Inland Empire Health Plan

BHT Q3 2020
Provider Training

Grievance Questions	
How long does it take to receive the results of an investigation on a grievance?	The Plan resolves standard grievance cases within 30 days and expedited cases within 72 hours. Providers are welcome to contact G&A at any time to inquire on the case status or to request a copy of the resolution letter via fax or email.
HCPC Codes	
Can master's level bill for the FBA?	No, a master's level may assist in the FBA under the supervision of a BCBA.
Can a staff or a supervisor that does not have a BCBA lead the social skills group?	A BCBA must lead the social skills group.
How do you request increase in PT hours? Updated report with explanation of need?	Yes.
Under the H0032-HO modifier and H0032, is the ratio for indirect supervision hours 50%?	Yes, it is 50%.
Are we allowed to use the S5111 code? Are there MUEs for h-codes?	S5111 is subject to a max quantity of 1 per day and the H Codes are not subject to MUE limits to allow the providers to bill 1 unit/15 min.

CPT Code	Outpatient Services*	IEHP Rate
S5111	Home Care Training, Family; Per Session (provided by BCBA, BCaBA or MA staff)	$80 Flat Rate
H0031	Mental Health Assessment, by Non-Physician (Functional Behavior Assessment provided by BCBA/BCBA-D/LMFT/LCSW/Ph.D)	$22.50/per 15 min
H0032	Mental Health Service Plan Development by Non-Physician (Program Supervision provide by non-certified / non-licensed clinician)	$18.75/per 15 min
H0032-HO	Mental Health Service Plan Development by Non-Physician - Master's Degree Level (Program Supervision provide by BCBA/ LMFT/LCSW)	$22.50/per 15 min
H0032-HP	Mental Health Service Plan Development by Non-Physician-Doctoral level (Program Supervision provide by BCBA-D/ Ph.D)	$22.50/per 15 min
H2014	Skills Training and Development, per 15 minutes	$10/per 15 min.
H2019	Therapeutic Behavioral Services, per 15 minutes (1:1 Therapy)	$12.50/per 15 min

ABA School Template	
Where do we find the school template?	https://iehp.org/en/providers/provider-resources?target=forms#BH
Could in the school could mean in the current "school at home" setting?	Yes, remote school is considered the school setting at this time during designated school hours.
If we include the School template in the Progress Report template, we do not need to add the school template separately correct? And instead of school services being for the school year it would only be for 6 months correct?	Yes, in regards to the template being included in the report that is correct. The school services template will need to be updated annually for the academic school year.
Can you clarify again if a member is already approved for services and you are now requesting some of those hours to be provided during online learning where in the school form do we state that the member already has services but you are just requesting for 50% or less of those hours to provide behavior support during school at home.	This form shall be updated annually with new requests (each school year) and/or with any changes made to the members school services and/or accommodations. This can be added to the recommendations section.

Care Coordination	
What code would you use when doing collaboration?	H2019 if the 1:1 Behavior Interventionist is attending any school setting or appointment. A person with a master's degree should use H0032 without any modifier. H0032-HO should be used by a BCBA and H0032-HP should be used by a BCBA-D for in person visits or consultation.
Are other providers required to respond to requests to coordinate care? For example, ABA agency receives permission to consult/collaborate with member's speech provider and attempts to contact them, are they required to respond?	No, if outreach is made and there is no response you may document this outreach in the Progress Report under Care Coordination.
Does that work if child is not present?	Member does not need to be present if the Provider is consulting with Teacher, PCP, Dentist, etc.
Appointment of Representative (AOR)	
Does IEHP notify the provider if AOR has been completed?	No, IEHP does not notify the Provider.
Is there some specific support IEHP has on how to get this AOR? When do you advise family to start this process?	Families can call IEHP if they need further clarification or assistance. There is no standard process and IEHP may speak to parents/guardians to inform them that their child is turning 18 soon and there needs to be an alert on file with IEHP to speak on their behalf.
Who do we check this AOR with?	The parent or caregiver.
If our agency has our own authorization form for the clients that are 18 or over, would the parents/guardian still need to call IEHP or can we send you our copy?	No, the AOR is a specific IEHP form that needs to be completed.

