Vermont Developmental Disabilities Services Division: FAQ to Accompany Encounter Data Claims Submission Guidance

2/28/20

Introduction:

To support provider understanding of encounter data Submission expectations, DAIL DDSD has developed a DDSD Encounter Data Submission Guidance for Agency-Managed and Shared-Managed Services, herein referred to as "DDSD Encounter Data Guidance" or "Guidance". Providers were asked to send any questions they had after receiving the Guidance. This document is intended to address the specific questions DDSD has received to further clarify information regarding DDSD encounter data claims submissions. This document is a supplement to the DDSD encounter data guidance and should be used together with the DDSD encounter data guidance and all relevant provider resources to gain a full picture of DDSD encounter data requirements. The questions and answers 1-58 were published on 1/23/20. Questions 59- 74 are being added 2/28/20. This document will continue to be updated as new questions are submitted to DDSD.

Questions and Answers Published 1/23/20:

General Medicaid Operations Questions:

Q1: What are the various data sources that inform DDSD Encounter Data Claims submissions?

A1: There are a variety of sources of information for the encounter data claims. Data used to populate encounter data claims may come from:

- Your agencies own staff, likely utilizing an Electronic Medical Record; or information from timesheets,
- Shared Living Providers,
- A subcontractor of your agency, who may bill you via invoice; or
- ARIS in their capacity as the Fiscal/Employer Agent (F/EA) for ARIS paid services.

Regardless of the data source, agencies need to include all service delivery utilization data in encounter data claim submissions.

Q2: Does Vermont Medicaid have provider resources that provide step by step directions for how to submit claims and how to use the online claims submission platform?

A2: Yes. The Vermont Medicaid provider portal http://www.vtmedicaid.com/ contains a wealth of information to guide Medicaid providers in understanding and complying with general Medicaid policies and operations. A few examples include, but are not limited to:

- Vermont Medicaid General Billing and Forms Manual: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf
- Vermont Medicaid General Provider Manual: http://www.vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf
- CMS 1500 Claim Form Presentation: http://www.vtmedicaid.com/assets/resources/CMS1500Presentation.pdf
- Information on Vermont Medicaid's online claims submission platform known as "PES": http://www.vtmedicaid.com/#/pes

Additionally, providers are encouraged to contact either the DXC call center, or their region's assigned provider representative with any questions about claims submissions, denials, or other. Detailed contact information can be found at the Vermont Medicaid Provider Portal, or at http://www.vtmedicaid.com/assets/manuals/ProviderRepMap.pdf.

Q3: Do I have to include a Place of Service (POS) code on my DDSD encounter data claims submissions?

A3: Yes. POS is a required field on a Medicaid claim form (Box 24, B). If you do not include a POS code, your encounter data claim will deny. DAIL has selected the following POS codes as allowable for DDSD encounter data claims. If you submit a POS that is not on the following list, your claim will deny:

- 12 Home
- 18 Community
- 39 Adult Day Care
- 53 Community Mental Health Center
- 99 Other Unlisted Facility

For ARIS paid services, ARIS has been directed to include POS 12 (Home) on all encounter data claims.

Q4: I noticed that the definitions provided for allowable place of service (POS) codes does not correspond with the Federal Medicare/Medicaid Service Locations which are hard coded into my EMR (as follows), why is this?

DDSD Provided Place of Service Code Definitions

- 12 Home
- ***18 Community***
- ***39 Adult Day Care***
- 53 Community Mental Health Center
- ***99 Other Unlisted Facility***

Federal Medicare/Medicaid Locations

- 12 Home
- ***18 Place of Employment-Worksite***
- ***39 Unassigned***
- 53 Community Mental Health Center
- ***99 Other Place of Service***

A4: POS codes are 2-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains the nationwide use of POS codes (https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set). Vermont Medicaid acknowledges the misalignment between some definitions assigned by Vermont Medicaid and CMS. While Vermont Medicaid works to address this issue across all Vermont Medicaid operations, providers should use the codes with the Vermont Medicaid specific definitions referenced in the DDSD encounter data reporting guidance.

Q5: Is there a list of all place of service codes utilized by Vermont Medicaid?

A5: Yes. More information, including a link to the CMS Place of Service Codes for Professional Claims can be found under the header place of service (POS) in the Vermont Medicaid General Billing and Forms Manual: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf.

Q6: There are several procedure code modifiers included in the DDSD Encounter Data Guidance. Why is the DDSD asking me to use them on my encounter data claims? Isn't this going to make my billing more complicated?

A6: While they may add additional complexity to encounter data claims reporting, procedure code modifiers give the DDSD the information it needs to apply an appropriate value (rate) to a service, which may vary when different service delivery circumstances exist. This information will be used in the reconciliation process, so it is important that the correct value is applied to each service delivered. Ultimately the reconciliation process will allow the State to ensure appropriate payments to providers.

Q7: How do I know what these modifiers mean and which procedure codes I should use them with?

