HFS - Behavioral Health Providers and MCOs Meeting in Greater Chicago Region - Cigna HealthSpring Responses

Topic		Issue/Question	Vendor	Response
Authorizations	1	We would like to have links and/or contact numbers to secure authorizations for medications not on the approved lists. Where can we find the l inks and/or contact numbers?	Humana/ Beacon, Harmony Wellcare	N/A
	2	A Member who has Transition of Care benefits is sometimes being told authorization is required and other times told authorization is not required from the same carrier. What is the plan to resolve some of these very preventable issues?	ALL	All out of network providers are required to request authorization. If the provider is in network and the services are outpatient with the exception of IOP, ACT, CST, CSI, or CSR, no authorization is required.
	3	Authorization process cumbersome and lengthy. Response time slow or non-existent. Large administrative burden following up on approvals/denials that result in hours being spent trying to get an answer. What is being put in place to address the issue?	CCAI	N/A
	4	If the MCO does not have 24 hour/7 day a week prior authorization capabilities – how are we to handle prior auth of an off-hours admission? We do not want to admit someone in the evening/overnight/over a weekend only to get a retro denial of the admit on the next business day. Especially, IP SA detox and Crisis admits.	ALL	Planned admissions should be authorized prior to the admission using services available during regular business hours. Emergency admissions occurring after hours are expected to meet Emergency admission criteria and can be authorized the next business day. Since the onset of the MMAI/ICP program Cigna-HealthSpring - we have had only 1 denial on initial authorization. It was not an after-hours admission.
	5	Please explain why PsychHealth will not provide authorization for telephonic Crisis Intervention, and requires authorization to be secured after the face-to-face Crisis Intervention service has been rendered?	CountyCare/ PsychHealth	N/A

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	6	Please explain why PsychHealth (for individuals with CCAI benefit) is only authorizing Mental Health Assessment for every client at a minimal level: • 4 units authorized for an initial assessment (Takes an average of 8 units to complete) • Annual re-assessment (per Rule 132) not authorized. • For returning clients, a new assessment will be authorized (4 units) but only if they have been out of services longer than 6 months.	CountyCare/ PsychHealth	N/A
	7	We are finding that SA providers are underserved in Utilization Management departments at some MCOs. In one instance (Cenpatico) there is currently only one UM rep handling SA cases. This means that often, when pre-certification is required, staff at the treatment facility must wait for a return call from the UM rep, and then must spend 45+ minutes reading clinical documentation to the MCO employee, who is taking notes on the recited clinicals. Many medical specialties have pre-cert forms made available by payers to streamline the authorization process; can DASA assist MCOs in developing pre-cert forms that can be submitted along with clinical documentation? For services rendered to patients in crisis (i.e. medical detoxification) we would like to see MCOs relax the requirements for pre-certification; specifically, an increased allowed timeframe for notification. Some plans, like CountyCare, have done this for DASA providers, many of the ICPs however, still require pre-cert.	ALL	Cigna-HealthSpring requires prior authorization for residential levels of care. We do not intend to change this requirement at this time. Providers have the option of submitting a request as expedited which reduces the turnaround time for a decision. Emergency admissions occurring after hours are expected to meet Emergency admission criteria and can be authorized the next business day.

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	8	Beacon MMAI is revamping their auth process and requirements as of 8/8/14 and will be revising a new auth process as of 10/1, until then, they verbally notified providers that they are giving an additional 60 day "free" authorization starting as of 8/8. We have no formal documentation regarding this since they are not ready and still writing it up (per my conversation with them yesterday). When can providers expect this policy in writing?	Beacon	N/A
	9	BCBS and Cigna require prior authorization for CST (before beginning services). Will you be authorizing in units or for a time frame?	BCBS and Cigna	Cigna-HealthSpring understands that customers who are appropriate for CST services often require ongoing support for an extended period of time. Authorizations are provided both with units and during a time duration. Cigna-HealthSpring encourages providers to seek prior authorization to ensure services will be reimbursable. However, if a provider starts care without an authorization on file, they should contact the plan as soon as possible to discuss the individual case. If the provider is in network and the services require authorization, authorization is required. Claims denied for no authorization may be appealed and will be subject to retrospective medical review. It may be necessary to provide documentation of the reason for failing to provide timely notification as well as clinical documentation.
	10	CountyCare/IlliniCare require prior authorization for CST and SASS before beginning services). Will you be authorizing in units or for a time frame?	CountyCare/ IlliniCare	N/A

