DMHA Electronic Billing System
Business Rules

Version <4.0>

Revision History

Date	Version	Description	Author
03/04/2019	1.0	Original Document	Terry Cook
10/31/2019	2.0	DMHA Electronic Billing System Update	Mark Loggins
1/1/2020	2.1	DEBS Update	Mark Loggins
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10/1/2023	4.0	DEBS Update	Mark Loggins

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Business Rules

1. <Introduction>

1.1 Purpose

1.1.1 The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP), were awarded the 2018 State Opioid Response to the Opioid Crisis Grants (SOR). The program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). As of 2020, the State Opioid Response Grant has expanded access include stimulant use disorders. The purpose of the SOR funded DMHA Electronic Billing System (DEBS) is to provide a billing platform for approved Substance Used Disorder (SUD) services for persons with an opioid use disorder.

1.1.2 DMHA has added additional, non-SOR, funding streams to DEBS, including State funds and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS). These funds are subject to their own qualifying standards for appropriate use.

1.2 Scope

1.2.1 SOR funding will be utilized to pay for room and board (with and without one provided meal) and a per diem at facilities certified by Indiana Affiliation for Recovery Residences (INARR) and DMHA, **exclusively for clients with an** opioid use disorder diagnosis **or a stimulant use disorder diagnosis.** These facilities shall be an INARR certified Level II, III, or IV recovery residence and open to residents receiving all 3 of the FDA approved medications for the treatment of opioid use disorder (OUD); methadone, buprenorphine, and naltrexone. These funds shall only be used for clients with no third party payer. The service provider is also mandated to perform a Government Performance and Results Act Assessment (GPRA). This assessment shall be completed upon intake of client, 6 months after intake, and upon discharge from services.

1.2.2 SOR funding will be utilized to provide approved medication for opioid use disorders and evidence based treatments to clients at a community mental health center (CMHC) or any DMHA approved addiction care provider, **exclusively for clients with an** opioid use disorder diagnosis **or a stimulant use disorder diagnosis.** All participating CMHCs must allow their clients access to all and any 3 of the FDA approved medications for the treatment of Opioid Use Disorder (OUD); methadone, buprenorphine, and naltrexone. These funds shall only be used for clients with no third party payer. The service provider is also mandated to perform a Government Performance and Results Act Assessment (GPRA). This assessment shall be completed upon intake of client, 6 months after intake, and upon discharge from services.

1.2.3 SOR funding will be utilized by select community providers to incentivize clients in completing the GPRA 6 month follow up. Selected providers will offer non-cash incentives to

clients with an opioid use disorder or a stimulant use disorder for completing the 6-month follow-up assessment.

1.2.4 State funds will be utilized by select providers to provide evidence based treatment for mental health and substance use disorders in county jails. All participating providers must allow their clients to access any of the 3 FDA approved forms of medication for opioid uses disorder; methadone, buprenorphine, and naltrexone. Clients must have a diagnosis of a mental health or substance use disorder to be eligible. Providers must attest that all documentation is being kept and available upon request of DMHA approvers.

1.2.5 Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant funds will be utilized by select providers to provide evidence-based, residential treatment services for substance use disorder. All participating providers must allow their clients to be on any of the 3 FDA approved forms of medication for opioid use disorder; methadone, buprenorphine, and naltrexone. Services must follow the ASAM 3.1 or 3.5 guidelines. Providers must attest that data is entered into DARMHA and that the client is eligible for funded services.

1.2.6 State funds will be utilized by select providers to provide case management and skills trainings for pregnant persons and women with newborns following a discharge from a residential facility. All participating providers must allow their clients to access any of the 3 FDA approved forms of medication for opioid use disorder. Participants must be a pregnant person or a mother with a newborn. Providers must attest that all documentation is being kept and available upon request of the DMHA approvers.

1.3 References

[This subsection provides a complete list of all documents referenced elsewhere in the **Business Rules** document. Identify each document by title, report number (if applicable), date, and publishing organization. Specify the sources from which the references can be obtained. This information may be provided by reference to an appendix or to another document.]

