Brain Injury Services Targeted Case Management

A Guide for Providers

Brain Injury Services Targeted Case Management Quick Facts

What is Brain Injury Services Targeted Case Management (BIS TCM)?
BIS TCM are state plan case management (CM) services for Medicaid-eligible individuals aged 18 years or older who live in the community, have a physician-documented diagnosis of traumatic brain injury (TBI), and have severe functional limitations due to their TBI, as indicated by the *Mayo Portland Adaptability Inventory (MPAI-4)* assessment. Individuals residing in an inpatient facility may qualify for BIS TCM if being discharged to community (certain qualifications must be met).

What are the case manager's responsibilities as part of the BIS TCM?

- Obtain client history
- Develop individualized service plan (ISP)
- Assist in developing, locating, obtaining, or scheduling of needed medical/support services
- Periodically monitor the care that the individual is receiving
- Revise and update the ISP as needed
- Complete and update in ISP a minimum of one BIS TCM activity each month and at least one face-to-face contact with the individual at least every 90 calendar days

What are the required qualifications and requirements for becoming a BIS TCM provider?

- Be accredited by Commission on Accreditation of Rehabilitation Facilities
- Guarantee individuals' access to 24-hour emergency services
- Demonstrate ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for reimbursement
- Have administrative/financial management capacity to meet state/federal requirements
- Have ability to document and maintain individual case records in accordance with state and federal requirements

What are the required case manager qualifications for providing the BIS TCM?

- Have a bachelor's degree from an accredited college or university, or be a registered nurse
- Be a Qualified Brain Injury Support Provider or Certified Brain Injury Specialist

What are the billing codes and reimbursement rates for BIS TCM?
The following codes are billed as a monthly unit as authorized by the managed care organization (MCO):

- **S0280** = Assessment for BIS TCM services once every 6 months.
- **S0281** = BIS TCM services
- Reimbursement rate for one unit of each of **S0280** and **S0281** = DMAS Fee Schedule

Important Note About Reimbursement

To be reimbursed for services provided through fee-for-service and managed care, enrolled individuals and providers must follow their contracts with the respective managed care organizations and DMAS.

Contact Information

Provider Enrollment
In-state: **1-804-270-5105** | Toll-free: **1-888-829-5373**
Email: VAMedicaidProviderEnrollment@Gainwelltechnologies.com

Provider Helpline
Available Monday through Friday from 8 AM to 5 PM; for provider use only.
Have Medicaid provider ID number available.
In-state: **1-804-786-6273** | Toll-free: **1-800-552-8627**

For additional information about BIS TCM, visit: **dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/brain-injury-services**.

S0281 BIS Case Management Services

Members receiving BIS TCM services must meet member eligibility/medical necessity criteria. Submission of medical records or physician attestation/documentation is not required to validate a TBI diagnosis but must be maintained as part of the medical record by the BIS TCM provider.

Approval Criteria

- TBI diagnosis criteria and functional needs – *MPAI-4* score criteria are both met

Denial Criteria

- TBI diagnosis criteria and functional needs – *MPAI-4* score criteria are not met
- Members residing in a facility where BIS TCM services span beyond 6 months

Partial Denial Criteria

- Authorization requests that span greater than six months
- Overlapping BIS TCM authorizations (member transitioning from one BIS TCM to another BIS TCM provider)
- Overlapping CM authorizations (Member has CM authorization in place and is now choosing BIS TCM; initial CM authorization will be end dated resulting in a partial denial)

Authorized from and through date requirements:

- S0281 CM is authorized in subsequent dates using a calendar month based on the end date of the intake period. Access the MCO Service Authorization Form.
- S0281 cannot be authorized for more than a six-month timeframe.
- SO281 may not be authorized if a member resides in a facility for a prolonged period.

