Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

'401' Behavioral Health Redesign Webinar

May 22, 2017

Behavioral Health Redesign

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Good Morning:

Welcome to the BH Redesign "401" webinar that is scheduled 10:00 am until 3:00 pm. We will begin promptly at 10:00 and will be recording the webinar.

We will break as close to 12:00 noon as possible for a one hour lunch.

We will be tracking questions using the webinar interface but please keep in mind that due to the volume of registrations/participants, we are unlikely to be able to answer every question.

Audio is available via either your computer or by telephone by calling +1 (415) 930-5321. The telephone audio PIN is shown after you join the webinar.

The slide deck is available via download through the webinar control panel and it will be posted to the bh.medicaid.ohio.gov website along with the recording.

Behavioral Health Redesign

Agenda

- Welcome and Opening Remarks
- Policy Updates
- BH Redesign and Managed Care
- BH Redesign Benefit Package: Mental Health
- H2017 and H2019: Different Uses
- Nursing Scope of Practice – RNs and LPNs
- Crisis Services
- BH Redesign Benefit Package: Substance Use Disorder (SUD) Services
- ASAM Outpatient Level of Care 1 SUD Group Counseling
- ASAM Outpatient Level of Care 2 Intensive Outpatient and Partial Hospitalization
- Staffing for ASAM Residential Levels of Care
- Benefit Administration Timeline, Policies, and Program Integrity
  - Services Which are - ALWAYS Prior Authorized -
  - Services With Prior Authorization - Per Billing Provider -
  - Services With Prior Authorization - Per Medicaid Enrollee -
  - Services With - No State-Defined Benefit Limits -
- Coordination of Benefits
- Supervision Requirements
- Reporting Supervisor

- Practitioner Enrollment and Affiliation
- Resources on How to Enter a Prior Authorization
- National Correct Coding Initiative (NCCI)
- Peer Recovery Support
- Medicaid-Funded Assertive Community Treatment (ACT)
- Intensive Home-Based Treatment (IHBT)
- Care Coordination
- ODM and OhioMHAS Rules Update
- Stakeholder Resources
- BH Redesign Work Book Updates
- Urine Drug Screening Recent Update
- Place of Service Recent Updates
- Documentation Requirements Recent Update
- IT Resources and EDI File Testing (Fee for Service)
- BH Monitoring
- BH Redesign Website

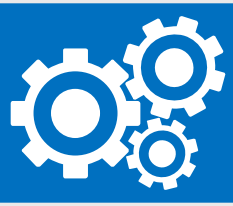
Ohio Medicaid Behavioral Health Redesign Initiative

The Redesign Initiative is an integral component of Ohio's comprehensive strategy to rebuild community behavioral health system capacity

The Initiative is based on key Medicaid behavioral health reforms implemented in four steps:

Elevation
Financing of Medicaid behavioral health services moved from county administrators to the state.

Expansion
Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 500,000 residents with behavioral health needs.



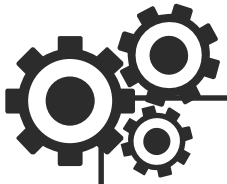
Modernization
ODM and OhioMHAS are charged with modernizing the behavioral health benefit package to align with national standards and expand services to those most in need

Integration
Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.

Ohio Medicaid Behavioral Health Redesign Initiative - Where We Are Today

Elevation – ***Completed*** as of July 1, 2012.

Expansion – ***Completed*** as of January 1, 2014.



Modernization – Underway, ODM and OhioMHAS are modernizing the community behavioral health benefit package to align with national standards and expand services to those most in need. **Implementation on target for July 1, 2017.**

Integration – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. **Implementation on target for January 1, 2018**.

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Policy Updates

Behavioral Health Redesign

Policy Updates

Refer to slides 38, 41 – RNs/LPNs

1

Medicaid coverage of a "doctor and a nurse on the same day"

Solution

- ODM has revised the reimbursement policy to allow a provider to be reimbursed for a physician visit (Evaluation and Management code) and a Registered Nurse (RN)/Licensed Practical Nurse (LPN) nurse visit (H-code, T-code) on the same day
  - RN: H2019/T1002
  - LPN: H2017/T1003

Policy Updates

Refer to slide 69 – ASAM staffing

2

Staffing Requirements for SUD Residential

Solution

- ODM removed from its rules any language regarding staffing requirements in the Substance Use Disorder (SUD) rules
- Providers will need to document, in accordance with general Medicaid policy, the services provided in the residential setting and adhere to the ASAM criteria for each level of care

Policy Updates

Refer to slides 30, 31 on MH Day Treatment & slides 57, 62 on SUD IOP & slide 65 on SUD PH

3 MH Day Treatment, SUD Intensive Outpatient and SUD Partial Hospitalization

Solution

- ODM has revised the reimbursement policy to allow a provider to be paid for day treatment and a group counseling service on the same day – same policy has been implemented for SUD IOP and SUD PH

Policy Updates

Refer to slide 99 – Supervision Requirements section & slide 107 – General Supervision

4 General Supervision vs. Direct Supervision

Solution

- ODM revised the minimum supervision requirements for psych assistants, social work trainees, marriage and family therapist trainees, counselor trainees, chemical dependency counselor assistants to general supervision (supervisor available by phone)
  - Direct supervision will be optional for these practitioners providing CPT codes

- Note: Payment rate will differ for general versus direct supervision for these practitioners:
  1. Trainees/Assistants under general supervision will receive 85% of their supervisor's rate
     - Psych assistants: 85% of 100%
     - Social worker trainees, marriage and family therapist trainees, counselor trainees, and chemical dependency counselor assistants: 85% of 85% (72.25%)
  2. Trainees/Assistants billing CPT codes under direct supervision will receive their supervisor's rate if the supervisor's NPI is on the claim in the supervisor field and their practitioner modifier is also reported

