BH LINK Program
(BH LINK) Service Provider Billing Manual

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1. Overview

This billing manual is designed to be a reference document for consumers, family members, providers of primary care, behavioral healthcare, social services, and hospitals involved in the BH LINK service. This manual has been developed by the Rhode Island Executive Office of Health and Human Services (EOHHS), including Medicaid and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to guide service implementation and billing.

2. Definitions

BH LINK – A non-residential (less than 24 hours), community-based service that assesses, monitors, and provides case management for individuals who are under the influence of substances, and/ or who are having a mental health crisis. The BH LINK service provides a less- traumatic, less costly setting than the Emergency Department. Individuals are provided case management to connect them to treatment for substance use disorders (SUD), and/ or mental health services.

Required Services –BH LINK providers are required to assess, monitor, and provide case management.

Eligible BH LINK Providers – Providers must be certified by EOHHS to provide BH LINK services.

Service Delivery – BH LINK is delivered in a person-centered, recovery-oriented, strength-based model of care. A key component is allowing individuals to stabilize in a safe environment and connecting them with the services they need (e.g., outpatient therapy, medication management, medication assisted treatment, detoxification etc.). Assessment and monitoring occurs throughout the duration of the encounter.

3. Billing for BH LINK services and encounter data requirements

BH LINK providers are paid through a bundled payment. Bundled payments allow multiple disciplines to work with and assess an individual in one single encounter and claim. The BH LINK provider should submit claims for BH LINK services using the bundled payment methodology herein. Providers shall bill for Medicaid members only. Providers will use the designated code (S9485) for the bundled daily payment. The encounter rate for this service is $598.50 per encounter. This rate can only bill once in a 24-hour period.

In addition, a provider should include all applicable details on the claim, these details are:

a. T1016 (Care management, per 15 minutes), maximum units: 7 (32)
b. H2011 (crisis intervention, per 15 minutes), maximum units 4 (16)

c. 90792 (psychiatric evaluation), maximum unit 1
d. 99211/TD (nurse service, per 5 minutes), maximum units 24 (96)

Provider should include all details as applicable for the service provided to the individual. There is no additional reimbursement for these details.

Here is a billing example:

Claim Line 1 - 1/1/20-1/1/20, S9485, 1-unit, billed amount is $598.50
Claim Line 2 – 1/1/20-1/1/20, T1016, 4 units, billed amount is $0
Claim Line 3 – 1/1/20-1/1/20, 90792, 4 units, billed amount is $0

Medicaid providers delivering other Medicaid-covered services outside of the BH LINK service bundle may bill in accordance with the state's billing procedures. This bundle may be billed once daily per Medicaid beneficiary with no restriction on the number of times per month, so long as it does not exceed once per day.

The provider must include the Provider NPI and assigned taxonomy (405300000X) for this bundled service**.**

Providers are responsible for verifying the member's eligibility before submitting claims for the bundled payment. The provider shall bill if the minimum service requirement for BH LINK has been met. If the provider bills for an individual in an institutionalized setting or long-term residential, the institutional or long- term residential provider, will not be able to be paid for that Date of Services. The BH LINK provider and the institutional/ long-term residential provider will need to review a process for this.

Members will be determined eligible for BH LINK service based on the following criteria:

a. Are 18 years of age or older;
b. Eligible for Medicaid;
d. Immediate need at encounter is substance use or mental health related;
e. Do not have any abnormal vital signs; and
f. Do not have any signs of physical trauma, illness, or environmental emergency.

Service Line (aka Shadow) Billing

As part of the claim submission, the provider shall include codes that match the BH LINK activities that the client received during the encounter. These activities must be included in the detail/service billing lines. The provider must include at least one detail/service level detail on each claim, billed at $0.00, to receive payment for the full BH LINK bundled rate. These services include, the following:

a. T1016 (Care management, per 15 minutes), maximum units: 32
b. H2011 (Crisis intervention, per 15 minutes), maximum units 16
c. 90792 (Psychiatric evaluation), maximum unit 1
d. 99211/TD (Nurse service), maximum units 240

e. 90791 TD (Registered Nurse), maximum unit 1
f. 90791 HP (Psychologist), maximum unit 1
g. 90791 AJ (Licensed Clinical Social Worker/Independently Licensed Clinical Social Worker), maximum unit 1
h. 90791 HO (Licensed Mental Health Counselor), maximum unit 1
i. 90791 HF (Licensed Chemical Dependency Professional), maximum unit 1
j. 90791 TD TF (PCNS), maximum unit 1
k. 90791 UA (Principal Counselor/Counselor), maximum unit 1

All BH LINK services shall be recorded in 15-minute units. The first unit must last a full 15- minutes; additional units during the same encounter shall be rounded up/down as necessary. This level of detail shall be included in the claims submitted to Medicaid.

