

# Brain Injury Services Targeted Case Management

## A Guide for Providers

### Brain Injury Services Targeted Case Management Quick Facts

#### What is Brain Injury Services Targeted Case Management (BIS TCM)?

BIS TCM are state plan case management (CM) services for Medicaid-eligible individuals aged 18 years or older who live in the community, have a physician-documented diagnosis of traumatic brain injury (TBI), and have severe functional limitations due to their TBI, as indicated by the *Mayo Portland Adaptability Inventory (MPAI-4)* assessment. Individuals residing in an inpatient facility may qualify for BIS TCM if being discharged to community (certain qualifications must be met).

#### What are the case manager's responsibilities as part of the BIS TCM?

- Obtain client history
- Develop individualized service plan (ISP)
- Assist in developing, locating, obtaining, or scheduling of needed medical/support services
- Periodically monitor the care that the individual is receiving
- Revise and update the ISP as needed
- Complete and update in ISP a minimum of one BIS TCM activity each month and at least one face-to-face contact with the individual at least every 90 calendar days

#### What are the required qualifications and requirements for becoming a BIS TCM provider?

- Be accredited by Commission on Accreditation of Rehabilitation Facilities
- Guarantee individuals' access to 24-hour emergency services
- Demonstrate ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for reimbursement
- Have administrative/financial management capacity to meet state/federal requirements
- Have ability to document and maintain individual case records in accordance with state and federal requirements

#### What are the required case manager qualifications for providing the BIS TCM?

- Have a bachelor's degree from an accredited college or university, or be a registered nurse
- Be a Qualified Brain Injury Support Provider or Certified Brain Injury Specialist

#### What are the billing codes and reimbursement rates for BIS TCM?

The following codes are billed as a monthly unit as authorized by the managed care organization (MCO):

- **S2080** = Assessment for BIS TCM services once every 6 months.
- **S2081** = BIS TCM services
- Reimbursement rate for one unit of each of **S0280** and **S0281** = [DMAS Fee Schedule](#)

## Important Note About Reimbursement

To be reimbursed for services provided through fee-for-service and managed care, enrolled individuals and providers must follow their contracts with the respective managed care organizations and DMAS.

## Contact Information

### Provider Enrollment

In-state: **1-804-270-5105** | Toll-free: **1-888-829-5373**

Email: [VAMedicaidProviderEnrollment@Gainwelltechnologies.com](mailto:VAMedicaidProviderEnrollment@Gainwelltechnologies.com)

### Provider Helpline

Available Monday through Friday from 8 AM to 5 PM; for provider use only.

Have Medicaid provider ID number available.

In-state: **1-804-786-6273** | Toll-free: **1-800-552-8627**

For additional information about BIS TCM, visit: [dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/brain-injury-services](https://dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/brain-injury-services).

## S0281 BIS Case Management Services

Members receiving BIS TCM services must meet member eligibility/medical necessity criteria. Submission of medical records or physician attestation/documentation is not required to validate a TBI diagnosis but must be maintained as part of the medical record by the BIS TCM provider.

### Approval Criteria

- TBI diagnosis criteria and functional needs – *MPAI-4* score criteria are both met

### Denial Criteria

- TBI diagnosis criteria and functional needs – *MPAI-4* score criteria are not met
- Members residing in a facility where BIS TCM services span beyond 6 months

### Partial Denial Criteria

- Authorization requests that span greater than six months
- Overlapping BIS TCM authorizations (member transitioning from one BIS TCM to another BIS TCM provider)
- Overlapping CM authorizations (Member has CM authorization in place and is now choosing BIS TCM; initial CM authorization will be end dated resulting in a partial denial)

### Authorized from and through date requirements:

- S0281 CM is authorized in subsequent dates using a calendar month based on the end date of the intake period. Access the [MCO Service Authorization Form](#).
- S0281 cannot be authorized for more than a six-month timeframe.
- S0281 may not be authorized if a member resides in a facility for a prolonged period.