Policy Updates

Refer to slide 164 – Documentation Requirements

5

Documentation Standards

Solution

- Documentation requirements in the rules were aligned to eliminate confusion between the ODM and OhioMHAS rules

Policy Updates

Refer to slide 161, 162 – POS 23, 99 updates

6

Places Of Service (POS) 23 & 99

Solution

- ODM pays for certain behavioral health services when rendered in an emergency room setting (POS 23) or in the community (POS 99). See July 1, 2017 BH Provider Manual for specific guidance.
- Note: Federal law prohibits Medicaid payment for services rendered when someone is incarcerated (42 CFR 435.1009)

Policy Updates

7 Transportation

Solution

- ODM modified its rules to clarify that transportation in and of itself is not reimbursable
- The expectation under general Medicaid rules applicable to all providers is that the nature of the services will be properly documented to support medical necessity

Policy Updates

Refer to slide 139 – ACT Eligibility & slide 143 – ACT Checklist

8

Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) for Assertive Community Treatment (ACT)

Solution

- State will allow an SSI or SSDI determination to stand in the place of an Adult Needs and Strength Assessment (ANSA) score, assuming all other eligibility criteria for ACT are met

Policy Updates

Refer to slide 71 – Updated Timeline

9 Continuity of Fee-For-Service (FFS) Rates for Managed Care

Solution

- MCPs (including MyCare) will keep the FFS rates as a floor for what they pay through December 31, 2018
- There will be an 18 month period with FFS rates for MyCare as they start in July. MyCare Plans will follow FFS prior authorization policies for a 12 month period.

Policy Updates

Refer to slide 23 – CBHC Labs

10

Community Behavioral Health Center (CBHC) Laboratories

Solution

- When the MyCare plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare plan is directed to accept the CBHC laboratory into their panel to allow for continuity of care
- MyCare plans may negotiate with CBHC laboratories

Policy Updates

11 Outpatient Hospital Clinics

Solution

- ODM will allow hospital-based agencies to maintain provider types 84 and/or 95 if they choose to until January 1, 2018, but must comply with all other aspects of BH Redesign on July 1, 2017
- Note: If a hospital has received the Joint Commission's behavioral health accreditation, OhioMHAS will deem them certified

Policy Updates

Refer to slide 42 – TBS/PSR Reimbursement

12 Therapeutic Behavioral Services (TBS) / Psychosocial Rehabilitation (PSR)

Solution

- TBS/PSR services rendered in an office (POS 11) or a CMHC (POS 53) for more than 90 minutes provided by the same agency, to the same recipient, on the same calendar day will be paid at 50% of the rate. TBS/PSR services provided in all other places of services will be paid at 100% of the rate after 90 minutes.

Policy Updates

13

Collateral Contacts

Solution

- A Medicaid reimbursable collateral contact, as referred to in Ohio Administrative Code rules 5160-27-04 and 5160-27-08, occurs when the practitioner contacts individuals who play a significant role in a Medicaid recipient's life
- The information gained from the collateral contact can provide insight into treatment OR basic psychoeducation provided to that collateral contact can assist with the treatment of the Medicaid recipient

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BH Redesign and Managed Care

Behavioral Health Redesign

Medicaid Managed Care Plans - Today

buckeye health plan.

CareSource®

MOLINA HEALTHCARE

PARAMOUNT

UnitedHealthcare Community Plan

BH Services are "CARVED OUT" Until January 1, 2018

- *Ohio **Medicaid** recipients enrolled in a Medicaid managed care plan can receive community behavioral health services through any participating Medicaid BH Provider agency.*
- ***Two Exceptions: Respite & all inpatient psychiatric services as of July 1, 2017 (including Institutions for Mental Diseases-IMDs)***
- *Coordinated or associated primary health care, (pharmacy, laboratory services) are the responsibility of MCPs. Check for any needed prior authorization.*

*Paramount is a Medicaid Managed Care Plan **but not** a MyCare plan*

MyCare Ohio Managed Care Plans - Today

aetna®
AETNA BETTER HEALTH® OF OHIO

buckeye health plan.

CareSource®

MOLINA HEALTHCARE

UnitedHealthcare®
Community Plan

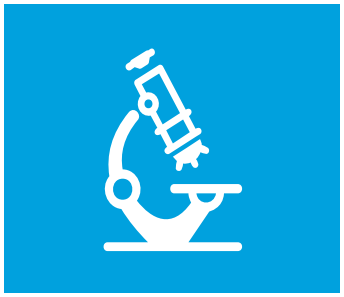
BH Services are "CARVED IN"

- *Ohio **Medicare and Medicaid** recipients enrolled in a MyCare Ohio plan receive community behavioral health services through their MyCare Plan.*
- *Providers will need to be contracted with MyCare Plan and MAY need prior authorization for certain services.*

*Aetna is a MyCare plan **but not** a Medicaid Managed Care Plan*

Community Behavioral Health Center (CBHC) Laboratories for MyCare

Refer to slide 16 – Policy Update #10



Guidance

- When the MyCare plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare plan is directed to accept the CBHC Laboratory into their panel to allow for continuity of care.

- CBHC laboratories are *not* included in policy that MyCare plans must maintain 100% of FFS as a floor – just the BH benefit package.
- MyCare plans will be able to negotiate payments.

- For non-laboratory providers with a CLIA waiver, information on how to add this will come as soon as possible.

MyCare Prior Authorization

Starting in June 2017, MyCare plans will begin processing prior authorization requests for ACT and IHBT. MyCare plans will begin processing prior authorization requests for all other BH services (per state defined limits) in July, 2017.

