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Vermont Medicaid Supervised Billing Manual for Behavioral Health

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

This manual is intended for behavioral health services. Supervised billing for behavioral health services means that a qualified licensed provider can bill for covered clinical services within their scope of practice provided by a qualified non-licensed provider when the qualified non-licensed provider is under their direct supervision. Please note, this is for supervised billing only. For information regarding Incident-To billing for licensed physicians, please see the General and Billing Forms Manual.

Requirements as described below apply only to clinical services, and are not applicable to case management, specialized rehabilitation or emergency care and assessment services. The Health Care Administrative Rule 9.103 Supervised Billing and related rules can be found on the Agency of Human Services website at: https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar. Providers use of supervised billing practices are subject to the requirements of the administrative rule.

Section 2 Conditions for Supervised Billing

DVHA expects non-licensed providers follow the Office of Professional Regulation (OPR) guidance for their profession. In accordance with OPR's regulations, DVHA allows a qualified licensed provider to bill for clinical services provided by a qualified non-licensed provider as supervised billing. Please refer to the conditions as stated in section 9.103.3 in the above referenced rule, as well as information at OPR: https://sos.vermont.gov/allied-mental-health/.

In addition, the following conditions must be met to bill Vermont Medicaid:

1. Effective January 1, 2016, Non-licensed providers engaged in post-degree supervised practice must be listed on the Roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State and obtain their license within five years, https://sos.vermont.gov/allied-mental-health/.
    a. In response to the COVID-19 Federal Public Health Emergency, DVHA has authorized an extension of the deadline by one year for those providers **engaged in post-degree supervised practice** that were rostered as of January 1, 2016 and were required to obtain their licensure by January 1, 2021. **The one-year extension will expire July 1, 2022, this is the final extension**.
    b. A review may be requested to DVHA in cases of extenuating circumstances where a non-licensed provider may not obtain a license. This request must be clearly articulated as to what steps were taken and why a license is not able to be obtained. Please refer to OPR guidance on rostered providers: https://sos.vermont.gov/allied-mental-health/.
        i. Exception to the roster requirement:
            1. DVHA 'grandfathered' non-licensed providers that submitted a waiver form, during the time DVHA was accepting waiver forms. Those that have been approved, are not subject to the roster requirements as long as the following criteria is met:
            2. Employment is maintained with the agency/employer in which they were granted the waiver.
            3. Continue education requirements of licensure for profession, as outlined by the Office of Professional Regulation or in the Vermont Department of Health's Alcohol and Drug Abuse Program Administrative Rules.
            4. Maintain records showing attendance and participation in the continuing education activities claimed. Examples of acceptable records include, certificates of attendance received during the instruction, receipt of registration and the activity's time schedule, signature of facilitator, or brief summary of the work content. These records are subject to inspection and verification upon request.
            5. Must receive supervision meeting the criteria outlined in the 9.103 Administrative rule:
                - 9.103.3(a)(1) Adhere to the supervision requirements specified by his or her scope of practice, including regular, face-to-face ongoing supervision to the qualified non-licensed provider.

Section 3 Procedures for Billing

1. Practices/Agencies must maintain documentation on unlicensed master's level individuals providing clinical services that includes the following:
    a. Name of rostered, unlicensed provider.
    b. Degree and discipline.
    c. Name of supervising provider.
    d. Status of license-eligibility:
        i. License-eligible.
        ii. Rostered non-licensed and noncertified psychotherapists.
        iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.
        iv. Addiction counselors fulfilling required hours of supervised work experience.
    e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.
2. Supervising providers must use their unique Medicaid provider number for services provided by unlicensed providers.
    a. For claims submitted to Vermont Medicaid, the following pricing modifiers must be used:

Modifier	Definition	Information
HO	Master's Degree Level	*This modifier is required when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Master's Degree Level." The reimbursement rate is 76% of the fee schedule.*
HN	Bachelor's Degree Level	*This modifier is required when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Bachelor's Degree Level." The reimbursement rate is 66% of the fee schedule.*

3. **Use of the above modifiers by Designated Agencies and Specialized Service Agencies: For any claims submitted to DMH or VDH (preferred providers) fund sources, the modifiers in the above table are required unless billing for Eldercare, Reach Up, or Success Beyond Six services then the modifiers will not be required.**
4. In the event of a supervisor's short-term absence (e.g. vacation) where another licensed provider is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider's internal policy.
5. For neuropsychological testing, the supervising provider must conduct an initial face-to-face neurobehavioral status exam to determine the medical necessity for neuropsychological testing and the extent of such testing. Evaluations, including initial neurobehavioral status exam, administration of all tests, final report, and feedback session, if held, should be billed to Vermont

Medicaid at the conclusion of the process on a single claim. The patient's record should include documentation of dates and times of face-to-face ongoing supervision to the unlicensed clinician. For other documentation requirements and best practice guidelines please see Local Coverage Determination (LCD) *Psychological and Neuropsychological Testing (L34646).*

Section 4 Billable Services Provided by Supervised Non-Licensed Providers

Clinical services within the provider's scope of practice, including:

- Diagnosis & Evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Medical Evaluation/ Management
- Medication/ Psychotherapy

Section 5 Non-Reimbursable Services Under Supervised Billing

- Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid provider.
- Services performed by a non-licensed provider who cannot practice independently and is not actively working toward licensure.
- Case Management, Specialized Rehabilitation or Emergency Care and Assessment Services.

Section 6 Contact Gainwell Technologies with Questions

Questions with adherence to supervised billing should be addressed to Gainwell Provider Services by calling 800-925-1706. Billing inquiries can also be addressed to the Gainwell Provider Representative assigned to your coverage area: Provider Representative Coverage Map.

Section 7 Medicaid Fraud

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed.
- Providing and billing for unnecessary services.
- Billing for a higher level of services than actually performed.
- Charging higher rates for services to Vermont Medicaid than other providers.
- Coding billing records to get more reimbursement.
- Misrepresenting an unallowable service on bill as another allowable service.
- Falsely diagnosing so Vermont Medicaid will pay more for services.

Suspected fraud, waste or abuse should be reported to the DVHA Program Integrity Unit at https://dvha.vermont.gov/providers/program-integrity, by phone at 802-241-9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, at 802-828-5511.