## Service Authorization (SA) Review – Ongoing BIS TCM Services

BIS TCM providers requesting ongoing BIS TCM services must submit a SA request with:

1. Updated MPAI.
2. BIS TCM point of contact (POC).

### Approval Criteria

- MPAI-4 score criteria is met
- BIS TCM POC meets the MCO CM standards

## Overlapping Authorizations of Case Management Services

Authorization for and the delivery of BIS TCM services cannot overlap with other Care Management services, including ID/DD waivers. Overlapping of services are not reimbursable. Prior to authorizing BIS TCM services, the Aetna Better Health authorization review will determine if the member is receiving Care Management services from another provider through reviewing claims and authorizations. Brain Injury Providers should note that only one Care Management service can only be authorized for a member per month.

As always, providers have appeal rights for partial denials that may occur.

## Members Residing in a DD Waiver

Members who reside in the DD waiver receive CM services as part of their waiver. These members can be identified with an open DD Waiver Level of Care (Y, S or R). For members choosing BIS TCM services over DD waiver CM services, contact the DMAS BIS Unit at [braininjuryservices@dmas.virginia.gov](mailto:braininjuryservices@dmas.virginia.gov) before requesting authorizations for BIS TCM services.

## Important Claims Information

- Rendering Provider is the facility NPI for **Brain Injury**.
- Taxonomy must be included on call claims forms.

You must file claims within 365 days from the date you provided services unless there's a contractual exception. You have 365 days from the paid date to resubmit a revised version of a processed claim.

All claims must be submitted with this information:

- Member's name, date of birth, and ID number
- Type of service
- Date and location of service

## Submitting Claims Online

You can submit claims or resubmissions online through ConnectCenter using payer ID: 128VA. This is our provider claims submission portal via Change Healthcare (formerly known as Emdeon). To register, visit the ConnectCenter portal and follow the prompts to “Sign Up” and enter Vendor Code 214557.

Visit [AetnaBetterHealth.com/Virginia/File-Submit-Claims.html](https://AetnaBetterHealth.com/Virginia/File-Submit-Claims.html) to learn more.

## Submitting Claims by Mail

You can also mail hard copy claims or resubmissions. Mark resubmitted claims clearly with “resubmission” to avoid denial as a duplicate. Mail your claims to:



Aetna Better Health of Virginia  
PO Box 982974  
El Paso, TX 79998-2974

## EFT/ERA Registration Services

Electronic funds transfer (EFT) makes it possible for us to deposit electronic payments directly into your bank account. Electronic remittance advice (ERA) is an electronic file that contains claim payment and remittance info sent to your office. Aetna Better Health has partnered with Change Healthcare to offer EFT/ERA Registration Services (EERS) to all of our providers.

Visit [PayerEnrollServices.com](https://PayerEnrollServices.com) to enroll in EERS.

To learn more about EFT/ERA, visit our *Claims* page on our website:

[AetnaBetterHealth.com/Virginia/File-Submit-Claims.html](https://AetnaBetterHealth.com/Virginia/File-Submit-Claims.html).

## Additional Billing Information

The provider manuals maintained by DMAS, which are available on their website, are a great resource for billing providers. Chapters 5 in each provider manual contains billing guidelines. To access the DMAS Provider Manuals Library, go to [vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library](https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library).

## Helpful Tips

- Always confirm member’s enrollment at the beginning of each month.
- Use only appropriate location codes where service was provided. Place of service code sets are generally available on the CMS website.
- If a patient has another insurance in addition to Medicaid, then an EOB will be required with claim submission.
- If you are not participating with the other insurance carrier, an attestation stating nonparticipation is required to be included with each claim submitted for that member.
- Email [AetnaBetterHealth-VAProviderRelations@Aetna.com](mailto:AetnaBetterHealth-VAProviderRelations@Aetna.com) for claims questions.

## Paper Remittances

At first glance, a paper remittance can look confusing. Below, we've outlined some of the main components of a paper remittance.

### Section A

This section contains high-level claim payment details and basic provider data.

