

SCL THERAPY TRANSITION WEBINAR
February 15, 2017
Questions and Answers

Morning Webinar:

1. Is March 15th a hard date for transition of PT, OT and speech language pathology from the SCL waiver to the state plan? Is the transition dependent on approval of the waiver renewal?

March 15th is the date planned for the transition. It is based on communication with CMS about the SCL renewal and has been identified as the best date for the therapy transition.

2. If the 15th, is "targeted" how much notice will providers receive when CMS approval has been received?

Providers received notice on February 1st that the therapy transition is scheduled for March 15th. This is the only notice providers will receive.

3. Is there a plan to transition therapy services from the Michelle P. and Acquired Brain Injury waivers to the state plan too?

Yes, we'll also need to transition therapy services from those waivers to the state plan, but that date has not been determined. DMS will give at least a 30-day notice when a date is set.

4. Do you always bill off the Medicaid Fee Schedule for Codes? Because for example several codes for PT & OT Evaluations/Re-evals have changed as of 1/1/2017 that aren't reflected on the fee schedule on the DMS site.

Yes, providers should bill from the Medicaid Fee Schedule. The Fee Schedule has now been updated to reflect the 2017 codes. The process may take 60 days before a new code appears on the fee schedule. Providers may request coverage of a code not on the fee schedule which will be considered on a case-by-case basis.

5. Is the episode value discipline specific?

Refer to the fee schedules on the DMS site as the value is included on the fee schedule next to each code.

6. Is there a maximum number of visits that can be requested if the frequency is not on the script?

The physician order does not have to specify the maximum number of visits. However, if the frequency is listed on the script, you must follow that frequency.

7. Is there a maximum number of visits that can be requested when utilizing the therapy extension transition spreadsheet?

For the transition, providers may not request more visits than the member was already approved for through the waiver. If there's been a change and the member now needs additional therapy, you need to submit the request along with documentation of why the change is needed.

8. Do you have to stick to the treatment plan overview (for example, 6 times a week x 12 weeks), or can weekly totals be more/less every week as long as you don't go over total visits?

As long as you don't go over the total visits, the number of visits may vary from week to week.

9. I have received one PA for Medicaid but there is not a service code, how do we know which code was approved?

PAs are approved based on the visit. The provider may determine which codes are appropriate to be included within a visit as long as they are included on the fee schedule. It's also important for providers to understand correct coding guidelines—what the code is and what the requirements are to bill that code.

10. Even though this is focused on the SCL waiver therapy transition, do the first 20 state plan therapy visits that don't require prior authorization apply to Medicaid recipients who do not receive waiver services?

Any fee-for-service Medicaid recipient in need of therapy services may receive 20 therapy visits without prior authorization each calendar year. Although waiver members are not part of managed care, if serving a member who is assigned to a Managed Care Organization (MCO), the MCO may establish its own prior authorization requirements and processes. In order to serve a member assigned to an MCO, you will need to contract with that MCO.

11. Is there a maximum number of units that can be billed in a visit?

There's not a maximum number of particular codes or disciplines that can be provided in one visit. However, due to National Correct Coding Initiative (NCCI) guidelines, there are certain codes that cannot be billed together in one visit or on the same day. Providers should be aware of and follow correct coding guidelines. For more information on NCCI, please visit <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/>.

12. Does the 6 month transition period for recipients currently in the SCL waiver apply to dual eligible recipients?

Yes, providers may submit the first two therapy PA requests for Medicaid waiver recipients who are dually eligible for Medicaid and Medicare based on the same number of therapy visits previously approved through the SCL waiver. Please be aware that Medicare must typically be billed before Medicaid for dual eligible recipients. See Question #13 for more information about billing for Medicaid/Medicare dual eligible recipients.