EOHHS and BHDDH will review the data contained in the submissions for the individuals receiving BH LINK services to validate that the minimum program standards were provided to the members and to collect data to review the quality of the service.

Process for confirming Medicaid eligibility: Medicaid eligibility will be confirmed using the Healthcare Portal (HCP). To access the HCP, providers must obtain a Trading Partner ID (TP ID). Please visit the HCP page on the EOHHS website for more information on:

- Enrolling as a Trading Partner
- Registering a Trading Partner
- How to use the HCP

Once enrolled, it is the provider's responsibility to ensure recipients are eligible for Medicaid. Providers will need to confirm that recipient's coverage includes Benefit Plan Details that state Categorically or Medically Needy for the dates of service being searched. BH LINK services are considered out of plan services. If the Medicaid Beneficiary has a managed care plan, services will be billed to Fee-for-Service Medicaid, not the health plan.

4. Discharge Criteria

Discharge from BH LINK services shall occur when:

- An individual no longer meets eligibility criteria to participate;
- Individuals and program staff mutually agree to the termination of services;
- Assessments indicate a need for higher or lower level of care; or
- An individual refuses services and requests discharge, despite the team's best efforts to engage with the individual.

5. Notice Process and Appeals

- Once it is determined an individual shall receive BH LINK services, providers must complete a form that ensures that the individual has consented to

participate in BH LINK services. This is a voluntary program. If consent is not properly captured and attested to in the member's record, the State reserves the right to recoup any funds paid for the service.

- As part of the initial intake process, members are to be given a written copy of the BHDDH and EOHHS process to file a complaint, appeal a decision or request a hearing. The process to file a complaint with the state mental health authority (BHDDH), is written in the Rule and Regulations for the Licensing of Behavioral Healthcare Organizations, Section 19, Concern and Complaint Resolution Procedure. The Appeal Process is written under the Executive Office of Health and Human Services, Medicaid Code of Administrative Rules, Section 0110 Complaints and Hearings.

- Provider shall maintain all records for any follow up auditing upon the request of the State for the period dictated by State or Federal record retention policy. Patient records shall include documentation of services delivered, resources provided, and any follow-up indicated. This is to include but is not limited to:

    1. Date, start time/end time of contact with BH Link provider.
    2. All (intake, COWS, and/or CIWA) completed assessments including diagnoses, dated and signed by RN or MD.
    3. All progress notes/ case management notes/ referrals must be signed.
    4. Reason for/location of discharge.

6. Program Integrity

EOHHS shall engage in periodic audits to review clinical criteria on a sample of members from each provider. The audit may be based on a random sample of members or on a targeted sample of members if there are anomalies in service mix, metrics, staffing, or other programmatic characteristics.

7. Other References

The provider may refer to the certification standards for additional requirements for BH LINK services.

Appendix I
List of Billing and Procedure Codes

Program code	Modifier	Service	Rate	Unit Basis
S9485	N/A	BH LINK Encounter	$598.50	Daily
T1016	N/A	Case Management	$0.00	Per 15-minutes
H2011	N/A	QMHP Crisis Intervention	$0.00	Per 15-minutes
90792	N/A	MD Psychiatric Evaluation	$0.00	90-minutes (Expectation is 60 minutes face to face and 30 minutes of documentation time.)
99211	TD	Nurse Service	$0.00	Per 5-minutes
90791	TD	RN Assessment	$0.00	90-minutes
90791	HP	PhD Assessment	$0.00	90-minutes
90791	AJ	LICSW/LCSW Assessment	$0.00	90-minutes
90791	HO	LMHC Assessment	$0.00	90-minutes
90791	HF	LCDP Assessment	$0.00	90-minutes
90791	TD/ TF	PCNS Assessment	$0.00	90-minutes
90791	UA	PC/C Assessment	$0.00	90-minutes