Strong Families Vermont (SFVT) Family Support Home Visiting Program Medicaid Manual

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Section 1   Overview of SFVT Family Support Home Visiting

Strong Families Vermont (SFVT) provides parent and early childhood home visiting services that utilize federally approved and state approved evidence-based home visiting models. The SFVT Family Support Home Visiting Program offers a sustained service using the international evidence-based home visiting model Parents as Teachers (PAT). The SFVT Family Support Home Visiting Program is intended for Medicaid members who are pregnant, expecting, parenting, and children from birth through age five years of age. The SFVT Family Support Home Visiting Program is provided by a trained family support home visitor. Covered services include case management, parent education, care coordination, screening and assessment, group connections, and resource support and referrals.

This manual describes the requirements and process for Strong Families Vermont (SFVT) Family Support Home Visiting Program eligible individuals to receive services from a family support home visitor who is directly enrolled with Vermont Medicaid.

1.1   Definition

An evidence-based home visiting model approved by the Health Resources and Services Administration (HRSA) and selected/adopted by the Vermont Department of Health (VDH) to be provided to Medicaid families in Vermont under the Children's Integrated Services (CIS) Strong Families Vermont (SFVT) Family Support Home Visiting Program.

Section 2   Family Support Home Visitor

A CIS home visiting professional trained and certified in the evidence-based model Parents as Teachers (PAT) used by the SFVT Family Support Home Visiting Program.

The Vermont Department of Health (VDH) – Family and Child Health (FCH) Division, in partnership with the Department for Children and Families (DCF) – Child Development Division (CDD) have developed the CIS SFVT continuum of home visiting services, which includes sustained family support home visiting. With additional funding, the expansion of sustained family support home visiting services is underway to implement these services throughout Vermont. This will allow all CIS regions to provide the parent and early childhood evidence-based home visiting model Parents as Teachers (PAT) to more families with Medicaid.

Trained early childhood or human service professionals from CIS partner agencies deliver a long-term, evidence-based home visiting program for families through regular and consistent visits through age five. The program strengthens the parent-child relationship, builds social connections, prevents child abuse and neglect, and promotes optimal child development, and school readiness.

2.1   Member Eligibility Criteria

To be eligible to receive the SFVT **Family Support Home Visiting Program**, participants must be enrolled in Vermont Medicaid.

For enrollment in the SFVT **Family Support Home Visiting Program** individuals can enroll during pregnancy or expecting a newborn, and at any point postpartum through the child's fifth birthday.

**This is designed to be a 2-year program with a model fidelity requirement to enroll a family with a child who will not age out of the program before 2 years, however, it is recognized that some families will not stay or need the full 2 years of service.

2.2   Referral Requirements

A health care professional may refer a member to the SFVT Family Support Home Visiting Program; however, a referral is not required for participation. A physician, or other licensed clinician, such as a social worker, nurse practitioner or local health department worker may also refer members for this service. Members can refer themselves. Prior authorization is not required for the SFVT Family Support Home Visiting Program.

2.3   Requirements for Participation

- SFVT Family Support Home Visiting Program is voluntary.
- SFVT Family Support Home Visiting Program must be provided by a Community Health Worker - Family Health Educator (Family Support Home Visitor or Parent Educator) from a Public Health Agency and is directly enrolled in Vermont Medicaid.
- It is the responsibility of the Community Health Worker – Family Health Educator (Family Support Home Visitor or Parent Educator) to complete the Medicaid enrollment process which is available here: https://vtmedicaid.com/#/provEnrollDataMaint.
- Community Health Worker - Family Health Educators (Family Support Home Visitor or Parent Educator) who are not enrolled with Vermont Medicaid cannot submit claims for reimbursement.

2.4   Roles and Responsibilities

2.4.1   Provider Type

SFVT Family Support Home Visitor (must enroll)

SFVT Family Support Home Visiting Supervisor (must enroll if providing services)

New provider type/specialty:

- Provider Type: T48 Community Health Worker
- Specialty Type: 060 Family Health Educator

2.4.2   Qualifications

Education required:

- Minimum of a bachelor's degree in a human services-related field (i.e., Social Work, Counseling, or Early Care and Education). If minimum education requirement is not met, please contact the SFVT Program Manager at the Vermont Department of Health to discuss a waiver application.

- Parents as Teachers (PAT) Foundational and Model Certification. PAT model certification is obtained from PAT National Center. Please contact the SFVT Program Manager at the Vermont Department of Health for any assistance with registering for this training.

Skills, Knowledge, and Experience Required:

- Must be trained in and maintain the evidence-based home visiting certification as a Parents as Teachers (PAT) Certified Parent Educator.