MyCare plans will follow established procedures for prior authorization of BH services.

However, prior authorization requests **must be expedited in *3 days*** for the following services:

- ***ACT***
- ***IHBT***
- ***SUD Residential***

Reminder: Providers can request expedited prior authorization for any service.

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

BH Redesign Benefit Package: Mental Health

Behavioral Health Redesign

BH Redesign Changes Support the Treatment of Mental Illness

Efforts

- ✓ Expanding MH Benefit package
- ✓ Adding family psychotherapy both with and without the patient
- ✓ Adding primary care services, labs & vaccines
- ✓ Adding coverage for psychotherapy, psychological testing
- ✓ Adding evidence based/state best practices:
  - Assertive Community Treatment (ACT) - adults with SPMI
  - Intensive Home-Based Treatment (IHBT) - youth at risk of out of home placement
- ✓ Expanding community based rehabilitation: Therapeutic Behavioral Services (TBS) & Psychosocial Rehabilitation (PSR) & maintaining coverage of Community Psychiatric Supportive Treatment (CPST)
- ✓ Maintaining prior authorization exemption for second generation antipsychotic medications when dispensed by physicians with a psychiatric specialty and in the standard tablet/capsule formulation

Medicaid Mental Health Benefit – Pre July 1, 2017

Psychiatric Diagnostic Evaluation w/ Medical

Assessing treatment needs & developing a plan for care

Mental health Assessment

Assessing treatment needs & developing a plan for care

Pharmacological Management

Services provided by medical staff directly related to MH conditions and symptoms

Partial Hospitalization

Teaching skills and providing supports to maintain community based care

Crisis Intervention

Services for people in crisis

Community Psychiatric Supportive Treatment (CPST)

Care Coordination

Mental health counseling

Individual and group counseling may be provided by all credentialed practitioners

Respite for Children and their Families

Providing short term relief to caregivers

Office Administered Medications

Long Acting Psychotropics

Medicaid Mental Health Benefit – July 1, 2017

Psychotherapy CPT Codes
Individual, group, family and crisis

Psychiatric Diagnostic Evaluation
Assessing treatment needs & developing a plan for care

Medical
(Office/Home, E&M, Nursing)
Medical practitioner services provided to MH patients

Assertive Community Treatment (ACT)
Comprehensive team based care for adults with SPMI

Intensive Home-Based Treatment (IHBT)
Helping SED youth remain in their homes and the community

Group Day Treatment
Teaching skills and providing supports to maintain community based care

Crisis Services
Covered under crisis psychotherapy and other HCPCS codes

Community Psychiatric Supportive Treatment (CPST)
Care Coordination

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Screening and brief interventions for substance use disorder(s)

Therapeutic Behavioral Service (TBS)
Provided by paraprofessionals with Master's, Bachelor's or 3 years experience

Psychosocial Rehabilitation (PSR)
Provided by paraprofessionals with less than Bachelor's or less than 3 years experience

Respite for Children and their Families
Providing short term relief to caregivers

Office Administered Medications
Long Acting Psychotropics

Psychological Testing
Neurobehavioral, developmental, and psychological

MH Outpatient: Medical Services

Medical Service CPT Codes
99201-99205 – Evaluation and Management, Office, New Patients
99211-99215 – Evaluation and Management, Office, Established Patients
99341-99345 – Evaluation and Management, Home, New Patients
99347-99350 – Evaluation and Management, Home, Established Patients
+99354 – Prolonged service-first hour
+99355 – Prolonged Service-each add. 30 mins
+90833 – Psychotherapy add on, 30 min
+90836 – Psychotherapy add on, 45 min
+90838 – Psychotherapy add on, 60 mins
+90785 – Interactive Complexity
96372 – Therapeutic Injection

All codes are subject to NCCI edits

MH Group Day Treatment - Hourly

Refer to slide 9 – Policy Update #3

	Rate Development and Methodology	
H2012	85% of the bachelor's rate for QMHS+3	$15.76 Hourly Per Person
H2012	Assumes 1 hour of unlicensed BA providing group activities in an average group size of four for rate setting purposes	$18.54 Hourly Per Person
H2012	Assumes 1 hour of unlicensed MA providing group activities in an average group size of four for rate setting purposes	$21.05 Hourly Per Person
H2012	Assumes 1 hour of licensed practitioner providing group activities in an average group size of four for rate setting purposes	$28.10 Hourly Per Person

MH Group Day Treatment: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio
   a. For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the unit (30+ minutes). Service is billed in whole units only.
   b. If person doesn't meet the minimum, 90853 or H2019 (HQ: Modifier for group) may be used.
2. Other services must be billed in addition to H2012. H2012 can only be billed if the person attends the minimum amount of time (30+ minutes) in a group which doesn't exceed the practitioner to client ratio.

MH Group Day Treatment - Per Diem

Refer to slide 9 – Policy Update #3

	Rate Development and Methodology	
H2020	85% of the bachelor's rate for QMHS+3	$88.87 Per Diem Per Person
H2020	Assumes 5 hours of unlicensed BA providing group activities in an average group size of four for rate setting purposes	$104.55 Per Diem Per Person
H2020	Assumes 5 hours of unlicensed MA providing group activities in an average group size of four for rate setting purposes	$117.05 Per Diem Per Person
H2020	Assumes 5 hours of licensed practitioners providing group activities in an average group size of four for rate setting purposes	$140.51 Per Diem Per Person

MH Group Day Treatment: Additional Details

1. Maximum group size: 1:12 Practitioner to client ratio
   a. For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the per diem (2.5+ hours).
   b. If person doesn't meet the minimum, 90853, H2019 HQ, or H2012 may be used.
   c. Service is billed in whole unit only.
   d. Other services must be billed in addition to H2020. H2020 can only be billed if the person attends the minimum amount of time in a group (2.5+ hours) which doesn't exceed the practitioner to client ratio.
2. ***Only one H2020 per diem, per patient, per day***
3. ***Must be nationally accredited***
4. ***Must be supervised by a licensed independent practitioner***

Expanded Medicaid Managed Care Respite Service

On February 1, 2017, Medicaid respite services became available for children with mental health needs who are enrolled in Medicaid Managed Care. The definition of "respite services," eligibility criteria and provider qualifications are described in Ohio Administrative Code rule 5160-26-03.

