IMC Provider Symposiums FAQ Summary

Below is a summary of frequently asked questions from provider symposiums across the state and where MCOs are aligned in their answer.

Billing and Data

Question: Will MCOs pay for multiple services on the same day for a single member?

Answer:

- Yes. If the services are covered, multiple services can be billed on the same day.
- Please use modifier 25 and a unique diagnosis to indicate a distinct and separately payable service.

Question: What happens when a member changes MCOs while bedded in a facility or inpatient?

Answer:

- On 1/1/19: Financial responsibility switches from the BHOs to the MCOs.
- After 1/1/19: Any members that switch MCOs when currently BEDDED in a facility, the originating MCO who issued the authorization is financially responsible until treatment is completed.

Question: Can a patient remain open in SUD Outpatient when they enter an SUD inpatient facility?

Answer:

- Yes, MCOs do not require providers to close an episode of care when members enter inpatient.
- However, there are limits to what services the outpatient provider can provide while the patient is in an inpatient facility.

Contracts & Monitoring

Question: What if I have questions about the rates for specific services (i.e. Peer Services)?

Answer:

- Any fee schedule is negotiable and MCOs will negotiate and contract individually with providers. This includes any value based payment, evidenced based practices, and others.
- MCOs look forward to partnering with providers and learning more about their services and funding structures.

Question: Who do we report Critical Incidences to and for what?

Answer:

- Critical incidences are reported to the MCOs and must be reported for members in active care in any setting (Outpatient, Inpatient, Residential, etc).

- More information and clarification around critical incidences are coming from the HCA and feel free to reach out to your MCOs with any questions.

Authorizations

Question: Will concurrent reviews be completed for involuntary stays?

Answer:

- Yes. MCOs still require concurrent reviews for involuntary patients.
- The concurrent reviews for involuntary stays are typically not as extensive. MCOs will primarily be asking for any status updates on the patient's ITA, current treatment, and if MCOs can assist with anything.

Question: What is the process for pre-authorization for outpatient services?

Answer:

- Prior authorization is not required for a majority of outpatient services.
- Prior authorization is not needed for emergent services.
- Please see the All MCO PA grid for which outpatient services require prior authorization.

All MCO PA Grid.pdf

Question: For services that require notification within 24 hours, does the 24 hours include weekends?

Answer:

- Yes, any services started on or just prior to the weekend must be submitted within 24 hours.

Provider Rosters & Credentialing

Question: How often must provider rosters be updated and what changes do we have to report?

Answer:

- Please report any new staff or any providers that have left your agency. MCOs are required to keep their online provider directory as up to date as possible.
- Any provider not included in an MCO's roster will likely have their claims rejected/denied.

Question: Providers must give 60 days notice for changes to provider roster?

Answer:

- If the provider is practicing under a facility that is credentialed with the MCO, you do not need to provide 60 days advanced notice for new providers.
- It is still very important to notify the MCO of all new/leaving providers by updating your provider roster regularly.
- To ensure no denied/rejected claims, it is best to hold onto claims from new providers until the MCO has confirmed that your new roster has been updated.

Eligibility

Question: How does eligibility for incarcerated members work?

Answer:

- If a member is incarcerated for 30 days or more, their coverage is suspended (not terminated). They are auto-enrolled in the same MCO (Unless they elect a different one) upon release.
- MCOs will ensure eligibility is in place so that providers can engage with the member ASAP. MCOs encourage providers to check with MCOs beforehand that eligibility is reinstated.

Question: What is the best way to check for eligibility?

Answer:

- ProviderOne is the best source of truth and eligibility. ProviderOne will show the member's assigned MCO and BHSO status.