- Screening, assessments, and evaluation.

- Knowledge of child development.

- Knowledge of family-centered care.

- Knowledge of cultural competence and culturally sensitive care.

- Demonstrated capacity to provide all core elements of case management services including:
    - Comprehensive client assessment
    - Comprehensive care/service plan development
    - Linking/coordination of services
    - Monitoring and follow-up of services
    - Reassessment of the client's status and needs

- Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

- Demonstrated experience with the target population.

Section 3   Procedures and Resources

3.1   Obtaining an NPI

Every agency must have a National Provider Identifier (NPI) from the National Plan & Provider Enumeration System (NPPES) NPPES (hhs.gov) before services can be reimbursed. If this step is skipped, there will be an error when you enroll your home visitor. First you must create an account for NPPES. This occurs through the Identity & Access Management System (I&A).

Once you have an account, you can log into NPPES and obtain an NPI for your agency (not individual). You will need your legal business name and Employer Identification Number (EIN). To select the taxonomy code for your agency, go to the following list: Taxonomy (nucc.org). The code you select should be unique and not already used by your agency with Medicaid. SFVT providers have used a taxonomy from the non-individual agencies and ambulatory health care facilities section such as case management, community/behavioral health, public health, and community health.

Once hired, you must obtain an NPI for your home visitor (and supervisor if providing services). Log into your agency's NPPES account NPPES (hhs.gov) to obtain an NPI for your home visitor. You should obtain an NPI for your home visitor as soon as possible. You cannot receive Medicaid reimbursement for any SFVT services provided before an NPI was obtained. You will indicate that you are applying for an NPI for an individual in your organization (the middle option). This will require their social security number. The taxonomy code is 172V00000X (Individual- Other Service Provider- Community Health Worker).

For help with creating an I&A account, email: EUSSupport@cgi.com

For help with obtaining an NPI, email: customerservice@npienumerator.com

3.2   Agency Enrollment in Medicaid

SFVT Family Support Home Visiting Program enrollment process:

- Go to the Medicaid Provider Enrollment Module.
- You may enroll as a Group or a Facility.
- Select Provider Type T21- State Designated Children's Medical Services.
- Select Specialty Type 060- Family Health Educator.
- Select a unique taxonomy that your agency is not already using with Medicaid. To choose a taxonomy, go to the following list: Taxonomy (nucc.org).

For more information and instructions on using the Provider Management Module, please visit https://vtmedicaid.com/#/provEnrollResources.

If you are unable to complete the online application, contact the Gainwell Enrollment Department at vtproviderenrollment@gainwelltechnologies.com for assistance.

3.3   Home Visitor Enrollment in Medicaid

SFVT Family Support Home Visitor enrollment process:

- To enroll, re-enroll or revalidate, please visit the online Provider Management Module.
- To begin a new enrollment or to re-enroll, click Menu on the top right-hand corner of the screen. Select Provider Enrollment and then New Enrollment.
- You may enroll as an Individual or Individual Within a Group.
- The Provider Type to select is T48 - Community Health Worker and Specialty Type 060 - Family Health Educator - Taxonomy 172V00000X - Community Health Worker.

Revalidation of enrollment occurs every 5 years. You will receive notices 90 and 45 days prior to the expiration of your enrollment with all necessary information to revalidate. Once you have received this information, you may visit the Provider Management Module homepage. Click Menu on the top right-hand corner of the screen. Select Provider Enrollment and then Resume/Revalidate Enrollment.

