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ADP BULLETIN

| Title: Change in Billing Procedures for Methadone Maintenance Treatment Services | | Issue Date: January 13, 2012 Expiration Date: None | Issue No. 12 - 03 |
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| Deputy Director Approval<br><br>dave neilsen<br>Deputy Director<br>Program Services Division | Function:<br>[ ]Information Management<br>[ ]Quality Assurance<br>[ ]Service Delivery<br>[X ]Fiscal<br>[ ]Administration<br>[ ] | Supersedes Bulletin/ADP Letter No.<br>Supplements but does not supersede #11-01for methadone maintenance treatment services only | |

## PURPOSE

Effective immediately, Drug Medi-Cal (DMC) methadone maintenance treatment services (MMTS) claims can be submitted to the Short Doyle/Medi-Cal (SDMC) system without proof of billing Other Health Coverage (OHC) insurers. This bulletin provides instructions and deadlines to counties and direct contract service providers for submission and resubmission of claims for MMTS provided from November 1, 2009 forward. Of major importance is the **February 29, 2012**, due date on Page 3 for submitting/resubmitting claims for service dates from November 1, 2009 to June 30, 2010, to ensure the prompt payment of claims.

## BACKGROUND

Federal Medicaid and California Medi-Cal laws and regulations require billing a recipient's OHC before billing Medi-Cal. As communicated in the Department of Alcohol and Drug Programs (ADP) Bulletin #11-01, for recipients identified by the Medi-Cal Eligibility Data System (MEDS) as having OHC, the SDMC billing system will deny DMC claim payment if the service provider does not include an Explanation of Benefits (EOB) or if the EOB states that the claim was denied because the services were not provided by an OHC plan provider, and/or because the services were not authorized according to the OHC's requirements.

Bulletin #11-01 required that Medi-Cal service providers bill a recipient's OHC prior to billing Medi-Cal in order to receive payment from the OHC, or a notice of denial from the OHC indicating that:

- The recipient's OHC has been exhausted; or
- The specific service is not a benefit of the OHC.

In many cases, the OHC did not send the appropriate notice, but instead responded by denying the claim because the services were not authorized according to the OHC's requirements. This process not only effectively precluded the Medi-Cal provider from billing DMC, it left the provider with virtually no means of obtaining reimbursement for services provided.

## DISCUSSION

Title 42 Code of Federal Regulations Part 433.138 requires that a service provider bill parties who are legally responsible to pay, and California Code of Regulations, Title 22, Section 51005, subdivision (a) requires Medi-Cal recipients to fully utilize benefits available through other programs before utilizing Medi-Cal covered benefits. Therefore, the responsibility to utilize OHC prior to billing Medi-Cal rests with providers and recipients. However, for MMTS, proof of OHC billing will no longer be required as part of the claim adjudication process. When the service provider determines that MMTS are not available through the recipient's OHC, then the service provider may bill DMC. The determination of whether a recipient's OHC covers MMTS can be as simple as asking the recipient if the recipient's OHC covers MMTS.

Subsequent to the release of Bulletin #11-01, the California State Medicaid Plan was amended (Amendment TN No. 10-016, approved March 21, 2011) to require that services such as MMTS be rendered by a consistent provider who has an established relationship with the recipient. MMTS providers have such a relationship with recipients.

## CONCLUSION

Technical instructions for these specific claims will be identified in ADP's Companion Guide Appendix (for Version 4010 transactions) and ADP's Companion Guide (for Version 5010 transactions), which will be available upon release of this bulletin, on the SDMC system information webpage at https://mhhitws.cahwnet.gov/systems/sdmc/docs/public/short_doyle_-_medi-cal_phase_ii.asp. As noted in the discussion, providers and recipients remain responsible for utilizing available OHC prior to billing Medi-Cal. However, for MMTS procedure codes, proof of OHC billing will no longer be required as part of the claim adjudication process.

The MMTS (also known as Narcotic Treatment Program (NTP)) procedure codes and modifiers are:

| Service Modality Description | Non-Perinatal Program | Perinatal Program |
|---|---|---|
| NTP Methadone Dosing | H0020 HG | H0020 HD HG |
| NTP Individual Counseling | H0004 HG | H0004 HD HG |
| NTP Group Counseling | H0005 HG | H0005 HD HG |

DMC Claim Processing Instructions for MMTS

This bulletin supersedes ADP Bulletin #11-01 only with respect to MMTS.

Counties and direct contract providers may submit replacement claims for any claims for MMTS provided from November 1, 2009, through December 31, 2011, that were denied with reason code "22"; indicating that MEDS reflected OHC available to the client but that the claim did not reflect a billing to the OHC.

Counties and direct contract providers may also submit original claims for any MMTS/DMC services provided from November 1, 2009, through December 31, 2011, that have not previously been billed to DMC, including services that were billed to the OHC and denied for reasons listed as unacceptable in ADP Bulletin #11-01 and services not billed due to provider concerns regarding existing OHC. Counties and direct contract providers are authorized to use delay reason code "10" when submitting such claims later than 30 days after the end of the month of service.

The claims that meet the above-mentioned criteria may be submitted without regard to any time limit that would otherwise apply to them, if they are provided within the following time periods:

- For service dates from November 1, 2009, through June 30, 2010, the original or replacement claims must be submitted or resubmitted to the SDMC system by **February 29, 2012**. If a claim for the same time period is submitted/resubmitted after February 29, 2012, then reimbursement will be from another source through a process that could take up to two years.

- For service dates from July 1, 2010, through December 31, 2011, original or replacement claims must be submitted or resubmitted to the SDMC by June 30, 2012.

Original and replacement claims for MMTS provided on of after January 1, 2012, must be submitted within the timelines generally applicable to DMC claims.

## Records Retention

Counties and service providers shall retain all records relevant to the decision and application of the instructions announced in this bulletin, and consistent with the records retention requirements identified in the State Administrative Manual and in the trading partners' Negotiated Net Amount-Drug Medi-Cal contract with the State.

## REFERENCES

Social Security Act, Title 19, Sections 1901 and 1902, Subdivision (a)(25)
Title 42 Code of Federal Regulations, Parts 433.138, and 433.139.
Welfare and Institutions Code Sections 14005, 14023.7, 14024, and 14124.90
California Code of Regulations, Title 22, Sections 51005, 50761, and 50763
California State Medicaid Plan (Amendment TN No. 10-016, approved March 21, 2011).

## QUESTIONS/MAINTENANCE

Questions concerning the policy change announced in this bulletin may be directed to:

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Counties having questions concerning the operational and claim processing details in this bulletin may direct them to your assigned Fiscal Management and Accountability Branch (FMAB) analyst. Analyst assignments are posted on ADP's website at: http://www.adp.ca.gov/NNA/files/1011_FMAB_County_Assignment_Listing.xls.

Direct contract provider questions may be submitted to the assigned FMAB direct provider analyst. Analyst assignments are posted on ADP's website at: http://www.adp.ca.gov/NNA/files/1011_DP_Assignments-072011.xls.

## DISTRIBUTION

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