Brain Injury Services Program Guide

Sentara® Health Plans

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Purpose of the Guide

This guide provides detailed information for Brain Injury Service (BIS) providers conducting business with Sentara Health Plans.

Note: The Sentara Health Plans Provider Manual, a more extensive resource, is your trusted source for the health plan's policies and procedures.

Sentara Health Plans Resources for Providers

Upon receipt of a referral, and before the delivery of BIS care management services, the BIS care manager must complete a BIS assessment. The BIS care manager will conduct a face-to-face evaluation at the members' residence to:

- Determine the member's qualifying diagnosis of traumatic brain injury (TBI) as defined
- Initiate the Mayo-Portland Adaptive Index-4 (MPAI-4) assessment related to the severity of the brain injury and the member's level of functioning once the TBI diagnosis has been confirmed
- Interpret the MPAI-4 results for comprehensive service planning purposes
- Implement the person-centered planning process

As part of the intake process, the BIS care management provider must collect existing medical documentation that substantiates the member's diagnosis of a TBI.

If there is no documented diagnosis, then the BIS care manager and/or the member's assigned Sentara Health Plans care manager will assist the member in accessing a physician who can assess further and document whether the member has an eligible BIS care management diagnosis. Sentara Health Plans will support new cases by assisting BIS care management providers with locating active service providers from the provider network.

BIS care management providers should communicate with Sentara Health Plans to coordinate care for members not meeting the Virginia Department of Medical Assistance Services (DMAS) definition of TBI criteria.

Provider Obligations

Provider obligations are found in your provider agreement.

Health Plan Obligations

Sentara Health Plans obligations are found in your provider agreement.

Conflict of interest separation from HCBS providers

Pursuant to 42 CFR 441.301(c)(1)(vi), "providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered plan of care, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered plans of care in a geographic area also provides HCBS.

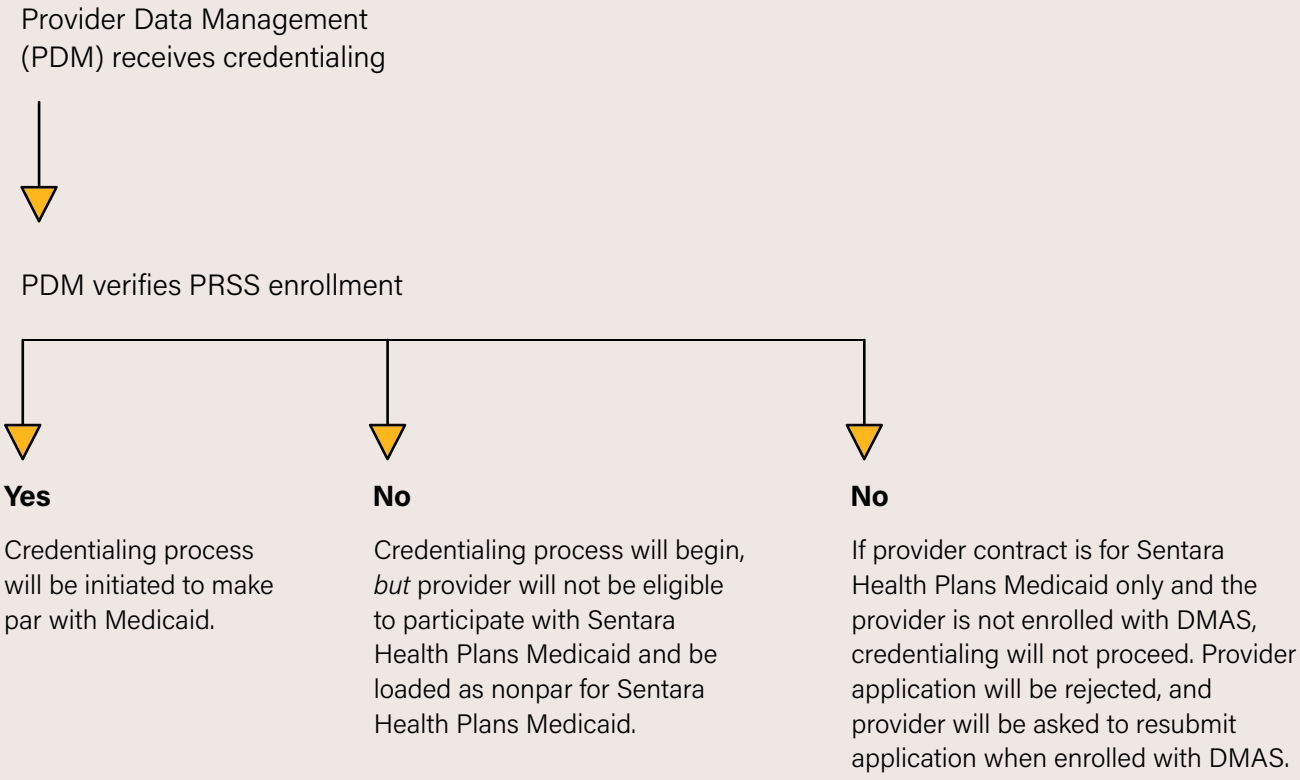
Provider Services Solution (PRSS)

All Medicaid managed care network providers must enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act.

