Questions and Answers regarding the *DDS Encounter Data*

Submission Guidance, v.4, 2/19/21

1. We implemented a new EHR in October. When our MSR was built, we were advised not to include DS clients. Will this need to be addressed?

   Answer: Once agencies begin reporting to the MMIS, they may discontinue reporting into the MSR. Since we are requiring agencies to move towards full reporting into the MMIS starting 3.1.21, your agency should focus its efforts on reporting to MMIS moving forward. It is not necessary to go back to report in MSR.

2. What is the anticipated start date of the "accurate encounter data 6-month window period for payment reform look back?

   Answer: DAIL will monitor each agency's submissions of encounter data with the goal of assessing completeness and accuracy. DAIL will be regularly communicating with providers to review and address data quality issues and will work with providers to address any issues in an expedient manner. DAIL's goal is that encounter data quality will be sufficient to begin building the six-month baseline no later than the third quarter of 2021. This decision will not be made without provider awareness.

3. Can you send a copy of the PowerPoint to providers?

   Answer: DAIL has posted it on the DDS website. https://ddsd.vermont.gov/sites/ddsd/files/documents/Encounter_Data_Submission_Guidance_V.4%202.19.21_PowerPoint.pdf

4. Regarding the future reconciliation process, is there any discussions or thought process to if a provider at the end of that year actually provides more service than authorized rather than less, and can they be compensated for that?

   Answer: The reconciliation process has not been finalized, although there have been some discussions regarding whether there would be certain plus or minus percentage threshold or reconciliation band for which the agency would be reimbursed fully. Stakeholders will have the opportunity to provide input into the design of the reconciliation process.

5. Will there be any reporting or indicators during the year of how an agency is doing in aggregate regarding reconciling payments to encounter claims. And will the year be calendar or fiscal year? This has implications for FY performance or revenue

earnings, particularly if a payback is needed. Will there be an opportunity for comparing the state's data vs the agency's data before determining that an agency needs to pay back funds due to underutilization?

Answer: Although the reconciliation process has not been finalized, the question has come up in the payment model work group. DAIL is leaning towards the State fiscal year for ease of alignment with the State budgeting process, however this (any many other) decisions need to be made before finalizing the payment model. Agencies will receive a weekly remittance advice (RA) from Gainwell including information on all paid, zero-pay, denied, and suspended claims. Agencies can use this information to track utilization against their service plan expectations. Because the parameters of the payment model have not been finalized, it is not known at this time what additional reporting DAIL may need to give providers to monitor the expectations of the payment model, or any associated reconciliation rules. A gap between paid claims and approved encounter claims could represent either under-utilization or under-reporting, which would prompt different actions by the provider. While the reconciliation process has not been finalized, it is likely that the process would include an opportunity to comparing state to provider data prior to final decision related to payments for a FY.

6. Have you stated what the threshold for payback will be for reconciliation?

   Answer: No, that is still to be determined. Payment model work group discussions have discussed the possibility of an incremental approach that begins with a wider threshold to allow time for providers to adjust to what may be a change in their revenue, understanding that the threshold would narrow over a few years to a longer-term level. Again, stakeholder will have an opportunity to provide input into the design of the reconciliation process.

7. In which fiscal year will the reconciliation process start?

   Answer: We are not sure yet. It will not start until the new payment model has been designed and is ready for implementation. There are multiple steps to get to that point, so it definitely will not be FY22.

8. Is it possible when you make changes in the guidance (in the future) to mark them so we can easily tell what the changes are, instead of having to read through the entire document each time to try and find them?

Answer: Yes, there were a lot of changes with this last version, so we did not do that. Going forward, we can agree to send a memo to the providers outlining the changes and highlighting their location in the document.

9. Can you tell me where to access the AMA and Health Care Procedure Coding System manuals?

   Answer: These are commercially available manuals. They are available from a variety of vendors who are easily located online.

10. Will you be allowing 02 for telehealth?

    Answer: We have not yet set up the codes for reporting telehealth. Recent COVID-19 state of emergency specific telehealth expansions have further complicated the discussion. DAIL is working on this now and will have additional guidance soon.

11. For services paid for through ARIS, what provider IDs are used?

    Answer: The provider agency's HCBS provider ID is used in the billing provider field. ARIS's unique provider ID for encounter data will be entered in the rendering field. This will identify the encounter as a service that was paid for through ARIS rather than through the provider agency.