13. What if a provider is not a Medicare provider - in the case of a dual eligible member?

By law, Medicaid is a payer of last resort, meaning that if a Medicaid-eligible individual has another form of insurance (for example, Medicare), that insurance entity is responsible to pay for medical costs before Medicaid pays. If you are not already enrolled with Medicare, you may need to enroll as a Medicare provider and bill Medicare for these services first, if you provide therapy services to individuals who are covered by both Medicaid and Medicare (dual-eligible). Medicare does not recognize all provider types that Medicaid recognizes and, therefore, some HCBS waiver providers will not be able to enroll as a Medicare provider. As a general rule, if Medicare recognizes the provider type in which you are licensed as a Medicaid provider, then you will need to enroll as a Medicare provider and bill Medicare first for these services. It is the provider's responsibility to determine if they need to enroll as a Medicare provider.

14. How long are MD Orders good for?

Physician orders are good for 90 days. More specifically, if a provider requests therapy now and the order was written 30 days ago and is for 90 days, the PA will be issued for the 90 days requested in the order. We're following Medicare guidelines on how often a physician order is needed for therapy.

15. Where do you get informed on coding guidelines?

Most coding guidelines can be found through an internet search. There are also coding books that can be purchased, which include information on who may perform the service, units, limitations, and codes that cannot be billed together. National Correct Coding Initiative guidelines also apply to codes used to bill Medicaid, and those can also be located through an internet search.

16. After transitioning individuals from the waiver to the state plan (using the Therapy Extension Spreadsheet), is any documentation (scripts, progress notes, etc.) required to request the first two PAs, or do those requirements not come into effect until the third PA under the state plan is being issued?

The requirements for the physician order and any supporting documentation do not come into effect until the third PA request. Since we're transitioning, the physician order and documentation carries over from the previously approved waiver services.

17. Can you speak to when a member has another private insurance, for example Humana?

By law, Medicaid is a payer of last resort, meaning that if a Medicaid-eligible individual has another form of insurance (for example, private insurance), that insurance entity is responsible to pay for medical costs before Medicaid pays. The provider would need to bill the private insurance company before billing Medicaid.

18. Is there any phone number/specific person we can reach out to when utilizing the therapy transition spreadsheet?

Please use the therapy email address included in the second presentation: TherapyPA_Request@hpe.com. HPE is setting up new telephone lines and will share the telephone number for questions once it is available.

19. Please explain if an agency has become a Mobile Health Service provider are they also a Type 76?

To be enrolled with Medicaid as a Multi-Therapy Agency, Provider Type (PT) 76, the provider must be licensed unless the provider is exempt from licensure. The licensure types that may be utilized by PT-76 agencies are listed

on the DMS provider enrollment website and include Adult Day Health, Special Health Services Clinic, Rehabilitation Agency, or Mobile Health Service. Many PT-76, Multi-Therapy Agencies, are licensed as Mobile Health Services which allows agencies to deliver services in the community, including at another provider's service location. Providers should contact the Office of Health Policy (502-564-9592) and the Office of Inspector General (502-564-7963) to determine whether licensure is required.

If providers are only providing one discipline, then the provider should enroll as that profession's group. For example, if only providing physical therapy, the agency should enroll as a PT Group (Provider Type 879) and have the individual therapies enroll and link to that group.

20. Will therapies be billed under the Medicaid optimum choice eligibility group?

These eligibility groups or plans are not relevant for billing therapy services. Providers should verify that the recipient is Medicaid eligible. If the individual is served by an MCO, you would need to contact the MCO for prior authorization. Please remember that waiver participants are not enrolled in managed care. If you identify a waiver participant who is assigned to an MCO, please notify DMS. As a state plan provider, you are eligible to serve Medicaid members who are enrolled in managed care. You would need to contract with the MCO in order to serve these members.

21. Could we go ahead and transfer MPW during this transition using the transition spreadsheet?

No, only the SCL waiver therapies are being transitioned to the state plan effective March 15, 2017. This transition will occur in each of the waivers, at a date specified for that particular waiver. Providers will be given at least a 30-day notice when a transition date is set for the other waivers.

22. Will you send out the answers given to these questions being asked?

Responses will be posted on the DMS web site.

23. Have the MCO's been notified about accepting a multi-therapy agency (MTA) as a billable entity?

Yes, the MCOs are aware of Provider Type 76, MTA. The MCO should also recognize the licensure of the agencies that have enrolled as an MTA.