Section A

WHITE STOCK

Billing Provider Name: AIT LABORATORIES

TIN: 621433252

NPI: 1689639544

Line of Business: Aetna Better Health - FloridaHealthy Kids

Remit Date: 02/21/2022

Beginning Balance: 0.00

Discount: 0.00

Interest: 6.54

Refund Amount: 0.00

Amount Recouped: 0.00

Amount Paid: 66.86

Ending Balance: 0.00

Payment #: 1006975

**A1:** Page number

**A2:** Billing Provider Name

**A3:** TIN & NPI

**A4:** Line of Business

**A5:** Discount & Interest

**A6:** Payment #

### Section B

This section illustrates key fields a provider may refer to when reviewing individual claim information. This section has been re-designed to be easier to interpret and quickly find important claim payment details.

Member Name: [redacted] Member #: 20211013 Claim #: [redacted] Claim Status: REVERSED

Acct #: [redacted] Date Received: 20211013 Auth#: [redacted] Place of Service: 81

Claim Provider: AIT LABORATORIES Billed DRG: [redacted] DRG: [redacted]

Adjustment of Claim #: 21286E0100447

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/CAP	Billed Amt.	Allowed Amt.	Not Payable Remark	Member Responsibility				Paid Amount	
										Ded PR1	Coins PR2	Copay PR3	Other Remark		
1	10/07/21	U0003		-1	FFS	-125.00	-100.00	-25.00	CO45	0.00	0.00	0.00		-100.00	
2	10/07/21	U0005		-1	FFS	-31.25	-6.25	-25.00	CO45	0.00	0.00	0.00		-6.25	
Payment # 1006975 Claim Totals							-156.25	-106.25	-50.00		0.00	0.00	0.00	0.00	-106.25

Member Name: [redacted] Member #: 20211013 Claim #: [redacted] Claim Status: PAID

Acct #: T4245380 Date Received: 20211013 Auth#: [redacted] Place of Service: 81

Claim Provider: AIT LABORATORIES Billed DRG: [redacted] DRG: [redacted]

Adjustment of Claim #: [redacted]

Interest Amount: 0.65

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/CAP	Billed Amt.	Allowed Amt.	Not Payable Remark	Member Responsibility				Paid Amount	
										Ded PR1	Coins PR2	Copay PR3	Other Remark		
1	10/07/21	U0003		1	FFS	125.00	67.50	57.50	CO45	0.00	0.00	0.00		67.50	
2	10/07/21	U0005		1	FFS	31.25	24.12	7.13	CO45	0.00	0.00	0.00		24.77	
Payment # 1006975 Claim Totals							156.25	91.62	64.63		0.00	0.00	0.00	0.00	92.27

**B1:** Member Name & Member #

**B2:** Claim # & Claim Status

**B3:** Acct #

**B4:** Claim Provider/Adjustment of Claim

**B5:** Billed DRG & DRG

**B6:** Line#: Service From-To

**B7:** Serv Code, Rev Code, Units FFS/CAP

**B8:** Billed & Allowed Amount

**B9:** Member Responsibility

### Section C

This section is an example of a remit document showing the applicable claim remarks in the code descriptions area.

Member Name:	Member #:	Claim#:	Claim Status:
Acct #:	Date Received: 20211015	Auth#:	DENIED
Claim Provider: AIRLIFE MEDICAL LLC	NPI #:	Billed DRG:	Place of Service: 12
Adjustment of Claim #: 21291E0051728			DRG:
Claim Level Messages: MA67	Section C Remarks and Code/Description		

Line #	Service From - To	Serv Code	Modifier	Rev Code	Units	FFS/CAP	Billed Amt.	Allowed Amt.	Not Payable	Remark	Member Responsibility				Paid Amount
											Ded PR1	Coins PR2	Copay PR3	Other	
1	10/02/21	E0305	RR KI KX		1	FFS	16.56	0.00	-8.36	CO26 OA23 N52 N650	0.00	0.00	16.56	16.56	0.00
Payment #							16.56	0.00	0.00		0.00	0.00	16.56	16.56	0.00

Provider Summary:	Interest Paid: 0.00	Discount/Penalty: 0.00	Provider Claims Total:	Billed Amt. 16.56	Allowed Amt. 0.00	Not Payable 0.00	Ded 0.00	Coins 0.00	Copay 16.56	Other 16.56	Paid Amount 0.00
Check Date:	Check Number:	Check Amount:	Claim Level Messages: M467								

**Code/Description**

CO - Contractual Obligations. Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.  
 OA - Other adjustments.  
 PI - Payer Initiated Reductions. Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract betw  
 PR - Patient Responsibility.