12. For billing of the PMPM for HCBS, is the threshold for billing one unit of service or 6 units?

    Answer: On 7/1/20 DAIL issued guidance defining the threshold for billing the PMPM as at least one unit of service in the month. On December 4, 2020 subsequent guidance was issued indicating that the threshold was increased to 6 units. See https://dail.vermont.gov/sites/dail/files//documents/DDSD_COVID_Flexibilities_FAQ_Nov_2020.pdf This change was related to the COVID 19 pandemic response. DAIL clarifies that the threshold for billing the PMPM is 6 units. This may be any 6 units of service across all service categories. The other rules related to suspensions and terminations outlined in the document linked above continue to apply.

13. Can you review the guidance related to providers contracting for adult day services?

    Answer: People who self or family manage can use community support funding to attend an adult day program. In that case, the encounter should be coded as community supports, group, facility-based using code T2021HW and place of service

code 39. ARIS will submit the claims for self/family managed services. For shared or agency-managed services, the same codes should be used, but the provider agency will submit the claims. These services should be paid for through a subcontract with the adult day program and not through ARIS.

14. Why do most activities have all service locations as approved locations?

    Answer: DAIL choose 5 location codes as allowable for the DDS encounter claims. DAIL did not want to get too prescriptive on a procedure code by procedure code basis, so all 5 service locations were set as allowable. However, it is expected that agencies use the correct place of service code for the service. For some services it could make sense that you set up in your system that certain procedure codes are associated with a single POS code. For example, residential services such as group homes could be associated with the code for home. In other circumstances, it is possible that a service would be provided in a number of the locations, so there would need to be the option for selecting the correct POS code.

15. Is the guidance saying we are only allowed to have 1 Individual therapy service per month?

    Answer: No. It is saying one individual therapy session per day. There may be rare circumstances where a person has a second session in a day and the subsequent session would need to include the 76 or 77 modifier to indicate that it was a separate session in the same day.

16. Could you please clarify whether there were Vermont definitions for procedure codes?

    Answer: Appendix B of the Encounter Data Submission Guidance includes a column labeled Service Description for each procedure code. This column includes the service description from the CPT or HCPCS manual and for some procedure codes, in parentheses, the Vermont name for that service. Additionally, Appendix C includes a Vermont DDS service definition for each service under the "Reportable" column.

17. In Section AA for 76 and 77 modifiers the guidance says "may use the 76 or 77 modifiers to report separate repeat encounters on the same day for the same service." Does MAY USE indicate Not required? We are facing an issue where we don't believe our EHR can do this in a manner that would be feasible or produce clean claims from the end users. Is this required? Or can we roll up each of these services into one claim per day even if it was performed by different staff people.

Thus, completely ignoring the 77 modifier and not using either of the 76 or 77 modifiers ever. Just one rolled up claim?

Answer: For most services, rolling up all the minutes of a service provided on the same day is allowable and is recommended. The exception is when the service is provided by clinicians billing with their own unique provider ID in the rendering field. If two different clinicians (billing with two unique provider IDs) provided a repeat of the same service on the same day, two encounters should be submitted, the second one with the 77 modifier. This would prevent a denied claim for a duplicate service.

18. When we have a client with Medicare and bill that first for therapy/psych services, Medicare does the cross over to FFS Medicaid and we receive an actual payment. Should that be recouped and then the agency would bill waiver?

Answer: The rules related to billing Medicare and third-party insurance prior to billing Medicaid have always been in place with Medicaid responsible for any remaining co-insurance and deductible after all other insurer payments have been made. HCBS services have historically been billed as a bundled payment that is not covered by other insurers. The services that may be covered by Medicare and third-party insurers are generally the clinical services such as psychiatry and therapy services. Now that the encounter claims will be submitted to the MMIS, regular Medicaid billing processes for identifying, and verifying payments from, other sources of insurance will be followed. When a person has other insurance, clinical services that are not billed to Medicare and third-party insurers first will be denied. DAIL is aware that there is additional work to be done to address both the mechanics of dealing with these claims as well as the program implications for providers and recipients. DAIL will continue to work on this issue and provide future guidance. In the short run, providers will continue to receive their monthly PMPM payments, but they will also receive denied encounter claims. There is no immediate issue with that as the process for reconciling paid claims to encounter data will not start in the near future.