Requests for coverage of respite services must be made to and approved by the child's managed care plan in accordance with the OAC rule requirements, as this service is fully "carved in."

A MITS Bits detailing this update was released on Feb. 6th and can be found at:
http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/bh-mits-bits-respite-service-and-policy-change.pdf

Policy Reminder

Children's BH Services

No diagnosis edits for children services provided by licensed practitioners

Intensive Home-Based Treatment (IHBT)
- *OhioMHAS certification*
- *Fidelity Review by CWRU meeting Medicaid requirements*
- *Prior Authorization*

Additional Services
- *Psychological Testing*
- *Vaccinations via VFC program*

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H2017 and H2019: Different Uses

Behavioral Health Redesign

Mental Health Services-Therapeutic Behavioral Services (TBS) and Psychosocial Rehabilitation (PSR)

TBS are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's treatment plan. ((OAC) 5160-27-08)*

PSR assists individuals with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with an individual's behavioral health diagnosis. ((OAC) 5160-27-08)*

*TBS and PSR are services provided by unlicensed mental health practitioners

Therapeutic Behavioral Services
H2019 HN – TBS, office (Bachelor's)
H2019 HO – TBS, office (Master's)
H2019 UK – TBS, office (QMHS: high school and 3 years+ experience)
H2019 HN HQ – TBS, office, group (Bachelor's)
H2019 HO HQ – TBS, office, group (Master's)
H2019 UK HQ – TBS, office, group (QMHS: high school and 3 years+ experience)
H2019 HN – TBS, home or community, (Bachelor's)
H2019 HO – TBS, home or community (Master's)
H2019 UK – TBS, home or community (QMHS: high school and 3 years+ experience)
Psychosocial Rehabilitation
H2017 HM – PSR, office, (less than a Bachelor's/less than 3 years experience)
H2017 HM – PSR, home or community (less than a Bachelor's/less than 3 years experience)

MH TBS or PSR Services Provided to Patients in Crisis

Guidance for Providing TBS or PSR to Patients in Crisis

Unlicensed practitioners may only provide and bill Medicaid for TBS or PSR provided to a patient in a crisis only if the recipient of the intervention(s):

1) is known to the system (agency)
2) is currently carried on the unlicensed practitioner's caseload (they know each other), and
3) a licensed practitioner has recommended care.

MH TBS or PSR Crisis Billing for Unlicensed Practitioners

H2019

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

- Per 15 minutes: **Master's, Home/Cmty**
- Per 15 minutes: **Bachelor's, Home/Cmty**
- Per 15 minutes: **QMHS+3, Home/Cmty**
- Per 15 minutes: **Master's, Office**
- Per 15 minutes: **Bachelor's, Office**
- Per 15 minutes: **QMHS+3, Office**

H2017

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

- Per 15 minutes: **Less than Bachelor's, Home/Cmty**
- Per 15 minutes: **Less than Bachelor's, Office**

All codes are subject to NCCI edits

MH Registered Nurse Providing Nursing Services to a Patient in a Crisis

Guidance for Registered Nurses Providing Crisis Services

Registered Nurses may provide crisis nursing services regardless of:

- Whether or not the individual is on their case load; or
- Whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).

MH Registered Nurse Providing Nursing Services to a Patient in a Crisis Billing Guidance

H2019	Per 15 minutes: **Home/Cmty**	
UT modifier will be used to differentiate a crisis service vs. a non-crisis service	Per 15 minutes: **Home/Cmty**	
	Per 15 minutes: **Office**	
	Per 15 minutes: **Office**	

All codes are subject to NCCI edits

MH Nursing Services by Registered Nurses and Licensed Practical Nurses

Refer to slide 7 – Policy Update #1

HCPCS Codes for Nursing Activities

Registered Nurse

H2019 - Home/Community, per 15 minutes

H2019 - Office, per 15 minutes

H2019 HQ - Office, Group, per 15 minutes

Licensed Practical Nurse

H2017 - Home/Community, per 15 minutes

H2017 - Office, per 15 minutes

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Nursing Scope of Practice – RNs and LPNs

Behavioral Health Redesign

RN/LPN Scopes of Practice

Ohio Medicaid follows the guidance of the Ohio Board of Nursing regarding the Scopes of Practice for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs)

The Ohio Board of Nursing guidance on nursing scope is here: http://www.nursing.ohio.gov/PDFS/Practice/RN_and_LPN_Scope_of_Practice.pdf
Questions regarding RN or LPN scope of practice should go to the Board of Nursing at practice@nursing.ohio.gov.

What services can a nurse perform?
Any service or activity that falls within their professional scope of practice as defined by the Ohio board of Nursing. If a nurse performs the service, it should be billed as a nursing service.

- Note that the scopes for RNs and LPNs is significantly different. Activities are not interchangeable.

Each licensee is responsible for knowing and working within their scope of practice.