For more information and instructions on using the Provider Management Module, please visit https://vtmedicaid.com/#/provEnrollResources.
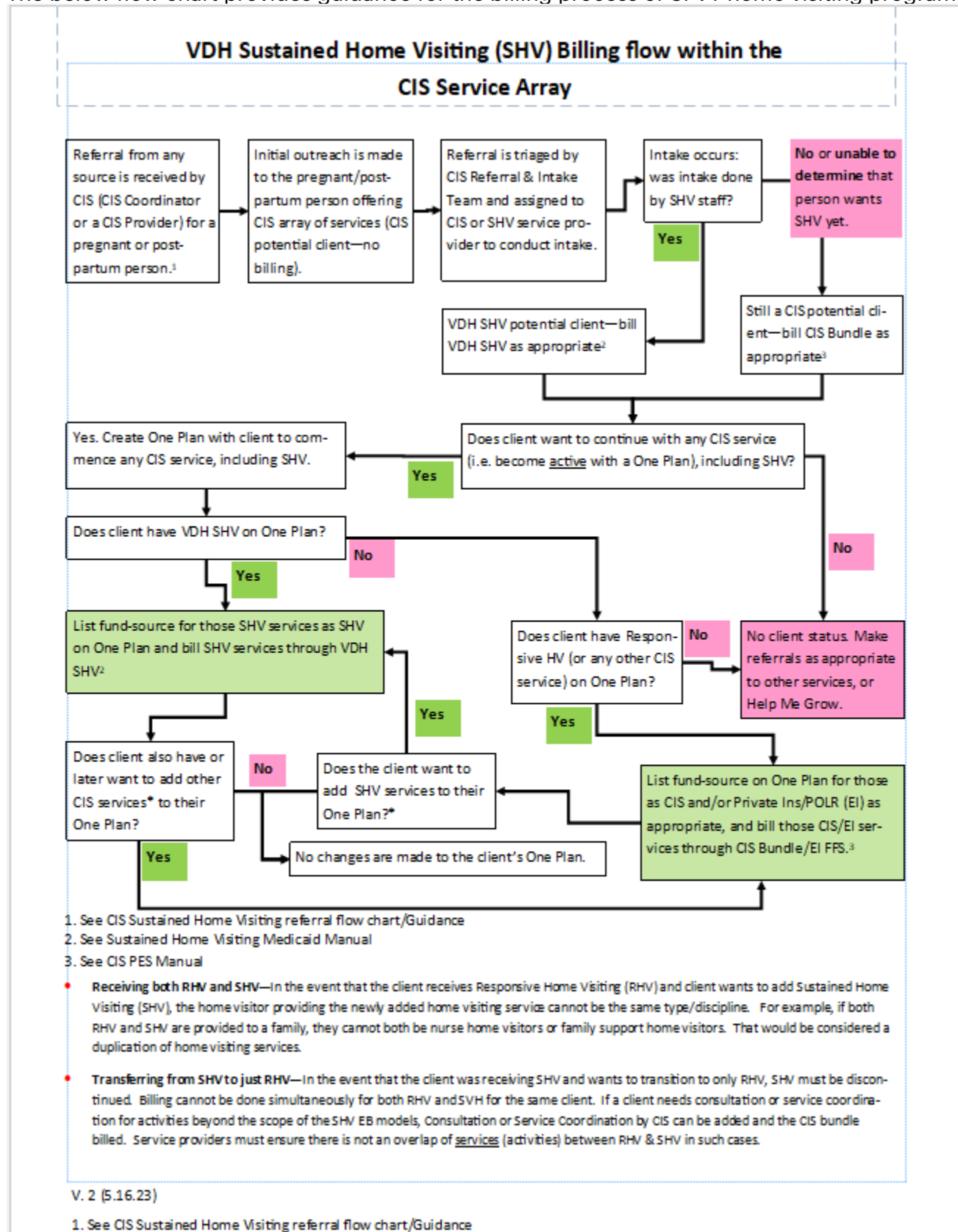
If you are unable to complete the online application, contact the Gainwell Enrollment Department at vtproviderenrollment@gainwelltechnologies.com for assistance.

3.4 Monthly Billing

One monthly claim is submitted to Medicaid for all services provided to a client during the month through the code T2023, Targeted Case Management. Targeted Case Management encompasses personal visits as defined by Parents as Teachers and related service coordination. Targeted Case Management may include an in-person visit, telehealth or activities with the client and/or their family; or in-person, telehealth, or activities between members of the care team with or without the client present. A minimum of one unit of service, 15 minutes, is required (defined as 8+ minutes by Medicaid). Limitations that disallow the use of the SFVT Family Support Home Visiting Program rate include any service delivery funded by another mechanism (such as Children's Integrated Services), and communication that occurs by email, audio-only, text, voicemail, and/or postal mail.

Section 4   SFVT Flow Chart

The below flow chart provides guidance for the billing process of SFVT home visiting programs.

VDH Sustained Home Visiting (SHV) Billing flow within the CIS Service Array

Referral from any source is received by CIS (CIS Coordinator or a CIS Provider) for a pregnant or post-partum person.[1]

→ Initial outreach is made to the pregnant/post-partum person offering CIS array of services (CIS potential client—no billing).

→ Referral is triaged by CIS Referral & Intake Team and assigned to CIS or SHV service provider to conduct intake.

→ Intake occurs: was intake done by SHV staff?

No or unable to determine that person wants SHV yet.

Yes → VDH SHV potential client—bill VDH SHV as appropriate[2]

→ Still a CIS potential client—bill CIS Bundle as appropriate[3]

Does client want to continue with any CIS service (i.e. become <u>active</u> with a One Plan), including SHV?

Yes → Yes. Create One Plan with client to commence any CIS service, including SHV.