To answer the question, at this point, when you receive revenue from Medicare, private insurance or Medicaid for clinical services, this amount should be shown as revenue received and deducted from your total annual allocation on your HCBS spreadsheet. Agencies have the option of tracking this type of revenue received over the FY and reflecting it just once on their June spreadsheet.

19. For camp codes, please clarify for a 2-week session of camp is it 14 units for 14 days?

    Answer: No, the unit would be 1 for 1 full session. Then the cost of the camp would be included on the encounter as the charged amount. Also, this is the one service we are allowing for the encounter and payment to be made ahead of receiving the service. This is because camp is typically prepaid. Because the MMIS cannot make a payment for a date of service in the future, the date of service can be the invoice date, rather than the date of actual attendance at the camp for this service only.

20. Page 10, Section O reads: "Encounter data for Shared Living may continue to be reported when a person is in a crisis bed so long as the Shared Living Provider (SLP) contract is in place. If there is no contract in place for an SLP, Shared Living is not being provided and there is no SLP to be paid. Funds can be shifted to crisis." In those circumstances when an individual does not have an identified SLP (under contract) and also not in a crisis bed (ex. VCIN), where should the funds be shifted to continue to pay for caregivers as the team works on securing an SLP. Should we still be shifted the funds from housing supports to crisis line in these situations and reporting out? Or respite? Given some of our more challenging individuals it can take months before another SLP is identified and that person bounces around from 2-3 different homes.

    Answer: If possible, you should enter into a short-term contract with an SLP and report out under Shared Living. If that is not possible, the SLP funds can be shifted to the service categories which will be used to provide the supports. Then, report out on whatever service category is actually delivered.

21. Do all the supervised billing modifiers apply to the Encounter Data? For instance, if we have someone who is a Licensed Clinical Social Worker provide an assessment, do you want us to submit the AJ modifier? If so, I assume the HW would be first correct?

    Answer: DAIL has not yet set up the DDS program with the supervised billing modifiers. This is another piece of encounter data work that is in progress. So, for now, providers should not add them to encounter claims for DDS because the MMIS has not yet been programmed to accept them as allowable procedure code/modifier combinations for DDS waiver.

22. In situations where there are 2 individuals in the same shared living home, but one of them is funded under the Choices for Care / Adult Family Care home program and

the other is funded by DDS, should we be submitting the code modifier for 2 people served for the DDS funded person even though one is in a different program?

Answer: No, use the 1:1 modifier. The DDS encounter data should reflect only those people funded through DDS.

23. For H2019, Therapeutic behavioral services, can you give us some examples of services that would be reported using this code?

Answer: Appendix B includes the codes/modifiers and the service name (there is the CPT or HCPCS name for the code as well as the Vermont name for the service in parentheses for some procedure codes). In Appendix C, under the Vermont service name, under the reportable column, there is definition of that service. So, specifically, here is the VT service name and definition for H2019 therapeutic behavior services:

Service Definition: *Behavioral Support, Assessment, Planning and Consultation Services* include evaluating the need for, monitoring, and providing support and consultation for positive behavioral interventions/emotional regulation.

Appendix C specifies that encounters are submitted under this code when they are provided by a behavior consultant rather than by the service coordinator who may be developing a behavior support plan and training staff on implementation as part of the person's ISA. Generally, on the HCBS spreadsheets that are submitted monthly to DAIL, there is a line item for this service under the Supportive Services heading. The behavior consultant may be an agency staff, or it could be a consultant contracted by the agency.

24. For S0215, non-emergency transportation, we usually attach the mileage to the service that is being provided, such as community supports. Should we report all non-emergency mileage under this code instead?

Answer: This code is only for those workers paid through ARIS, not agency staff. You should continue to include mileage as a component of the service being provided by agency staff or a subcontractor. In the future, that cost will be incorporated into the rate for each subcategory of service, so there is not a need to report mileage for agency staff or subcontractors. There is not a way to include infrastructure costs like this in the rates for workers paid through ARIS.

25. For S5415, we do not have any licensed shared living homes, so we are thinking we won't need to use this code unless we get a licensed shared living home in the future. Is this accurate?