CO26 EXPENSES INCURRED PRIOR TO COVERAGE  
 MA67 ALERT: CORRECTION TO A PRIOR CLAIM  
 N52 PATIENT NOT ENROLLED IN THE BILLING PROVIDER'S MANAGED CARE PLAN ON THE DATE OF SERVICE.  
 N650 THIS POLICY WAS NOT IN EFFECT FOR THIS DATE OF LOSS. NO COVERAGE IS AVAILABLE.  
 OA23 THE IMPACT  
 PR3 CO-PAYMENT

**Not Payable Remark:**  
 CO26  
 OA23  
 N52  
 N650

**Member Responsibility Remark:**  
 PR3

If you have any questions please contact the Claims Department at 1-844-645-7371 visit our website at [www.aetnabetterhealth.com/Florida](http://www.aetnabetterhealth.com/Florida)

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**C1:** Claim Level Messages  
**C3:** Code/Descriptions

**C2:** Remark for each service line  
**C4:** Code reference

## Resubmitting a Claim

You can resubmit a claim through ConnectCenter or by mail.

If you resubmit through the ConnectCenter portal, you'll need to mark your resubmission with a number for the frequency code:

- "7" for replacement or adjustment claims
- "8" for voided claims

If you resubmit by mail, you'll need to include these documents:

- A completed *Claim Resubmission/Reconsideration Form*
  - Available on our website at:  
[AetnaBetterHeath.com/Virginia/providers/file-submit-claims.html](http://AetnaBetterHeath.com/Virginia/providers/file-submit-claims.html)
- An updated copy of the claim — all lines must be rebilled
- A copy of the original claim (reprint or copy is acceptable)
- A copy of the remittance advice where we denied or incorrectly paid the claim
- A brief note describing the requested correction
- Any other required documents

## Claim Reconsiderations

A claim reconsideration is a request that we previously received and processed as a clean claim. It's a review of a claim that a provider believes was paid incorrectly or denied due to processing errors.

When you send a reconsideration, be sure to include:

- A claim form for each reconsideration
  - Available on our website at:  
**[AetnaBetterHeath.com/Virginia/providers/file-submit-claims.html](https://www.aetna.com/betterhealth/virginia/providers/file-submit-claims.html)**
- A copy of the remit/Explanation of Benefits (EOB) page for each resubmitted claim, with a brief note about each claim you're resubmitting
- Any information that the health plan previously requested

You can file a claim reconsideration by mail. Mail your reconsideration form and all supporting documents to:

Aetna Better Health of Virginia  
Attn: Reconsiderations  
PO Box 982974  
El Paso, TX 79998-2974

## The Appeals Process

### When Claims Don't Go as Planned

You have the right to appeal our claims determinations within 60 calendar days of receipt of the claim denial. You can file an appeal if:

- We denied reimbursement for a medical procedure or item you provided for a member due to lack of medical necessity or no prior authorization (PA) when it was required
- You have a claim that has been denied or paid differently than you expected and wasn't resolved to your satisfaction through the dispute process

### Denials based on medical necessity criteria:

- You have seven calendar days to request a Peer-to-Peer reconsideration. To request a Peer-to-Peer, call Member Services at **1-833-459-1998**.
- If you are not satisfied with the Peer-to-Peer result, you will be able to submit a formal appeal with Aetna Better Health. If you are not satisfied with the appeal result, you may then submit a formal appeal to DMAS.

