



State of New Mexico  
Medical Assistance Program Manual  
**Supplement**



**DATE: May 12, 2014**

**NUMBER: 14-03**

**TO: ACCREDITED RESIDENTIAL TREATMENT CENTERS, RESIDENTIAL TREATMENT CENTERS, AND TREATMENT FOSTER CARE AGENCIES**

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**SUBJECT: BILLING INFORMATION FOR RESIDENTIAL TREATMENT CENTERS AND TREATMENT FOSTER CARE**

**I. Residential Treatment Services Level of Care (LOC)**

All admissions and continued stays for Medicaid Fee for Service recipients in a residential treatment center (RTC), RTC group home, and accredited residential treatment center (ARTC) require authorization in the form of an approved level of care (LOC) from the Medical Assistance Division (MAD) Third Party Assessor -Molina TPA.

Molina TPA will authorize the LOC and a span of dates within that level of care. If a LOC changes, a new LOC is approved with a new date span.

The provider does not put a prior authorization number on the claim when a level of care has been authorized and the service is billed using the UB-04 institutional claim format.

Rather, the provider bills the service using the appropriate revenue code for the service. Molina TPA enters the approved service into the Medicaid payment system using a "LOC code". When the provider bills the correct revenue code on the claim, the Medicaid payment system matches that revenue code to the approved "LOC code" and pays the claim.

In order for the claim to be paid, the revenue code must match the equivalent "LOC code" that Molina TPA has entered into the Medicaid payment system.

Following the January 1, 2014 transition of Medicaid Fee for Service (FFS) behavioral health (BH) services to MAD and FFS BH claims through Xerox, Molina TPA may have inadvertently provided a prior authorization number rather than an approved RTC LOC.

Most if not all of these have been corrected, but it did result in some claims being denied. MAD is working with Molina TPA to correct the authorization LOC and Xerox to adjust any claims that can be paid.

**COVERED DAYS:** Note also that since ARTC, RTC and RTC Group Home stays are billed on the UB format and are considered residential stays, the total covered days corresponding to the span of days covered by the claim must be stated in one of the form locators (39-41) as a value code. The value code for COVERED DAYS is 80 and the number of covered days must be stated.

If not all days are being covered, then the NON COVERED DAYS for which the value code is 81 must be reported also. The COVERED DAYS less the NON COVERED DAYS must equal the total number of days billed.

## II. Treatment Foster Care Authorizations

Treatment Foster Care (TFC) Agencies must receive prior authorizations for TFC services for Medicaid Fee for Service recipients. This approval also comes from Molina TPA, but because this service is billed using the CMS 1500 professional claim format, the provider is given an authorization number which must be placed on the claim. A “LOC code” is not used in the process.

Molina TPA will authorize the TFC service for the procedure code with a span of dates and provide the prior authorization number to the provider.

The procedure code for TFC I is S5145; the procedure code for TFC II is S5145 with a modifier U1. If there is a change in the service such as going from TFC II to TFC I, Molina TPA must issue a new authorization with a new authorization number.

## III. Matching the Provider with the RTC LOC or the TFC Authorization

Often, because these providers have more than one entity with the same NPI number, when the claim is billed the correct taxonomy must be used on the claim in order for the claim to pay the correct Medicaid provider number.

In order for the claim to be paid, the provider number given to Molina TPA at the time of the authorization request for RTC or TFC services must match the provider who is submitting the claim.

A proper match will exist when the provider does one of the following:

- a. The provider gives the correct Medicaid Provider ID to Molina TPA when the request is made, and then places the correct NPI and taxonomy on the claim (as described below). This is the recommended method.
- b. The provider gives the correct NPI and taxonomy to Molina TPA when the

request is made and then places the correct NPI and taxonomy on the claim.

MAD is seeing a number of instances where the authorized LOC may be for an RTC and the provider uses the correct taxonomy and the revenue code for an RTC on the claim, but the LOC or authorization by Molina TPA is under a different provider number, such as the entity's free-standing psychiatric hospital provider number.

Following the instruction above will prevent this problem. See the billing chart in SECTION IV for correct taxonomies when billing Fee-for-Service claims.

Also, the service and dates of service on the claim must be the same services authorized by Molina TPA.

However, it is also essential that the provider not combine two different authorizations on the same claim line. For TFC, it cannot even be on the same claim.