    Answer: Yes. There is a slight mismatch between the national code definitions and the Vermont definitions. S5145 is for children and S5140 is for adults in national coding. For DDS, we say S5145 is for licensed and S5140 is for unlicensed. There is no problem in using S5140 for all SLPs serving adults. For kids, shared living homes are sometimes licensed because the child is in DCF custody and the home is considered a licensed foster home. On a rare occasion a child not in custody goes into SLP, and the home is not licensed. In these circumstances, the agency should use S5145 as the code, even if the home is not licensed. We will create alignment between the codes on the next version of the Medicaid Manual.

26. When would we use the S5160 or S5161 codes?

    Answer: These codes were set up for use by agencies who have a Remote Support option available. This type of support was first set up at the Howard Center and now a few other agencies are starting to use it as well. You would not use these codes unless your agency sets up the Remote Support service.

27. Would College Steps or Global Campus be the types of services that we would report under the T2012 code?

    Answer: T2012 should be used to report participation in College Steps, or other post-secondary program when HCBS funds are used to support participation. Global Campus participation is supported by grant funds, not HCBS, so you would not use T2012 for that service. However, if staff supports a person to participate in Global Campus, the staff person's time would be reported based upon the category of support being provided (e.g., community supports, respite, etc. using the codes identified for those services.)

28. When would we use the S5165 code? We have used one-time funding for home modifications, when appropriate. Should we use this code instead? Will we get reimbursed for home modifications?

    Answer: When HCBS funds are used to pay for Home Modifications, an encounter claim should be submitted using S5165. The claim should include the dollar amount spent on the modification. When one-time funds are used rather than HCBS, you would not submit an encounter claim. The use of one-time funds that are not HCBS are reported on separately to DDSD.

29. When should we use T2039 vehicle modifications?

    Answer: When HCBS funds are used to pay for Vehicle Modifications, an encounter claim should be submitted using T2039. The claim would include the dollar amount spent on expenses related to maintaining accessible transportation. All costs related to maintaining access to accessible transportation are allowable, up to the capped amount in the System of Care Plan which currently is $6,475 per year. Sometimes there are just short-term expenses like a repair and other times there are long term expenses like a loan or lease payment. One thing to note is if there are more than one type of expense in a single day, the costs should be added up for that day with one encounter claim being submitted. When one-time funds are used rather than HCBS, you should not submit an encounter claim. The use of one-time funds that are not HCBS are reported out separately to DDSD.

30. For the Group Living encounters, I am still not sure I completely understand what the coding will look like. If we have two staff on each shift, with three individuals in the home, does each staff enter their time for the shift in three separate entries? One for each individual in the home? For example, Staff X worked an eight-hour shift alongside Staff Y in a residential home that supports three people. Do both Staff X and Staff Y each submit three separate entries for the eight-hour shift? Would there be a separate entry for each client in the home, with each entry reporting 8 hours per client, using the T2033 HW code and the UP modifier? Also, if there are three eight hour shifts in any given day, do we report the encounters for each shift the same way?

    Answer: In terms of the encounter data for group homes, use T2033HW and the modifier that represents the typical size of the group home. For a 3-bed home, use UP; 4 bed home – UQ; 5 bed home – UR; and a 6-bed home – US. The number of staff working per shift on that day does not matter. Also, if there is a temporary vacancy or someone is absent on a given day, you should not adjust the modifier for number of people served. What you are reporting is whether an individual received services in a specific group home on a given day. So, staff reporting their time is not needed for the purposes of the encounter data. Eventually there will be a rate set for a day of service in a specific group home and the rates will take into consideration typical staff ratios.

    DAIL is trying to make it uncomplicated for providers as the staffing ratios and number of people receiving services in the home on any given shift is likely to be variable within and across days.

DAIL does not known exactly how your agency is setting up the flow of information from the provision of service to the generation of the encounter data. However, the only information that is needed for group home reporting is whether the person was in the home on a given day.

31. Our agency purchases accessible vans for individuals for their use. How should we submit the encounters for vehicle modifications (T2039)?

    Answer: You could submit one encounter for the year that includes the total amount allocated to the person for the year. You could also divide the total allocation for the year by 12 and submit one encounter per month with the monthly dollar amount.

32. For the T2021 code, are both the B01 individual and the B02 Group codes going to use all of the modifier codes listed in the packet? Or does the B01 use only the U1 and U2, and the B02 use the rest of them?

    Answer: Look at pages 58, 59 and 60 of the guidance, under the column heading HCBS service to see which modifiers to use for individual, group and group facility-based community supports. In order to set your system up correctly for reporting, you will need to look at the general guidance as well as all the Appendices.