Service Authorization (SA) Review – Ongoing BIS TCM Services

BIS TCM providers requesting ongoing BIS TCM services must submit a SA request with:

1. Updated MPAI.
2. BIS TCM point of contact (POC).

Approval Criteria

- *MPAI-4* score criteria is met
- BIS TCM POC meets the MCO CM standards

Overlapping Authorizations of Case Management Services

Authorization for and the delivery of BIS TCM services cannot overlap with other Care Management services, including ID/DD waivers. Overlapping of services are not reimbursable. Prior to authorizing BIS TCM services, the Aetna Better Health authorization review will determine if the member is receiving Care Management services from another provider through reviewing claims and authorizations. Brain Injury Providers should note that only one Care Management service can only be authorized for a member per month.

As always, providers have appeal rights for partial denials that may occur.

Members Residing in a DD Waiver

Members who reside in the DD waiver receive CM services as part of their waiver. These members can be identified with an open DD Waiver Level of Care (Y, S or R). For members choosing BIS TCM services over DD waiver CM services, contact the DMAS BIS Unit at braininjuryservices@dmas.virginia.gov before requesting authorizations for BIS TCM services.

Important Claims Information

- Rendering Provider is the facility NPI for **Brain Injury**.
- Taxonomy must be included on call claims forms.

You must file claims within 365 days from the date you provided services unless there's a contractual exception. You have 365 days from the paid date to resubmit a revised version of a processed claim.

All claims must be submitted with this information:

- Member's name, date of birth, and ID number
- Type of service
- Date and location of service

Submitting Claims Online
You can submit claims or resubmissions online through ConnectCenter using payer ID: 128VA. This is our provider claims submission portal via Change Healthcare (formerly known as Emdeon). To register, visit the ConnectCenter portal and follow the prompts to "Sign Up" and enter Vendor Code 214557.

Visit **AetnaBetterHealth.com/Virginia/File-Submit-Claims.html** to learn more.

Submitting Claims by Mail
You can also mail hard copy claims or resubmissions. Mark resubmitted claims clearly with "resubmission" to avoid denial as a duplicate. Mail your claims to:

Aetna Better Health of Virginia
PO Box 982974
El Paso, TX 79998-2974

EFT/ERA Registration Services
Electronic funds transfer (EFT) makes it possible for us to deposit electronic payments directly into your bank account. Electronic remittance advice (ERA) is an electronic file that contains claim payment and remittance info sent to your office. Aetna Better Health has partnered with Change Healthcare to offer EFT/ERA Registration Services (EERS) to all of our providers.

Visit **PayerEnrollServices.com** to enroll in EERS.

To learn more about EFT/ERA, visit our *Claims* page on our website: **AetnaBetterHealth.com/Virginia/File-Submit-Claims.html**.

Additional Billing Information

The provider manuals maintained by DMAS, which are available on their website, are a great resource for billing providers. Chapters 5 in each provider manual contains billing guidelines. To access the DMAS Provider Manuals Library, go to **vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library**.

Helpful Tips

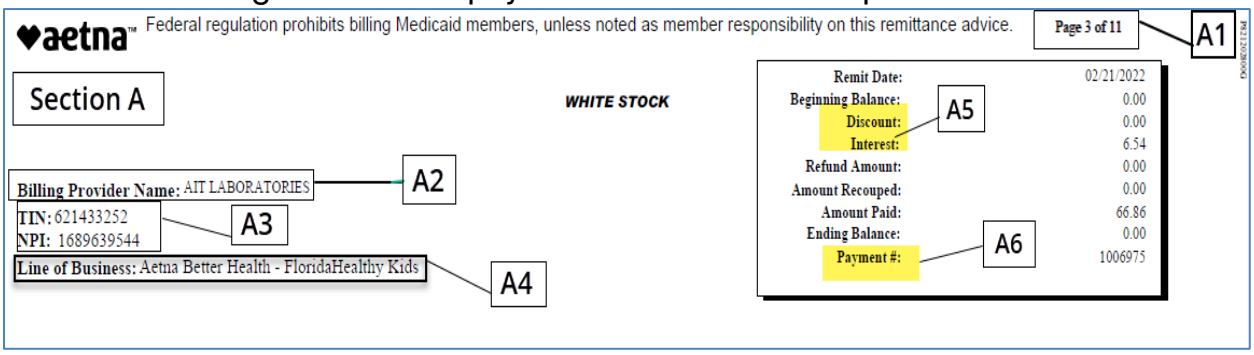
- Always confirm member's enrollment at the beginning of each month.
- Use only appropriate location codes where service was provided. Place of service code sets are generally available on the CMS website.
- If a patient has another insurance in addition to Medicaid, then an EOB will be required with claim submission.
- If you are not participating with the other insurance carrier, an attestation stating nonparticipation is required to be included with each claim submitted for that member.
- Email AetnaBetterHealth-VAProviderRelations@Aetna.com for claims questions.

