Hennepin Health
Provider Bulletin

August 2023

SUBJECT
Important SUD provider information regarding claims, rates, and billing questions

PROVIDERS AFFECTED
Substance use disorder (SUD) service providers

KEY POINTS
- Hennepin Health has completed configuration system updates to correct errors identified in the reimbursement of claims. All claims received with dates of service beginning January 1, 2022, were reviewed. **It is important to note that providers do not need to resubmit claims.**
- Effective January 1, 2022, DHS increased payment for SUD providers who satisfy criteria specializing in population-specific treatment in non-residential and residential SUD settings. SUD programs who qualify may bill U3, U4 and/or U6 modifier(s) to receive the rate enhancement. Providers should check to make sure they are accurately billing the correct amount for the increase.

BACKGROUND

Underpaid claims
Hennepin Health has completed configuration system updates to correct errors identified in the reimbursement of claims. All claims received with dates of service beginning January 1, 2022, were reviewed. Underpaid claims reprocessing began on July 27, 2023, and upon completion later this month, Hennepin Health will audit those claims to ensure the claims were reprocessed correctly. It is important to note that providers do not need to resubmit claims.

Population specific rate enhancement
It is important that SUD treatment programs that meet enrollment licensing requirements with Minnesota Department of Human Services (DHS) bill modifiers to account for increased costs for additional staff and monitoring.

Effective January 1, 2022, DHS increased payment for SUD providers who satisfy criteria specializing in population-specific treatment in non-residential and residential SUD settings. SUD programs who qualify may bill U3, U4 and/or U6 modifier(s) to receive the rate enhancement. Providers should check to make sure they are accurately billing the correct amount for the increase. Hennepin Health is unable to exceed the billed amount for payment.

Initially, the rate enhancement for non-1115 Waiver SUD providers were not applied. System programming was completed on July 7, 2023 to increase the rates to include all SUD providers. Claims will be adjusted back to January 1, 2022, to correct payment rates.

DHS has more information, including rates, on their website: Substance Use Disorder (SUD) Services (state.mn.us)

Overall modifier rate enhancements

The following enhancement services have additional payment rates that apply: co-occurring services, medical services, disability responsive, culturally specific, and clients with children. Providers who have met criteria to bill for the rate enhancement can bill the enhancement on all claims under the qualifying site.

> Example: Providers who are staffed to provide medical services and meet adequate staffing standards of appropriately credentialed medical staff to assess and address the client's health needs can bill HH modifier on all claims provided and the qualified facility, not only of members receiving the medical services. The enhanced rates are needed to fund providers for overall increased costs associated to address specific client complexities.

Provider billing questions

Some providers have inquired on claim denials. Listed below are examples for claim denials.

1. Incorrect procedure code with type of bill
    - CARC - CO16: Claim/service lacks information or has submission/billing error(s). Type of bill codes identifies where the patient is receiving services.
    - RARC - MA30: Missing/incomplete/invalid type of bill.
    - 089x or 13x describes the member is receiving outpatient SUD rehabilitation services. The HCPCS code of H2035 is used to reimburse hour(s) of services provided in an outpatient setting.
    - Type of bill code 86x indicates the member is receiving service in a residential substance use disorder treatment setting. H2036 HCPCS code is used to for the daily reimbursement for residential services.

2. Invalid discharge code information
    - CARC - CO16: Claim/service lacks information or has submission/billing error(s). Type of bill codes identifies where the patient is receiving services.
    - RARC - N50: Missing/incomplete/invalid discharge information.

Claim frequency code is the fourth digit of the type of bill submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

Patient discharge status codes identify if the patient is still receiving treatment or where they were discharged.

It is important the course of treatment documented in the patient's medical records matches what is billed on the claims.

Examples of frequency codes commonly used on SUD claims:

1 = Admit through discharge
2 = Interim – first claim: Use for first claim of an expected series of bills
3 = Interim – continuing claim: Use when a bill for which utilization is chargeable for same confinement and Interim First frequency code has already been used.
4 = Interim – last claim
7 = Corrected claim
8 = Void claim

Patient discharge status code is a field on the 837I (UB04) must correspond with the frequency codes noted above.

1 – Discharged to home or self-care
2 – Discharged/transferred to short-term general hospital
3 – Discharged/transferred to skilled nursing facility
4 – Discharged/transferred to a facility that provides custodial or supportive care
6 - Discharged/transferred to home care
7 – Left against medical advice or patient discontinued care
20 – Patient expired
30 – Still inpatient

Examples of common errors

- Type of bill 891 or 861 (admit through discharge) with discharge status code 30 (still inpatient).
    - The Type of bill frequency code indicates the entire treatment has been billed however the discharge status is indicating still inpatient.
- Type of bill 893 or 863 (Interim – continuing claim) with discharge status code "01" discharge to home.
    - The frequency code of "3" indicates member is still a patient but discharge status code of "01" indicates member discharged to home.

Please check the frequency code to ensure it is consistent with the discharge status code.

Valid, invalid modifier usage

UC modifier is billed to represent a combination of modifiers HH (co-occurring) and U5 (medical complexity). If billing UC modifier with HH or U5 modifiers, the claim will be denied for invalid modifier combination.

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Corrections to previously submitted claims

If making a correction to a previously submitted claim, use frequency "7". Corrected claims billed without frequency code "7" will be denied as duplicate.

RESOURCES

- Hennepin Health Customer Services: 612-596-1036 (press 2)
- Hennepin Health website: www.hennepinhealth.org