33. For codes S5135 and T2017:
    a. Supervised Living has been changed to Code S5135 and the definition is to encounter just those claims that apply to individuals who receive supports in their own apartment or home.
    b. Code T2017 (formally supervised living) has changed to In-home Family Supports – meaning hourly home supports for individuals living with family caregivers and Shared Living hourly supports meaning hourly home supports for individuals living with SLPs.

    Can we assume that we do not need to delineate between In-Home Family Supports and Shared Living hourly home supports? All claims for these two services can be submitted with T2017.

    Answer: Yes, that is correct. You will use T2017 for both In-home Family Support and Shared Living hourly supports. If there is a need to distinguish who received each service (by state or providers), reports can be run to query who received SLP services and service encounters submitted under T2017 and who had encounter claims using T2017 without SLP services.

34. Our agency serves 2 sisters who see a therapist together – because 90847 Family psychotherapy only has a U1 modifier, can 90853 Group psychotherapy be used for this service?

    Answer: No, when family psychotherapy is provided, the claim only includes one "identified patient" for the purposes of billing. The clinician chooses one of the family members. See the CPT manual for billing instructions.

35. T2012 Post-Secondary Education and Technical Training Support. Can this code be used for those students in Project Search who are funded by Medicaid Waiver Funds?

    Answer: Yes, T2012 was identified as the code to use to report participation in Post-secondary Education and Technical Training programs that are funded through Home and Community-based (aka "waiver") funds. Project Search is considered a Technical Training program. Additional information will be provided soon to agencies and the Post-secondary Education and Technical Training programs regarding reporting of encounter data.

36. Code S5161 Remote Support – Our agency has 5 individuals using Safety Connections, a remote support program. We currently pay a stipend to each local responder to be "available" if a problem arises and we pay Howard Center for monthly on-going daily check-ins. The individuals contact Howard Center each evening. Our local responder sends a text to the Howard Center to say they are the responder for the evening, if something comes up, but they don't go out unless contacted by the Howard Center. How do we encounter the stipend? We have 2 monthly encounters for the same service, one to the Howard Center and one to our Responder.

    Answer: The full monthly amount for providing remote support should be included on the claim. In other words, add up all the costs for the month and submit one claim for the month. Alternatively, you may add the cost of the remote support fee, plus the stipend amount and submit that as monthly claim under S5161 and use the Supervised Living code (S5135) for a separate encounter when the on-call worker needs to provide in-person support.

37. Code (T2039) Transportation Services – Vehicle Modifications –

    a. We have 3 families that have vans funded through the HCBS. I see from the definition that these cannot be encountered.

       Answer: Individuals living in their family home was inadvertently deleted from the service definition. Vehicle modification is available to individuals living at home with their family. The guidance will be corrected to include those individuals.

    b. The definition also says "add up all costs for dates of service for the individual" does that mean they do not actually have to be entered on the date of service? Can we add up the services for the month and enter a claim?

       Answer: The encounter data should reflect the date a service was received. However, multiple encounters cannot be submitted for the same date of service. So, if any dates of service overlap, add the costs together and submit as one claim. For example, a monthly lease payment and a repair might overlap on the same day. In that case, add the costs together and submit one claim for that date of service. Because there may be more than one expense during a month, and in an effort to avoid a duplicate claim denial, it may be easier to not use a date range for example, the first to the last date of the month, on a claim for the monthly lease or loan payment. Instead, you could use the date of service on the invoice. It is important to note that a claim cannot be submitted for a date of service that is in the future.

    c. "maintenance of accessible transportation" – Would like clarification of what to encounter. Lease/Loans, outright purchase, repairs, inspection, registration, insurance. Example: outright purchase for $35,000 equals one encounter.

       Answer: All costs related to maintaining access to accessible transportation are allowable, up to the capped amount in the System of Care Plan which currently is $6,475 per year. The full purchase amount of $35,000 would not be allowed on a claim.

38. If we have one staff person providing service to two different individuals, for four hours, as an example, how do we record that with the new modifier codes? Do we bill each supported individual for the full four hours and use the UN modifier code

for each? Or do we split the four-hours between the two individuals and bill two hours to each individual using the UN modifier code?

Answer: For two people supported at the same four hours by one staff person, there should be an encounter for each person for 4 hours, using the UN modifier.

