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<tr><td>Medicaid Reimbursement for Rehab Services: Changes to Occur July 1, 2009</td><td>Information from Bill Lessard:<br>• Providers are currently reimbursed through agency “rates” which is provider specific cost based rate subject to a ceiling. Moving to fee schedule July 1, 2009 as authorized by the General Assembly as part of the budget.<br>• The current reimbursement system is non-standard compared to other payors. (Current system uses revenue codes.)<br>• Starting July 1, providers will bill on CMS 1500 form using CPT codes<br>• 7/9 codes are visit codes; 2 of the codes are 15 minute units.<br>• Intention was to achieve the same level of reimbursement through this method as the current method with the exception of putting off adjustments for inflation this year. Rates are about 93 – 94% of what Medicare pays.<br>• The rates are for fee for services. DMAS doesn’t dictate rates to MCOs. There is still opportunity to negotiate rates. The intent is to make it easier for MCOs to have a rate schedule that will be easier for providers to agree to.<br>• There will be a transition with cost report requirements. CSB rates will still be based on full cost.<br>• CSBs will continue on cost based reimbursement until the EI changes are implemented.<br>• Detailed information about the changes will be sent via a DMAS memo.<br>Discussion:<br>• Therapists are required to use correct codes and many of the codes are not included on this list.<br>• Without the availability of all of the codes, providers will have to bill private payors and Medicaid using different codes (if the service was one for which the specific code is not part of DMAS’ list of codes) for clients with Medicaid as secondary.<br>• Providers stated that it is not possible to provide early intervention speech services for $58 and predicted that Part C will have to pay the full cost of the service if there are no Medicaid providers available. Alternatives suggested included:<br>    o Continuing to allow private EI providers to continue with cost-basis until</td><td></td></tr>
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| | October so Part C will not have to make up the difference in the reduction of funds from DMAS.<br>o Use of ARRA funds to help cover the cost of providing the services<br>**<u>Next Steps:</u>**<br>• A DMAS memo will be sent to providers explaining the new requirements<br>• Brian and Bill will take back input from the meeting for internal discussion, including the question of whether there are any options for compensating EI providers for travel/extra time costs during the July-Sept 2009 period. | |
| **DMAS Claim System** | **<u>Next Steps</u>**<br>• Brian will email information and mock ups of how the claim system will work | |
| **What is billable to DMAS?** | • **"Billable Moments" are face to face time with child and/or family**<br>• The reimbursement rate for EI takes into account all of the functions/activities that are required in order to have those "billable moments"<br>**<u>Billable to DMAS:</u>**<br>• Direct services with child and/or family<br>• Team meetings with child and/or family<br>**<u>Non billable to DMAS (Other funds must be used to support these activities)</u>**<br>• Team meetings without the family and/or child<br>• Eligibility Determination<br><br>Targeted Case Management has different rules | • The service packages for MCOs will be comparable to the fee for service package. |
| **Who can bill MCOs – do you have to be in the network?** | • Any qualified EI Provider can bill the MCO. Details are being address concerning whether a provider who is not in the MCO network will be reimbursed at a reduced rate.<br>**<u>Next Steps:</u>**<br>• An individual from DMAS's MCO division will attend a future meeting to address specific questions. | |
| **Preauthorization for MCOS** | • It is expected that the differing preauthorization procedures required by MCOs will continue.<br>• Will pre-authorization be required for team meetings? | |

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<tr><td>Early Intervention Codes – and – Maximum Units That Can be Billed</td><td>Codes:<br><u>T 1023</u> – Assessment (clinical evaluation) – to determine treatment needs in order to determine plan of treatment; Brian said this includes the IFSP development<br>This code is for billing by Reimbursement Group I (PT, OT, SLP, RN/NP)<br><u>T1024</u> – Co- treatment in natural environment or team meetings. This code can be used for the IFSP meeting.<br><u>T1027</u> – Developmental Therapy Services – Services provided by Reimbursement Group II<br><u>T1015</u> –Center-based services – reimbursed at 60% of the EI rate – Both Reimbursement Groups use this code<br><u>G0151</u> – PT in the home<br><u>G0152</u> – OT in the home<br><u>G0153</u> – Speech in the home<br><u>G0154</u> – RN or Nurse Practitioner in the home<ul><li>All units are 15 minutes.</li><li>T1023 – Assessment (clinical evaluation). Daily maximum number of units per child is 18 and annual maximum units/child is 36. (The "year" starts on the day the child is determined eligible for Part C).</li><li>The maximum daily units/per child for any combination of all of the other codes 6 units/provider with a maximum of 18 units/child for all providers</li><li>DMAS is bypassing duplicate check edits – so that it will not be an issue for several individuals in the same agencies to bill for the same code for the same day.</li><li>A supervising therapist and the supervised therapist (PT and PTA, for example) can both bill for their time on a joint visit.</li></ul>Part C needs to address how to record supervision system for OTA and PTA – in order</td><td><ul><li>The same codes will be used to bill MCOs as fee for services</li><li>The same claim methodology will be used for fee for services and for MCOs</li></ul></td></tr>
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| | to provide the authorization for the billing for both the PT and the PTA<br>• The DMAS claims system will allow billing by two providers of the same discipline<br>Part C needs to figure out how to put this on the IFSP.<br>• There is not a DMAS requirement, nor are there claims edits to require a discipline specific assessment be done/billed prior to a discipline billing for treatment<br>**Discussion:**<br>• Private providers may have same travel costs for evaluations done in centers if they are not their locations and they are not scheduled back to back<br>• Some evaluations cannot be done in natural environment due to family reasons (foster care, etc.)<br>• How will providers know if all of the child's assessment units for the year have been used?<br>o Can use ARA system to see if there are units available<br>o Service coordinators track units used/available<br>o Medicaid reports<br>• Providers requested that there be specific codes for each reimbursement group rather than having one code with different reimbursement rates depending on who provided the service (in order to limit level of complexity and potential for error).<br>• Need a separate assessment code for educators and other EI Professionals to use to bill for assessment.<br>• Need group treatment rate<br>• Part C needs to clarify requirements for billing when twins, triplets, etc are treated together.<br>**Next Steps**<br>• Internal discussions will occur about the issues raised today<br>• DMAS documents will be sent to ITF members | |
| **MD Signature on IFSP** | **Preliminary Decision:**<br>• Current requirement is 21 days | |
| **Third Party Liability – children who have** | • Medicaid has regulations that say you can't charge the families who have Medicaid for services that are covered by Medicaid | |