1.3.1 *Billing System Definitions and Reimbursement Rates*

1.3.2 *Facility Administration Guide or User Manual (Located within DEBS application)*

1.3.3 INARR Recovery Residence Levels of Support (https://www.inarr.org/standards-ethics/support-levels/)

1.3.4 CSAT GPRA Data Collection (https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra)

1.3.5 DSM 5 Criteria for Opioid Use Disorder via Oregon Pain Guidance (https://www.oregonpainguidance.org/wp-content/uploads/2019/07/DSM-5-Criteria-OPG-form.pdf?x91687)

1.3.6 *Data Assessment Registry Mental Health & Addiction (DARMHA) https://dmha.fssa.in.gov/DARMHA/Default*

2. <Overview>

2.1.1 The DMHA Electronic Billing System (DEBS) Agency Agreement is an agreement between DMHA and the DEBS Designated Agency. This agreement operates similarly to a contract between the two agencies and can be terminated by either party with a 30-day written notice. Once an agency is approved to become a designated DEBS Agency, they will receive written notification, along with the agency agreement. The agency is asked to have the appropriate party sign the agreement and return the agreement to the DMHA Electronic Billing System administration in a timely manner. Once the agreement is returned, your agency officially becomes a Designated DEBS Agency.

3. <**Service Definitions**>

Appendix A – Jail Treatment
Appendix B – Residential Treatment (DARMHA req)
Appendix C – Skills Training for New Mothers
Appendix D – Recovery Residences (GPRA req)
Appendix E – SUD Treatment (GPRA req)
Appendix F – GPRA 6-month follow up incentive (GPRA req)

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4. <Billing System Access Rule>

DMHA Electronic Billing System (DEBS) is available here:
https://secure.in.gov/apps/fssa/voucher/

Step 1: Contact FSSA, via JIRA HelpDesk, or your Facility Admin requesting a new user be created
Step 2: You will receive an email directly from FSSA DEBS
Step 3: Click on the link within the email **clicking here and logging into the portal**

Important Notes:

- *A work email address is required to setup new accounts.*
- *If the work email domain is through Microsoft – users will be prompted to follow their work email password procedures to setup the Access Indiana account.*
- *If the work email domain is not through Microsoft, users will be prompted to follow the Microsoft password procedures.*
- *The Access Indiana account will be used as the Single Sign On into DEBS.*
- *Users are created with an enabled status because, on accepting the invite, they will be enabled to do activity in the application.*
    - *Facility Admins can disable a user at any time including before they accept their invitation.*

5. <Attestation>

Upon initial enrollment into the billing system, and with any new system updates, the user must read and agree to the attestation message. The user should read the terms. Should the client or user have any questions regarding the attestation statements, they are to email their DMHA program director for clarification. Refusal or failure to acknowledge the attestation, by clicking on the "I agree to all terms outlined above" button, will prohibit the user from entering the billing system.

6. <Assessment for services>

Providers utilizing State Opioid Response grant funds must complete the Government Performance and Results Act (GPRA) Assessment. The GPRA must be completed for each client or resident receiving these services. The client or resident should be assessed at intake, 6 month mark, and at discharge. The DEBS will have a built-in platform to enter the GPRA information. The GPRA measures should be recorded and entered into the DEBS as close to the time of the assessment as possible. DEBS Claims will not be approved without successful completion of the GPRA. Non-compliance with intake, 6 month mark, and discharge procedures may lead to a DEBS Invoicing Agency being suspended or denied access to DEBS.

Providers utilizing Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) funding must enter client level data into DARMHA prior to filing a claim in the DEBS system. A DARMHA ID is required to create a client record in DEBS.