↓ Does client have VDH SHV on One Plan?

Yes → List fund-source for those SHV services as SHV on One Plan and bill SHV services through VDH SHV[2]

No → Does client have Responsive HV (or any other CIS service) on One Plan?

No → No client status. Make referrals as appropriate to other services, or Help Me Grow.

No (from "Does client want to continue...") → No client status. Make referrals as appropriate to other services, or Help Me Grow.

Yes (from "Does client have Responsive HV...") → List fund-source on One Plan for those as CIS and/or Private Ins/POLR (EI) as appropriate, and bill those CIS/EI services through CIS Bundle/EI FFS.[3]

Does client also have or later want to add other CIS services* to their One Plan?

No → Does the client want to add SHV services to their One Plan?*

Yes (Does client also have...) → (to "Does the client want to add SHV services...")

Does the client want to add SHV services to their One Plan?* → No changes are made to the client's One Plan.

Yes (Does the client want to add SHV services...) → List fund-source for those SHV services as SHV on One Plan and bill SHV services through VDH SHV[2]

1. See CIS Sustained Home Visiting referral flow chart/Guidance
2. See Sustained Home Visiting Medicaid Manual
3. See CIS PES Manual

- **Receiving both RHV and SHV**—In the event that the client receives Responsive Home Visiting (RHV) and client wants to add Sustained Home Visiting (SHV), the home visitor providing the newly added home visiting service cannot be the same type/discipline. For example, if both RHV and SHV are provided to a family, they cannot both be nurse home visitors or family support home visitors. That would be considered a duplication of home visiting services.

- **Transferring from SHV to just RHV**—In the event that the client was receiving SHV and wants to transition to only RHV, SHV must be discontinued. Billing cannot be done simultaneously for both RHV and SVH for the same client. If a client needs consultation or service coordination for activities beyond the scope of the SHV EB models, Consultation or Service Coordination by CIS can be added and the CIS bundle billed. Service providers must ensure there is not an overlap of <u>services</u> (activities) between RHV & SHV in such cases.

V. 2 (5.16.23)

1. See CIS Sustained Home Visiting referral flow chart/Guidance

Section 5   Submitting Electronic Claims to Gainwell Using PES

To submit claims, you can use a clearing house or use Gainwell Technologies free software, Provider Electronic Solutions (PES), https://vtmedicaid.com/#/pes.

To get step-by-step guidance on how to enter claims using PES, please refer to the PES Software User Guide: https://vtmedicaid.com/assets/pes/DXCPESUserGuide.pdf.

How to bill for services:

Please use HCPCS Code T2023 with the appropriate ICD 10 code for the services delivered.

Section 6   Provider Electronic Solutions (PES) Billing

6.1   List Function Overview

The list function has been added to the software for two reasons. First, it allows a provider to enter information that is frequently used and then access this information in a transaction using a Drop-Down Data Window (DDDW) and second, it reduces the size of the transaction screens by requiring certain information to be entered into a list.

There are many data elements included in the software that are required to generate a HIPAA compliant format. This is especially true of provider and client information. As a result, the Provider Electronic Solutions software requires that these lists be entered prior to completing a transaction. Additional lists include procedure code, diagnosis code, revenue center code and place of service.

There are two lists that have been populated with data. They are Carrier, which lists the codes and names of other insurance companies and the Place of Service list. Both lists may be updated to add, delete, or change the information to better serve your office. Please be aware that the codes listed are standard codes and may not be changed without notice resulting from HIPAA or Gainwell updates.

The lists may be accessed from the Main Menu by selecting the List option or by double-clicking in the appropriate field. This option allows a provider to add the information, as they need it, rather than requiring that all information be entered prior to keying a transaction.

Once the information has been keyed into the list, it is available from the DDDW to populate the fields. Although not all the information from the list will appear on the transaction screen, it will be used when formatting the HIPAA transaction prior to submission.

Lists may be sorted by the row headers. The client list is sorted by selecting the Client ID, Last Name, or First Name heading. Selecting the header one time will sort in ascending order. Selecting twice will sort in descending order. Upon opening, the Client and Provider lists are sorted by the ID number.