Key Points:

- How to Enroll: From **virginia.hppcloud.com**/, go to Menu, then Provider Enrollment, and select either New Enrollment or Enrollment Status.
- Only one enrollment application is necessary in PRSS, even if you participate with more than one managed care organization (MCO).
- All new MCO-only providers must first enroll with PRSS prior to requesting credentialing with one or more of the managed care health plans.

DMAS/PRSS Verification Workflow



Confidentiality

- Provider agrees that all medical records, protected health information (PHI), and any other personal information about a member will be maintained within the United States and treated as confidential
- Additionally, the provider will maintain all medical records and financial, administrative, and other billing records and documents concerning services provided to members for 10 years or as required by applicable laws and according to industry standards.

Provider Services: Care Coordination

- The care coordination staff, which includes nurses, social workers, and healthcare administrative support professionals, collaborates with members, providers, healthcare teams, and community resources to assess and identify members' holistic needs.
- They develop individualized care plans and work to ensure that all prescribed treatment resources are provided to members.
- Through ongoing efforts, the staff helps members achieve their specific goals and navigate the healthcare system by offering education, advocacy, and support.
- They also assist with treatment needs during hospital stays, facilitate access to appropriate resources within the community, and support smooth transitions to and from long-term care facilities or community living settings.

BIS Care Management Team

- Comprised of nurses, social workers, and other healthcare professionals with advanced degrees
- Conducts telephonic and face-to-face assessments dependent on the member's level of care
- Coordinates members' urgent needs with BIS TCM provider as needed
- Conducts interdisciplinary care team (ICT) meetings as needed
- Assists BIS TCM providers with locating in-network resources such as
  - Rehabilitative or treatment providers
  - Recent facilities and/or hospitals
  - Commonwealth Coordinated Care Plus (CCC Plus) and developmental disability (DD) Waiver Service providers
  - Primary care provider (PCP) assignments & Specialists
- Ensures BIS TCM services are always in place
- Reviews BIS TCM's plan of care to verify member's needs are being met based on provider submitted MPAI-4 Assessment

BIS TCM Provider Qualification

BIS TCM provider agencies must be CARF-accredited or DBHDS-licensed, and case managers must meet DMAS education and certification requirements.

Member Eligibility

To be eligible to receive BIS case management (CM) services, the member must reside in the community or be planning for discharge from a facility within six months.

Members:

- Enrolled with Sentara Health Plans **are** eligible
- Enrolled in FAMIS fee-for-service (FFS) and FAMIS Managed Care Organization (MCO) are **not** eligible
- 18 years and older **are** eligible
- May reside in a facility and be eligible for BIS CM six months before their expected discharge

Intake Process

Determine member's qualifying diagnosis of TBI.

Provider must collect existing medical documentation that substantiates the member's diagnosis of a TBI as defined.

Initiate the MPAI-4.

Interpret the MPAI – 4 results for comprehensive service planning .

Implement person-centered planning process.

Sentara Health Plans will support new cases by assisting the BIS CM providers with locating active service providers from your networks.

BIS CM providers should communicate with Sentara Health Plans to coordinate care for members not meeting the DMAS definition of TBI criteria.

Determining Medical Necessity: BIS CM Criteria

Traumatic brain injury (TBI) Diagnosis – A TBI is defined as brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.

Exclusions: Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, anoxia, brain tumor, Alzheimer's disease and other conditions causing dementia, and other neurodegenerative diseases) is not considered to be a TBI.

MPAI-4 T-Score

- T-scores of 60 and above are eligible.
- If a member has a MPAI T-score of 50 through 59, the member must meet a score of four on at least one of the three functional ability index deficits on the assessment. (Refer to Section 4.4, MPAI-4 T-Scoring).
- T scores of 49 and below are not eligible.

Both criteria must be set to approve BIS CM

BIS Targeted Case Management

Targeted case management involves the following:

- Making medical necessity determination
- Assessing members' immediate health and safety needs as well as urgency
- Making service determination based on members' needs and care preferences to the maximum extent possible
- Exploring use of local community resources
- Vetting case management agency to ensure the appropriate skills and staffing are available for ongoing support

Targeted Case Management (TCM) Plan of Care Review

Sentara Health Plans will review the TCM plan of care to ensure that all services align with the MPAI functional deficits. The member's TCM must:

1. Cover a six month span
2. Identify health and safety concerns
3. Address physical limitations, cognitive impairments, behavioral health concerns, and substance use issues
4. Incorporate available resources including current services received, durable medical equipment (DME), home modifications, highest level of education, and family/caregiver support
5. Identify environmental barriers, including all current and potential social and physical barriers
6. Align with assessment and member's preferences