A7: In "Appendix A: Modifier Definition Key" of the DDSD Encounter Data Guidance you can find the modifier definitions[1]. In "Appendix B: Encounter Data Code/Modifier Combinations" you can find a procedure code by procedure code list of all services for which use of a modifier is either allowed or required. If a modifier is not listed in combination with a procedure code,

[1] Modifier definitions are aligned with the 2019 HCPCS Level II Professional Edition Manual definitions. In the case of modifiers U1-U5, these codes are available for a "state defined level of care as defined by each State". The DDSD has applied DDSD specific definitions for these modifiers to use in DDSD encounter data claims.

then it is not an approved procedure code modifier combination and will result in a denial of the encounter data claim submission. It is also important to note that the order of modifiers has been defined in appendix B and must be followed. Finally, if questions remain, in "Appendix D: Inclusive List of Code/Modifier Combinations" you can find a list of all procedure code and modifier combinations. If an encounter data claim is submitted with a procedure code modifier combination that is not on this list (the exact order matters) then the claim will deny. There are still a few services for which the state is working to identify procedure codes and/or modifiers. These will be added in subsequent version of the Guidance.

Q8: The encounter data guidance indicates that modifiers UN and UP can be used with procedure code T2021 when encountering group community supports. What if you have more than 3 people served? Can we use UQ, UR or US as well?

A8: No. DDSD intends to issue a policy requiring that the maximum ratio for group community supports is 1 staff per 3 people served. It is the Division's stance that higher staff to participant ratios represent challenges related to individualization of services, potential quality concerns and health/safety risks.

Q9: I'm confused by time-based procedure codes and reporting units for DDSD encounter data claims. For example, the Vermont Medicaid Manual for Developmental Disabilities Services says that 15 minutes to 30 minutes = 2 billing units, but the DDSD Encounter Data Guidance says that 15 minutes = 1 billing unit. Also, are there any "rounding" rules that apply to DDSD encounter data claims?

A9: The Vermont Medicaid Manual for Developmental Disabilities Services provides guidance (pg. 8) for service units of time **not** defined by CPT or HCPCS codes. For DDSD encounter data claims, all covered services are represented by CPT and HCPCS codes, so the Vermont Medicaid Manual for DDSD guidance does not apply to DDSD encounter data. Rather, the DDSD encounter data codes follow correct and accurate coding as defined in the current billing manuals. For time-based procedure codes, the unit of time is obtained when the mid-point is passed ("rounding" rule). The following are some examples:

This means that for a 15-minute code:

- One unit is achieved if 8 minutes of service are delivered
- Two units are achieved if 23 minutes of service are delivered
- Three units are achieved if 38 minutes of service are delivered, and so on.

This means that for a 30-minute code:

- One unit is achieved if 16 minutes of service are delivered
- Two units are achieved if 46 minutes of service are delivered
- Three units are achieved if 76 minutes of service are delivered, and so on.

This means that for a 50-minute code:

- One unit is achieved if 26 minutes of service are delivered
- Two units are achieved if 76 minutes of service are delivered
- Three units are achieved if 126 minutes of service are delivered, and so on.

This means that for a 60-minute (hour) code:

- One unit is achieved if 31 minutes of service are delivered
- Two units are achieved if 91 minutes of service are delivered
- Three units are achieved if 151 minutes of service are delivered, and so on.

Q10: For codes that say 1 unit = 1 session, such as 90791, 90792, and 90853 is there a minimum amount of time that must be incurred before I can begin billing?

A10: No, these is not a minimum amount of time that must be incurred before you can begin billing. These codes are considered untimed codes and are designed to represent the full encounter regardless of duration.

Q11: If this is a "zero-pay" claim, what should I put in the Charge field (24F) and Total Charge field (28) on the claim form?

A11: The MMIS has been programmed to pay an amount of $0 regardless of charges included on a claim form. When ARIS F/EA populates the 837 claims file, they will include a billed amount in the charge fields. This amount represents the amount the employee was paid plus employer taxes and sick leave funds. For services paid through provider agencies, DDSD has learned that for accounting purposes some providers often include a charge of $0.01 on encounter data claims to minimize the expectation that these claims are tied to significant revenue source, or that there is significant unearned revenue represented in the payments. Agencies can follow this practice if it is helpful. Otherwise, they should enter $0.

Q12: If a consumer receives 3 encounters for a particular service (for example service coordination) in the same day, do I have to record this as 3 separate line items on my encounter data claim, or can I roll them up into one line item with 3 units?

A12: None of the codes being used for DDSD encounter data have a unit that is measured by an encounter or session that would be acceptable to bill more than one per day. If a service is done during separate encounters or times during the same calendar day, and the code's unit is time based, please refer to the next Question/Answer.

Q13: When a code is "time based" (15 minutes, 30 minutes, 1 hour etc.) can our staff track time spent on the same individual and the same service at different points throughout the day and then report the cumulative time?