Paper Remittances

At first glance, a paper remittance can look confusing. Below, we've outlined some of the main components of a paper remittance.

Section A

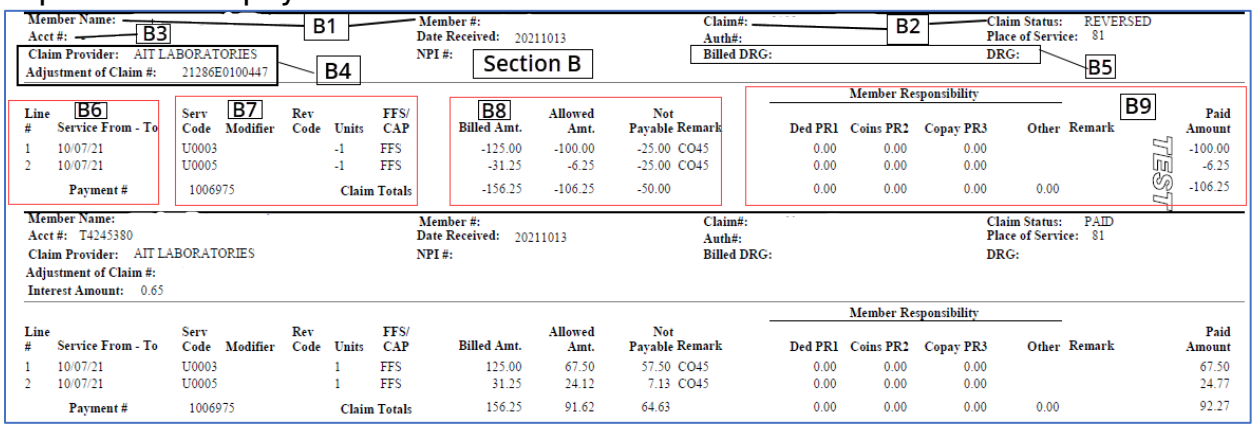
This section contains high-level claim payment details and basic provider data.



A1: Page number
A2: Billing Provider Name
A3: TIN & NPI
A4: Line of Business
A5: Discount & Interest
A6: Payment #

