Medicaid Direct Tailored Care Management Provider Claims Billing Guidance

Purpose:

This billing guide serves as an overview of the Medicaid Direct Tailored Care Management claims and encounters processes and procedures for Tailored Care Management 12/1/2022 through 3/31/2022. The information contained in the guide is targeted for Department certified Tailored Care Management providers (AMH+ & CMAs).

Background:

Through Tailored Care Management, Medicaid Direct beneficiaries will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all their needs: physical health, behavioral health, I/DD, traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health related resource needs.

Main Billing Guidance Takeaways:

- From 12/1/22 to 3/31/23 The Department will be assigning eligible TCM Beneficiaries to certified Tailored Care Management (TCM) entities i.e., AMH+, CMA, or a Medicaid Direct PIHP to receive TCM services.
- LME/MCOs will be paid for TCM through a capitation rate from 12/1/22 through 3/31/2023. LME/MCOs will not submit any claims to the Department for these payments during this time span.
- TCM providers (AMH+ and CMAs) will be paid through a blended TCM rate and will be required to submit TCM claims to their respective contracted LME/MCOs for the first TCM contact with a member per month. LME/MCOs will need to process and pay these TCM provider claims.
- LME/MCOs will submit the TCM Provider claims to NC Tracks as encounters. LME/MCOs will not submit any TCM encounters to EPS during this time.
- All TCM interactions/contacts should be documented by the respective TCM entity performing the service(s). TCM Providers should submit that data to their respective LME/MCOs through the Patient Risk List (PRL).
- LME/MCOs should submit all TCM interactions/contacts for their eligible TCM population to the Department through the BCM051 operational report. LME/MCOs should include their TCM contacts as well in that report.
- LME/MCOs should have processes to archive historical Tailored Care Management claims data submitted to the State for Federal and/or State audit purposes. Please refer to the LME/MCO contract for detailed information.

Tailored Care Management Claims Billing Guidance for TCM Services Furnished by AMH+/CMAs:

AMH+ and CMA Claims Submission to LME/MCOs:

AMH+ and CMAs which furnish TCM services are required to submit a TCM Claim to their respective contracted LME/MCOs for only the first TCM interaction with a beneficiary per month. Guidelines for submission of TCM Claims to the Medicaid Direct PIHPs are below:

- AMH+/CMAs should identify a beneficiary's first TCM interaction of a given month based on date of service.

- AMH+/CMAs should not bill for or perform TCM services if a member is concurrently receiving a duplicative service.
    - Duplicative services include:
        - ACT
        - HiFi Wrap Around
        - Critical Time Intervention
        - Child ACTT
    - The Department will communicate any additional services identified as duplicative to TCM as appropriate.
    - **Note:** Tailored Care Management can be billed for the first and last month that a member is receiving a duplicative service(s) to allow for transitional care management.
- Procedure code: Tailored Care Management service claims should be submitted with procedure code T1017 and the HT modifier
- Billing & Rendering Provider:
    - AMH+ providers should submit the NPI and Location Code of the provider that furnished the services as the billing and rendering provider for TCM Claims.
    - CMAs providers should submit the Administrative Site (NPI and Location Code) of the provider that furnished the services as the billing and rendering provider for TCM Claims. CMAs will establish an Administrative Site with PIHPs for each county where members are served.
- Billing Taxonomy code: AMH+/CMAs should submit the appropriate taxonomy for which they are enrolled with NC Medicaid.
- Place of Service Code: AMH+/CMAs should submit the location where the service was rendered such as in a School, Home, Place of employment, etc.
- Diagnosis Code(s): All claims submissions require diagnosis codes for processing. TCM Claims need to have at least one Medicaid Recognized diagnosis code to process. Other than validation a diagnosis code is present, there will be no edits specific to Diagnosis code for TCM Claims
- Claim Amount: AMH+/CMAs should submit claim amount based on the blended TCM rate for all TCM beneficiaries. The Department will publish the blended TCM rate to the LME/MCOs and the TCM Providers.

Medicaid Direct PIHP Adjudication of AMH+ and CMA TCM Claims:

After receiving the TCM claim(s), LME/MCOs will adjudicate the AMH+/CMAs Tailored Care Management claim(s). Their adjudication process must:

- Validate that Billing and Rendering Provider information aligns with the guidance shared above based on date of service
- Validate that AMH+/CMAs are only submitting one claim per beneficiary per month for the first TCM Claim of the month for a given beneficiary based on date of service. The first claim received for a date of service within the month would be paid and any claims received after that for service in the same calendar month would be denied.
- Validate that the TCM beneficiary did not also receive any duplicative service(s) within the same month that they received a TCM service except within the first and last month to allow for transitional care management.

Payment to AMH+/CMAs:

Tailored Care Management Claims that meet all the requirements and rules will be processed and paid by the LME/MCOs at the blended TCM rate regardless of the claim billed amount and no lesser of logic will be used.

Tailored Care Management interactions and the BCM051 Report:

LME/MCOs will populate the BCM051 report with all Tailored Care Management interactions that they provided as well as those interactions provided by Tailored Care Management providers who will submit those on the Patient Risk List (PRL) to their respective LME/MCO. This report will be submitted on monthly cadence to NC Medicaid by LME/MCOs. LME/MCOs and Tailored Care Management providers should reference the Data Specification Guidance (Patient Risk List) for more detailed information regarding the use of the Patient Risk List (PRL) File.

Supporting Tailored Care Management Reference Documentation:

LME/MCOs and TCM Providers shall utilize the Tailored Care Management Billing Guide in conjunction with the Beneficiary Assignment file and the TCM Duplicative Services and identification criterion as sources of truth when submitting and/or adjudicating TCM Claims.

The Department will send a monthly report to the LME/MCOs that will include their respective members that are receiving Duplicative Services and are part of the excluded population through secure email. The 1st submission will start around Mid-November, the Department will confirm the 1st submission date by 10/31/22.

Resources/Links:

- Data Specifications and Requirements for sharing Patient Risk List File
- https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set