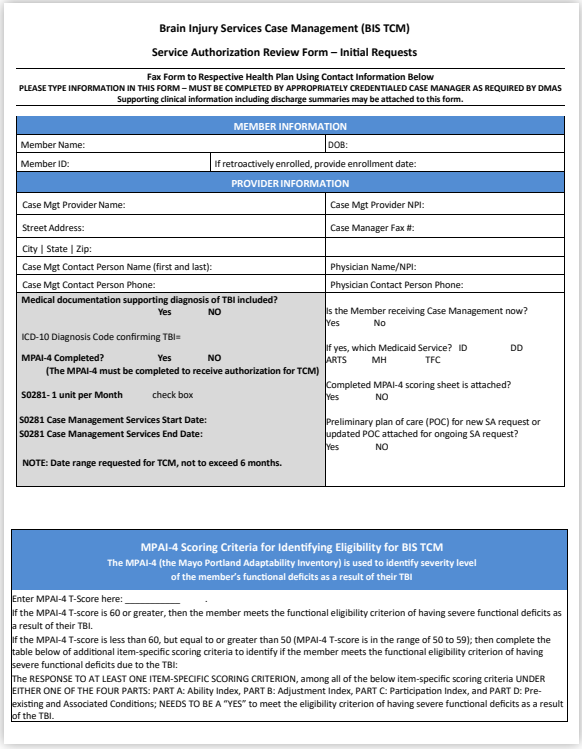
Service Authorization Review Form

BIS CM providers will complete and submit the DMAS approved Service Authorization (SA) Request Form. Approval for these services will be reviewed by the utilization management (UM) medical review team.

The BIS CM will be requesting SA approval for:

- BIS Case Management Assessment (S0280)
- BIS Case Management (S0281)

Authorization cannot overlap any other authorized case management services. Overlapping of these services is not reimbursable.



Brain Injury Services Case Management (BIS TCM)

Service Authorization Review Form – Initial Requests

Fax Form to Respective Health Plan Using Contact Information Below
PLEASE TYPE INFORMATION IN THIS FORM – MUST BE COMPLETED BY APPROPRIATELY CREDENTIALED CASE MANAGER AS REQUIRED BY DMAS
Supporting clinical information including discharge summaries may be attached to this form.

MEMBER INFORMATION	
Member Name:	DOB:
Member ID:	If retroactively enrolled, provide enrollment date:
PROVIDER INFORMATION	
Case Mgt Provider Name:	Case Mgt Provider NPI:
Street Address:	Case Manager Fax #:
City | State | Zip:	
Case Mgt Contact Person Name (first and last):	Physician Name/NPI:
Case Mgt Contact Person Phone:	Physician Contact Person Phone:
Medical documentation supporting diagnosis of TBI included? **Yes NO** ICD-10 Diagnosis Code confirming TBI= **MPAI-4 Completed? Yes NO** **(The MPAI-4 must be completed to receive authorization for TCM)** **S0281- 1 unit per Month** check box **S0281 Case Management Services Start Date:** **S0281 Case Management Services End Date:** **NOTE: Date range requested for TCM, not to exceed 6 months.**	Is the Member receiving Case Management now? Yes No If yes, which Medicaid Service? ID DD ARTS MH TFC Completed MPAI-4 scoring sheet is attached? Yes NO Preliminary plan of care (POC) for new SA request or updated POC attached for ongoing SA request? Yes NO

MPAI-4 Scoring Criteria for Identifying Eligibility for BIS TCM
The MPAI-4 (the Mayo Portland Adaptability Inventory) is used to identify severity level of the member's functional deficits as a result of their TBI

Enter MPAI-4 T-Score here: _____ .
If the MPAI-4 T-score is 60 or greater, then the member meets the functional eligibility criterion of having severe functional deficits as a result of their TBI.
If the MPAI-4 T-score is less than 60, but equal to or greater than 50 (MPAI-4 T-score is in the range of 50 to 59); then complete the table below of additional item-specific scoring criteria to identify if the member meets the functional eligibility criterion of having severe functional deficits due to the TBI:
The RESPONSE TO AT LEAST ONE ITEM-SPECIFIC SCORING CRITERION, among all of the below item-specific scoring criteria UNDER EITHER ONE OF THE FOUR PARTS: PART A: Ability Index, PART B: Adjustment Index, PART C: Participation Index, and PART D: Pre-existing and Associated Conditions; NEEDS TO BE A "YES" to meet the eligibility criterion of having severe functional deficits as a result of the TBI.

Prior Authorization Tool

Sentara Health Plans' Prior Authorization List (PAL) is used to determine authorization requirements for Medicare Medicaid, and Individual & Family Plans. **This does not include self-funded groups.** It is accessible via the Payer Space under 'Resources' in Availity, and under the 'Authorizations' tab on the Sentara Health Plans **website**.

- Key changes in authorization requirements are updated on our **website**.
- Providers will not be required to obtain an authorization for certain medical supplies or services when the request does not exceed certain limits.
- Details regarding limits will be noted in the 'Exceptions' column of the Prior Authorization List.

Note:

Overlapping Authorizations

Authorization for BIS CM services cannot overlap with another BIS CM service or any other authorized case management services. The overlapping of these services is not reimbursable. Refer to section 10.0 Claims/Billing – Service Limits for the list of case management procedure codes.

BIS CM services (S0281) from the initial BIS CM provider can overlap with a BIS Assessment (S0280) being completed by another BIS CM provider.

BIS CM services (S0281) cannot overlap between the two BIS CM providers.

DD Waiver

Members that reside in the DD Waiver receive case management services as part of their waiver. These members can be identified with an open DD Waiver Level of Care (Y, S, or R).