6.2   How to Bill Provider Lists
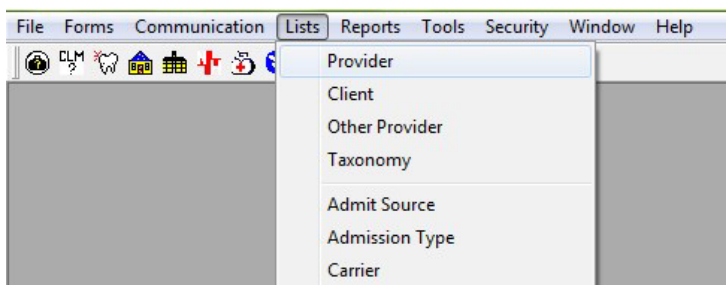
1. Click on **Lists** and select **Provider**.

2. Enter the fields listed below:
   Each of fields listed are required.

   a. **Provider ID/NPI** - Enter Group NPI

   b. **Provider ID/NPI Code Qualifier** - Select XX

   c. **Taxonomy Code** - Enter Group Provider Taxonomy

   d. **Entity Type Qualifier** - Select 2 (non-person)

   e. **Last/Org Name** - Enter Full Group Provider Name

   f. **SSN/Tax ID** - Enter Tax ID

g. **SSN/Tax IF Qualifier** - Select 24

h. **Line 1** - Provider address *This address cannot be a PO Box.

i. **City** - Town

j. **State** - State

k. **Zip** - Zip Code *You must enter entire zip code including last 4 digits, if you don't know the last 4 digits enter four zeros' (as shown below).

3. Click **Save** (right hand side)

4. Then click **Add** (right hand Side)

Note: If you don't have an individual rendering provider; If your Agent/Group information is also going to be your rendering provider on your claim you will need to enter in your Agent/Group information twice. Once using the steps above, and then a second time following the instructions listed below.

6.3 How to Bill Client Lists
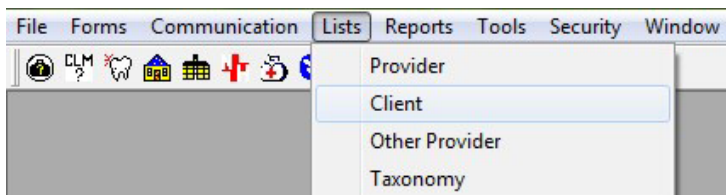
1. Click on **Lists** and select **Client**.

2. Enter the fields listed below:

a. **Client ID** - Enter VT Medicaid's UID number

b. **ID Qualifier** - Select MI

c. **Account #** - Your account number *It doesn't matter what is recorded in this field, however, there must be something in this field.

d. **Client SSN** - Leave blank *Please do not enter the patient's SSN number, because it's not needed for the processing of the claim.

e. **Last Name** – Patient's last name

f. **First Name** – Patient's first name

g. **Clients DOB** – Patient's date of birth

h. **Gender** - select Female or Male

i. **Line 1** – Provider's address

j. **City** - Town

k. **State** - State

l. **Zip** - Zip Code *You must enter entire zip code including last 4 digits, if you don't know the last 4 digits enter four zeros' (as shown below).

3. Then click **Save** (right hand side)

4. If you have more clients to add, click **Add** (right hand side). If not, click close or the red X in the upper right-hand corner.

6.4   Adding a Diagnosis

1. Click on **Lists** and select **Diagnosis ICD-10**.

2. Enter the fields listed below:

   a. **Diagnosis Code** - Enter your ICD-10 Diagnosis Code without the decimal point.

   b. **Description** - Enter your description for the diagnosis.

3. Then click **Save** (right hand side)

4. If you have more diagnosis codes to add, click **Add** (right hand side). If not, click close or the red X in the upper right-hand corner.

Below are the **approved diagnosis codes** allowable by this program:

- Z71.89 other specified counseling, may be used for any age client
- Z32.3 encounter for childcare instruction, may be used for caregiver as the pregnant/postpartum client
- Z76.2 encounter for health supervision and care of healthy infant and child, may be used for age 21 and under

