Wyoming Medicaid Questions Worksheet

Workshop Name: Behavioral Health Redesign

Date	Question	Answer
6/4/2024	What is the HE modifier?	The HE modifier will be used to signify that a Mental Health program is being utilized.
6/4/2024	What is the HG modifier?	The HG modifier will be used to signify an Opioid Addiction Treatment Program.
6/4/2024	What is the T35 plan?	T35 is the program code for the BHC-Full benefit plan.
6/4/2024	What is the T36 plan?	T36 is the program code for the BHC-Screen benefit plan.
6/4/2024	Are reserve bed days to be billed on a UB or Professional claim?	I am not sure what a reserve bed day is. However, ALL services are to be billed using a Professional claim (J).
6/4/2024	Is TPL required? Per the training, TPL is not required. If the provider were to submit claims with TPL for the BHC Full/Screen benefit plans would Medicaid pay the lessor of Logic?	BHC providers are required, under the terms of their contracts, to bill other insurance before billing the BHD Program. The BHD Program is the payor of last resort.
6/4/2024	Providers spoke with Ben and Dani – and are under the impression that coinsurance and copayment, if TPL is billed, would be covered. Please elaborate for the providers.	45 CFR § 156.1250 Insurance providers must accept cost sharing payments (state government exception).
6/4/2024	H0019 (Long Term Residential Care)	It would be the individual's primary counselor/therapist. This will be shown in

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	What provider would be the treating on the claim, i.e., a primary practitioner of the facility? In this setting, multiple contacts by different individuals per day would be made with the member.	the Behavioral Health Centers (BHC) provider manual.
6/4/2024	T2024 – 1-day eligibility (BHC-Screen) How is the eligibility date determined?	The term should be one (1) year for both BHC Full and Screen plans.
6/4/2024	When the T2024 screening appointment needs to be changed (example illness), who does the provider contact?	See above.
6/4/2024	What provider types/specialty will be able to provide each service? Dani – within the CMS-1500 provider manual, *Chapter 12 Behavioral Health*, there are tables that outline the taxonomies and code/modifiers.	We are currently working on this information for the provider manual.
6/5/2024	When will eligibility appear in BMS?	7/1/2024.
6/5/2024	During discussions we determined that it would be beneficial for the providers and the Call Center to have a table (PDF) of the BHC Full codes with the Medicaid covered codes referenced. Do you	I am fine with you creating one but would want final approval before posting or sharing.

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	approve us to create for the Wyoming Medicaid website?	
6/5/2024	When the contractual amount (known as Cap) is met for an EIN, can the provider bill the BHC-Full eligible member? Additional information: The provider mentioned they currently use a sliding scale when billing the members.	The legislation that authorized the new plans requires the providers to continue to serve when the cap is met. Based on that language, the provider cannot bill the eligible member.
6/5/2024	If a member is on the incarcerated plan How or when would the member become eligible for the BHC Full plan.	The BHC Full plan will pay for services for incarcerated individuals meeting the priority population definitions. There are some exceptions. The individual would need to meet the definition of a priority population. They would do that by completing the Medicaid application, BHC intake packet and assessment. For those in a DOC-run facility, they should be receiving services from an in-house provider.
6/5/2024	If the modifiers HQ and HD are added to code S9480 as allowed, you must also add modifier GT or claims will deny.	This information will be listed in the BHC provider manual.

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	Which codes can be allowed via telehealth?	
6/5/2024	Will the Behavior Health Division still provide the Dollar Draw Down Reports to providers, so they know their CAP amounts?	The Division will provide a report to the providers regarding the claims against the service cap.
6/5/2024	Can Provider Services Call Center direct providers to BHD for cap amounts, or can you provide us the with Dollar Draw Down frequency that we can remind the providers of?	Since the providers will be receiving reports from the Division monthly, the Call Center can let callers know it will be part of the monthly report packet they receive or direct them to the Division for more information.
6/11/2024	Will there be an additional Medicaid Member number for the BHR plans?	No – they will not have a separate or secondary Medicaid ID.
6/18/2024	Procedure code 90839 is not allowed on a coexisting Medicaid plan. BHR plans do not require Prior Authorization – but it is indicated that this code will need a Prior Authorization. Will this code be available after the BHR goes live?	Prior Authorizations will not be needed as this procedure code is not allowed for traditional Medicaid plans. Example – Adult/KIDA/KIDB/etc. CMS-1500 provider manual will be updated to reflect these changes.
6/25/24	Will timely filling remain the same for BHD claims as it is now?	The FY25 contracts with the BHCs have a requirement to submit claims within 90 days from the date of service.