RTC example:

If Molina TPA has authorized the LOC for two different authorization time periods, the provider cannot bill one line that includes both of those dates.

Assume a span of dates authorized at the admission, and then another span of dates authorized as a continuation.

<u>Begin Date</u>	<u>End Date</u>	<u>Service</u>	<u>Review Type</u>	<u>Approved Units</u>
05/05/2014	06/05/14	ARTC	I – initial	30
06/06/2014	06/15/14	ARTC	C-continuing	7

If billing weekly:

Claim for 5/05/14 thru 5/11/14 would use revenue code 1001 7 units (out of the 30 authorized)

Claim for 5/12/14 thru 5/18/14 would use revenue code 1001 7 units

Claim for 5/19/14 thru 5/25/15 would use revenue code 1001 7 units

Claim for 5/26/14 thru 6/02/14 would use revenue code 1001 7 units

Claim for 6/03/14 thru 6/05/14 would use revenue code 1001 3 units

Claim for 6/06/14 thru 6/12/14 would use revenue code 1001 7 units

But note that when billing, a provider cannot cross the two LOC approval spans such that a line contains a date range that has falls into two different approvals. The provider cannot bill a line that goes from 6/03/14 through 6/09/14 because those dates fall into two different approvals. Otherwise, the claim will be denied with a message saying the claim does not match some portion of the authorization.

For TFC, if there is more than one authorization, each with a different authorization

number, the provider cannot bill them on the same claim. The provider must state the authorization number on the claim and cannot exceed the date range of services within the authorization. If additional dates are authorized under a different authorization number, a separate claim must be sent with the appropriate authorization number and services.

IV. Billing Chart for ARTC, RTC, RTC Group Home, and TFC I & TFC II Services

It is essential that providers use the correct taxonomy for each provider type and service when billing Fee for Service claims. Please refer to the below chart for billing guidance.

PROVIDER	HSD MAD PROVIDER TYPE and TAXONOMY	FORM	TYPE OF BILL	REVENUE CODES	MODIFIER OR LOC	NOTES
<b>ARTC</b> (Accredited Residential Treatment Facility)	Type 216  TAXONOMY 322D00000X	UB	89X	<b>1001 - Psychiatric</b>	LOC is AR3. (Providers do not put LOC on the claim)	ARTCs must be licensed & certified by CYFD  Limited to recipients under age 21
<b>ARTC</b> (Accredited Residential Treatment Facility)	Type 216  TAXONOMY 322D00000X	UB	89X	<b>1002 – chemical dependency</b>	LOC is AR4. (Providers do not put LOC on the claim)	ARTCs must be licensed & certified by CYFD  Limited to recipients under age 21
<b>RTC (Non-accredited Residential Treatment)</b>	Type 217  TAXONOMY 320800000X	UB	89X	<b>0190</b>	LOC is TR1. (Providers do not put LOC on the claim)	Non-accredited RTCs must be licensed and certified by CYFD  Limited to recipients under age 21
<b>RTC – Group Home Residential Treatment (non-Joint Accreditation) Group Home</b>	Type 219  TAXONOMY 320800000X	UB	89X	<b>1005</b>	LOC is TR2 (Providers do not put LOC on the claim)	Must be certified by CYFD.  Limited to recipients under 21

<b>Treatment Foster Care Agency</b> <b>TFC I (level I)</b>	Type 218 TAXONOMY 253J00000X	CMS 1500		<b>HCPCS</b> <b>S5145</b>	No modifier	TFC agencies must be licensed and certified by CYFD  Limited to recipients under 21
<b>Treatment Foster Care Agency</b> <b>TFC II (level II)</b>	Type 218 TAXONOMY 253J00000X	CMS 1500		<b>HCPCS</b> <b>S5145</b>	<b>Modifier U1</b>	Limited to recipients under age 21  TFC agencies must be licensed and certified by CYFD

Note these instructions do not apply to IHS or Tribal 638 facilities. Information will be provided to them separately. Also, for recipients enrolled in managed care organizations (MCOs), please follow the specific instructions from each MCO for billing for services to their members.

We appreciate your participation as a Medicaid provider. If you have further questions on billing for these services when provided to Medicaid FFS recipients, please contact Sally Wait at (505) 476-7153 or at [sallyanne.wait@state.nm.us](mailto:sallyanne.wait@state.nm.us)