A13: Yes, because these zero-pay claims are for data collection purposes, DDSD will allow the time to be rolled up and reported on one line of the claim for the time devoted to the same individual on the same date of service for any given time-based service code. Detailed reporting should still be maintained and available upon request by DDSD that would illustrate the total number of minutes of service delivered for the date of service.

Here is an example of calculating cumulative time across a day:

Client	Date	Service	Start	Stop	Minutes
Bob	01/08/2020	T1016 service planning and coordination (15 min)	08:15	08:28	13
	01/08/2020	T1016 service planning and coordination (15 min)	10:11	10:42	31
	01/08/2020	T1016 service planning and coordination (15 min)	02:10	02:30	20
	01/08/2020	T1016 service planning and coordination (15 min)		**Total for Date of Service**	**64**

Zero-pay claim:

Line 1 01/08/2020 T1016 4 units

The rules for "rounding" up or down as described in answer 9 above should be applied to the total cumulative minutes for the day.

Q14: What if a code crosses over two Dates of Service (DOS)? How many units and which dates do I submit?

A14: If a service, such as hourly (not daily) respite care, is performed during two calendar days consecutively, such as a night shift that goes past midnight, the service should be reported using the time-based code. Actual dates of service and hours for each date of service should be reported on the claim.

Example:

Respite worker reports on their timesheet: 9:00pm 01/05/2020 – 8:00am 01/06/2020

Zero-pay claim:

Line 1	01/05/2020	S5150 (respite 15 minutes)	12 units
Line 2	01/06/2020	S5150 (respite 15 minutes)	32 units

For services for which the unit of service is a day (e.g. daily respite, 24-hour residential service), the date of service should be reported as the date in which the service started with one unit being reported.

Q15: Procedure Codes 99211-99215 are defined as evaluation and management of an established patient, and procedure codes 99201 – 99205 are defined as evaluation and management of a new patient. Only the codes for established patients were included in the most recent draft of encounter data guidance, does that mean I can't encounter claims for new patients for these services?

A15: It is DDSD's intention that services can be encountered for all people served utilizing correct coding conventions. Unfortunately, through reviews of our selected code lists both internally at the state and by providers, no one had mentioned these missing codes. DDSD will work to correct this issue to comply with correct coding as soon as possible. Although it will not be consistent with correct coding, in the short term, until this issue is addressed, agencies may submit the encounters for new individuals for evaluation and management under the codes that most closely align with the service being delivered, which is likely the codes for established people. During the initial phase of collecting encounter data, the information will be used primarily to determine the volume of this service being provided to individuals and not for the purposes of reimbursement. So, the state will still have the information it needs for the initial phase of the project.

Q16: Similarly, 90833, 90836 and 90838 are considered "add on" codes to the previously mentioned evaluation and management codes and have not been included in the DDSD encounter data guidance. Does this mean I cannot use these codes?

A16: See answer to Question 15.

Q17: Procedure code H0046 is not a time-based code and is being used to encounter an emergency crisis bed day. If there a minimum time threshold for when this code can be reported?

A17: In an effort to align with guidance for mental health services, the minimum threshold for encountering the initial emergency crisis bed day is defined as completion of intake into the facility. Staff will continue to document one encounter per day until the date of discharge. For stays in VCIN, the day of discharge should not be reported as an encounter for that day. For

agency run beds, there is not a strict rule in policy, but the rule of thumb is if the person is discharged in the morning, the day is not reported, but if the person discharges in the afternoon or later, they may report that as a crisis bed encounter for that day.

Q18: Do Supervised Billing Rules apply to IDDS Services? If so, how do I submit encounter data that complies with Medicaid policy and use of supervised billing modifiers (HO, AJ, AH, and HN)?

A18: The DDSD does not intend to make any modifications to existing Medicaid supervised billing guidance as outlined in the Vermont Medicaid General Provider Manual. To remain consistent with correct coding convention, DDSD will be seeking to add these codes to a future version of encounter data guidance as soon as is possible. As noted in the answer to question 16, during the initial phase of collecting encounter data, the information will be used primarily to determine the volume of this service being provided to individuals and not for the purposes of reimbursement. So, the state will still have the information it needs for the initial phase of the project.

Q19: What do I do if I received an encounter data claim denial? Should I try to resubmit it? How do I resubmit it?

A19: Providers will receive a Remittance Advice (RA) containing information on all DDSD encounter data claims, including whether they were successfully processed to completion, or resulted in a claim denial. All claims denials will include a denial reason code. DDSD service providers are welcome to research claim denials, and if it is found that the reason for the denial can be appropriately addressed, resubmit the claim. Please reference the Vermont Medicaid General Provider Manual for detailed information regarding claims submission and/or resubmission processes. For questions related to claims denials, please contact either the DXC call center, or your region's assigned provider representative. Detailed contact information can be found at the Vermont Medicaid Provider Portal, or at http://www.vtmedicaid.com/assets/manuals/ProviderRepMap.pdf.

