Billing Instructions (RTS)

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INTRODUCTION

Behavioral Health Services Administrator (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Billing Instructions (RTS)

All Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) service providers must be under contract with Magellan of Virginia. Magellan of Virginia enrolled providers must contact Magellan directly for information on reimbursement and claims processing instructions.

Residential Treatment Services Per Diem

The following Medicaid covered services are included in the facility per diem reimbursement for the PRTF or TGH.

Per Diem Component Cannot be reimbursed separately from or in addition to the per diem	Psychiatric Residential Treatment Facilities	Therapeutic Group Home
Room and Board	Yes	No
Daily Supervision	Yes	No
Treatment Planning	Yes	Yes
Skills Restoration and ADL Restoration Interventions	Yes	Yes
Care Coordination	Yes	Yes
Crisis Response	Yes	Yes

See the list below for services that may be billed separately from the PRTF and TGH per diem. Services billed separately from the TGH per diem are covered by the youth's MCO. Services billed separately from the PRTF per diem are covered by DMAS or its relevant FFS contractor. DMAS has a number of FFS contractors depending on the service provided. No other services may be billed for youth residing in a residential treatment setting unless approved by DMAS or its contractor as an EPSDT medically necessary service.

- Physician services;
- Other medical and psychological professional services including those furnished by licensed mental health professionals and other licensed or certified health professionals, i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners;
- Outpatient hospital services;
- Pharmacy services;
- Physical therapy, occupational therapy and therapy for youth with speech, hearing or language disorders;
- Laboratory and radiology services;
- Durable medical equipment including prostheses/orthopedic services and supplies and supplemental nutritional supplies;
- Vision services;
- Dental and orthodontic services;
- Non-emergency transportation services including transportation to appointments and family engagement; and
- Emergency services including outpatient hospital, physician and transportation services

** Limited Community Mental Health Rehabilitative Services (CMHRS) may also be allowed, see Chapter 4 of the CMHRS manual for details.

Services Provided Under Arrangement and Medically Necessary EPSDT Services in a PRTF

The 21st Century Cures Act (Cures Act) requires that states must make available any services coverable under 1905(a) of the Act and the EPSDT benefit for youth residing in a PRTF and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility.

The PRTF benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. In some cases a PRTF may choose to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. This shall require such services to be components of the PRTF benefit when included in the child's plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. For services provided under arrangement, the PRTF must oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician.

Services provided under arrangement shall be documented by a written referral from the PRTF. For purpose of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

As the Cures Act requires that youth in PRTFs are guaranteed full access to the full range of EPSDT services, a plan of care is not necessary to authorize any other medically necessary services and Medicaid services may be provided by community practitioners not affiliated with the facility.

Rate Setting Process for New PRTFs

All new PRTF providers are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the PRTF Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. The PRTF Facility Rate cannot exceed $393.50 per day. Drugs and professional services must be billed directly to the MCO or the BHSA (professional services) / BHSA (pharmacy), depending on the member's benefit.

A copy of the pro-forma cost reporting form RTF-608 can be found on the Medicaid Web Provider Portal at https://www.virginiamedicaid.dmas.virginia.gov under "Provider Services" and "Provider Forms Search" section. Complete the RTF – 608 Cost Reporting Form in accordance with the following instructions and submit with additional documentation per Attachment A – Submission Instructions. The completed cost report with additional information as described in the instructions should be submitted to the DMAS cost settlement and auditing contractor.

ICD-10 (RTS)

In accordance with CMS requirements, Magellan of Virginia will move to the exclusive use of ICD-10

CM diagnostic coding structure for electronic diagnosis and billing purposes on October 1, 2015. At that time, ICD-10CM will be the only recognized HIPAA compliant coding system; therefore, it will be the only one accepted on all Magellan electronic forms and transactions. In addition, in Section I of the DSM5 titled 'Use of the Manual' and in the subsection called the 'Coding and Reporting Procedure', the paragraph informs clinicians about this upcoming transition to ICD10 in October. To assist providers, the corresponding ICD10 diagnosis codes are provided alongside the listed DSM5 diagnosis codes in anticipation of this change in recording protocols. As a result of this change, for dates of service Oct 1, 2015 and forward, providers must use ICD-10CM codes. For dates of service prior to October 1, 2015, providers will continue to use ICD- 9 codes.

All claims processing and reimbursement information can be found by contacting Magellan at 1-800-424-4536 or by email at VAProviderQuestions@MagellanHealth.com or by visiting the Magellan of Virginia website at:

http://www.magellanofvirginia.com/for-providers-va.aspx

Magellan's provider website, www.MagellanHealth.com/provider, offers an extensive set of **user-friendly**, Web-based tools designed to give providers convenient access to online resources and support.

This **secure** site allows providers to more efficiently perform the day-to-day tasks associated with serving consumers - from checking eligibility and submitting claims to staying current on training and industry best practices in a trusted, easily navigated online environment.

www.MagellanHealth.com/provider

Additional billing information for services provided under arrangement

Please refer to Magellan of Virginia’s billing instructions for managing services provided under arrangement.

Behavioral health providers with billing questions can call Magellan of Virginia at 800-424-4046 or email VAProviderQuestions@MagellanHealth.com. Non-behavioral health providers with billing questions can call the HELPLINE at 800-552-8327 (804-786-6273 Richmond area or out-of-state).