TEXAS Health and Human Services

Contents

HCBS-AMH Frequently-Asked Questions

HCBS-AMH Billing

When a participant is still enrolled in a facility and trying to transition to the community, how should the RM bill for services? Should the provider bill under "Transition Services" or "Recovery Management Services?"

All services provided by the RM while the participant is in the state hospital fall under the auspices of Facility Discharge Services, previously called Transitional Services.

The Recovery Management Facility Discharge Fee (Transitional Fee) is a one-time fee paid to the RM for the first three months of the provision of Recovery Management transitional services. The amount of this one-time Recovery Management Facility Discharge fee is $1,842.87 and is not dependent on the participant's length of stay during these three months of Recovery Management transitional services.

After a period of three months of residing in a state hospital, Recovery Management Facility Discharge services will be paid at a daily rate of $19.28. However, the RM is not eligible to bill for Recovery Management Facility Discharge services provided after the participant's stay exceeds 180 days.

Are HCBS-AMH services billed as fee-for-service?

Yes, HCBS-AMH enrollees are served through a fee-for-service delivery system where providers are paid for each service. Rates are posted at Texas HHS website - Rate Analysis Adult Mental Health Program.

How can I bill my claims?

The HCBS-AMH Provider will email the HCBS-AMH Encounter Invoice to HHSC via encrypted mail. The Encounter Invoice shall be submitted no later than 5:00 pm (Central Time) 15 calendar days following the last day of the month of service. The service month will be the first day of the month through the last day of the month.

HCBS-AMH service providers will use the Clinical Management for Behavioral Health Services (CMBHS) to submit encounter data and as claim payment system when the system becomes available for HCBS-AMH. The system is currently under development and once CMBHS has this capacity and is made available, the HCBS-AMH providers will use it to directly submit service encounters and IRPs and the CMBHS will automatically process claims on monthly basis.

How were billing rates set?

HHSC held a formal rate hearing in 2014 to take input from potential providers to ensure the rates were set appropriately and correspond to the intensity of the services required to meet the needs of the participant. Payment rates for HCBS-AMH services were developed based on payment rates determined for other programs that provide similar services.

Will documentation be required to support services billed on the invoice?

HHSC may request additional documentation at any time to verify reimbursed services are being provided in accordance with the requirements of the HCBS-AMH Program. This verification process includes request for documentation to support clinical necessity of services and program documentation requirements. (See Provider Manual Documentation of Service Provision).

What constitutes sufficient documentation?

Documentation that is an accurate clinical representation of the services or attempted services provided.

Is service authorization required to be reimbursed for services rendered?

Services provided without prior authorization are subject to non-payment. The IRP serves as the authorization document for services. This means services must be on the IRP, approved by HHSC prior to the provision of HCBS-AMH services.

If a provider is providing both the recovery management and provider agency service array, is the provider required to submit two separate invoices?

Yes, the direct service provider will submit only one billing invoice to HHSC for all participants served and the RME will submit only one billing invoice for recovery management services to participants served. If a provider offers both service array and recovery management services, the provider will submit two separate billing invoices.

Is there an overall cap for HCBS-AMH services?

HCBS-AMH does not have an overall cap for billing services.

Is there a cost cap on minor home modifications and adaptive aids? What is the process for billing minor home modifications and adaptive aids?

Providers are reimbursed for minor home modifications and adaptive aids based on actual cost; therefore, a receipt is required to ensure reimbursement. Both minor home modifications and adaptive aids require prior authorization and submission of bids prior to billing. The annual cap for adaptive aids is $10,000 per participant per year. Minor home modifications have a participant limit of $7,500.00 per lifetime. Once that maximum is reached, $300 per IRP year/participant is allowed for repair, replacement, or updating of existing modifications.

What is the current Peer Support rate based on? Why is the rate lower than rehabilitation?

The current rate for peer support is based on a formal rate hearing conducted in 2014. HHSC solicited input from potential providers to ensure the rates were set appropriately and correspond to the intensity of the provision of services required to meet the needs of the participant. In the HCBS-AMH program, peer support is considered different than psychosocial rehabilitation. Because of this, the educational requirements for HCBS-AMH peer support specialists differ from requirements for HCBS-AMH providers of psychosocial rehabilitation. The educational requirements for peer support are in line with requirements for paraprofessionals and the service rates were based off the service rates for a paraprofessional.

Can Peer Support be billed for a group?

The peer support services in the HCBS-AMH program are designed to provide advocacy and foster recovery-oriented skills to help participants enhance their recovery. Peer support services are provided on an individual basis and can't be billed for a group.

How is room and board paid?

The cost of room and board is not included in the HCBS-AMH rate for participants with Medicaid. For persons who are in the process of reinstating Medicaid benefits and indigent participants, Flexible Funds available through HCBS-AMH can be used for room and board.

If a participant enrolled in HCBS-AMH require a CNA, what service would that be billed under?

Certified nursing assistant (CNA) services fall under Personal Assistance Services, which come under Acute Care Services provided by the MCO.

What does the * on the billing rates mean?

The * is tied to the Acute Care code in the applicable Texas Medicaid Fee Schedule located on the TMHP website (see Fee Schedules).