24. Once a patient is transitioned do the providers need to maintain the same paperwork that was required for SCL ie. yearly dental and health exams?
Overall waiver participant health information that SCL providers are required to maintain by the SCL regulation would be the responsibility of the SCL waiver provider providing the SCL service. The state plan therapy provider would be required to maintain information related to the therapy services provided to that waiver participant.
25. What if the CMS approval of the SCL renewal application does not come by March 15th?
See the response to Question #1.
26. Is there information available readily regarding the audit process for therapy providers under the state plan? Frequency? Monitoring tools used? Etc?
DMS does not generally schedule routine audits of state plan providers, as we do for waiver providers. Instead, DMS is constantly reviewing utilization data for state plan services to identify patterns outside the norm or reflect potential incorrect or fraudulent billing. Once claims that are outside the norm are identified, Medicaid's Division of Program Integrity conducts record reviews to determine if the documentation supports the billing and to determine if there have been any erroneous billing, coding or usage errors resulting in overpayment. If the audit reveals possible fraudulent activity then a referral is made to the Office of the Inspector General, Attorney General's Office of Medicaid Fraud and Abuse, and/or appropriate Federal agency. More information regarding overpayments is outlined in 907 KAR 1:671.
27. What is the best seminar to attend for billing training? Or is it best to just call?
Reach out directly to your HPE provider representative and they can set up individualized training. If you do not know who your provider representative is, call the HPE provider inquiry line (800-807-1232).
28. If a patient has Medicare and Medicaid, I just want to clarify that we can bill Medicaid if we are not a Medicare provider.
See the response to Question #13.

29. Does a Type 76 have to also have a Mobile Health Service license?

See the response to Question #19.

30. What's the easiest way to find the training information?

Billing instructions are available at the following link:

<http://www.kymmis.com/kymmis/Provider%20Relations/billingInst.aspx>. For specific billing questions, please contact HPE Provider Inquiries at 800-807-1232.

31. Do you foresee EPSDT going to this system?

If a service is otherwise available through the state plan without limitation, it should not be covered through EPSDT. Previous communication was sent to EPSDT providers that services will need to transition from EPSDT to the state plan therapy benefit. No date has been for that transition. DMS plans to transition therapy from all the waivers first. DMS will give providers at least a 30-day notice and hold another webinar prior to implementing that transition.

Afternoon webinar:

32. On the Therapy Transition Spreadsheet... How flexible are the reviewers with conversion of ONGOING SPEECH units (currently 15 minute increment on waiver) to visits (untimed episode under straight Medicaid). For example, a PA that has 16 units on it - Some clients need/receive 1 visit per week for an hour, while others need/receive 2 visits for 30 minutes. So for some clients, 16 units would need to convert to one visit, while for other clients, it would need to convert to 2 visits. Is this ok?

This should be okay as long as you are following correct coding guidelines. We're allowing the waiver PAs to be submitted as visits, and within the visit, the provider may include the appropriate number of units following correct coding guidelines..

33. How do we know if a prescribing agent is a KY Medicaid provider when we're requesting the order?

You may utilize the on-line provider directory at <https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx> for fee-for-service providers, or the on-line directory of each of the Managed Care Organizations. You may also call DMS Provider Services at 855-824-5615.

34. Is there somewhere that gives a description for the 5 digit codes on the DMS fee schedule?

See the response to Question #15.

35. Can we specify a specific Start date for PAs if we send in Therapy Transition spreadsheets early, or will medicaid automatically use 3/15 as the start date for straight Medicaid PAs sent in on spreadsheets?

March 15 will be the start date. If the provider would like to stagger the end dates of the PAs, the provider should indicate varying end dates on the therapy transition spreadsheet they submit to HPE. This way, all the PAs will not require renewal on the same date. Contact HPE if you have further questions on this process.

36. Do we need to get new orders to accompany the requests on the Therapy Transition Spreadsheet?

No, new physician orders are not required with the Therapy Transition Spreadsheet.

37. So the therapy provider completes and submits the transition spreadsheet, not the case manager correct?

Correct. The state plan therapy provider completes and submits the therapy transition spreadsheet. The state plan therapy provider should work with the previous (waiver) therapy provider to get any needed background information. The case manager should help to facilitate this communication.