There may be times when services were provided by a worker paid through ARIS or a subcontractor and those associated encounter claims are denied. In those cases, the provider may need to reach out to ARIS or the sub-contractor for additional information to allow them to correct and resubmit the claim.

Q20: Will I receive separate Remittance Advice (RA) records for my H2022 HCBS paid claim billing and my zero-pay encounter data claim billing?

A20: No, RA reports do not separate paid and zero paid claims. For more information on RA processes, please reference the Vermont Medicaid General Provider Manual**.**

Q21: I have multiple locations where services are delivered under a single HCBS Medicaid provider ID. Is it possible to receive an RA that breaks out encounter data claims by each location?

A21: The only way to receive a separate RA for each location is to request a separate Medicaid Provider ID for each location. If an agency is interested in pursuing this option, they should let DDSD know as more research will need to be done to ensure that the MMIS encounter data design can accommodate this request.

Q22: Both DVHA and DMH allow telemedicine for many similar services as long as the rules outlined in the Vermont General Medicaid Provider Manual and Vermont Medicaid General Billing and Forms Manual are met. Does the DDSD allow for a similar application of Medicaid Telemedicine policies?

A22: This question does not pertain to encounter data. This would need to be a policy consideration for DDSD. Telemedicine for services such as psychiatry and therapies can be less effective for individuals with developmental disabilities due to communication challenges. This could be considered at the next revision of the DDS Medicaid Manual.

Q23: Should I update the Transaction Type Code on the 837P (in segment BHT06) to send with "RP" to indicate capitated encounters, rather than "CH" for fee-for-service billing?

A23: Yes, RP is an accurate and acceptable code for this field.

ARIS Specific Questions:

Q24: I understand that agencies are responsible for submitting encounter data for services paid by ARIS. How will we do this?

A24: The encounter data guidance includes a full section (point 3 under general information) on how agencies will receive information on services paid by ARIS. Agencies have options for how they will pass this information through to the MMIS for encounter data claim submissions. Available options include the following, and there may be others:

- Agency submits the completed 837 claims file provided by ARIS directly to the MMIS.
- Agency inputs information from the 837 report (excel file) provided by ARIS into your EMR, and process these claims just as you would any other encounter data claim.
- Agencies could develop an agreement with ARIS to submit the 837 claims file on their behalf. DAIL would require that the agency review the 837 report first and then approve ARIS's submission of the report. In all situations because the agency is listed as the billing provider in box 33 on the claim form and that is who receives the RA.

Under shared management, agencies retain responsibility for the services that are provided by workers paid through ARIS and therefore agencies are ultimately responsible for the submission of encounter data claims. ARIS has built in significant controls to ensure the quality of the files sent to agencies, but it is possible that a claim denial may occur on an encounter data claim for an ARIS paid service. Should a denial occur for a denial reason that an agency cannot reconcile

on their own, agencies should collaborate with ARIS to request updated or corrected information as needed.

Q25: Is there a list or table of codes that are "allowed" to overlap for encounter data purposes. That way, we would have a comprehensive list and cross reference to what can be paid together and what CANNOT be paid as an overlapping shift. We will also want to confirm if overlapping shifts with other programs will remain allowable (i.e., CPCS/AFCR, etc.).

A25: DAIL is working on generating a table of codes that are allowed to overlap. We will need to reach out to the other programs to confirm allowable overlaps with those programs. We will also need to further consult with ARIS regarding how this will be used in their system. The policy about what services may overlap would also need to apply to services paid through provider agencies. This will require additional consultation with agencies in order to develop workable policies.

Q26: In the Encounter data guidance it indicates that ARIS will be listed as the "Attending provider". Shouldn't this say Rendering provider"? What is the difference?

A26: The terms attending provider and rendering provider are often used interchangeably to mean the same thing, and both terms reference the same box (24j) on the CMS 1500 claim form. To be consistent with the term used on the claim form, we will update the Guidance to use the term "rendering."

Q27: If ARIS is listed as the Attending (rendering) provider, does that mean ARIS will receive the Remittance Advice (835) for all encounter data claims for ARIS paid services?

A27: No. The remittance advice is sent to the billing provider listed in the billing provider field (box 33) on the CMS 1500 claim form, not the rendering provider. Per DDSD encounter data instructions, ARIS will populate all 837 files with the provider ID which corresponds to the DA/SSA in the Provider ID field, and the ARIS Provider ID in the rendering ID field of the claim.

DDSD Program Operations and Policy Specific Questions:

Q28: There are two codes that ARIS currently submits to me, AVE and MB1. Do these codes need to be included on encounter data claims for ARIS paid services?

A28: For the MB1 (Community Supports Mileage) currently, we do not have a procedure code for mileage for community supports through ARIS, but we will add one as soon as we can. For AVE, use the transportation code listed in the Encounter Data Guidance (T2039).

Q29: Will the IDDS Medicaid Manual be updated to reflect these new codes?

