support</b>	H0036	HQ	04-Homeless Shelter	Y	8.67 / 15-min Unit
	Community Support	Group	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
			99-POS not identified	Y	
	H0036		04-Homeless Shelter	Y	\$19.19/15-min Unit
	Community Support	Individual	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
			09-Prison/Correctional facility	N	
	H0036	UK	04-Homeless Shelter	Y	19.19 / 15-min Unit
	Community Support <sup>1</sup>	Collateral	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
			09-Prison/Correctional facility	N	
	H0036	HS	04-Homeless Shelter	Y	19.19 / 15-min Unit
	Community Support	Family Without consumer	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0036	HR	04-Homeless Shelter	Y	19.19 / 15-min Unit
	Community Support	Family With consumer	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0036	U1	14-Group Home	Y	19.19 / 15-min Unit
	Community Support	CRF			

<sup>1</sup> H0036 Community Support UK Collateral procedure code may be used when a provider has contact with another treatment provider to discuss the consumer's treatment when the consumer is not present. All collateral contact billed for through Community Support UK must be face to face.

- CBI Providers may bill for collateral, family, and telephone contacts under CBI procedures codes H2022, H2033, and H2033HU. No other modifier codes are required.
- Act Providers may bill for collateral, family and telephone contacts under ACT procedure code H0039 only.



MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
	H0036	AM	04-Homeless Shelter	Y	19.19 / 15 min Unit
	Physician Team Member <sup>2</sup>		11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0038		04-Homeless Shelter	Y	19.19 / 15-min Unit
	Self-help/Peer Support		11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H0038	HQ	04-Homeless Shelter	Y	8.67 / 15 min Unit
	Self-help/Peer Support	Group	11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
	H2023		11-Office	Y	16.25/15min Unit
	Supported Employment		53-Community MH center	Y	
	(Therapeutic)		99-POS not identified	Y	
<b>Crisis/Emergency</b>	H2011		04-Homeless Shelter	Y	33.57 / 15-min Unit
	Crisis Emergency		11-Office	Y	
			12-Home	Y	
			14-Group Home	Y	
			15-Mobile Unit	Y	
			53-Community MH center	Y	
			99-POS not identified	Y	
<b>Rehabilitation/Day Services</b>	H0025		53-Community MH center	Y	144.77 / Day

<sup>2</sup> H0036AM Physician Team Member procedure code should be used for community support (required by the consumer's approved IRP/IPC) that is provided by a community support worker (CSW)/peer specialist in conjunction with medication somatic services, when both services are provided at the same time. Medication/somatic is a rehabilitation service that must be rendered by a psychiatrist, or an APRN working in collaboration with a psychiatrist. The psychiatrist and the CSW/peer specialist must appropriately document the visit, including the reason for the CSW/peer specialist participation, and the documentation needs to be consistent with the IRP/IPC. The IRP/IPC needs to describe the specific intervention that will be provided by the CSW/peer specialist; such as: support during stressor situations, education and support for the consumer, assistance with self-monitoring and medication compliance and be specifically tied to the consumer's diagnosis and needs.

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
	Day Services				
	(1 day at least 3 hours)				
<b>Intensive Day Treatment</b>	H2012		53-Community MH center	Y	164.61 / Day
	Intensive Day Treatment				
	(1 day at least 5 hours)				
<b>Community-Based Intervention<sup>3</sup></b>	H2022		11-Office	Y	31.35 / 15-min Unit
	Community-Based		12-Home	Y	
	Intervention - CBI		14-Group Home	Y	
	(Level II) IHCBS		53-Community MH center	Y	
			99-POS not identified	Y	
	H2022		11-Office	Y	31.35 / 15-min Unit
	Community-Based		12-Home	Y	
	Intervention – CBI		14-Group Home	Y	
	(Level III) IHCBS- short term		53-Community MH center	Y	
			99-POS not identified	Y	
	H2033		11-Office	Y	57.42 / 15-min Unit
	Community Based		12-Home	Y	
	Intervention - CBI		53-Community MH center	Y	
	(Level I) MST		99-POS not identified	Y	
	H2033	HU	11-Office	Y	
	Community-Based		12-Home	Y	57.42/ 15-min Unit
	Intervention – CBI		53-Community MH center	Y	
	(level IV) FFT		99-POS not identified	Y	
<b>Assertive Community Treatment (ACT)</b>					\$31.57/ 15-min Unit
	H0039		04-Homeless Shelter	Y	
	Assertive Community	Individual	11-Office	Y	
	Treatment - ACT <sup>4</sup>		12-Home	Y	
			14-Group Home	Y	
			53-Community MH center	Y	