For member's choosing BIS CM services over DD Waiver CM services, contact the DMAS BIS Unit at **braininjuryservices@dmas.virginia.gov** before authorizing BIS CM services review.

Service Limits

Limits	Description
Monthly - S0280/S0281	One unit per month
Place of Service	02, 03, 04, 10. 11, 12, 13, 14, 19, 20, 21, 22, 23, 32, 33, 51, 53, 54, 55, 56, 57, 71, 72, 99
Rolling Year - S0280	Limit 2 per year unless a brain injury triggering event*
Overlap S0280 and S0281	Only 1 unit per month, cannot overlap between same BIS providers.
Overlap S0281 and S0280	Overlap is allowed between BIS CM Provider A and BIS CM Provider B - submitting an assessment
Overlap S0281	Only one BIS CM provider per month - 1 unit per month
Overlaps allowed with limits	All community services except Case mgt codes
Case Mgt Overlap Codes not allowed	G9012
T1016	Tx Foster Care CM
T1017	ID CM
H0023	MH CM
T2023	DD CM
H0006	ARTS CM
DD Waiver LOC	BIS CM services cannot overlap with an open DD Waiver level of care

**Other care management services may not be reimbursed while BIS case management is authorized. Refer to the DMAS Provider Manual for detailed claims, billing, and service limits. All BIS cases are reviewed with consideration to the member's unique needs and situation.*

Care Gap Closure Best Practices

1. Use appropriate documentation and correct coding
2. Maintain appointment availability for patients with recent emergency department visits
3. Explain the importance of follow- up appointments to your patients
4. Contact patients who do not keep initial appointments and reschedule them as soon as possible
5. Encourage follow-up visits via telehealth when appropriate to the principal diagnosis
6. Submit claims and encounter data timely

Diagnosis Coding Documentation Guidelines

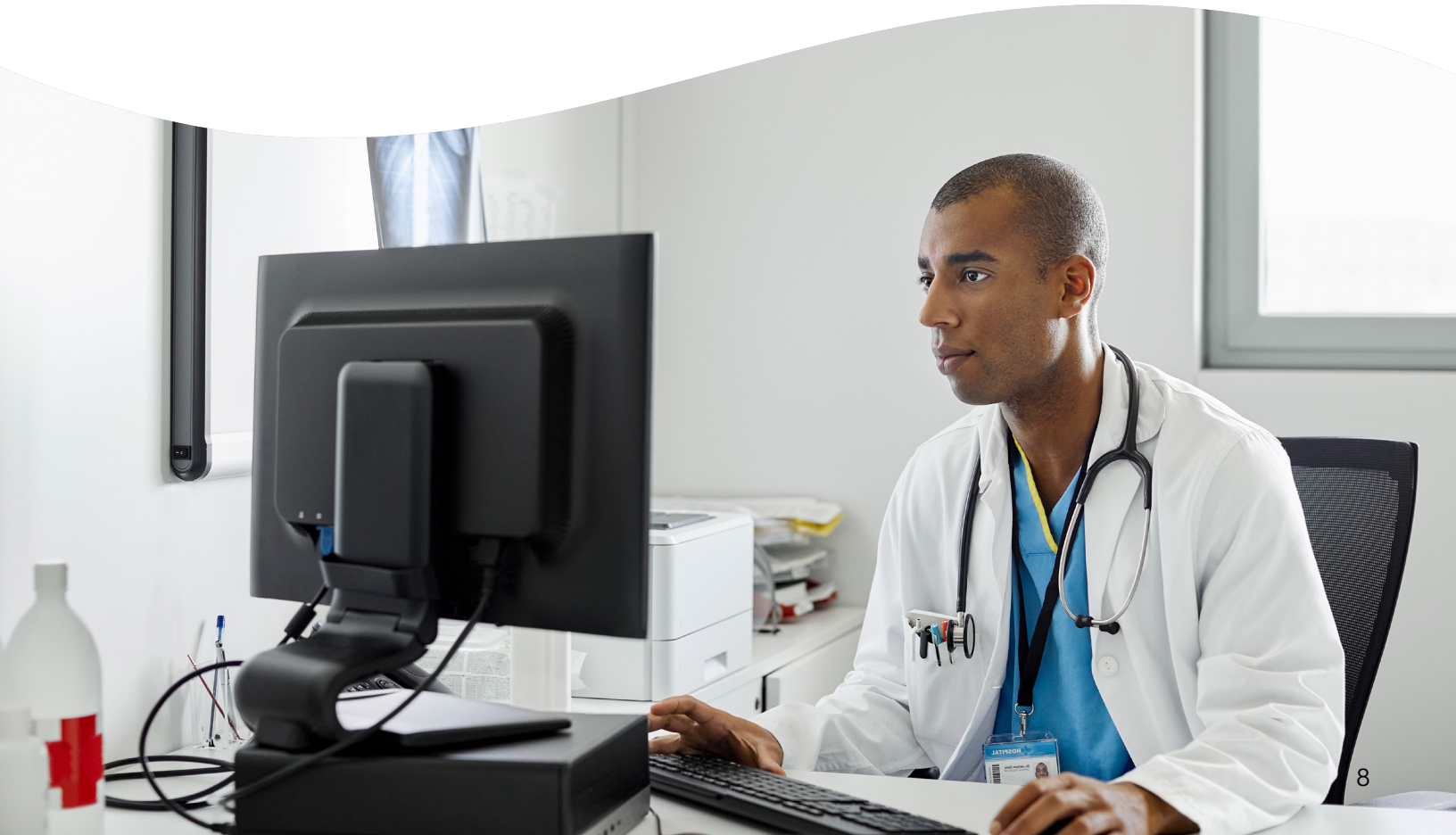
- Document and code diagnoses to the highest specificity of the patient's condition:
- Example: Patient has diabetes type 2 with CKD stage 4:

  ✗ Less specificity: E11.8 (DM2 w/unspecified complications.