A29: Yes. There will be a section of the Medicaid Manual for Developmental Disabilities Services that will specifically address encounter data reporting guidelines. The Developmental Disabilities Payment Reform Project includes multiple work streams (encounter data, payment model, standardized assessment). The DDSD will be updating the Medicaid Manual for DDS with finalized policy and program guidance as they are developed over the course of payment reform.

Q30: How will we report services under the College Steps Program via encounter data claims?

A30: Currently, no encounter data code exists for the College Steps Program. Providers will be required to keep track of all paid invoices and report an aggregate annual amount at the end of the fiscal year or if/when a College Steps participant transfers to another agency. The division will work to identify an encounter data code for the College Steps Program by the end of the fiscal year for reporting purposes.

Q31: In reviewing the guidance it seems that T2021 is being suggested for community support. I currently use this code for PASSAR we cannot report out both. How will this be handled.

A31: This procedure code is used for billing of PASRR Specialized Day Services and will be used to report encounter data for community supports. You will continue to use this code for billing Specialized Day Services. When you submit an encounter claim for Home and Community-based Services Community Supports, the procedure code will be combined with the HW modifier and the HCBS provider ID number that will distinguish the HCBS encounter from the fee-for-service Specialized Day Service.

Q32: I'm confused by conflicting guidance regarding MSR submission requirements in DS payment reform and Mental Health Payment Reform, why is one department continuing to require MSR data submissions and one is not?

A32: The 2014 state auditor's report found significant data quality issues with DDSD MSR encounter data. Rather than working to address these MSR data quality issues, the DDSD made the strategic decision to adopt the MMIS as the single source of information for DDSD encounter data and will discontinue use of the MSR once this shift is complete. DDSD does not have an ongoing need for MSR data. DMH has informed DAIL that they presently have a continued need for the data in the MSR and thus are continuing with both reporting systems at this time.

Q33: If we stop reporting to the MSR, how will this impact our electronic financials (EFINS)? Aren't they connected?

A33: Some agencies utilize information from the MSR for their monthly EFINS reports to the state. Agencies may continue to use MSR, but are not required to do so, once they are reporting all information on encounters to MMIS. Agencies may want to consider how information from MSR that was used for EFINS can be remapped in their systems.

Q34: I have questions about what cost centers to report procedure codes under in my electronic financials (EFINS). Specifically, where do I report the following codes: H2019/T2025/H2032? Are these considered clinical?

A34: H2019 is behavior consult, T2025 is communication and H2032 is other supportive services that fall under the category of Supportive Services. Although they are not clinical services, there currently is no cost center for Supportive Services, so you may continue to report these under clinical services at this point.

Questions Specific to Reportable vs. Non-Reportable Actions Guidance in Appendix C

Service Planning and Coordination:

Q35: Appendix C lists "hiring" and "recruiting" as a reportable action for service planning and coordination. How do I link the action of hiring to a specific Medicaid member in a DDSD encounter data claim form? I typically don't know the specific client the staff will serve when I am in the recruiting and hiring process, and staff typically serve more than one Medicaid member.

A35: Upon further review, the Encounter Data Reporting Guidance is being modified to remove hiring, recruiting, training and supervision of staff as reportable actions. The cost of these activities will now be covered as program support which is included in the rate for each service.

Q36: "Paperwork, record keeping not related to tasks listed in service definition" are listed as non-reportable actions. I need further clarification on what is reportable and what is not. Specially, are developing/writing Person Centered Plans, Person's Story, ISA and all related attachments, Outcome Reviews, Home Visit notes, Progress/contact notes, Needs Assessments, CIRs, and EFS reportable actions or not?

A36: Developing/writing Person Centered Plans, Person's Story, ISA and all related attachments, Outcome Reviews, Home Visit notes, Progress/contact notes, Needs Assessments, CIRs, and EFS are not reportable actions under the encounter data policy. However, these actions are built into the established rate for the service by way of the productivity adjustment and some of these activities are covered under program support. For more information, see the rate study presentation and power point presentation on components of a rate. See revised Encounter Data Submission Guidance for what is and is not reportable for this service.

Q37: Why are "housing safety pre-inspections, follow-ups and reporting to the State" listed as non-reportable actions? These activities are directly related to coordination/oversight of shared living home supports.

A37: Housing safety pre-inspections, follow-ups and reporting to the State are considered program support and as such, are included in the rate structure.

Q38: Are 1:1 crisis supports reportable as service coordination if the individual doesn't have funding in the individual crisis line? These supports are related to implementing the ISA and/or BSP.

A38: The category of service that should be reported is the one that meets the definition of the service in the System of Care Plan. A specific activity is only reportable if the action is listed as a reportable

action in the Guidance. So, in most instances, 1:1 crisis supports should be reported as such, not as service coordination. It is acknowledged that it may be difficult at times to determine whether the service being provided falls under Service Coordination or Emergency/Crisis assessment, Support or Referral. Agencies should report the service that most closely aligns with the service definition. The Division is in the process of developing additional guidance on what is reportable and not reportable under crisis services and this will be included in a subsequent versions of the Guidance.