### Denials based on administrative reasons:

- Send appeal request using the formal provider appeal process.
- Appeals should state Formal Provider Appeal on the document(s) and should be mailed to:  
Aetna Better Health of Virginia  
Attn: Appeals Coordinator  
PO Box 81040, Cleveland, OH 44181
- Reviewers may not always ask for additional clinical information. If a service is denied, you will be contacted by the reviewer, faxed a denial authorization, faxed a denial letter, and a denial letter will be mailed to you.

## Contact Us

We're here for you to answer any questions you may have.



### Our contact information

Lilibet Elling, Provider Relations: [EllingL@Aetna.com](mailto:EllingL@Aetna.com)

Cynthia Beadle, Contracting: [BeadleC2@Aetna.com](mailto:BeadleC2@Aetna.com)

- **Cardinal Care:** Megan C Krumich, [KrumichM@Aetna.com](mailto:KrumichM@Aetna.com)
- **LTSS:** Leticia W Boone, [BooneL1@Aetna.com](mailto:BooneL1@Aetna.com)
- **Provider Relations:** Lilibet "Lili" Elling, [EllingL@Aetna.com](mailto:EllingL@Aetna.com)
- **Contracting:** Cynthia "Cindi" S Beadle, [BeadleC2@Aetna.com](mailto:BeadleC2@Aetna.com)



## Your patients have extra benefits that can improve their health.

By being a member of Aetna Better Health, your patients have access to a wide range of added benefits that can help them better meet their health needs, all at no cost. Call **1-800-279-1878 (TTY: 711)** to speak to a Care Manager to learn more about these benefits.

### For all members

**Extra help with rides:** Members can enjoy free rides to local resources or services — up to 30 round trips or 60 one-way trips each year.

**Free cell phone:** Free Android™ smartphone with free data, texts, and minutes; 10 GB monthly hotspot

**General Educational Development (GED):** CampusEd is a free online resource that can help members earn their GED and start a new career. We'll also pay for members' GED test (up to \$120).

**Hearing care:** One hearing exam, \$1,500 toward hearing aids, plus 60 batteries each year, plus unlimited visits for hearing aid fittings

**Home meal delivery:** Home-delivered meals after hospital discharge for seven days.

**Mental health support through Pyx:** A personalized program to support members' health. Pyx Health helps members get the most from their health plan, at no cost.

**MyActiveHealth Management:** A personalized and interactive mobile program that sends texts on diabetes education and support; personal care; appointment and medication reminders; and exercise/weight goal setting and tracking

**Over-the-Counter Health Solutions® period stipend:** \$20 monthly for members with periods to spend on period products through CVS Pharmacy®

**Vision care:** One eye exam, plus \$250 toward eyewear

**Weight management:** Personalized weight management with a registered dietitian, which includes a 12-week certified nutritionist program and six counseling visits

**Wellness Rewards:** Members can get gift cards for taking care of their health. Kids also get extra perks, like free swimming lessons and sports

physicals, plus up to a \$25 gift card when they join the Ted E. Bear, M.D.® Wellness Club!

### For moms and children

**Benefits for new moms:** Eligible members who are pregnant through one year postpartum can get \$25 monthly to spend on over-the-counter items for them and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get 300 free size 1 baby diapers delivered to their home after their baby is born.

**Breastfeeding support through Pacify:** 24/7 access to a national network of International Board-Certified Lactation Consultants® and doulas via live video consultation

**Youth sports physicals:** Annual sports participation physical for members 6 to 18 years old

**Youth swimming lessons:** Water safety and swimming lessons for members 6 years and younger

**Healthy food card:** Eligible members can get \$50 added to a special debit card every month to buy healthy groceries at nearby stores.

### For those with certain health conditions

**Asthma program:** Members with asthma can get one set of hypoallergenic bedding and between \$150 and \$400, depending on area of service, to use towards one deep carpet cleaning annually.

**Memory care:** Two door alarms and six window locks available to members diagnosed with dementia or Alzheimer's disease (requires prior authorization)

**Therapeutic shoes or shoe inserts:** Eligible members with diabetes with a prescription from a podiatrist or orthopedic doctor can get pair of therapeutic shoes or shoe inserts per year (up to \$200 annually).