  ✓ Highest specificity: E11.22 (DM2 w/CKD), N18.4 (CKD Stage 4)

- All diagnoses submitted must be accurate and completely documented in the medical record
- Ensure all diagnoses documented and coded during the encounter are included on the claim

Ref: CMS - Centers for Medicare and Medicaid Services; ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification



Compensation and Billing: Critical Elements

1. Rates and Compensation: Provider will collect payments for covered services.
2. Provision of Covered Services: Provider will not limit the provision of covered services to a member because of or based on any compensation arrangement between Sentara Health Plans and provider.
3. Billing: Provider will bill for covered services according to billing and claims submission policies as outlined in the **Provider Manual**.
4. Timely Filing is not more than 365 days after the date on which those services are rendered. Claims received by Sentara Health Plans after 365 days may be denied for payment. Provider shall not seek any payment from members for claims denied by Sentara Health Plans under this section.
5. Clean Claims: Provider shall make its best effort to submit claims correctly.
6. National Provider Identifier (NPI) Number: All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number will be rejected or denied.
7. A valid NUCC taxonomy code is required for billing. Claims submitted without a taxonomy code will be rejected or denied.

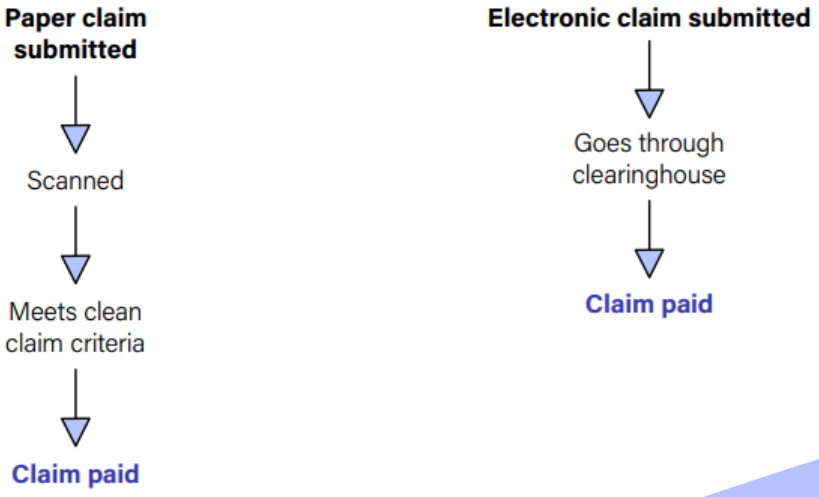
   For BIS TCM providers, the appropriate taxonomy is:

   - 251B00000X (Case Management)

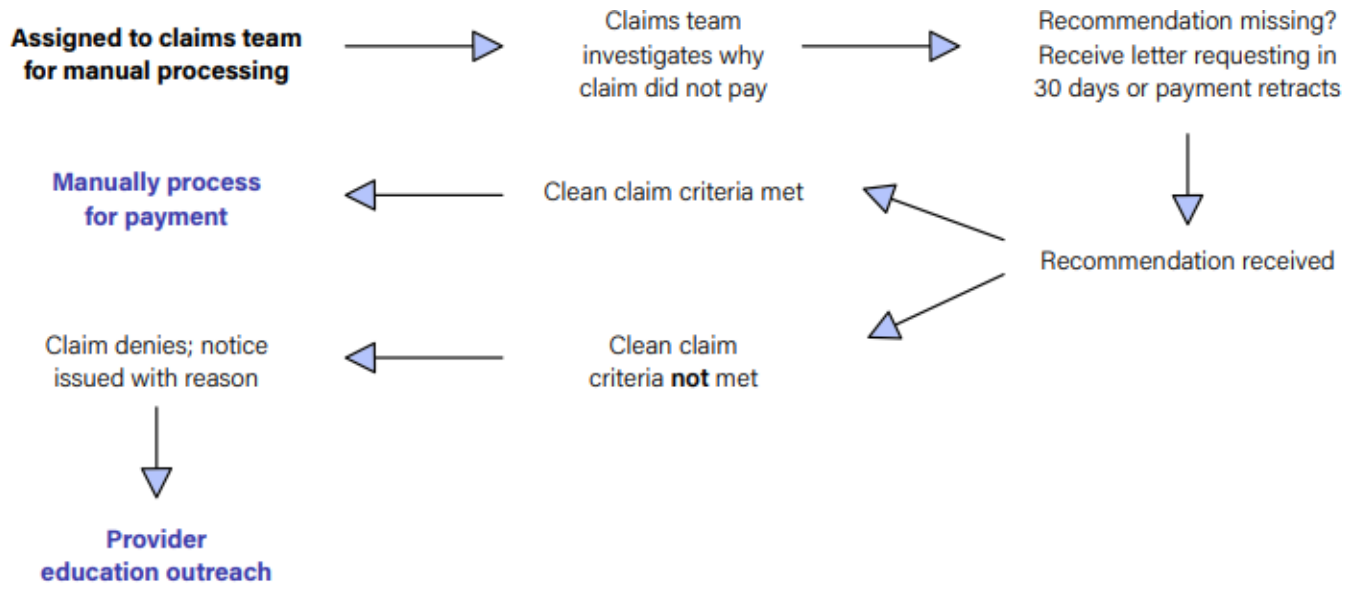
   Other valid NUCC taxonomies may be used based on the provider's entity type. The previous requirement for 2084P0301X (Brain Injury Medicine physician) does not apply to most BIS TCM providers.