6.5   Adding a Procedure/HCPCS Code

Please use HCPCS Code T2023.
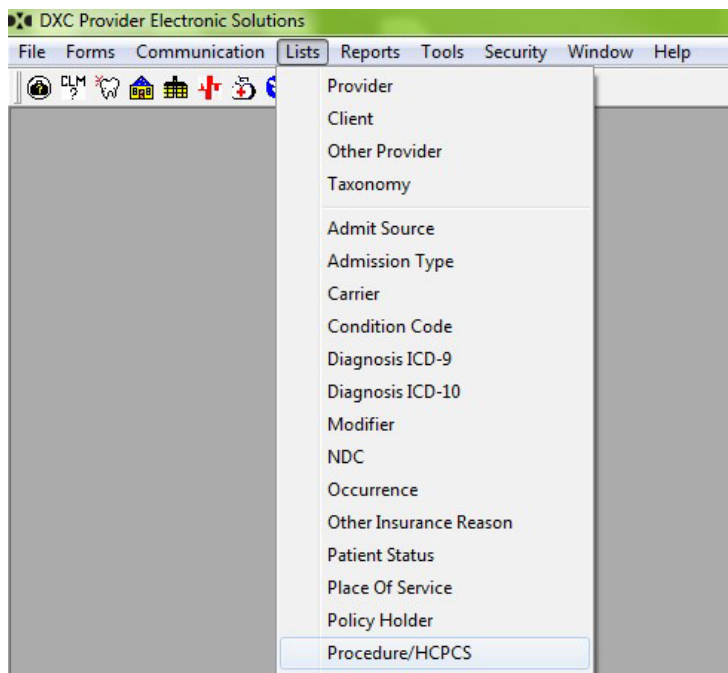
1. Click on **Lists** and select **Procedure/HCPCS**.
2. Enter the Procedure/HCPCS.
3. Enter the description of your procedure/HCPCS.
4. Then click **Save** (right hand side)
5. If you have more procedure/HCPC codes to enter, click **Add** (right hand side). If not, click close or the red X in the upper right-hand corner.
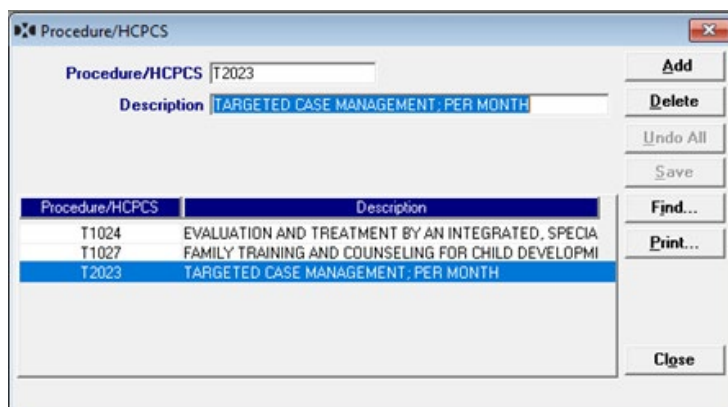
6.6   Building your Claim

Click on the Blue Medical symbol (837 Professional), on the main menu.
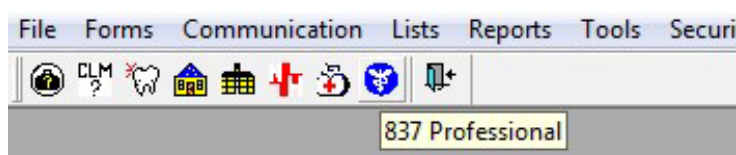
Now we can start building the claim.

6.7   HDR1 Tab

1. Click the drop down on the field labeled provider ID/NPI and select your provider information.

2. Hit the tab button on your keyboard. Hitting tab will fill in the rest of the group provider information.

3. Click the drop down on the field labeled Client ID and select the patient you are trying to bill for.

4. Hit the tab button on your keyboard. Hitting tab will fill in the rest of the patient information.

5. That is all the information you need to enter into HDR1 tab.

HDR1 Example

6.8   HDR2 Tab

1. Click the drop-down arrow next to the field labeled **Type** and select **10 (ICD-10)**.
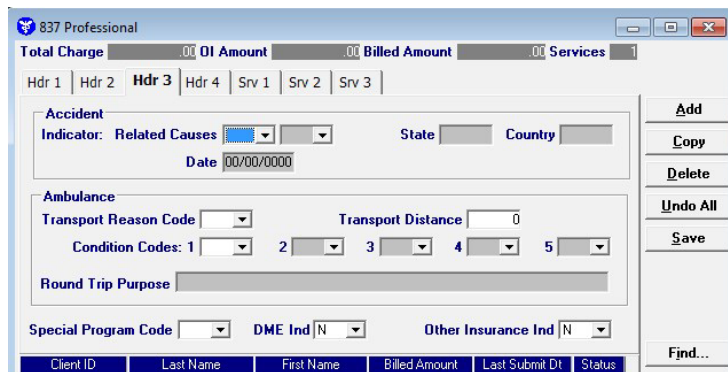
2. Now click the drop down next to field **1** and select the diagnosis code for the patient you are billing for.

HDR2 Example
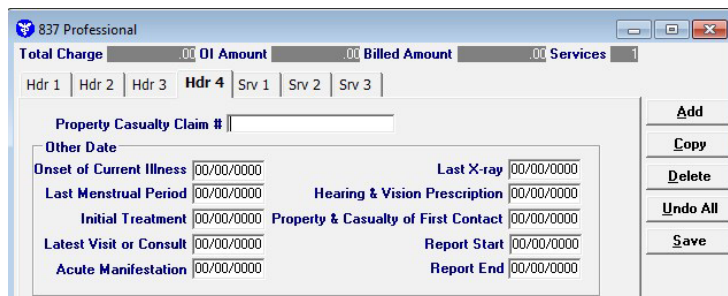
6.9   HDR3 Tab

You do not have to enter any information in this tab and can move right to HDR4.