Section B

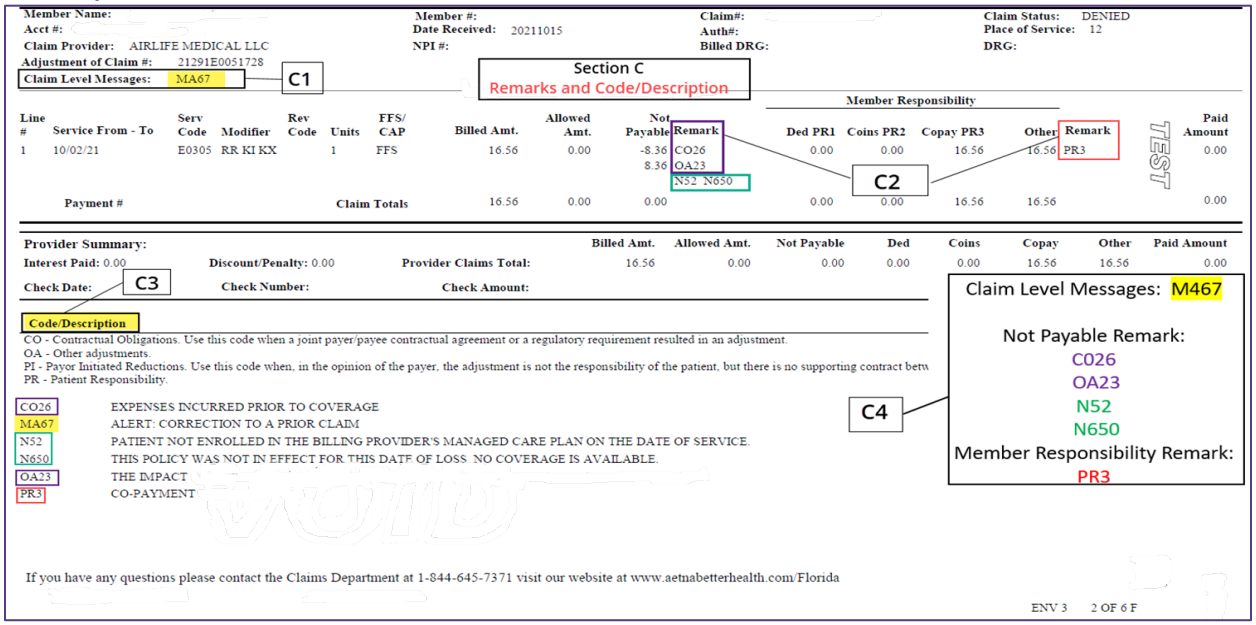
This section illustrates key fields a provider may refer to when reviewing individual claim information. This section has been re-designed to be easier to interpret and quickly find important claim payment details.



B1: Member Name & Member #
B2: Claim # & Claim Status
B3: Acct #
B4: Claim Provider/Adjustment of Claim
B5: Billed DRG & DRG
B6: Line#: Service From-To
B7: Serv Code, Rev Code, Units FFS/CAP
B8: Billed & Allowed Amount
B9: Member Responsibility

Section C

This section is an example of a remit document showing the applicable claim remarks in the code descriptions area.



C1: Claim Level Messages
C2: Remark for each service line
C3: Code/Descriptions
C4: Code reference

Resubmitting a Claim

You can resubmit a claim through ConnectCenter or by mail.

If you resubmit through the ConnectCenter portal, you'll need to mark your resubmission with a number for the frequency code:

- "7" for replacement or adjustment claims
- "8" for voided claims

If you resubmit by mail, you'll need to include these documents:

- A completed *Claim Resubmission/Reconsideration Form*
  - Available on our website at: **AetnaBetterHeath.com/Virginia/providers/file-submit-claims.html**
- An updated copy of the claim — all lines must be rebilled
- A copy of the original claim (reprint or copy is acceptable)
- A copy of the remittance advice where we denied or incorrectly paid the claim
- A brief note describing the requested correction
- Any other required documents

Claim Reconsiderations
A claim reconsideration is a request that we previously received and processed as a clean claim. It's a review of a claim that a provider believes was paid incorrectly or denied due to processing errors.

When you send a reconsideration, be sure to include:

- A claim form for each reconsideration
    - Available on our website at: **AetnaBetterHeath.com/Virginia/providers/file-submit-claims.html**
- A copy of the remit/Explanation of Benefits (EOB) page for each resubmitted claim, with a brief note about each claim you're resubmitting
- Any information that the health plan previously requested

You can file a claim reconsideration by mail. Mail your reconsideration form and all supporting documents to:

Aetna Better Health of Virginia
Attn: Reconsiderations
PO Box 982974
El Paso, TX 79998-2974

The Appeals Process

When Claims Don't Go as Planned
You have the right to appeal our claims determinations within 60 calendar days of receipt of the claim denial. You can file an appeal if:

- We denied reimbursement for a medical procedure or item you provided for a member due to lack of medical necessity or no prior authorization (PA) when it was required
- You have a claim that has been denied or paid differently than you expected and wasn't resolved to your satisfaction through the dispute process

Denials based on medical necessity criteria:

- You have seven calendar days to request a Peer-to-Peer reconsideration. To request a Peer-to-Peer, call Member Services at **1-833-459-1998**.
- If you are not satisfied with the Peer-to-Peer result, you will be able to submit a formal appeal with Aetna Better Health. If you are not satisfied with the appeal result, you may then submit a formal appeal to DMAS.

