# Chat questions, November 2024

The following questions have one response below.

**Q: We are getting a lot of denials for exceeding units that don't appear to be correctly denying. We have counted from the date of service that denies six days back and six days forward (including the denied date) and neither are over the six per day OR 30 per rolling 7-day period. The provider line had mentioned that the system was incorrectly denying for exceeds unit a few weeks back and a resolution was found sometime around the end of October, but we are STILL getting denials that seem wrong. How is the system calculating these units and how can we better track them on an agency side? All programs have been adjusted to six-hour max per day so there is really no reason why we should have exceeded unit denials.**
**The provider line has been contacted several times over the course of the last six months due to this and the answers that are received are vague and not helpful. We have had claims sent back for review, but that is not sustainable to have to keep calling for reprocessing when the system should be set up to process it right from the beginning. We, as the agency, are losing money due to this in a decently large volume for what seems to be a system error on MA's end.**

**Q: In response to the concern above, we have contacted the provider resource center several times, this has not helped us in resolving this issue. We have gotten several different answers when calling in and no positive progress has been made. We need to resolve this as soon as possible. Is there specific contact we can reach out to?**

**Q: The resource center is time consuming and doesn't always bring a consistent message. I think an e-memo that outlines this issue, how to resolve for a specific provider (if possible), and when resolution more broadly is coming would be valuable.**

**Q: Agree with the above. We've had the experience others have had, and some nonsense about client had to be discharged before could get paid. Back and forth, and this being counter to everything CMS, DHS, ASAM and common sense for step down levels of care would indicate. Finally managed to get through that with one carrier after a very lengthy delay. If DHS has a uniform message and response this would be very helpful.**

A: Thank you for the information and concerns related to communication. Communication regarding billing related items is typically communicated through the MN-ITS mailbox and sometimes through Provider News and e-memos.

This issue has now been resolved. The last communication when out to providers and can be seen on the provider news: Substance Use Disorder services Individual (H2035) and Group (H2035 HQ) remittance advice remark code N362 issue resolved.

**Q: Is there a specific contact I can reach out to regarding specific issues with certain counties denying the BHF requests?**

A: It is best to work directly with the county to understand why the BHF request is being denied. Providing statutory requirements may also be helpful, much of the behavioral health fund eligibility guidance can be found

in MN Statutes, 254B.04. If this has already been done you can notify the sud.direct.access.dhs@state.mn.us mailbox and we will try to determine who the next best connection may be based on the situation.