Provider Network Requirements	
Provider Specialty Code	841
Taxonomy Code	251B00000X (Case Management)
Billing Codes	S0280 BIS Case Management Assessment
	S0281 BIS Case Management Services

Claims Pathway: Clean Claim/Auto Adjudication



Claims Pathway: Clean Claim Criteria NOT Met (manually processed)



Important Billing Requirements

- Case management services for the same individual must be billed by only one type of BIS provider.
- Billing can be submitted for case management only for months in which direct or client related contacts, activity, or communications occur; and must be documented in the clinical record and Individualized Service Plan (ISP).
- The provider should bill for the specific date of the face-to-face visit, the date the monthly summary note has been documented, or a specific date that the service was provided.
- Providers are not to span the month for case management services.
- Reimbursement will only be provided for "active" case management clients, as defined by DMAS.
- Federal regulation 42 CFR § 441.18 prohibits providers from using case management services to restrict access to other services.
- In accordance with 42 CFR § 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions.
- Services rendered during the same month as the admission to the IMD are reimbursable for individuals ages 22 to 64, if the service was rendered prior to the date of the admission.
- Services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management.
- Services provided to the individual are limited to six months of service, 180 calendar days prior to discharge from the facility.

Compensation and Billing: BIS Service Codes

Claims/Billing - Service Limits

Other care management services may not be reimbursed while BIS care management is authorized. Refer to the DMAS Provider Manual for detailed claims, billing, and service limits. All BIS cases are reviewed with consideration to the member's unique needs and situation.

Service Limits/Overlaps	
Limits	**Description**
Monthly S0280/S0281	One unit per month
Place of Service	02, 03, 04, 10. 11, 12, 13, 14, 19, 20, 21, 22, 23, 32, 33, 51, 53, 54, 55, 56, 57, 71, 72, 93, 99
Rolling Year - S0280	Limit two per year unless a brain injury triggering event
Overlap S0280 and S0281	Only one unit per month; cannot overlap between same BIS providers
Overlap S0281 and S0280	Overlap is allowed between BIS care management provider A and BIS care management provider B - submitting an assessment
Overlap S0281	Only one BIS care management provider per month - one unit per month
Overlaps Allowed With Limits	All community services except case management codes
Case Management Overlap Codes Not Allowed	G9012, T1016 (Tx Foster Care care management), T1017 (ID care management), H0023 (MH care management), T2023 (DD care management), H0006 (ARTS care management)
DD Waiver LOC	BIS care management services cannot overlap with an open DD Waiver level of care

Completing Paper Claim Forms

Sentara Health Plans requires the CMS 1500 Claim form version 02-12. For directions on filling out a paper form, we refer to the National Uniform Claim Committee (NUCC) guidelines.

- To expedite payment and avoid re-submission of claims, fill out the CMS-1500 claim form as completely and accurately as possible.
- Submit claims containing all data elements and industry-standard coding conventions.

Common Reasons for Claims Denials:

- Errors in member name. Hyphenated last names must be submitted correctly.
- The birth date submitted must match the birth date associated with the member ID number.
- For a complete list of the most common errors in completing the CMS 1500, see page 81 in the provider manual or download Avoiding Common Claim Submission Errors from the provider toolkit on our **website**.