<sup>3</sup> CBI Providers may bill for collateral, family, and telephone contacts under CBI procedures codes H2022, H2033, and H2033HU. No other modifier codes are required.

<sup>4</sup> Act Providers may bill for collateral, family and telephone contacts under ACT procedure code H0039 only.

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
			99-POS not identified	Y	
			09-Prison/Correctional facility	N	
	H0039	HQ	11-Office	Y	11.07/ 15-min Unit
	Assertive Community Treatment – ACT	Group	53-Community MH center	Y	
			99-POS not identified	Y	
<b>Counseling</b>	H0004	HQ	11-Office	Y	10.45 / 15-min Unit
	Counseling	Group	53-Community MH center	Y	
			99-POS not identified	Y	
	H0004	HA	11-Office	Y	20.31 / 15-min Unit
	Counseling On-Site	Age 0-21	53-Community MH center	Y	
		Individual	99-POS not identified	Y	
	H0004		11-Office	Y	19.50 / 15-min Unit
	Counseling On-site	Age 22 +	53-Community MH center	Y	
		Individual	99-POS not identified	Y	
	H0004	HS	11-Office	Y	19.50 / 15-min Unit
	Counseling On-site	Family Without consumer Age 22 +	53-Community MH center	Y	
			99-POS not identified	Y	
	H0004	HE	12-Home	Y	23.19 / 15-min Unit
	Counseling Off-Site	All ages	14-Group Home	Y	
		Individual	99-POS not identified	Y	
	H0004	HR	11-Office	Y	19.50/15-min Unit
	Counseling On-Site	Family with Consumer Age 22 +	53-Community MH center	Y	
			99-POS not identified	Y	
	H0004	HAHR	11-Office	Y	20.31/15-min Unit
	Counseling On-Site	Family with Consumer Age 0-21	53-Community MH center	Y	

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
			99-POS not identified	Y	
	H0004	HAHS	11-Office	Y	20.31/15min Unit
	Counseling On-Site	Family without Consumer Age 0-21	53-Community MH center	Y	
			99-POS not identified	Y	
<b>DMH Local / Non-Medicaid MHRS Services</b>					
	H2025				
	Supported Employment		11-Office	N	16.25/15-min Unit
	(Non-MHRS Vocational)		53-Community MH center	N	
			99-POS not identified	N	
	H2025	HQ	11-Office	N	4.06/15-min Unit
	Supported Employment		53-Community MH center	N	
	Group (non-MHRS Job Club)		99-POS not identified	N	
	DMH14		53-Community MH center	N	314.00 / Day
	Residential Crisis Stabilization				
	DMH20		11-Office	N	15.00 / 15-min Unit
	Team Meeting		53-Community MH center	N	
			99-POS not identified	N	
	DMH22		04-Homeless Shelter	N	Rate Negotiated by
	Jail Diversion –		09-Prison/Correctional facility	N	individual contract
	(Criminal Justice		11-Office	N	
	System – CJS)		12-Home	N	
			14-Group Home	N	
			53-Community MH center	N	
			99-POS not identified	N	
	DMH23		53-Community MH center	N	314.00 / Day
	No-Auth Residential Crisis Stabilization				