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	11	Some MCO's require pre-certification authorization and continued stay review, while others do not. In some cases we cannot speak with a case manager and must leave a message with clinical information, awaiting a call back. Our clients are typically in a crisis situation and our admits are considered urgent. We have many walk-ins seeking treatment and they are forced to sit, at times, for hours as we are waiting for a call back or are asked to return the following day because we have not heard back from the MCO. What can be done to make this a more timely process?	ALL	Cigna-HealthSpring requires prior authorization for residential levels of care and conduct concurrent reviews to determine if stays beyond the initial authorizations meet medical necessity criteria. We do not intend to change this requirement at this time. Providers have the option of submitting a request as expedited which reduces the turnaround time for a decision. Emergency admissions occurring after hours are expected to meet Emergency admission criteria and can be authorized the next business day.

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Topic		Issue/Question	Vendor	Response
	12	Currently, Aetna Better Health and CountyCare/Cenpatico do not require pre-authorizations for assessment and placement in outpatient and residential for in-network providers. Some MCOs require pre-certification for residential only and some for both residential and outpatient. Will all the MCOs consider adopting the policy and practice of not requiring pre-certifications? Most of our clients are referred to us in crisis situations from hospital emergency rooms, State mental health facilities, courts and jails, etc. Typically, the referral entity is looking for a transitional residential situation to stabilize and treat a client who otherwise....that is without our service.....would have to be admitted or treated in a more costly and more intensive or restrictive setting. Our experience with numerous cases of clients enrolled in MCOs is that the response for approvals for admissions and level of care is not always immediate or within a reasonable time period. Sometimes we need to leave messages on answering machines and are not returned calls in hours or days. This is an unacceptable practice for a client in crisis who then must be sent out while we await a response from the MCO. Usually, the client can't be found and is at risk of re-cycling various systems of care. This inadvertently becomes a costly venture for MCOs. This has even occurred with clients who are homeless. MCOs may find that more flexible admission and authorization policies will result in clinical common sense and cost efficient practices. Agencies are required to use ASAM criteria. Agency admission practices can be audited by MCOs to assure appropriate placement decisions.	ALL	Cigna-BH requires prior authorization for residential levels of care. We do not intend to change this requirement at this time. Providers have the option of submitting a request as expedited which reduces the turnaround time for a decision. If a situation is emergent, admission can occur with prior authorization decisions being made after the admission. Please refer to your provider manual for more information.
Billing	1	We would like an 835 return file for larger payers (that do not currently provide it). What is your reason for not offering this or are you in the process of developing it?	ALL	Providers may sign up with Emdeon our Electronic Claims Payor for 835 Files at no cost to them for paperless solutions to claims remittance advices.

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Topic		Issue/Question	Vendor	Response
	2	Claims are denied and services not submitted. Trying our best to get assistance to have resolved and have a sense that we are not supported by representatives. Is there any recourse when these types of errors occur? How can we recoup losses that are the mistakes on the MCO's systems?	Aetna Better Health, BCBS	N/A
	3	For the past 3 years IlliniCare has refused to compensate BH providers for psychiatric evaluations completed by the MD which HFS has compensated us for in past. After much advocacy, last April the state director for IlliniCare indicated she had obtained authorization for payment. However, we have not received an official announcement or the billing codes with which to do so. Can this be confirmed? Can we be provided with the billing codes?	IlliniCare	N/A
	4	Psychiatrists are MDs who bill directly to HFS as physicians, utilizing CPT codes (E & M) not HCPCS codes. These bills are processed by HFS differently than Rule 132 billing claims. This option was removed from physicians who work for mental health providers and assign payments to their employer. What is the reason this exist?	IlliniCare	N/A
	5	Psychiatrists as physicians have their own documentation requirements for compliance to CPT coding standards and their work does not match the M0064 definition of "simple medication management". What can be done so an accurate account of the type of services is billed?	IlliniCare	N/A

