Behavioral Health Therapy (BHT)

Best Practices Guide

August 2024

Eligibility

- Verify PHC Member eligibility at least once a month.
- Member eligibility can change during the course of the authorization period.
- Verify if there is other insurance on our website or with the parents, to ensure timely billing of all plans.
- Best practice is to use the Provider Portal/Online Services to check eligibility, submit and correct TARs and review Claims. The link for the portal is https://provider.partnershiphp.org/UI/Login.aspx

Primary Insurance

- If the member has other coverage, submit an Other Health Insurance (OHI) denial letter with the TAR to PHC to ensure claim processing.
    - If the TAR is remarked that we have received an OHI denial letter on file, we will pay the BHT claims as primary.
    - PHC pays for copays, coinsurances, and deductibles from the primary insurance EOB.
    - It is not required to submit the same denial letter with each claim.
- The PHC claim Dates of Service (DOS) and billed charges must match the primary EOB.
- Change the HCPCS codes to PHC codes with appropriate modifiers.
- Attach Non-Covered or exhausted benefit letters to claim billed to PHC.

Authorizations

- Request enough units to span the authorization period and according to the treatment plan.
- After billing, if there is justification for additional units, submit a new TAR with documentation.
    - Verify all documentation has been sent with each TAR request, such as the ROI.
    - ***ROI should be the first page when sending documentation.***
- Providers can request units be added through a TAR correction if the TAR is still active.
- Pended TARs: More information is needed; submit documentation timely or the TAR will be denied and you will have to restart the entire process.
- You can add units to an existing TAR through TAR Corrections on the Provider Portal. The request must be submitted within the date span of the TAR.

Claims

- Complete all required fields to process your claims for payment. Claims with missing or invalid data will be rejected or denied.
    - Denials - Corrected claims are not accepted. All denied claims must be corrected through the Claim Inquiry Form (eCIF) process to be paid.
    - Rejections - Resubmit corrected claims with the rejection letter for processing
- Avoid billing with a date span; bill by dates of services. Try to bill weekly.

Place of Service Codes

- If services are in multiple locations, on the same day with the same provider, you will need to split services on same day, different location, and same code. For example:
  - At home, H2012-HM, location 12, 4 units, 10/07/21
  - At the park, H2012-HM, location 99, 6 units, 10/07/21
- Only one (1) service line using the same date of service, same HCPCS and same modifier is payable.
- Accepted Place of Service codes: **11 (office), 12 (home), 41 (transportation),** and **99 (outside of home and office).** The **03 (school)** code can be used with a remark in box 32.

Mileage

- First 15 miles are not payable, use Place of Service code 41.

Supervision Code

- Use H0046, with the HO or HN modifier, for the supervision of the mid-level and/or paraprofessional services.

Direct Services

- Medi-Cal pays for Direct Services Only, meaning the child and/or family must be present for services.
  - Indirect or Creation of visual stimulation materials are not billable. Charting or documentation/note updates are not billable and considered part of the services.

Sending Secure

- Make sure to send any protected health information (PHI) secure. It is imperative that we all ensure that patient information is secure as protected by the Health Insurance Portability and Accountability Act (HIPAA).

PHC Policy

- Reference the PHC policy ***MPUP3126*** *Behavioral Health Treatment for Members Under the Age of 21* on our website at http://www.partnershiphp.org/Providers/Policies/Pages/UtilizationManagement.aspx