Registered Nurses and Licensed Practical Nurses

For services provided on and after July 1, 2017, the following CPT/HCPCS codes will be available for nursing activities rendered by RNs or LPNs as a replacement for MH pharmacological management (90863) and SUD medical/somatic (H0016) for all agencies:

CPT/HCPCS Codes for Nursing Activities

Refer to slide 7 – Policy Update #1

SUD	SUD & MH	MH
T1002	99211	H2019
T1003	96372	H2017
H0014		
H0048		

Note: used for Level 2-Withdrawal Management

Key Takeaways

1. Registered Nurses and Licensed Practical Nurses will need to enroll with Ohio Medicaid because they will be expected to be a rendering provider
2. When not billing with 99211, please be sure to select the correct code.

All codes are subject to NCCI edits

Recent Update: TBS/PSR Reimbursement

Refer to slide 18 – Policy Update #12

For TBS/PSR services rendered in a office (POS 11) or a community health center (POS 53) –

- Medicaid reimbursement for greater than 90 minutes of TBS/PSR services provided by the same billing provider, to the same recipient, on the same calendar day will be paid at 50% of the rate

All other places of services will be paid at 100% after 90 minutes.

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Crisis Services

Behavioral Health Redesign

Psychotherapy for Crisis Situations*

A new code has been added for psychotherapy for a patient in crisis

When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes

All codes are subject to NCCI edits

*** Guidance from - National Council for Behavioral Health, *CPT Code Changes for 2013: Impact on Behavioral Health Webinar*; November 9, 2012.**

Psychotherapy for Crisis Services Defined*

Psychotherapy for Crisis Services Definition

"An urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress."

*** Guidance from - National Council for Behavioral Health, *CPT Code Changes for 2013: Impact on Behavioral Health Webinar*; November 9, 2012.**

Psychotherapy for Crisis Services*

Presenting Problem

- Typically life-threatening or complex and requires immediate attention to a patient in high distress
- Codes include:
  - Urgent assessment and history of crisis state
  - Mental status exam
  - disposition

Treatment Includes

- Psychotherapy
- Mobilization of resources to diffuse crisis and restore safety
- Implementation of psychotherapeutic interventions to minimize potential for psychological trauma

Codes for crisis services CANNOT be reported in combination with:

- 90791, 90792 (diagnostic services)
- 90832-90838 (psychotherapy)
- +90785 (interactive complexity)

*** Guidance from - National Council for Behavioral Health, *CPT Code Changes for 2013: Impact on Behavioral Health Webinar*; November 9, 2012.**

Psychotherapy for Crisis Services*

- 90839 Psychotherapy for crisis; first 60 minutes
- +90840 Each additional 30 minutes
- Used to report total duration of face-to-face time with the patient and/or family providing psychotherapy for crisis
- Time does not have to be continuous but must occur on same day
- Provider must devote full attention to patient and cannot provide services to other patients during time period.

- 90839 (60 min) used for first 30-74 minutes
- Reported only once per day
- +90840 (each additional 30 min) report for up to 30 minutes each beyond 74 minutes
- Example: 120 min of crisis therapy reported:
  - 90839 X 1
  - +90840 X 2
- Less than 30 minutes reported with codes 90832 or +90833 (psychotherapy 30 min)

***Guidance from - National Council for Behavioral Health, *CPT Code Changes for 2013: Impact on Behavioral Health Webinar*; November 9, 2012.**

MH and SUD Crisis Services by Licensed Practitioners

Guidance for Licensed Practitioners Providing Crisis Services

Licensed practitioners may provide crisis care regardless of:

- Whether or not the individual is on their case load; or
- Whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).

If a licensed practitioner is providing the intervention, 90839 is billed. +90840 can be billed for each additional 30 minutes.

90839	Psychotherapy for crisis; first 60 minutes	MD/DOs and psychologists All other licensed practitioners*
+90840	Psychotherapy for crisis; each additional 30 minutes	MD/DOs and psychologists All other licensed practitioners*
90832 UT	Based on Medicare, can be billed with a UT crisis modifier if crisis service does not reach 31 minutes	MD/DOs and psychologists All other licensed practitioners*

*** Review supervision requirements for billing guidance**

All codes are subject to NCCI edits

MH and SUD Crisis Services by Unlicensed Practitioners

Guidance for Unlicensed Practitioner Providing Crisis Services

For unlicensed practitioners, crisis may only be billed to Medicaid if the recipient of the intervention is known to the system, currently carried on the unlicensed practitioner's caseload, and a licensed practitioner has recommended care.

If an unlicensed practitioner is providing the service to someone on their caseload, the practitioner will bill:

SUD Crisis Billing for Unlicensed Practitioners

H0004 UT

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

- Per 15 minutes

MH Crisis Billing for Unlicensed Practitioners

H2019 UT

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

- Per 15 minutes: **Master's, Home/Cmty**
- Per 15 minutes: **Bachelor's, Home/Cmty**
- Per 15 minutes: **QMHS+3, Office**
- Per 15 minutes: **Master's, Office**
- Per 15 minutes: **Bachelor's, Office**
- Per 15 minutes: **QMHS+3, Office**

H2017 UT

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

- Per 15 minutes: **Less than Bachelor's Home/Cmty**
- Per 15 minutes: **Less than Bachelor's Office Setting**

All codes are subject to NCCI edits

RN Nursing Services Delivered to a Patient in Crisis

Guidance for Registered Nurses Providing Crisis Services

Registered Nurses may provide crisis care regardless of:

- Whether or not the individual is on their case load; or
- Whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).