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Topic		Issue/Question	Vendor	Response
	6	Inappropriate denials for "duplicate services" The MCO's do not have their system configured correctly to pay out legit claims billed under the same CPT/HCPCS code on same DOS for different providers. Example: we are working with a client to transition them to an independent center; we bill for case management service and so does the indep center. The entity that gets their claim in first gets paid – other one denied for dup service. Both are legit claims. What can be done to correct this?	ALL	Software - "*Duplicate Rule Logic"* is utilized and editing vendors to help us manage these rules. Specific edits will fire that requires manual review before a claim can be denied as a duplicate.
	7	What can providers expect in terms of timeframes for resolutions to concerns over reimbursement?	ALL	The expectation is to resolve all provider issues / concerns within 30 days of receipt.
	8	Numerous issues remain regarding billing among most MCOs. How can MCOs solve provider billing problems in a more effective and efficient way? The issues tend to be specific in nature and extremely difficult to resolve. The following are just a few of countless examples: Harmony/WellCare refuses to approve residential services stating it is not a covered service and should be billed to DASA. Yet it is an identified billable service in our Harmony contract.	ALL	Providers can contact Customer Service directly and a Call Tracker (Call trackers are issue logs that are created and assigned to the assisting department) is created and forwarded directly to the Claims Department to be reviewed.
	9	Cenpatico/Illini Care has instructed us to use billing code H2036 for IOP (not a correct code for IOP according to HCPCS 2013) and H0005 for BCP. When we bill H2036 as instructed, the service gets denied stating "service not in contract." This denial comes to us even though we are following their instructions for payment and Cenpatico has already pre-authorized the service.	Cenpatico	N/A

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Topic		Issue/Question	Vendor	Response
	10	Instances have occurred with Cenpatico/IlliniCare where rejection letters on claims have been received. Well after the fact it was discovered that claims with rejection letters are NOT entered into the claim system at the MCO offices. Can all the MCOs enter ALL claims received, rejected or not, into their systems? We have several claims they are now denied for timely filing reasons even after providing the MCO with written documentation that the claim was handled and sent to their offices in a timely manner.	ALL	Cigna-HealthSpring utilizes an electronic clearing house that validates that basic required claims data elements are present. In instances where there are missing required elements the clearing house will reject the claim and respond to the provider with a reject reason. Those claims do not make it to the Claims System and will not be visible for review with providers.
	11	Timely filing rules are currently 90 days for the initial submission. The MCO will use the first day of service as their start date. Many of our clients, especially in the case of inpatient, may be in our care for up to 28 days. It has always been our practice to wait for discharge to submit the claim. By doing so we are automatically losing up to 1/3 of that restricted filing allowance. Can the MCO use 90 days from day of discharge rather than admission for clients treated in a residential program as the rule? The 90 count currently used is not 'business days' meaning MCOs count weekends and holidays.	ALL	Yes - Timely Filing rules are determined by the last DOS of the claim and Receive date. I.E. : DOS 8/1/14 - 8/28/14 Claim Received 8/30/14. This constitutes within the TFD.

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Topic		Issue/Question	Vendor	Response
	12	Nearly 3/4 of our clients are insured under Medicaid. Our problem is that we are unable to provide needed services to many of these clients because they have been switched from one provider to another. It is difficult for us to know when our clients have been switched. The clients get notification by mail but no notification is sent to the providers. Additionally we have lost a tremendous amount of revenue and are receiving many billing rejections due to these switches. We must call the DHS eligibility number at least twice weekly per client to determine if that client is eligible to continue to receive services. Some of our questions are- How are we to bill past services to the relevant MCOs for current clients? How far back are we able to bill for services to each MCO?	ALL	If the claim is submitted to the incorrect MCO that rejection letter will serve as proof of timely filing if and when forwarded to us after the filing deadline.
	13	Do we need CPT codes for billing MCOs?	ALL	Please see MCO Standardization Grid
	14	If we miss the relevant MCO cutoff date is there still a way to recoup payment for services?	ALL	Is this a question about Timely filing requirements?
	15	Are we able to bill for new patients who have already been switched if we are not part of the provider's network, specifically, County Care.	County Care	N/A