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| **private insurance plus Medicaid** | • Medicaid has federal requirements to collect third party payments<br>• Though Part C can allow families to decline use of private insurance, Medicaid is required to collect the third party payment<br>**Next Steps**<br>• DMAS and Part C are doing further research about how these situations should be handled | |
| **Monthly Data Reports** | • There will be monthly and annual reports from the Claims system sorted by the local lead agency for the child<br>• Reports will provide all Part C services paid for child per local system by DMAS to DMHMRSAS. Data on report will include locality, service provider, child first and last name, benefit plan, monthly intervention cost, monthly total services costs (including non-EI services). Reports will reflect date of services. Service Provider will be listed on the reports. Reports will include information only about services which have been billed.<br>• There will be an individual claim number for EI services. Two case management codes (MH and ID) will be tracked.<br>• The master enrollment report will track enrollees, date of birth, local lead, date enrolled in Part C, date of IFSP<br>• Staff in the Part C office will enroll the children in the special benefit packet in system – at this point the local lead will be tracked for the child.<br>• The local system must let the Part C Office know if the child moves to another local system so this can be entered in the data system<br>• Justification for billing Part C for children with Medicaid for service coordination will be required.<br>**Questions/Discussion/Request:**<br>• Will a child show up in the annual report for every system that the child was seen in during the year?<br>• Can Part C Office use the information from the DMAS reports to complete each local system's fiscal reporting information rather than the local system reporting the information?<br>**Next Steps:** | |

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| | • Brian will send mock up of reports | |
| **Provider Application Process** | • Application required for all providers<br>• NPI is required. Providers will have another provider type assigned to them. The taxonomy code ( 252YOOOOOX) used will alert the system to process the claim under EI.<br>• NPI info can be found on the DMAS website.<br>**Preliminary Decisions:**<br>• Consider development of a provider toolkit<br>• Put link on Part C Website to DMAS NPI info | |
| **Expense Revenue Reporting Form** | • CoCoA Steering Committee recommended that the new form be used starting July 1.<br>• The form for submitting the local system budget may be similar to page 3 of the expense/revenue reporting form.<br>**Discussion:**<br>• Barriers to use of the Expense-Revenue Reporting Form include:<br>  o Expectation that it will be an administrative burden and require additional resources<br>  o Concern that some local systems and some providers are unable to provide the information<br>  o ID Council, Leadership Council and data team concerns about reporting local funds<br>• Most providers consulted indicated that they could provide the data, though they requested that PT/PTA revenue be collapsed into one category; also OT and OTA revenue (page 3)<br>• Mary Ann stated that Maintenance of Effort is a policy issue – Feds have been clear that it includes federal, state and local funds. ARRA language is also very clear that those funds can't supplant existing funds. Fiscal audits from OSEP will look at maintenance of effort.<br>• Request was made for clarification from the AG to be provided to local systems about their responsibility for local dollars and maintenance of effort.<br>• More instructions/directions were requested in order to help people understand what is being requested so they can identify any potential barriers<br>• Mary Ann indicated that the Federal Government is requesting the breakdown of revenue by discipline. | |

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| | **Next Steps:**<br>• Mary Ann will take this input back to DMHMRSAS leadership.<br>• Revisions will be made to the form and it will be reviewed by the Grants Management Office<br>• Instructions will be developed for the form<br>• A Part C Statewide TA call will be scheduled to provide additional information about the reporting requirements on this form | |
| **Cost Revenue Reconciliation** | The Part C Office recognizes that the data available by the third quarter may not be sufficient to know what is needed by the local system and will take whatever action is needed to address. | |