38. Are we able to bill from KYMMIS the same way we bill waiver services or will we need a separate software?

Medicaid providers can bill from KYMMIS using their state plan therapy provider number.

39. Is there a handbook on codes that can be billed simultaneously?

See response to Question #15.

40. Can you speak more about the specifics of how and when the case manager amends the PCSP?

The PCSP should be amended when the services transition to the state plan.

41. Will we continue to bill anyone 21 and under through Michelle P Waiver or through the State Plan?

The current transition is only for SCL waiver participants. PT, OT and SLP services for children under 21 were transitioned from the Michelle P. Waiver to EPSDT services a few years ago. As indicated in the response to Question #31, we will need to transition those services from EPSDT to the therapy benefit in the state plan. DMS will notify providers when this transition is to occur. In the meantime, therapy services for children receiving Michelle P. Waiver services may be covered through EPSDT or the state plan therapy benefit, depending how the therapy provider is enrolled in Medicaid.

42. Case managers are wanting to confirm that we need to continue asking for POCs under the waiver until 3/15.

Waiver participants will need a waiver POC in place for therapy services until March 15th.

43. Does KYMMIS use the January 2017 CPT code handbook (most recent version)?

Yes. DMS uses the most recent version available.

44. Are the case managers required to send in a MAP 530 indicating an end date on the current Prior Authorizations that have been generated through Waiver before 3/15/2017?

No. HPE will systematically end date the existing waiver therapy PAs and issue new PAs for state plan therapy services based on the information provided on the Therapy Transition Spreadsheet.

45. How does the state plan differ from MCO?

As a state plan therapy provider, you may serve any Medicaid recipient including those in managed care. If you wish to provide therapy services to Medicaid recipients served by MCOs, you will need to contract with those MCOs. MCOs are required to cover all state plan benefits, including PT, OT and speech-language pathology. The MCOs may establish their own requirements and processes for prior authorization for services.

46. So is the spreadsheet sent through the case manager or the therapy service provider?

See response to Question #37.

47. On page 5 of the first handout it says the case manager is to "insert them as state plan services." Is that an option on MWMA? And what if a participant's current plan isn't on MWMA?

Yes—state plan services should be included in the plan of care (POC) in MWMA. If the POC is not in MWMA, the case manager should FAX the updated POC, with the therapy services shown as state plan services, to Carewise.

49. What if we have applied for a mobile health license, but have not heard anything back yet. We have heard it is ok to go ahead with services as long as an application has been submitted. Is this correct?

Licensure must be complete before you can enroll as a Medicaid provider or provide services to Medicaid members. If your licensure application is pending and you are not otherwise enrolled in a State Plan provider type, please contact Kate Hackett or Sapna Sairajeev at 502-564-1013 with your name and NPI. DMS will check on the status and try to assist in any way.

50. What is the processing timeline for becoming a Multi Therapy Agency Type 76?

DMS is expediting applications for the therapy transition with the majority taking only a few days or weeks. If you have not been enrolled after 30 days of receipt, contact Kate Hackett or Sapna Sairajeev at 502-564-1013.

51. If we have separate PT, ST, & OT group license numbers, is the mobile health required? Or is it just required for provider type 76?

Therapy groups composed of a single discipline (for example, physical therapists only) and owned by a professional of the same discipline do not require licensure as an organization and should enroll as a PT, OT or SLP group. Only those providers who want to provide two or more disciplines or are limited in where they can provide services should enroll as a PT-76. For specific questions about licensure, contact the Office of the Inspector General. Providers should ensure they are complying with all of Kentucky's health care laws as well as requirements for Medicaid enrollment.

52. If you have an ADT and have PT, ST and OT waiver participants come to you to receive services, do you need a mobile health number?

Licensure type governs the location where services can be provided. Adult Day Health Centers are permitted by their licensure to provide PT, SLP and OT services within their facility, but not in other locations. (Please note—this relates to licensed Adult Day Health Centers. Adult Day Training programs are typically not licensed, but certified waiver providers.) Mobile health licensure allows service provision in the provider’s facility, as well as in the home or community and other service settings.