Mental Health

H2019 UT

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

Per 15 minutes: **Home/Cmty**
Per 15 minutes: **Home/Cmty**

Per 15 minutes: **Office**
Per 15 minutes: **Office**

Substance Use Disorder

T1002 UT

UT modifier will be used to differentiate a crisis service vs. a non-crisis service

Per 15 minutes: **Home/Cmty**
Per 15 minutes: **Home/Cmty**

Per 15 minutes: **Office**
Per 15 minutes: **Office**

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

BH Redesign Benefit Package: Substance Use Disorder (SUD) Services

Behavioral Health Redesign

Medicaid Substance Use Disorder Benefit – Pre July 1, 2017

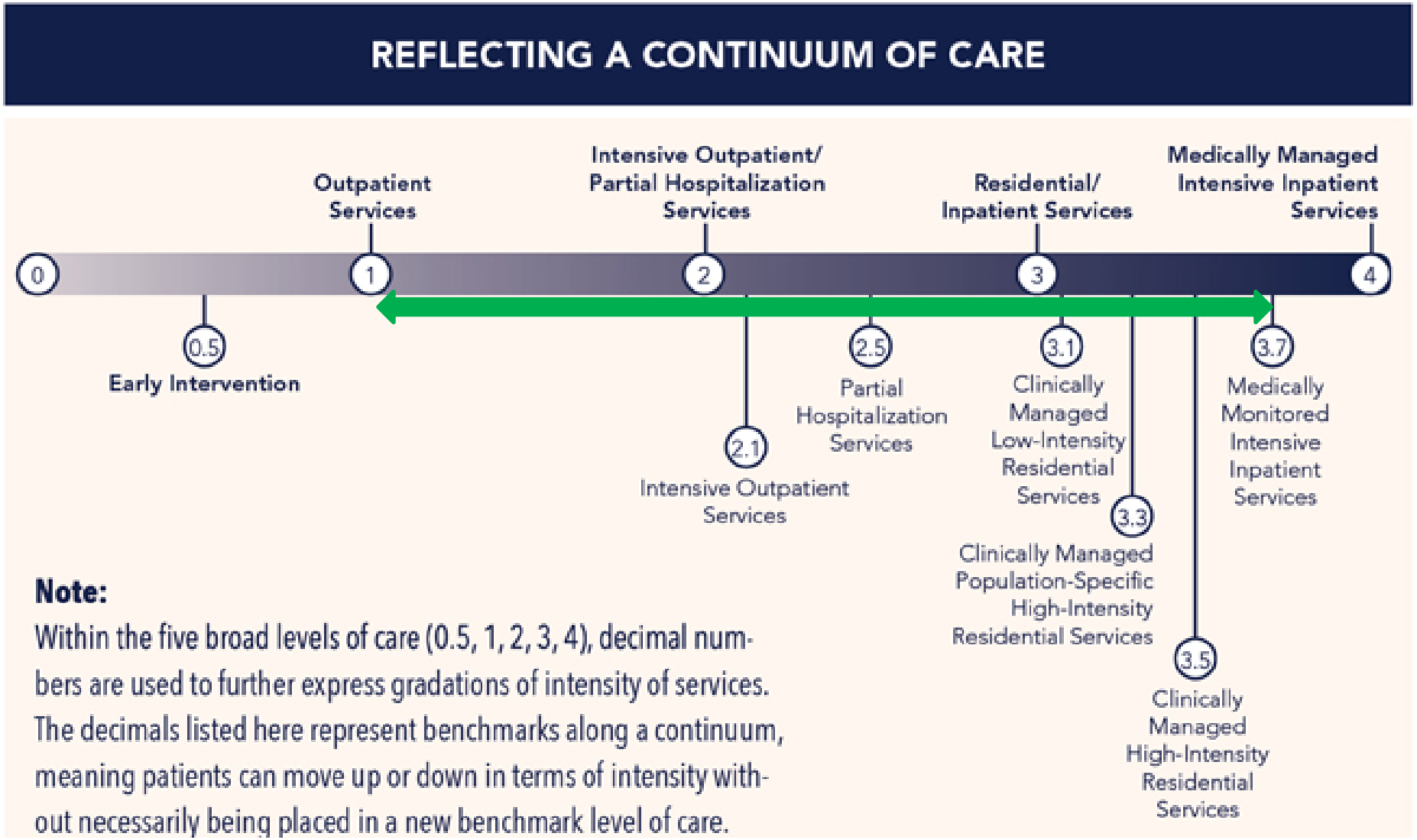
Outpatient

- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Group Counseling
- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic
- Methadone Administration

Residential

- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Group Counseling
- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic

ASAM Levels of Care



The green arrow represents the scope of Ohio's Medicaid BH Redesign.

Medicaid Substance Use Disorder Benefit – July 1, 2017

Outpatient Adolescents: Less than 6 hrs/wk Adults: Less than 9 hrs/wk	Intensive Outpatient Adolescents: 6 to 19.9 hrs/wk Adults: 9 to 19.9 hrs/wk	Partial Hospitalization Adolescents: 20 or more hrs/wk Adults: 20 or more hrs/wk	Residential

• Assessment
• Psychiatric Diagnostic Evaluation
• Counseling and Therapy
  ◦ Psychotherapy – Individual, Group, Family, and Crisis
  ◦ Group and Individual (Non-Licensed)
• Medical
• Medications
• Buprenorphine and Methadone Administration
• Urine Drug Screening
• Peer Recovery Support
• Case Management
	• Assessment
	• Psychiatric Diagnostic Evaluation
	• Counseling and Therapy
	  ◦ Psychotherapy – Individual, Group, Family, and Crisis
	  ◦ Group and Individual (Non-Licensed)
	• Medical
	• Medications
	• Buprenorphine and Methadone Administration
	• Urine Drug Screening
	• Peer Recovery Support
	• Case Management
		• Assessment
		• Psychiatric Diagnostic Evaluation
		• Counseling and Therapy
		  ◦ Psychotherapy – Individual, Group, Family, and Crisis
		  ◦ Group and Individual (Non-Licensed)
		• Medical
		• Medications
		• Buprenorphine and Methadone Administration
		• Urine Drug Screening
		• Peer Recovery Support
		• Case Management
			• Per Diems supporting all six residential levels of care including:
			  ◦ clinically managed through medically monitored
			  ◦ two residential levels of care for withdrawal management
			• Medications
			• Buprenorphine and Methadone Administration
			• Medicaid is federally prohibited from covering room and board/housing