Q39: Can two staff record this service at the same time? Examples of when this might occur include: if one staff is taking the person to the ER, and another is coordinating with a guardian or gathering additional information; or one staff is performing a record review, and another is at a home visit. Can both staff record their time?

A39: Only one staff person may report service coordination at the same time. Service coordination may be reported at the same time as other services, as long as the other service meets the definition of that service and is a reportable action.

Q40: Would an agency nurse code service coordination when coordinating medical service or medication and medical support?

A40: An agency nurse coordinating medical services or medication and support meets the definition of Medication and Medical Support (99211-99215) and should be reported as such.

Q41: The definition of service coordination is very broad. Could you give specific examples of paperwork that is not reportable?

A41: The following activities are not reportable under service coordination:

- Paperwork, record keeping not related to tasks listed in service definition
- Attending or receiving training
- Receiving supervision
- Completion of other employer required non-direct service tasks
- Staff paid time off
- When Service Planning and Coordination billing is suspended or terminated, consistent with requirements in the SOCP
- Housing Safety pre-inspections, follow-ups, and reporting to the State
- participating in meetings
- hiring, training, supervision of direct support staff
- Recruiting, training and oversight of home providers
- establishing and maintaining a case record
- reviewing and signing off on critical incident reports

Community Supports:

Q42: Why is "attending ISA meetings" listed as a non-reportable action?

A42: Attending ISA meetings is an activity that is built into the rate of Community Supports.

Employment Supports:

Q43: Why is "attending ISA meetings" listed as a non-reportable action?

A43: See above.

Q44: Can one staff train another staff on the job site with the individual present and both staff encounter this service?

A44: No, more than one staff cannot report encounter data for the same hours, same person, same service. For instances when a staff person is training another staff person, the costs for the person providing the training is considered a program support cost and built into the rate structure. The only time 2 staff can report the same hours, same person, same service is when 2:1 staffing has been authorized. In these cases, one encounter will be reported, but the modifier for 2:1 staffing will be used.

Q45: Are goals in the ISA to build vocational skills reportable? For example, building stamina and volunteering?

A45: No, these are not reportable. Only activities/services that meet the definition of a specific service are reportable as outlined in the encounter data guidance. The above-named activities do not meet the definition of employment services, but they could potentially be funded and encounterable under community services.

Group Therapy

Q46: Is group therapy performed by in-house staff, and anything contracted is clinical or other supportive services, for example, DBT?

A46: Group therapy under clinical services must be provided by licensed clinical or medical staff, based on our service definition, regardless of whether they are agency staff or contracted clinicians. Services provided by non-clinical staff that meet the definition for Supportive Services in the State System of Care Plan service definition are reportable under Supportive Services.

Medication and Medical Support:

Q47: Our consulting nurses' provider these services but many individuals who receive this support don't have funding under this category. Can this be reported under service coordination?

A47: No, this service should be reported under Medication and Medical Support (99211-99215). If providers have been funding these activities from the service coordination line, providers may choose to move money into the Medication and Medical Supports (Clinical) service line to align with services provided.

Q48: Is consumer specific training, for example, special care procedure reportable?

A48: Yes, nurses providing consumer specific training under Medication and Medical Support is reportable by the nurse. Consumer specific training is also reportable by professionals providing Behavioral Support, Assessment, Planning and Consultation Services and Communication Supports. Provision of general training, not specific to an individual is not reportable. Direct support workers *receiving* training may only report a service when the person is present and receiving a service.

Q49: Is more than one professional able to report during a medication check session? For example, the nurse, the psychiatrist, and the psychologist all attend a session. Can they each report encounters for the same session?

A49: No, only 1 medication check service can be encountered/reported. As noted in the Encounter Data Guidance, only one clinician can report an encounter for a medication check.

Emergency Crisis/Crisis Assessment Support and Referral

Q50: Is a person becoming homeless and emergency placement(s) need to be located consider ECCAS?

A50: The System of Care Plan defines crisis as time-limited, intensive supports provided for individuals who are currently experiencing, or may be expected to experience, a *psychological, behavioral, or emotional crisis.* Becoming homeless, in and of itself, is not a crisis. However, if an individual is in crisis, that caused them to become homeless and it met the service definition of crisis, it may be encountered under ECCAS.

Q51: Are unplanned medical emergencies considered a crisis? For example, significant injury causing a fall and immediate medical attention is needed?

A51: No, see above response.

Q52: If two or three people are dealing with a crisis, can they all report under separate encounters?

A52: Encounter data is always based on the service the person is receiving, and only the necessary number of staff should be involved. If additional crisis staff come on the scene, the service being received by the person is crisis and should be reported as such. The modifiers for 1:1 or 2:1 staff ratio may be used. 2:1 staffing is the highest ratio for the crisis encounter.