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
	DMH24		99-POS not identified	N	Case Rate
	Integrated Community				
	Care Project - ICCP				
	DMH25		11-Office	N	1¢ / Unit
	FlexN		12-Home	N	
			53-Community MH center	N	
			99-POS not identified	N	
	DMH26		11-Office	N	25.00 / Occurrence
	Transitional Service <sup>5</sup>		12-Home	N	
			53-Community MH center	N	
			99-POS not identified	N	
	H0032		09-Prison-Correctional facility	N	19.19 / 15-min Unit
	MH Service – Discharge Treatment		21-Inpatient hospital	N	
	Planning Institution		31-Skilled nursing facility	N	
	(MHS-DTPI) <sup>6</sup>		32-Nursing facility	N	
			51-Inpatient Psychiatric facility	N	
			56-Psych. Residential Treatment Center	N	
	H0032				
	MH Service – COC Treatment	HK	09-Prison-Correctional facility	N	19.19 / 15-min Unit
	Planning Institution		21-Inpatient hospital	N	
	(MHS-CTPI) <sup>7</sup>		31-Skilled nursing facility	N	
			32-Nursing facility	N	
			51-Inpatient Psychiatric facility	N	
			56-Psych. Residential Treatment Center	N	

<sup>5</sup> DMH26 (Transitional Service) – allows a one-time occurrence fee, per consumer, to a closing Core Services Agency (CSA), for assistance with the transitioning and documentation of its consumers to another CSA.

<sup>6</sup> H0032 Mental Health Service – Discharge Treatment Planning Institution (MHS-DTPI) procedure code should be used instead of Community Support procedure code when a mental health professional or credentialed worker from the community visits a consumer who is not enrolled in ACT or CBI in the hospital or other institutional setting (Institutes for Mental Disease [IMD] such as Saint Elizabeths Hospital and Psychiatric Institute of Washington (PIW), hospitals, nursing facilities [nursing homes or skilled nursing facilities], rehabilitation centers, PRTFs, RTCs, or correctional facilities for defendants or juveniles) for the purpose of mental health service plan development for the consumer in preparation for discharge (modifying goals, assessing progress, planning transitions, and addressing other needs, as appropriate after discharge to the community).

<sup>7</sup> H0032HK Mental Health Service – COC Treatment Planning Institution (MHS-CTPI) procedure code should be used for all continuity of care (non-discharge planning services) for consumers in institutional settings (including ACT and CBI consumers).

MHRS Service Category	Procedure Code	Modifier	Place-of-Service	Medicaid Reimbursable (Y or N)	Rate
	H0046	HT	09-Prison-Correctional facility	N	31.57/ 15 min Unit
	MH Service Discharge Treatment		21-Inpatient hospital	N	
	Planning Institution (MHS-DTPI) (ACT) <sup>8</sup>		31-Skilled nursing facility	N	
			32-Nursing facility	N	
			51-Inpatient Psychiatric facility	N	
	H0046	HTHA	09-Prison-Correctional facility	N	31.35/ 15 min Unit
	MH Service - Discharge Treatment		21-Inpatient hospital	N	
	Planning Institution (MHS-DTPI) (CBI) <sup>9</sup>		31-Skilled nursing facility	N	
			32-Nursing facility	N	
			51-Inpatient Psychiatric facility	N	
			56-Psych. Residential Treatment Center	N	
	H0037 <sup>10</sup>		53-Community MH center	N	144.77 / Day
	Community Psychiatric Supportive Treatment				
	Program – Rehab/Day Services (CPS-Rehab/Day) (1 day at least 3 hours)				

**Refer to Section 9.6 of MHRS Provider Authorization and Billing Manual for definitions of Place of Service (POS) codes.**

<sup>8</sup> H0046HT Mental Health Service – Discharge Treatment Planning Institution (MHS-DTPI), ACT procedure code should be used instead of Assertive Community Treatment (ACT) procedure code when an ACT provider visits a consumer in the hospital or other institutional setting for the purpose of mental health service plan development for the consumer in preparation for discharge.