6.10   HDR4 Tab

You do not have to enter any information in this tab, and you can now move to the SRV1 tab.

6.11   Srv1 Tab

Below is the list of fields that need to be completed, and what is required in each field:

- **From DOS** - Enter your date of service then hit tab. By hitting tab, it will fill in the To DOS field.
- **To DOS** - Enter your date of service.
- **Place of Service** - Select your place of service. The following codes can be used:
  - o   03 - School
  - o   04 - Homeless Shelter
  - o   10 - Telehealth provided in the patient's home
  - o   11 - Office
  - o   12 - Home
  - o   14 - Group home
  - o   99 - Other Place of Service
- **Procedure** - Select your CPT code (T2023).
- **Unit** - Enter the total days/units you are billing.
- **Billed Amount** - Enter your total charge.

SRV1 Example

6.12   Srv2 Tab

Under the Rendering Provider section please select:

1. Provider ID/NPI - Select either your Individual or Individual Within a Group provider number (Home Visitor).
2. Hit Tab on your keyboard. Hitting tab will fill in the rest of the provider information.

SRV2 Example

6.13   Srv3 Tab

You do not need to enter any information on this tab.
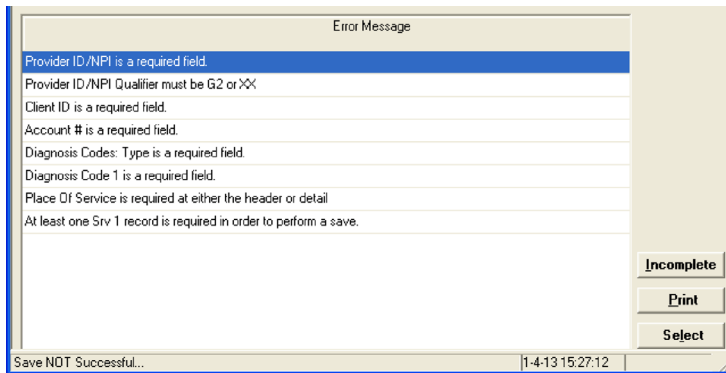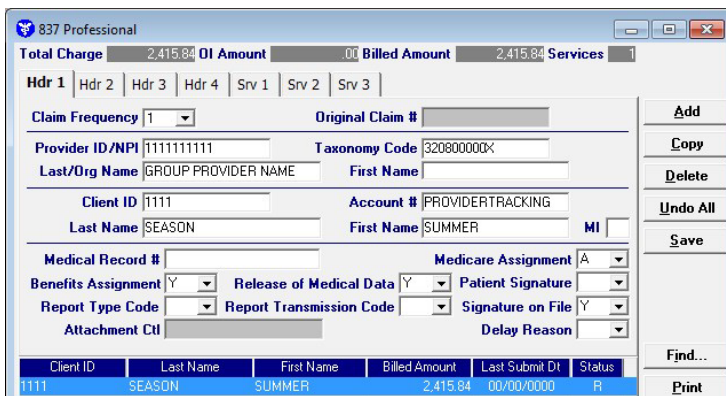
1. Click **Save** on right hand side.
2. If all the mandatory information has been entered, the claim will save and bring you back to the HDR1 tab.

If information is missing an Error Message box will pop-up.

- If this box appears, double click on the error and it will bring you to the field that needs to be corrected. Once the correction has been made, click Save on the right-hand side.

- Once the claim is saved you will see it listed on the HDR 1 tab in R status at the bottom. That means the claim is ready to be submitted.
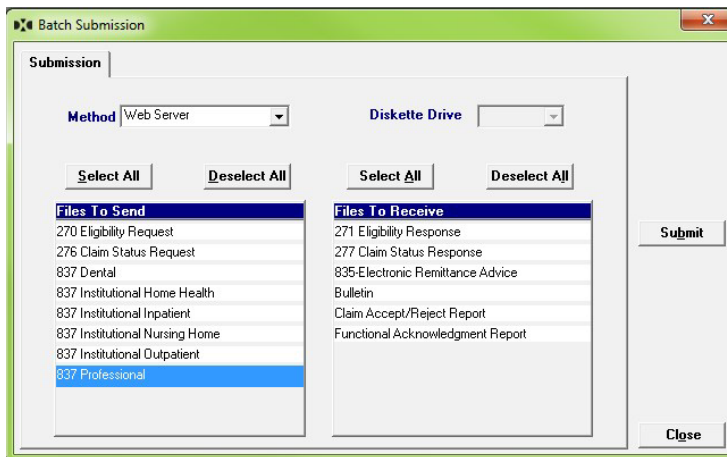