Definitions

- **Brain Injury Services Case Management (BIS CM):** Targeted Case Management TCM) services provided under the state plan, through contracted providers who specialize in serving those with severe TBI.
- **Billed Charge:** The actual amount charged by the provider for any covered service furnished to a member.
- **Clean Claim:** A claim that has no material defect (including any lack of required documentation).
- **Covered Services:** Those services, drugs, supply and equipment for which coverage benefits are available under the healthcare plans. Covered services beneficiaries are given benefits according to the terms and conditions of health plan.
- **Copayment:** Charges for covered services collected directly by the provider from members as payment in addition to the fees paid to the provider by the health plan.
- **Deductible:** A dollar amount which a member is responsible for paying before the covered service.
- **Electronic Health Record or EHR:** An electronic record of clinical services rendered by a participating provider to a member.
- **Fee Schedule:** A list of the maximum amounts allowed per unit for covered services.
- **Medically Necessary:** Those covered services as provided by a participating provider which are:
  - Required to identify, evaluate, or treat the member's condition, disease, ailment or injury, including pregnancy related conditions.
  - In accordance with recognized standards of care for the member's condition, disease, ailment or injury.
  - Appropriate with regard to standards of good medical practice.
  - Not solely for the convenience of the member, or a participating provider; and
  - The most appropriate supply or level of service which can be safely provided to the member.
- **Non-covered Services:** Those healthcare services that are not covered services.
- **Provider Network:** A group of participating providers that, through a contractual relationship, supports some or all products in which members are enrolled.
- **Quality Improvement or Utilization Management:** The processes established and operated by the health plan, or its designee, to evaluate and promote the quality and cost-effective delivery of covered services.
- **Traumatic Brain Injury:** A TBI is defined as brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.
- **Exclusions:** Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, anoxia, brain tumor, Alzheimer's disease and other conditions causing dementia, and other neurodegenerative diseases) is not considered to be a TBI.
- **Targeted Case Management:** Services aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.
- **BIS Assessment:** Determines whether the member meets the medical necessity criteria for initial and ongoing BIS case management services.
- Utilization Management: The practice of evaluating and monitoring the use of healthcare services to assess their appropriateness and quality.

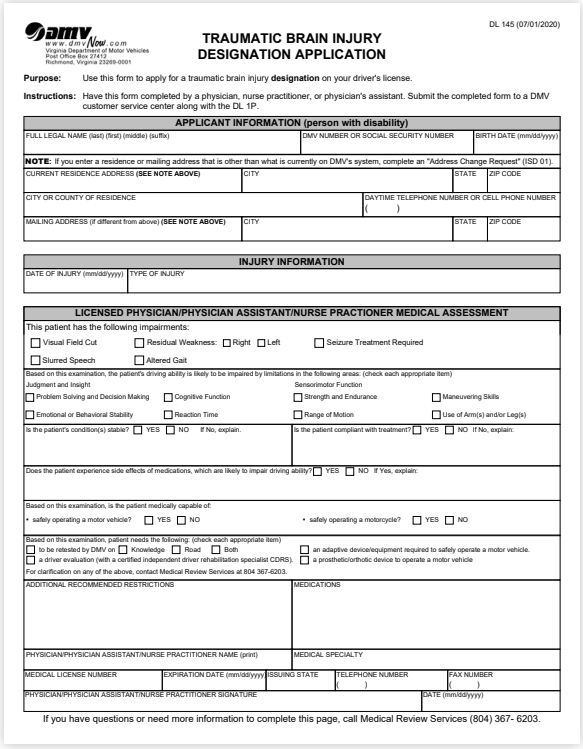
Appendix:

Virginia Department of Motor Vehicles

The Virginia Department of Motor Vehicles (DMV) requires a medical statement from a physician, physician's assistant, or nurse practitioner following the onset of a mental or physical condition that may impair someone's ability to safely operate a motor vehicle, even temporarily.

Purpose: Use this form to apply for a traumatic brain injury designation on the member's driver's license.

Source: Schultheis, M. T., & Whipple, E. K. (2014). Driving after Traumatic Brain Injury: evaluation and rehabilitation" interventions. Current Physical Medicine and Rehabilitation Reports, 2(3), 176–183. ***https://doi.org/10.1007/s40141-014-0055-0"***



DL 145 (07/01/2020)

TRAUMATIC BRAIN INJURY DESIGNATION APPLICATION

Purpose: Use this form to apply for a traumatic brain injury **designation** on your driver's license.

Instructions: Have this form completed by a physician, nurse practitioner, or physician's assistant. Submit the completed form to a DMV customer service center along with the DL 1P.

APPLICANT INFORMATION (person with disability)

FULL LEGAL NAME (last) (first) (middle) (suffix) | DMV NUMBER OR SOCIAL SECURITY NUMBER | BIRTH DATE (mm/dd/yyyy)

NOTE: If you enter a residence or mailing address that is other than what is currently on DMV's system, complete an "Address Change Request" (ISD 01).

CURRENT RESIDENCE ADDRESS **(SEE NOTE ABOVE)** | CITY | STATE | ZIP CODE

CITY OR COUNTY OF RESIDENCE | DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER ( )

MAILING ADDRESS (if different from above) **(SEE NOTE ABOVE)** | CITY | STATE | ZIP CODE

INJURY INFORMATION

DATE OF INJURY (mm/dd/yyyy) | TYPE OF INJURY

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTIONER MEDICAL ASSESSMENT

This patient has the following impairments:

☐ Visual Field Cut ☐ Residual Weakness: ☐ Right ☐ Left ☐ Seizure Treatment Required

☐ Slurred Speech ☐ Altered Gait

Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)

Judgment and Insight — Sensorimotor Function

☐ Problem Solving and Decision Making ☐ Cognitive Function ☐ Strength and Endurance ☐ Maneuvering Skills

☐ Emotional or Behavioral Stability ☐ Reaction Time ☐ Range of Motion ☐ Use of Arm(s) and/or Leg(s)

Is the patient's condition(s) stable? ☐ YES ☐ NO If No, explain. | Is the patient compliant with treatment? ☐ YES ☐ NO If No, explain:

Does the patient experience side effects of medications, which are likely to impair driving ability? ☐ YES ☐ NO If Yes, explain:

Based on this examination, is the patient medically capable of:

- safely operating a motor vehicle? ☐ YES ☐ NO
- safely operating a motorcycle? ☐ YES ☐ NO

Based on this examination, patient needs the following: (check each appropriate item)

☐ to be retested by DMV on ☐ Knowledge ☐ Road ☐ Both ☐ an adaptive device/equipment required to safely operate a motor vehicle.