<sup>9</sup> H0046HTHA Mental Health Service – Discharge Treatment Planning Institution (MHS-DTPI), CBI procedure code should be used instead of Community Based Intervention (CBI) procedure codes when a CBI provider visits a consumer in the hospital or other institutional setting for the purpose of mental health service plan development for the consumer in preparation for discharge.

<sup>10</sup> H0037 Community Psychiatric Supportive Treatment Program- Rehab/Day Services (CPS-Rehab/Day) is a community day treatment program provided to a consumer 30-60 days prior to discharge from a hospital or other institutional setting as part of the community integration plan to acclimate the consumer to community living.

## Appendix B: MHRS Service Limitations

Reference Section 9.4.2

The following table provides a list of MHRS billable services, along with the limitations on each:

<b><u>MHRS Core Services)</u></b>	<b><u>Limitations</u></b>
Diagnostic/ Assessment	<p><u>Limitations:</u> One (1) Diagnostic/Assessment is allowed every six (6) months (180 days). Additional units may be allowable if re-authorized by DMH for periodic assessment, pre-hospitalization screening, neuropsychological assessments and re-admission to Rehabilitation Day Services or IDT, or prior to 2<sup>nd</sup> unit within 6 calendar months if re-authorized by DMH. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment.</p> <p><u>Locations/Settings:</u> DMH certified Community Mental Health Rehabilitation Services Agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.</p>
Medication/Somatic Treatment	<p><u>Limitations:</u> No annual limits. Medication/Somatic Treatment shall not be billed on the same day as Assertive Community Treatment.</p> <p><u>Locations/Settings:</u> DMH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.</p>
Counseling	<p><u>Limitations:</u> Prior authorization is required after 160 units per year. Additional units allowable with reauthorization by DMH. Counseling shall not be billed on the same day as Rehabilitation Day Services, Intensive Day Treatment, Community-Based Intervention , or Assertive Community Treatment.</p> <p><u>Locations/Settings:</u> DMH-certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting, Residential Facility of Sixteen (16) Beds or Less.</p>
Community Support	<p><u>Limitations:</u> No annual limits. Community Support shall not be billed on the same day as Assertive Community Treatment or billed during a Rehab Day session. Community support shall not be billed on same day as CBI unless community support services are provided 30 days prior to discharge from CBI.</p> <p><u>Locations/Settings:</u> DMH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting, Residential Facility of sixteen (16) beds or less.</p>
Crisis/Emergency	<p><u>Limitations:</u> No annual limits. No service combination exclusions. Retrospective authorization from DMH required when ACT provided on same day as Crisis/Emergency.</p> <p><u>Locations/Settings:</u> DMH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting.</p>

<b><u>MHRS Specialty Services)</u></b>	<b><u>Limitations</u></b>
Rehabilitation Day Services	<p>Reauthorization after first 90 units of Rehabilitation Day Services.</p> <p>Rehabilitation Day Services may not be billed on same day as Counseling, Assertive Community Treatment, or CBI or same time as community support.</p> <p><u>Location/Setting:</u> DMH Certified Community Mental Health Rehabilitation Services agency.</p>
Intensive Day Treatment	<p><u>Limitations</u></p> <p>Prior authorization is required for first seven (7) days per DMH and for reauthorization for the second and any additional episodes of care beyond 7 days up to a maximum of 14 days within a twelve (12) month period. Shall not be billed on the same day as any other service, except for Crisis/Emergency, Community Support or Community Based Intervention. Additional units of Diagnostic/Assessment may be billed for each additional episode of care, with prior authorization from DMH, when Diagnostic/Assessment pre-hospital screening occurs for purposes of determining re-admission to Intensive Day Treatment services.</p> <p><u>Location/Setting:</u> DMH Certified Community Mental Health Rehabilitation Services agency.</p>
Community-Based Intervention	<p><u>Limitations:</u> Prior authorization is required for enrollment. Re-authorization required for continued treatment. Shall not bill Community-Based Intervention, Assertive Community Treatment, Rehabilitation Day Services, Counseling or Intensive Day Treatment on the same day. CBI shall not be billed on same day as community support unless community support services are provided 30 days prior to discharge from CBI.</p> <p><u>Location/Setting:</u> DMH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting.</p>
Assertive Community Treatment	<p><u>Limitations</u></p> <p>Prior authorization is required for enrollment. Re-authorization required for continued treatment.</p> <p>ACT shall not be billed on the same day as any other service, except for Crisis/Emergency for which retrospective authorization is required.</p> <p><u>Locations/Settings:</u> DMH certified Community Mental Health Rehabilitation Services agency, Home or other Community Setting.</p>