Denials based on administrative reasons:

- Send appeal request using the formal provider appeal process.
- Appeals should state Formal Provider Appeal on the document(s) and should be mailed to:
  Aetna Better Health of Virginia
  Attn: Appeals Coordinator
  PO Box 81040, Cleveland, OH 44181
- Reviewers may not always ask for additional clinical information. If a service is denied, you will be contacted by the reviewer, faxed a denial authorization, faxed a denial letter, and a denial letter will be mailed to you.

Contact Us

We're here for you to answer any questions you may have.

Our contact information

Lilibet Elling, Provider Relations: EllingL@Aetna.com
Cynthia Beadle, Contracting: BeadleC2@Aetna.com

- **Cardinal Care**: Megan C Krumich, KrumichM@Aetna.com
- **LTSS**: Leticia W Boone, BooneL1@Aetna.com
- **Provider Relations**: Lilibet "Lili" Elling, EllingL@Aetna.com
- **Contracting**: Cynthia "Cindi" S Beadle, BeadleC2@Aetna.com

Your patients have extra benefits that can improve their health.

By being a member of Aetna Better Health, your patients have access to a wide range of added benefits that can help them better meet their health needs, all at no cost. Call **1-800-279-1878 (TTY: 711)** to speak to a Care Manager to learn more about these benefits.

For all members

Extra help with rides: Members can enjoy free rides to local resources or services — up to 15 round trips or 30 one-way trips each year.

Free cell phone: Free smartphone with free data, texts, and minutes

General Educational Development (GED): CampusEd is a free online resource that can help members earn their GED and start a new career. We'll also pay for members' GED test (up to $120).

Hearing care: One hearing exam, $1,500 toward hearing aids, plus 60 batteries each year, plus unlimited visits for hearing aid fittings

Home meal delivery: Home-delivered meals after hospital discharge for seven days.

MyActiveHealth Management: A personalized and interactive mobile program that sends texts on diabetes education and support; personal care; appointment and medication reminders; and exercise/weight goal setting and tracking

Over-the-Counter Health Solutions® period stipend: $20 monthly for members with periods to spend on period products through CVS Pharmacy®

Vision care: One eye exam, plus $125 toward eyewear

Weight management: Personalized weight management with a registered dietitian, which includes a 12-week certified nutritionist program and six counseling visits

Wellness Rewards: Members can get gift cards for taking care of their health. Kids also get extra perks, like free swimming lessons and sports physicals, plus up to a $25 gift card when they join the Ted E. Bear, M.D.® Wellness Club!

For moms and children

Benefits for new moms: Eligible members who are pregnant through one year postpartum can get $25 monthly to spend on over-the-counter items for them and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get 300 free size 1 baby diapers delivered to their home after their baby is born.

Breastfeeding support through Pacify: 24/7 access to a national network of International Board-Certified Lactation Consultants® and doulas via live video consultation

Youth sports physicals: Annual sports participation physical for members 7 to 18 years old

Youth swimming lessons: Water safety and swimming lessons for members 6 years and younger

Healthy food card: Eligible members can get $50 added to a special debit card every month to buy healthy groceries at nearby stores.

For those with certain health conditions

Asthma program: Members with asthma can get one set of hypoallergenic bedding and between $150 and $400, depending on area of service, to use towards one deep carpet cleaning annually.

Therapeutic shoes or shoe inserts: Eligible members with diabetes with a prescription from a podiatrist or orthopedic doctor can get pair of therapeutic shoes or shoe inserts per year (up to $200 annually).