Supervised Living

Q53: Can you define "in and about the person's residence"? Is taking someone grocery shopping be a goal in the ISA under this service?

A53: Yes, grocery shopping could be goal in the ISA and be provided under Supervised Living. As defined in the service definition of Home Supports, "services include support for individuals to acquire and retain life skills and improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community."

Shared Living

Q54: When a person has no SLP under contract to be paid, is the State expecting that to be reported as respite or how is that to be reported?

A54: Encounter data is always based on the service the person is receiving. If a person is receiving Shared Living Services, according to the definition, it should be reported as such. There is no mechanism to report "long term respite", these arrangements should be converted to short-term SLP arrangements including short term contracts to ensure transparency and accuracy of data.

Behavioral Support, Assessment, Planning and Consultation Services

Q55: "Time developing and writing positive behavior support plans" is listed as a reportable action. Our service coordinators write BSPs, train and consult. Can we report under service coordination? Most individuals don't have funding under behavioral support. Reporting under behavioral assessment would require funding changes.

A55: This service line is reflective of the need for additional expertise and should only be reported when it's an additional service the person is funded for and receiving. General writing of the ISA is not reportable/encounterable under Service Coordination. If it's simply an addendum to the ISA, it's considered an activity under the implementation of the ISA. Training and consultation are not reportable under Service Coordination. The provision of training and consultation to direct support workers is reflected as a Program Support cost for each direct service category.

Q56: The DDSD encounter data guidance states "Encounter data may only be reported for this service when it is present as a separate item in the individualized service budget. Does this mean on the budget page or the respreads that was just done that it needs to be listed out as behavioral support and not just as a clinical line?

A56: Behavior Support services should be identified on agency HCBS spreadsheets as Supportive Services. When they are identified on the spreadsheet as a funded service, they are reportable only under the Behavioral Support, Assessment, Planning and Consultation Services code, and are not reportable under any of the Clinical Services.

Communication Support

Q57: "Consultation and training for team members and developing and writing communication plans" is listed as a reportable action. Our service coordinators write communication plans. Can this be reported under service coordination? Most individuals

don't have funding under this category. Reporting under communication support would require funding changes.

A57: This service line is reflective of the need for additional expertise and should only be reported when it's an additional service the person is funded for and receiving. General writing of the ISA is not reportable/encounterable under Service Coordination. If it's simply an addendum to the ISA, it's considered an activity under the implementation of the ISA. Training and consultation are not reportable under Service Coordination. The provision of training and consultation to direct support workers is reflected as a Program Support cost for each direct service category.

Other Supportive Services

Q58: "Skills-based training such as dialectical behavior therapy skills group or sexuality groups not provided by licensed clinicians" is listed as a reportable service. I provide this service to individuals who don't have funding in this area. Reporting under other supportive services would require funding changes.

A58: Yes, provider should change the funding to the appropriate service line in all cases. This will also require updating the ISA, including adding a goal for this service. If, however, there is no funding for the service in this line of a person's budget, do not report this service.

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Q59. We need to know the locations that correlate to each activity

A59. So long as you are using one of the five place of service codes, the encounter claim will be accepted. If you do not include a Place of Service (POS) code, your encounter data claim will deny. DAIL has selected the following POS codes as allowable for DDSD encounter data claims. Use the code that describes the location where the service occurred. If you submit a POS that is not on the following list, your claim will deny:

- 12 Home
- 18 Community
- 39 Adult Day Care
- 53 Community Mental Health Center
- 99 Other Unlisted Facility

For ARIS paid services, ARIS has been directed to include POS 12 (Home) on all encounter data. Code 39 should only be used for community supports provided at an Adult Day facility.

Q60. If an activity is performed (hourly home support) but the location is provided in both community and home what is the process? Does it remain as "Home" or does the location have to be switched? Is this one activity or two (one claim or two claims?)

A60. As a general rule, if an activity is performed in two different locations during one uninterrupted period, use the service code for the location where the majority of service was provided for the encounter. This may be submitted as one claim.

Q61. Complex temporary placements or vacant home positions this respite will be run through the agency how should this be encountered in CareLogic, should it be a manual claim? Or should this be put in the Schedule? (Francis Foundation)

A61. Encounter data should be reported according to the service definition it aligns with. Temporary placements are considered shared living and should have a short term SLP contract with all associated safety checks, background checks according to DDSD policy. How the data is entered by the agency is an agency decision.

Q62. Emergency DOC (Difficulty of Care Payment), are we allowed to encounter that? The DH contract requires that we give Home Providers a 30-day notice. We have to pay the previous provider the 30 days per the contract, AND we have to pay the new provider as well as the old to provider for residential supports. How do we encounter both?

A62. Encounter data relates to the services provided to a person, not to the expenses incurred by an agency. The agency may only submit one encounter per day for shared living. Agencies may pay the first shared living provider in accordance with their contract with the provider.

Q63. Home Modification? How to encounter?