#### **Other Services**

Residential Crisis Stabilization	<p><u>Limitations:</u> prior auth required after initial 2 days, for period up to 7 days, then re-authorization required for up to an additional 7 days (for maximum of 14 days total) .</p> <p><u>Locations/Settings:</u> DMH certified Community MH Rehab. Services agency.</p>
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## HEALTH INSURANCE CLAIM FORM

1. Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Group Health Plan <input type="checkbox"/> FECA Blk Lung <input type="checkbox"/> Other <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a. Insured's I.D. Number (For Program in Item 1) 123-45-6789	
2. Patient's Name (Last Name, First Name, Middle Initial) Test, Test		3. Patient's Birth Date Sex 01/01/1970 <input type="checkbox"/> M <input type="checkbox"/> F	
5. Patient's Address (No., Street) 1001 Any St. NE		6. Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
City Washington		City State DC	
Zip Code 20017		Telephone (Include Area Code) 202-555-5900	
8. Patient Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Student	
9. Other Insured's Name (Last, First, Middle Initial)		10. Is patient's condition related to: a. Employment? (Current or Prev.) <input type="checkbox"/> Yes <input type="checkbox"/> No b. Auto Accident? Place (State) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> c. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Other Insured's Policy or Group Number		11. Insured's Policy Group or FECA Number	
b. Other Insured's Date of Birth Sex <input type="checkbox"/> M <input type="checkbox"/> F		a. Insured's Date of Birth Sex <input type="checkbox"/> M <input type="checkbox"/> F	
c. Employer's Name or School Name		b. Employer's Name or School Name	
d. Insurance Plan Name or Program Name		c. Insurance Plan Name or Program Name	
10d. Reserved for Local Use		d. Is there another health benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, return to and complete item 9 a-d.	
<p>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</p> <p>12. Patient's or Authorized Person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>Signed Signature on File Date</p>			
14. Date of Current: Illness (First Symptoms) or Injury (Accident) or Pregnancy (LMP)		15. If patient has had same or similar illness, Give first date.	
17. Name of Referring Physician or Other Source		17a. NPI: 17b. NPI:	
19. Reserved for Local Use		16. Dates patient unable to work in current occupation. From To	
21. Diagnosis or Nature of Illness or Injury. (Relate Items 1, 2, 3, or 4 to Item 24E by Line) 1. 298.9 3. 2. 4.		18. Hospitalization Dates Related to Current Services From To	
24. A B C D E F G H I Date(s) of Service Place of Service EMG Type of Service Procedures, Services or Supplies (Explain unusual circumstances.) CPT/HCPCS Modifiers Diagnosis Code \$ Charges Days or Units EPSDT Family Plan COB		20. Outside Lab? \$ Charges <input type="checkbox"/> Yes <input type="checkbox"/> No \$0.00	
22. Medicaid Resubmission Code Original Ref. No.		23. Prior Authorization Number A20090101000	
25. Federal Tax I.D. Number 53-0196966 <input type="checkbox"/> SSN <input type="checkbox"/> EIN		26. Patient's Acct. No.	
27. Accept Assignment? (For govt. claims, see back) <input type="checkbox"/> Yes <input type="checkbox"/> No		28. Total Charges \$80.40	
29. Amount Paid \$0.00		30. Balance Due \$80.40	
31. Signature of Physician or Supplier Including Degrees or Credentials (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Rendering Prov: a. Provider NPI: b. Qual: ID: Signed Date		32. Service Facility Location Information DC CSA 35 K Street NE Washington, DC 20002-4216 a. NPI b.	
33. Billing Provider Info & Phone # DC CSA 35 K Street NE Washington, DC 20002-4216 202-442-4202 a. NPI b. Specialty Code:			