6.14   Submitting Claim(s)/Receiving Transactions

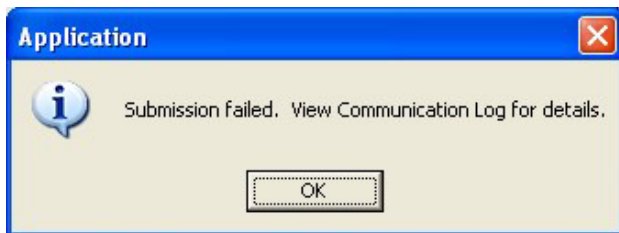1. Click on **Communication** on the main menu and select **Submission**.

2. Under **Files To Send** select **837 Professional**.
3. Click **Submit** on the right hands side.

This screen will appear if the submission was successful.

This screen will appear if the submission fails.

4. **Unselect the 837 Professional** under the **Files To Send**.

5. Under **Files to Receive**, select the reports named **Claim Accept/Reject Report** and F**unctional Acknowledgement Report**.

6. Once selected click **Submit**.

*Once the claims have been submitted, they will be in F status meaning they have been submitted.
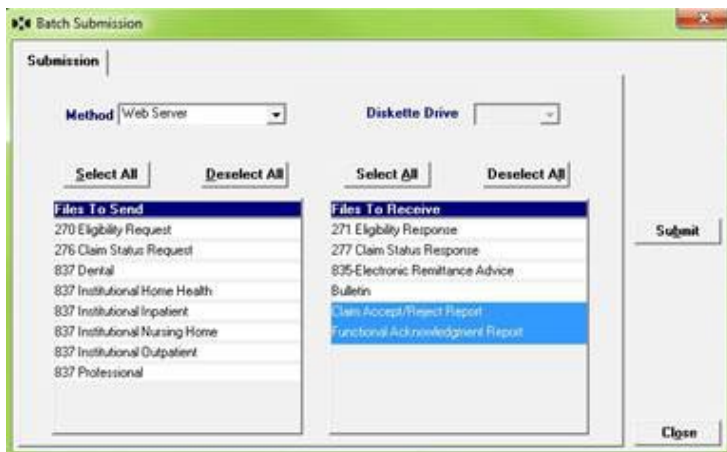
The **Claim Accept/Reject Report** and **Functional Acknowledgement Report** should be retrieved after each submission of 837 transactions. The Functional Acknowledgement will inform you of the HIPAA compliancy of the submission. This report pertains to the HIPAA compliancy of the entire file. In cases of rejection, it is the entire file that is rejected, and the error must be corrected prior to submitting the file. The Claim Accept/Reject Report is claim specific for errors that prevents Gainwell from processing the claim. In this case, only the claim(s) listed on the report were rejected. The remainder of the claims were accepted for processing.

6.15   How to Copy Claim in F status

When you go to bill again, you can copy the claim you previously submitted to make the process quicker. Then all you would have to do is change the dates of service, units and billed amount. Below is the instruction on how to copy a previously submitted claim.

1.   On the HRD 1 tab select the patient's name of the claim you would like to copy.

2.   Click **Copy** on the right-hand side. Once you click copy the "claim frequency" field will highlight blue.

3.   Click on the SRV1 tab and change the date of service, units, and billed amount, and any other changes you need to make.

4.   Once you have completed your change/update click the **Save** button on the right-hand side.

The new claim will be listed at the bottom of the screen in R status, which mean it's ready to be submitted.

Once the claim is submitted and processed it will be noted on a Remittance Advice.

Section 7   Remittance Advice

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. It indicates the status of all claims that have been submitted for processing. The RA is posted at https://vtmedicaid.com/#/home on a weekly basis, with your four most current RAs available.

Information regarding your remittance advice can be found at https://vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf section 3.12.

Section 8   Resources

Please contact your Provider Representative if you have any questions regarding policies or claim processing.

You can find your Provider Representative at https://vtmedicaid.com/assets/resources/ProviderRepMap.pdf.

You may also contact your Vermont Department of Health Strong Families Vermont Program Manager with questions and needs regarding enrollment and billing. https://www.healthvermont.gov/family/family-planning-pregnancy/strong-families-vermont-home-visiting

Section 9   Special Investigations Unit

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

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.