39. Here is a scenario of an SLP who hires a respite provider and is paying a daily rate, but the individual also goes out during the day for community supports. The respite provider has historically been paid 24 hour supports through the respite daily code. The employer considers the worker to be "on-call" as needed to provide care if the community supports were unsuccessful or unexpectedly unavailable. As a result, during these days, the individual could receive daily respite and hourly community support at the same time. Given the new requirements for submitting encounter data, there is a concern that the encounters would show that the person is receiving more than 24 hours of care in the same day (24 hours of respite + the community support hours).

    If the employer shifts to paying the respite worker hourly, then she will pay a higher hourly rate than she pays through the daily rate code. It could also result in the need to pay for a greater number of hours since up to 8 hours of sleep time can be excluded when using the daily rate code.

    How should the workers be paid and what worker to consumer ratios should be used?

    Answer: The US Department of Labor (DOL) has rules related for when workers must be paid. Here is a fact sheet from the USDOL that outlines when workers must be paid: https://www.dol.gov/agencies/whd/fact-sheets/79d-flsa-domestic-service-hours-worked

    Under the section around sleep hours, it indicates that when a person is working a 24-hour shift, up to 8 hours of sleep time may be excluded when the person is provided a place to sleep, and they get at least 5 uninterrupted hours of sleep. If the shift is less than 24 hours, sleep time cannot be excluded, and a worker must be paid on an hourly basis.

    In another section of this document labeled "hours worked", it indicates that a person can be considered working when they are "engaged to wait". What this means is that the person may not be working directly with the person, but they are

not free to use the time as they want. They need to be available if the person needs support as soon as help is needed.

So, in the circumstance described above, the employer would need to determine whether the respite worker was considered "engaged to wait" or whether they were actually free to use the time as they desired. If the worker is considered engaged to wait, they may be considered working and they could continue to use the daily rate (if they also meet the criteria for excluding sleep hours described above). If they are not "engaged to wait", the worker needs to be paid hourly. It is the responsibility of the employer to determine whether they can use the daily respite code and to have an agreement with the employee regarding expectations for the hours where they are "engaged to wait". Employer may consult the VT DOL for assistance in interpreting DOL rules. (802-828-4000)

Because the reporting will be under two separate service categories, the MMIS system would not process the encounter claims as a duplicate service, nor would each service exceed the 24-hour limit. Also, because the service is provided 1:1 for each of the workers during the time they are supporting the person, they should use 1:1 staffing ratio.

40. Can we submit encounters for the individuals paid through HCBS funding for non-HCBS funded individuals? This area specifically refers to a portion of the "Employment Program Base annual cost" column of our HCBS spreadsheet. Funding in this column is used to provide employment supports to individuals who do not have HCBS funding. This was put in place to replace a service previously funded by VR. If we attach the claim to them, would the encounter claim get kicked back as a non-waiver individual?

    Answer: The MMIS system for encounter claims for DDS HCBS was not set up to verify that the person is authorized for HCBS funding. However, it is set up to recognize whether the person has VT Medicaid. So, the encounter claims for these individuals should be approved as long as the person is currently enrolled in VT Medicaid.

41. I am paid through ARIS and I work with someone 1:1 and 2:1 during the same day for a daily respite service. Half the time it is 1:1 the other half of the time it is 2:1, how do I code this if it is a daily rate?

    Answer:

    - The worker who is providing daily respite would use the daily respite code and 2:1 staffing ratio.

- The worker providing hourly respite would use the hourly respite code and use the 2:1 staffing ratio (DOL rules require that this worker be paid hourly because it is a less than 24-hour shift.)
- Because two separate codes are being used, there will be two encounters entered for that day, one for daily respite and one for hourly. Because two codes are used, MMIS will not process this as a duplicate and the 24-hour limit will not be exceeded.
- Each encounter will be "valued" at the amount paid to each worker, plus employer taxes.
- The 2:1 staffing ratio will indicate for informational purposes that this is not a duplicate service.

42. If we are paying a therapist that is not employed by our agency via HCBS funding to provide psychotherapy services, are we required to include their NPI, or because they are not employed by the agency and it is a zero-pay claim, we can leave that out?

Answer: Generally, we would want to see the NPI of the rendering clinician on the claim. However, we understand that there is a potential issue with including the NPIs of clinicians that are not associated with your agency. We will need to conduct some more research on this question before providing further guidance.