• Level 1 Withdrawal Management (billed as a combination of medical services)	• Additional coding for longer duration group counseling/psychotherapy • Level 2 Withdrawal Management (billed as a combination of medical services)	• Additional coding for longer duration group counseling/psychotherapy • Level 2 Withdrawal Management (billed as a combination of medical services)	• Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem

SUD Outpatient: Medical Services

Medical Service CPT Codes
99201-99205 – Evaluation and Management, Office, New Patients
99211-99215 – Evaluation and Management, Office, Established Patients
99341-99345 – Evaluation and Management, Home, New Patients
99347-99350 – Evaluation and Management, Home, Established Patients
+99354 – Prolonged service-first hour
+99355 – Prolonged Service-each add. 30 mins
+90833 – Psychotherapy add on, 30 min
+90836 – Psychotherapy add on, 45 min
+90838 – Psychotherapy add on, 60 mins
+90785 – Interactive Complexity
96372 – Therapeutic Injection

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

ASAM Outpatient Level of Care 1 SUD Group Counseling

Behavioral Health Redesign

ASAM Outpatient Level of Care 1 SUD Group Counseling by Licensed Practitioners

Two billing codes are available for SUD group counseling provided by a licensed practitioner at the ASAM Level 1 outpatient level of care

Refer to slide 9 – Policy Update #3

Group psychotherapy (other than of a multiple-family group) — 90853

- Service may be rendered by a licensed practitioner providing psychotherapy in a group setting.
- 90853 may be billed when the service provided complies with AMA/CMS billing guidance and the session is 52 minutes or less.
- $21.63 per encounter licensed practitioner and $25.45 per encounter SUD physician.

SUD Group counseling 15-minuite unit for SUD licensed practitioners who are not physicians — H0005 HK

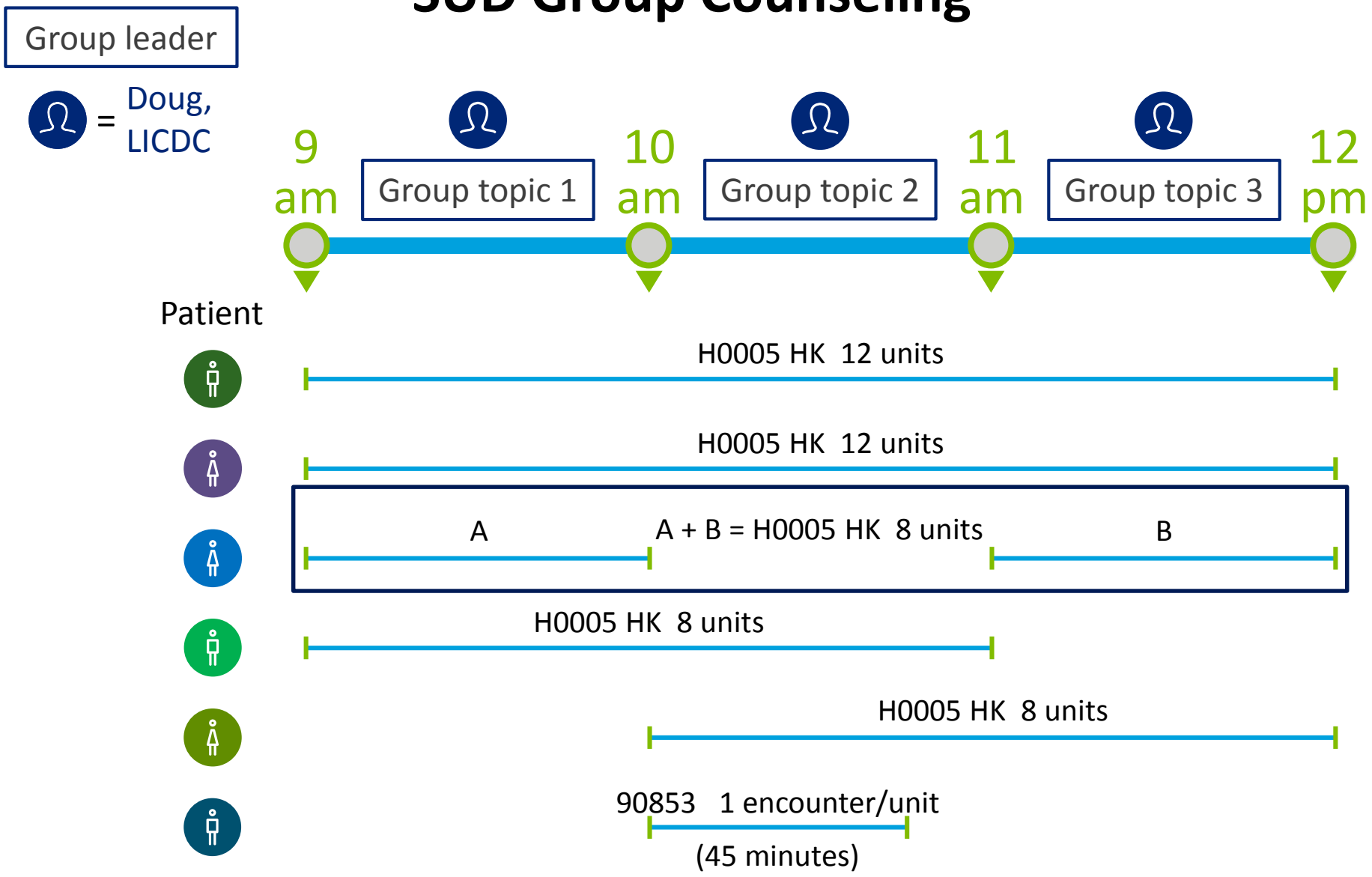
- H0005 may only be billed when a group session is 53 minutes or more and the practitioner bills for the correct number of 15-minute increments following AMA/CMS billing guidance.
- $7.21 per 15-minute unit.