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Topic		Issue/Question	Vendor	Response
	16	Are SUD Providers to submit claims for residential treatment or split bill for day of treatment and room and board? If any companies want us to continue to split bill what are the appropriate SUD billing codes for the day of treatment and for room and board? SUD Providers were previously given the Standardization Initiative billing codes; according to those codes 944 or 945 and H0047 is to be used for adult residential and 944 or 945 and H2036 is to be used for residential services under 20. We have received conflicting information regarding billing codes for adolescent residential treatment services; are providers to use H0047 or H2036 for services provided in an adolescent residential treatment program.	ALL	Bills do not require splitting for SUD providers. However, professional and facility claims require a different form type. As a rule, insurers do not instruct providers on how to bill but we understand providers are trying to make sure they submit in a way that is compliant for payment. Please refer to http://www2.illinois.gov/hfs/Pages/default.aspx for appropriate billing.
	17	In the past, if you were not a network provider with Harmony or Family Health Network, you were informed that there were no out of network benefits available, therefore you were able to bill Medicaid or DASA. Additionally, Harmony/Wellcare continues to state that residential is not a covered benefit. Who can the providers bill in this case? Will providers need to become a network provider with Harmony or Family Health Network in order to receive payment for services rendered, and will they be required to pay the Medicaid rates?	Harmony, FHN	N/A

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Topic		Issue/Question	Vendor	Response
	18	How would the MCO's want the providers to bill for residential treatment? Do they want us to bill as an all-inclusive rate or break out the residential rate for the treatment/Medicaid portion and domiciliary/DASA portion, and what revenue and procedure codes would like us to use? There seems to be some confusion on their end with revenue and procedure codes, as well as tying those codes to the bill type	ALL	See Attached MCO Standardization Grid
	19	With programs that have multiple rates for the same level of care in the same location, does the MCO have to create some modifiers to distinguish the program/rate?	ALL	Yes - This type of specific coding is Configured into the system.
	20	When a client comes in for treatment and is identified as a Medicaid or DASA client, and during the course of treatment their coverage changes to an MCO and we are not aware until after the fact. What is the billing process?	ALL	All out of network providers are required to request authorization for services payable by Cigna-HealthSpring when the customer is eligible with Cigna-HealthSpring. If the provider is in network and the services require authorization, authorization is required. Claims denied for no authorization may be appealed and will be subject to retrospective medical review. It may be necessary to provide documentation of the reason for failing to provide timely notification as well as clinical documentation.
Case Management	1	There is a huge difference between mental health case management and care management as the Health Plans practice it. Why is it that the Health Plans are not including or authorizing Case Management services?	ALL	If the provider is in network and the services are outpatient with the exception of IOP, ACT, CST, CSI, or CSR, no authorization is required. Cigna-HealthSpring does not require authorization for Case Management (T1016, including T1016 billed with modifiers)

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Contracting	1	Can the MCO's outline their role (if any) in working with the FHP and ACA adult populations? Can they describe their method of contracting w/existing providers? Can they indicate differences in services and credentialing?	ALL	N/A Cigna-HealthSpring is not participating in FHP/ACA
	2	BCBS is way behind in loading PCP's into their system. We have had a contract w/ them for months – our providers are still not loaded. Makes it very difficult for our Case Management staff to assist our clients in signing up for an MCO and selecting their PCP. What is the status of loading PCPs in your system?	BCBS	N/A
	3	Are some providers getting different rates than the Medicaid rates or are all the contracts the same in terms of reimbursement?	ALL	It really depends on the individual contract. It will be possible it is different.
	4	Back in June we completed applications with both BC ICP and Meridian and the contracts are still not loaded. How do we see participants and bill for them if the contracts are not loaded?	BCBS, Meridian	N/A
	5	The contracts/agreements are not written for behavioral health organizations or free standing facilities like many of the SUD's. We can spend months red lining and negotiating contract language to ensure that the language applies to our organization and the services we provide. These agreements do not address our services and problematic language includes line items related to drug formularies, staffing privileges and medical services. We have received Medical Group Agreements and Provider (Physician) Agreements rather than Facility or Ancillary Provider Agreements. Is it possible for an agreement specific to SUD, or Behavioral to be created?	ALL	I believe we can look at standard changes within our contract to meet the facilities' needs.