## CMS-1500 Billing Instructions

<u>Field</u>	<u>Title</u>	<u>Action</u>																
1A	Insured's ID Number	Enter the recipient's eight-digit DC Medicaid Identification number.																
2	Patient's Name	Enter the patient's last name, first name, and middle initial in this order.																
11C	Insurance Plan Name or Program Name	Enter plan name or program name if recipient has other insurance.																
11D	Is there another health benefit plan?	Mark the appropriate box.																
21	Diagnosis	Enter the Numeric ICD-9-CM diagnosis code.																
24A	Date(s) of Service	Enter the FROM and TO date of the service(s) in MM-DD-YY format.																
24B	Place of Service	For each line, enter the one code that best describes the place of service <table><tr><th><u>Code</u></th><th><u>Description</u></th></tr><tr><td>11</td><td>Office</td></tr><tr><td>12</td><td>Recipient's Home</td></tr><tr><td>51</td><td>Inpatient Psychiatric Facility</td></tr><tr><td>52</td><td>Psychiatric Facility-Partial Hospitalization</td></tr><tr><td>53</td><td>Community Mental Health Center</td></tr><tr><td>54</td><td>Intermediate Care Facility/Mentally Retarded</td></tr><tr><td>55</td><td>Psychiatric Residential Treatment Facility</td></tr></table>	<u>Code</u>	<u>Description</u>	11	Office	12	Recipient's Home	51	Inpatient Psychiatric Facility	52	Psychiatric Facility-Partial Hospitalization	53	Community Mental Health Center	54	Intermediate Care Facility/Mentally Retarded	55	Psychiatric Residential Treatment Facility
<u>Code</u>	<u>Description</u>																	
11	Office																	
12	Recipient's Home																	
51	Inpatient Psychiatric Facility																	
52	Psychiatric Facility-Partial Hospitalization																	
53	Community Mental Health Center																	
54	Intermediate Care Facility/Mentally Retarded																	
55	Psychiatric Residential Treatment Facility																	
24D	Procedure Code	Enter the CPT/HCPCS code.																
24E	Diagnosis Code	Enter the number of the diagnosis code entered in field 23 that relates to the service billed on each line.																
24F	Charges	Enter the procedure charge.																

**CMS-1500 Billing Instructions  
Continued**

<u>Field</u>	<u>Title</u>	<u>Action</u>
24G	Days or Units	Enter the frequency of units.
28	Total Charge	Enter the total of column 24F.
31	Signature of Physician or Supplier	Original signature and date
33A	Provider ID Number	10 digit Medicaid provider ID number.

## 12.0 Inquiries

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<b>Web Portal</b>	<a href="http://www.dc-medicaid.com">www.dc-medicaid.com</a>
<b>Xerox Call Centers</b> Xerox processes Medicaid claims for payment for the Department of Health Care Finance (DHCF). Contact the Xerox Call Center EDI Technical Support for Medicaid claim inquiries.	Provider Enrollment: (202) 906-8318 Provider Inquiry: (202) 906-8319  EDI Technical Support: (866) 407-2005 <a href="http://www.acs-gcro.com">http://www.acs-gcro.com</a>
<b>Eligibility Determination Information</b>	<b>Economic Security Administration:</b> (202) 724-5506 Inquiry Recertification: (202) 727-5355 Fax Request: (202) 724-2041  <b>Interactive Voice Response System (IVR)</b> (202) 906-8319
<b>Department of Mental Health (DMH)</b>	<b>Director of Provider Relations, DMH</b>  Venida Hamilton (202) 671-3155 <a href="mailto:Venida.hamilton@dc.gov">Venida.hamilton@dc.gov</a>