A63. The division is not requiring home modifications to be encountered at this time. The State needs to find an appropriate service code for this service. For now, providers should be maintaining records of home modifications and should be prepared to present those, if requested, to support billing of home modification lines.

Q64. When an individual is sent to State Funded Crisis Bed (VCIN) how do we encounter?

A64. VCIN stays would fall under "Emergency/Crisis Beds". See the DDSD Encounter Data Submission Guidance, pages 21 for service code and modifiers and page 37 for what is reportable.

Q65. VCIN Manual Claims: How to Encounter with Modifiers with Manual Claims. We won't know the staffing ratio. How to encounter those different modifiers?

A65. Because the agency pays VCIN for this service, they will need to request that information from VCIN.

Q66. For MMS if there are 2 staff for a 1:1 activity how to proceed? Should the multiple person enter non-reportable minutes so that it is still documented?

A66. The division identified procedure code modifier combinations to represent all allowable staffing ratios. If there is no option for a U2 modifier to indicate 2 staff to 1 person, and the agency includes the U2 modifier on the claim, the claim will deny. Non-reportable minutes of

service are just that, non-reportable for encounter data. If two workers are used for a service where only one worker has been authorized, the person's budget will be used more quickly, jeopardizing the person's access to needed services.

Q67. Service Locations – Need clearer definitions for staff and manual claims

First are we only using the 5 codes in the guidance or all the ones we have been using for MSR currently in the system. We currently have 12 service locations on our schedule.

- 03-school
- 11-office
- 12-home
- 14-group home
- 18 place of employment – worksite
- 21 inpatient hospital
- 23 emergency room – hospital
- 24 ambulatory surgical center
- 32 nursing facility
- 49 independent clinic
- 54 intermediate care facility
- 99 other place of service

A67: We are only using the 5 place of service codes in the encounter data guidance. Any use of additional place of service codes other than the 5 will result in a denied claim. If the division adds or revises additional place of service codes in the future, all providers will be notified and the encounter data guidance will be amended.

Q68. Modifiers – 2:1 – (2 SLP's to 1 individual served) Does this refer to a dual contract as in a couple who both want to be on the contract; or is it only when 2 DOC payments are going out for the same individual in that home?

A68. The U2 modifier should be used to indicate that 2 SLPs are needed simultaneously to provide support to the person and 2 SLPs *are* providing support simultaneously. The U1 modifier should be used when there is only one SLP providing services and when only one SLP at a time is needed to provide supports, regardless of whether two SLPs are contracted by the agency. UN should be used when 2 individuals are being supported in the home.

Q69. Modifier – UN (1 SLP for 2 individuals served), given there are 2 DOC payments (one for each person serviced) going to one home provider in the home. Shouldn't this just be a Modifier 1:1?

A69. No, as noted in A10, UN should be used to indicate that 2 individuals are being supported in the home. This information is being used for various reports related to the size of residential settings. It is not tied to payment or contracts.

Q70. Recognize how many times current DHP's are used to provide home supports for persons in crisis moving from home to home. Do we seriously need to move individuals from a 1:1 setting to a UN setting each time these situations happen? Agencies have some individuals who live with a DHP 1:1 for a week and then move to a DHP that is UN for a week. Again each individual is receiving 365 days of residential services.

A70: The unit of service for shared living is a day. The modifiers that reflect the service received on any given day should be utilized.

<u>Clinical bills</u>

Q71. Most will be done using the Manual Claim process. Given credentialing, is it necessary to identify the provider for the claim to be accepted?

A71: No, because these are HCBS services, it is not necessary to use the clinician's Medicaid provider ID and name in the rendering provider field on encounter claims. However, this field must be filled out. For services paid for through the provider agency, the agency should follow general Medicaid rules related to what to enter in the Rendering ID field. In the case of HCBS services, this means that agencies have the option of entering their HCBS provider ID, the medical director provider ID or the specific clinician's ID. For services that are paid for through ARIS, ARIS will be including a specific rendering provider ID in this field on the 837 claim form that will signify that the service was processed through ARIS payroll service.

Q72. Clinicians doing Record Review and preparation – should we be using Clinical Assessment (90791)?

A72: There are three service codes for clinical assessment (90791, 90792 and 96001). The agency should use the code that reflects the service being provided according to their definitions. In the DDSD Encounter Data Submission Guidance, it indicates that the service **"**Includes interviews with others who know the person well and review of relevant information" as reportable time. So, record review is reportable for Clinical Assessment. Other preparation activities that are described in the service definition and in the guidance as reportable may also be reported.

Q73. Psychiatric Med Checks - Medication and Medical Supports (Psychiatric)

A73: It is unclear what the question is. It may be helpful to consult the Encounter Data Guidance service definition of Psychiatric Medication check**.**

Q74. This is a "face to face" code; however where do we put Record Review or conversations with case managers regarding services "Clinical Assessment 90791"?

A74: See answer #14 above.