7. <Initial Enrollment in the Billing System>

7.1.1 Initial Enrollment of a client will require some mandatory information:

- To enroll a client into DEBS for a GPRA required fund, there is one (1) mandatory identification: the GPRA ID. This may be generated using the application tool or you may derive the client's GPRA ID from the Internal ID as long as it meets the system requirements.
- To enroll a client into DEBS for a DARMHA required fund, there is one (1) mandatory identification: the DARMHA ID. This will be available from DARMHA after the required data is collected. The ID will then need to be entered manually in DEBS at client creation.
- The provider may also enter the Internal ID into DEBS for further tracking.
- The provider will enter the First Initial, Last name, Last 4 SSN, and DOB for each client.

7.1.2 The provider must attest to the *enrollment* qualifications in relation to requirements from

the Agency Agreement regarding each client.

7.1.3 The provider must have patient read, understand, and sign the **42 CFR Release of Information** form within the application in order to claim for services. This form should be kept by the provider and stored in the client's file in case of an audit.

7.2 <Claims>

The provider will be given 10 days from the date of the provided service to enter all required GPRA and Billing System Requirements. DMHA is not obligated to approve claims for services provided more than 10 days before the claim. DMHA may request additional information to determine if a claim can be approved. Providers should not ask participants to make additional payments for the portion of their care that is paid by the SOR grant.

After a claim has been submitted, DMHA will review the claim. If the reviewer has any questions, they will be able to send a request back for more information in the billing system. When this happens, you'll received a notification stating the claim needs more information. The requestor will need to thoroughly respond to the request(s) in the review questions box and resubmit. The DMHA reviewer will then either approve, send back for more clarification, or deny the request.

7.2.1 Each claim may require the provider to answer **Prior Authorization** questions. These questions must be answered to the best of the provider's ability and with as much detail as possible. DMHA may ask for additional information in order to determine if the client is appropriate for services. Providers should respond to these requests within the next business day. DMHA is not obligated to approve a claim with unanswered prior authorization questions or further information pending beyond 10 days. If further documentation is requested by DMHA, files can be uploaded in DEBS under the "Select Action" Tab.

7.2.2 Any requests directed to providers for changes, edits, or more information regarding a claim should be addressed within the next business day. DMHA is not obligated to approve a claim with an unresolved issue beyond 10 days of notice.

7.3 <Claim Reimbursement>

Providers agree to accept reimbursement for services at the rate specified in the latest version of the DMHA Electronic Billing System as updated from time to time by DMHA. Providers should not ask participants to make additional payments for the portion of their care that is paid for by DMHA Electronic Billing System. DMHA is not obligated to reimburse for services claimed beyond 10 days of the provided service.

7.4 <Billing or Utilization>

The service provider should submit services rendered from the claim view by the end of the tenth (10^{th}) day. The provider must enter the correct number of days and units the claim has

been utilized. Claims may not span over the course of more than one month. Regardless of how many days are on a claim, a new claim must be started at the beginning of the next month.

7.5 <Closing a claim>

When a client leaves a provider, either for completion of services, leaves against medical advice, is removed from programming, etc., the facility must close the claim. Please enter in all necessary notes and choose the most appropriate options from the menu. NOTE: You must include documentation of step down/continuity of care/referral entity in your case note.

7.5.1 Refund Policy

In the event that monies vouched need to be returned to the State, the provider must submit a refund. The provider has seven (7) business days to notify the State. An email must be sent to the DMHA Program Director with reason for refund, client name, DARMHA ID, claim number and number of days to be refunded with total dollar amount. Refund checks must be mailed to DMHA Electronic Billing System, 402 W. Washington Street, Room W353, Indianapolis, IN 46204 or the given address on the downloadable form. The refund check must match the dollar amount of number of days to be refunded. Reasons for refund could include:

1. Client obtained 3rd Party payer in form of Medicaid, HIP, private or commercial insurance, Recovery Works, or any legitimate 3rd party payer source.
2. A provider is found to have claimed an incorrect amount of funds for services.

7.5.2 Refund Process

In order to submit a refund to the DEBS system, the claim must be closed either by the State Administrator or the vendor. After the claim is closed with the appropriate close reason, the vendor will click on the “Refund Services” tab to verify refund amount and reason. You will be instructed to download a form with unique information on your refund claim. This form will be sent in with your check to match payment to the DEBS system.