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	6	There is currently a lack of consensus between MCOs regarding billing procedures and appropriate CPT/HCPCS codes for SA services. This is leading to confusion during the credentialing process and for billing departments. Many provider relations reps at MCOs still are unaware that DASA providers have state-assigned rates that are not published by HFS. This is creating substantial delays in provider credentialing as the MCO attempts to reconcile rate issues. These facility specific rates must then be included in the reimbursement methodology article in the contract which must then be amended any time a program or rate is changed. What can be done to properly communicate these challenges to MCO credentialing departments and streamline the contracting process?	ALL	N/A- This question is for HFS
	7	Community Care Alliance is currently using PsychHealth to manage their behavioral health. In order to become a Community Care Alliance provider one must contract with PsychHealth. They have ridiculously low rates. Will they be required to pay the provider's Medicaid rates?	PsychHealth	N/A
Credentialing	1	Rule 132 does not require services be provided by licensed clinicians. The credentialing documentation we have received from Harmony, BCBS, Aetna Better Health and Cenpatico, is indicating they will only credential and pay for services provided by licensed clinicians. We don't understand why the some MCO's have put in an extra layer of credentialing that the state never required and is there any possibility of this being changed?	Aetna Better Health, BCBS, Cenpatico, Harmony Health Plan	N/A

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	2	Credentialing and re-credentialing as a CMHS provider is a concern that also involves: Contracts, Customer service and Claims and is currently a cost to our agency of $70,000. In good faith, we provide service to the payers' consumers without interruption. Yet, there is a significant payment problem due to the correct processing of our credentialing status. Specifically, that our agency's location NPIs are correctly in the payer's electronic system. When the contract is completed, it is not clear that the payer has entered our correct payee information to their EDI. It is discovered too late, when all claims to the payer are getting denied.	Aetna Better Health, BCBS	N/A
	3	We have been informed that as of 7/1/14 Harmony/Wellcare will be operating as the other MCO's and covering rule 132 services and credentialing agencies as facilities. Can we get this confirmed in writing? Can they provide agencies with written confirmation of their credentialing status?	Harmony Wellcare	N/A
	4	Many of the agreements we have seen are medical, individual or professional agreements and require credentialing of the staff and/or a list of credentialed staff. This is not applicable to SUD Providers. Alcohol and Drug treatment services are billed as facility services; reimbursement and rates are not based on staff credentials. Requiring staff rosters with credentials is an unnecessary use of an organization's resources. Can the contracts be revised to eliminate the staff credentialing/staff roster requirements?	ALL	If the contract is facility based- and it billed on a UB, the services should be processed and paid.
Customer Service	1	Specifically for Billing and Claim concerns, it has been difficult to find contacts who understand the question regarding MMAI and ICP group/plan of their own company. Several instances of being passed around and not getting concern resolved. What is being done to correct this issue?	Aetna Better Health, BCBS	N/A

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	2	Some MCO's have only 1 person to provide over site and serve as liaison to the BH agencies working with ICP and MMAI. Given the scope of responsibility it is difficult for them to respond to anything in a timely manner. We often wait weeks/months for a response to voice mails and emails. Does the MCO's have plans to expand staff? Is there a certain time frame in which they are expected to respond?	ALL	For Behavioral Health clinical and authorization concerns, please contact Heather L. Baroni Vice President, Health Services Cigna-HealthSpring Phone: 615.565.8110 ext. 508871 Cell: 615.886.8334 http://www.healthspring.com
	3	The workers at some benefit plans are giving out wrong information. Example - a call to HealthSpring – "Yes member is with us through Advocate and your agency does not show as in network". A call to Advocate – "HealthSpring handles all of the mental health benefits for this plan." A call back to HealthSpring – again told to call Advocate. At a request for a supervisor - "HealthSpring does handle this member's benefits and your agency is in network."	ALL	All Cigna-HealthSpring Customer Service Representatives are fully trained on the authorization and referral process. During their training, an internal resource is utilized to illustrate that Advocate manages their own authorizations and referrals through the use of their own health services department except for behavioral health services. The Behavioral Health Department telephone contact information is provided to all callers needing authorizations and/or referrals for Behavioral Health services. All Customer Service Representatives are encouraged to review this page each and every time Advocate network is discussed to ensure they are communicating accurate information and processes to all callers. Additionally, staff is provided with periodic knowledge checks that reinforces their understanding of the benefits, how to quote them, as well as utilization of our reference material. If any details can be provided regarding the example below we can pull the recorded calls from our phone system. We can then determine how the call was handle as well as any steps to address future calls.