Other Health Coverage (OHC)	
Some families indicate they do not have OHC, but IEHP shows they do. How do we go about that?	Details of our Member's other health coverage can be obtained the following ways: • Log on to IEHP's Provider portal at www.iehp.org • Call IEHP's Provider Relations Team at (909) 890-2054 • Log on to DHCS's Automated Eligibility Verification System (AEVS) at https://www.medi-cal.ca.gov/MCWeb/Login.aspx • Ask the parent to provide all Insurance Cards.
Can we continue to provide service under IEHP with an active auth, while completing an FBA under the OHC to avoid a lapse in services?	IEHP is giving a 30-day auth at the providers request if the provider needs time to begin services under the OHC. Services can be continued for 30 days under a current auth if the auth permits.
Where do we submit the denial?	If IEHP denied a claim requesting the primary payer's explanation of benefits, please mail a copy of IEHP's claim denial and a copy of the primary payer's denial to: IEHP PO Box 4349 Rancho Cucamonga, CA 91729-4349
My question is about BHT services for individuals without a diagnosis of Autism who have primary insurance (Other Health Coverage). As we know, on July 1, 2012, Senate Bill No. 946 was passed into law that required coverage for ABA Therapy for the coverage of only Autism. If BHT services is not a covered benefit for Commercial Insurers for individuals without a diagnosis of Autism in the state of California. Why is IEHP not accepting a member's explanation of covered benefits as sufficient information to process denied claims?	IEHP will accept a member's copy of an explanation of benefits as long as it contains the provider name, date(s) of service, procedure codes and billed charges.

Should we stop services if the family shows they have OHC?	Members must utilize their primary OHC for covered services. Providers are expected to verify eligibility and confirm if the Member has OHC prior to seeing any Member. If the primary OHC does not cover the service, the Provider should submit a copy of the source denial document to IEHP during the authorization request and claim submission. A denial for provider being outside the OHC Network is not a denial for BHT Services. Instead IEHP will accept an EOB that indicates BHT services are not covered under the member's current (this current year's) plan or a denial indicating BHT Services are not a covered benefit under the member's current (this current year's) plan.
Does IEHP reimburse families for Co-pays?	IEHP does not reimburse families for co-payments. If a member has OHC providers can submit claims for co-payments to IEHP. Please reference the attached Billing Balance Notice.
Is there a link for the OHC FAQ?	https://iehp.org/en/providers/provider-resources?target=claims Frequently Asked Questions (FAQs) - OHC (PDF)
Will the claims department accept the EOBs in lieu of a denial letter? What should we do?	The Claims Department will accept EOB's from the primary payer.

Other Questions	
I've been having a lot of issues trying to submit reports through COC, and therefore I sent them through Referral Request, as mentioned previously in an IEHP training to do so if needed. Now I'm having problems with some authorizations, they are getting referred to other vendors. How can I avoid this problem?	Please contact your Provider Services Representative with specific authorizations and the PSR will forward those to the SKI Team for further review.
We learned from the provider lines that there is a recent delay in processing authorization, is this still the case? Does this also impact initial referral for FBA?	There is no delay in processing authorizations. The delay may be from late submissions or canceled authorizations due to errors in reports, unclear requests, etc.
Does IEHP have a current expiration date for Telehealth services?	Currently, IEHP has been informed Telehealth will be approved through the end of 2020. All codes are being approved for either Telehealth or in person. It is unknown at this time how far past 2020 IEHP will continue Telehealth.
We submitted an application for the PAVE portal but still haven't gotten a response, is there any way IEHP can help us gain access to verify a member with Medi-Cal?	Use the link and register: https://www.medi-cal.ca.gov/MCWeb/Login.aspx

To: IPAs, PCPs, and Specialists

From: IEHP – Provider Relations

Date: February 13, 2019

Subject: **Balance Billing of IEHP Members**

IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from Members or other persons on behalf of the Member, for covered services. Additionally, under no circumstances can a Provider deny services to an IEHP Member for non-payment of a missed appointment or lack of payment for co-payments and deductibles, as applicable.

Per IEHP Provider Manual Policy MC_20B and MA_20B "Billing of IEHP Members":

- Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California and 22 CCR § 51002, it is illegal to bill an HMO Member for whom services were provided, except for non-benefit items or non-covered services.
- According to State and Federal regulations, it is illegal to bill a Medi-Cal Member for covered medical services. It is also illegal to bill a Member a co-payment amount for any reason or purpose under Medi-Cal managed care.
- Providers and practitioners are not allowed and must not bill Medi-Cal Members or attempt collection against a Medi-Cal Member as indicated above.

Additionally, 22 CCR § 51002 restricts Beneficiary Billing as follows:
"(a) A provider of service under the Medi-Cal program shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to:
(1) Collect payments due under a contractual or legal entitlement pursuant to Section 14000 (b) of the Welfare and Institutions Code.
(2) Bill a long-term care patient for the amount of his liability.
(3) Collect copayment pursuant to Welfare and Institutions Code Section 14134."

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.