☐ a driver evaluation (with a certified independent driver rehabilitation specialist CDRS). ☐ a prosthetic/orthotic device to operate a motor vehicle

For clarification on any of the above, contact Medical Review Services at 804 367-6203.

ADDITIONAL RECOMMENDED RESTRICTIONS | MEDICATIONS

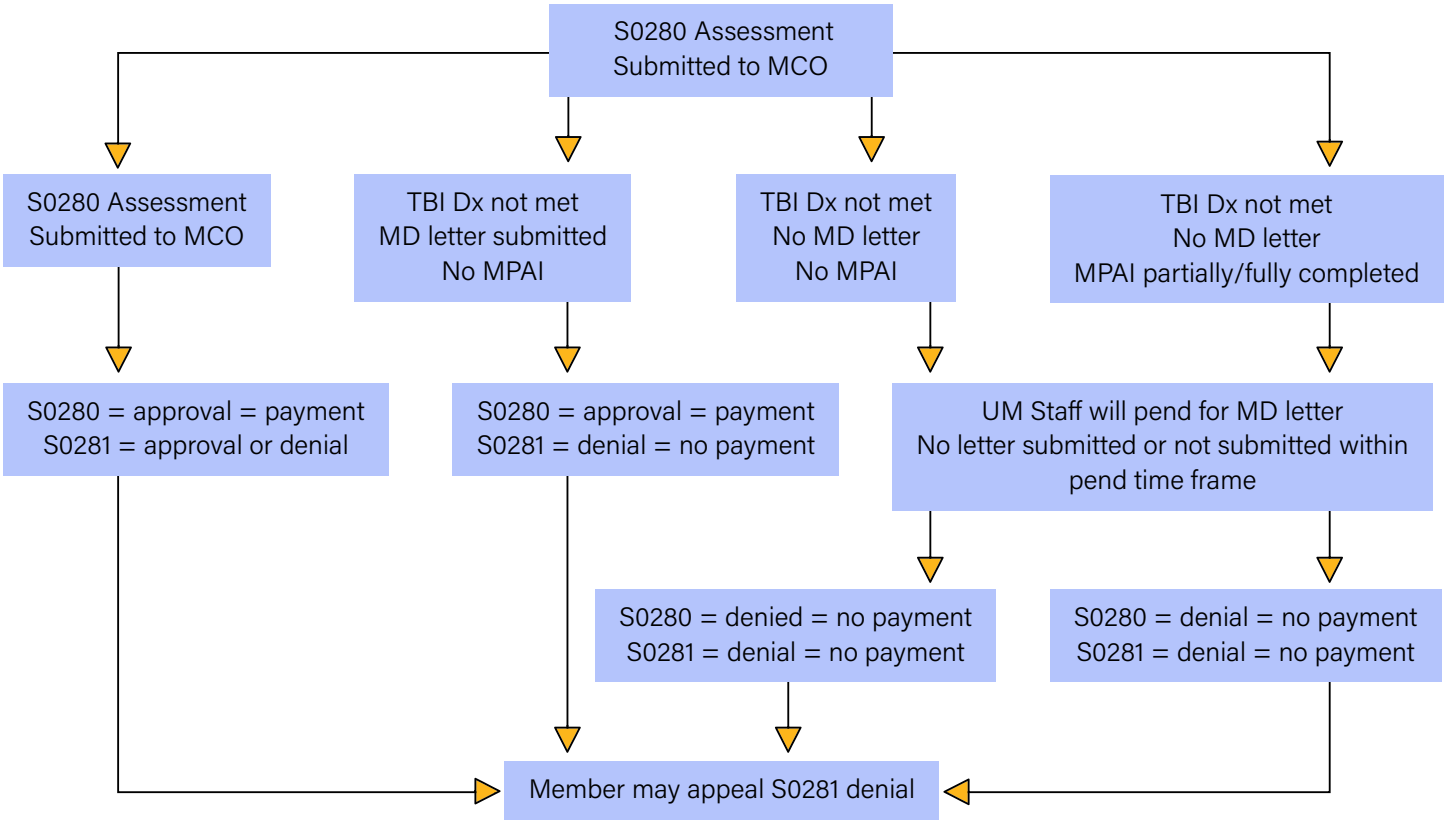
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print) | MEDICAL SPECIALTY

MEDICAL LICENSE NUMBER | EXPIRATION DATE (mm/dd/yyyy) | ISSUING STATE | TELEPHONE NUMBER ( ) | FAX NUMBER ( )

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE | DATE (mm/dd/yyyy)

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.

Claims Approval and Denial Criteria



Sentara Health Plans BIS Process Map