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Topic		Issue/Question	Vendor	Response
	4	How will the clinicians know who the care coordinator is for each client?	Beacon	N/A
	5	When there is a change (for example a code or policy change), how will the MCOs communicate this to the contracted providers?	ALL	If it is a standard code that is updated by the State, the fee schedule will be updated to reflect. However, if there is a policy change that materially affects the network, Cigna-HealthSpring will mail out letters, provide notice on websites.
Enrollment Verification	1	Currently we must call BCBS to obtain the Member's ID# (XOG...) and Group #, at time of enrollment (or after the SASS call) in our system, which is prior to the member's first visit. This information is not shown in the state's MEDI system when eligibility is verified. Will this information be available in MEDI in the near future?	BCBS	N/A
Manual	1	Are the MCO's required to have a provider manual reflective of practices and programs in Illinois? Many have a manual that is nationwide and not applicable. This makes rules/procedures confusing.	ALL	Cigna- HealthSpring has created and published Provider Manuals that are specific to Illinois and Program types. One for MMP and one for ICP.
Quality	1	How are MCOs defining and measuring quality?	ALL	Information about Cigna-HealthSpring's Quality Management philosophy and its expectations of its providers are detailed in the Cigna-HealthSpring provider manual which can be found at: http://careplanil.com/DownFile.Aspx?fileid=4179
	2	What are the MCO procedures for clinical record reviews and where can we find that information?	ALL	More information is needed - Is this in reference to authorization, HEDIS, fraud waste and abuse?

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Topic		Issue/Question	Vendor	Response
Services	1	We would like clear, written crosswalk of covered services including service limitations be made available. When can we expect this?	CCAI, Family Health Network, Harmony, HealthSpring, Humana, Meridian	TBA
	2	Why are your current service limitations so out a line with other providers?	IlliniCare	N/A
	3	Community Support Services – all Cenpatico staff not aware that first 200 units do not need prior auth. What can you do to educate all your staff?	Cenpatico	N/A
	4	Why is Cenpatico placing max benefit limits on H0004 and H0005 (both 8 units/day)?	Cenpatico	N/A
	5	We were informed that the service limitations attached to the Rule 132 services in Cenpatico/CountyCare's distributed "Cenpatico Illinois Covered Services and Authorizations Guidelines (version 8/5/14) are at the same level as originally imposed by the State. Crisis Intervention, for example, has limits to the service through Cenpatico; however, it is an unlimited benefit for all eligibility groupings through the state. Why is there an overly restrictive service limitation on Rule 132 services? What will you do to bring your policies in line with your practice?	CCAIL , CountyCare, IlliniCare	N/A

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	6	Case Management-LOCUS is not an authorized service by PsychHealth for individuals with CCAI benefit. How can providers meet DMH requirements to complete a LOCUS without authorization for payment?	CountyCare/ PsychHealth	N/A
	7	Treatment Planning is not an authorized service by PsychHealth for individuals with CCAI benefit. How can a provider meet DMH requirements to complete a Treatment Plan without authorization for payment?	CountyCare/ PsychHealth	N/A
	8	We have been having many issues with Cenpatico claims – codes changing, authorizations being denied…so it would be helpful to meet them in person. They are having trouble relating to what we do – they can't give us a definition of "DASA facility" … it's been a colossal waste of time to not get paid for services.	Cenpatico	N/A
	9	Some MCO's are requiring APL coding and rates; these codes do not seem applicable to SUD services nor are the rates the same as the DHS DASA SUD Provider rates (for example there are no codes for residential services and group is per event not time based and the rate for individual is lower than the DHS DASA rate.). Do the MCO's that are not utilizing DHS DASA codes and rates have any plans to do so that Provider reimbursement is in line with the State SUD Medicaid rates?	ALL	Cigna-HealthSpring utilizes DASA codes.
Sub-Contracting	1	Some of the MCO's contracts indicated you may not subcontract services. Does this mean all psychiatrists must be employees of the provider agency? Can you use contractors who work at your site? Can you use a locum tenens to fill needed psychiatry time?	ALL	Depends on the contract. If it is a facility contract, it operates as if an FQHC. The individual provider would not need to be listed.

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Training	1	Can the providers obtain copies of the training materials from the MCO's so they may hold group trainings at the facilities if web based training are not an option?	ALL	Yes, please call 1-866-486-6065 to contact provider relations and we will be happy to do a web ex or come out to the office.