SUD Group counseling 15-minute unit for SUD physicians — H0005 AF

- H0005 may only be billed when a group session led by a physician is 53 minutes or more and the practitioner bills for the correct number of 15-minute increments following AMA/CMS billing guidance.
- $8.48 per 15-minute unit.

All codes are subject to NCCI edits

Example: ASAM Outpatient Level of Care 1
SUD Group Counseling

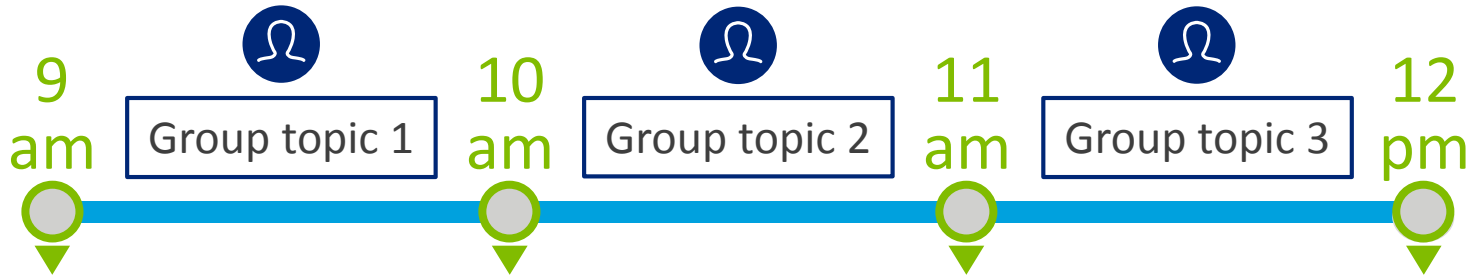


Example: ASAM Outpatient Level of Care 1
SUD Group Counseling CO-FACILITATION

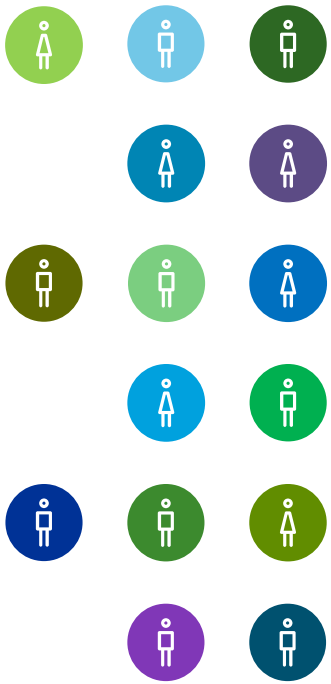
Group leaders

= Doug, LICDC

= Sysilie, CDCA



Patients



H0005 HK 12 units OR H0005 12 units

H0005 HK 12 units OR H0005 12 units

A + B = H0005 HK 8 units
OR
A + B = H0005 8 units

A

B

H0005 HK 8 units OR H0005 8 units

H0005 HK 8 units OR H0005 8 units

90853 1 unit (encounter)

(45 minutes)

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

ASAM Outpatient Level of Care 2 Intensive Outpatient and Partial Hospitalization

Behavioral Health Redesign

SUD IOP Level of Care Example – 16 Hours

Scenario (patient-specific weekly IOP schedule)

On Monday, Wednesday and Friday, the patient receives 2 hours and 30 minutes of group counseling, 1 hour of individual psychotherapy and 30 minutes of peer recovery support, the group counseling is provided by a LICDC and a CDCA (co-facilitators), the individual psychotherapy is provided by an LISW and the peer recovery support is provided by a certified peer recovery supporter. On Tuesday and Thursday the patient and their significant other receive 1 hour of family psychotherapy by an LISW and 30 minutes of case management provided by a care management specialist. On Sunday, the individual receives 1 hour of peer recovery support. On Thursday, the patient is called for an unscheduled urine drug screen.

Billing Structure

Code	Time	Service Name	Enc./Unit
Monday, Wednesday, Friday			
H0015 (HK)	2 hours 30 mins	IOP Group Counseling Lead by LICDC with CDCA assisting	Per Diem = 1
90837	1 hour	Psychotherapy 1 hour by LISW	Encounter = 1
H0038	30 min	Peer Recovery Support by PRS	Unit based (15 minutes) = 2
Tuesday and Thursday			
90847	1 hour	Family psychotherapy by LISW	Encounter = 1
H0006	30 min	Case Management by CMS	Unit based (15 minutes) = 2
Thursday only: H0048	1 unit	Urine Drug Screening - unscheduled	Collection and I-Cup, if applicable
Sunday			
H0038	1 hour	Peer Recovery Support by PRS	Unit based (15 minutes) = 4

Other Considerations:

1. Choose the code that best aligns with the service delivered and all documentation must support the billed service.
2. Ensure that services are provided within scope of practitioner
3. IOP level of care is between 9-19.9 hours for adults and 6-19.9 hours for adolescents

Scenario is for **illustrative purposes only** for today's training.

SUD Intensive Outpatient Level of Care: Group Counseling - Billing

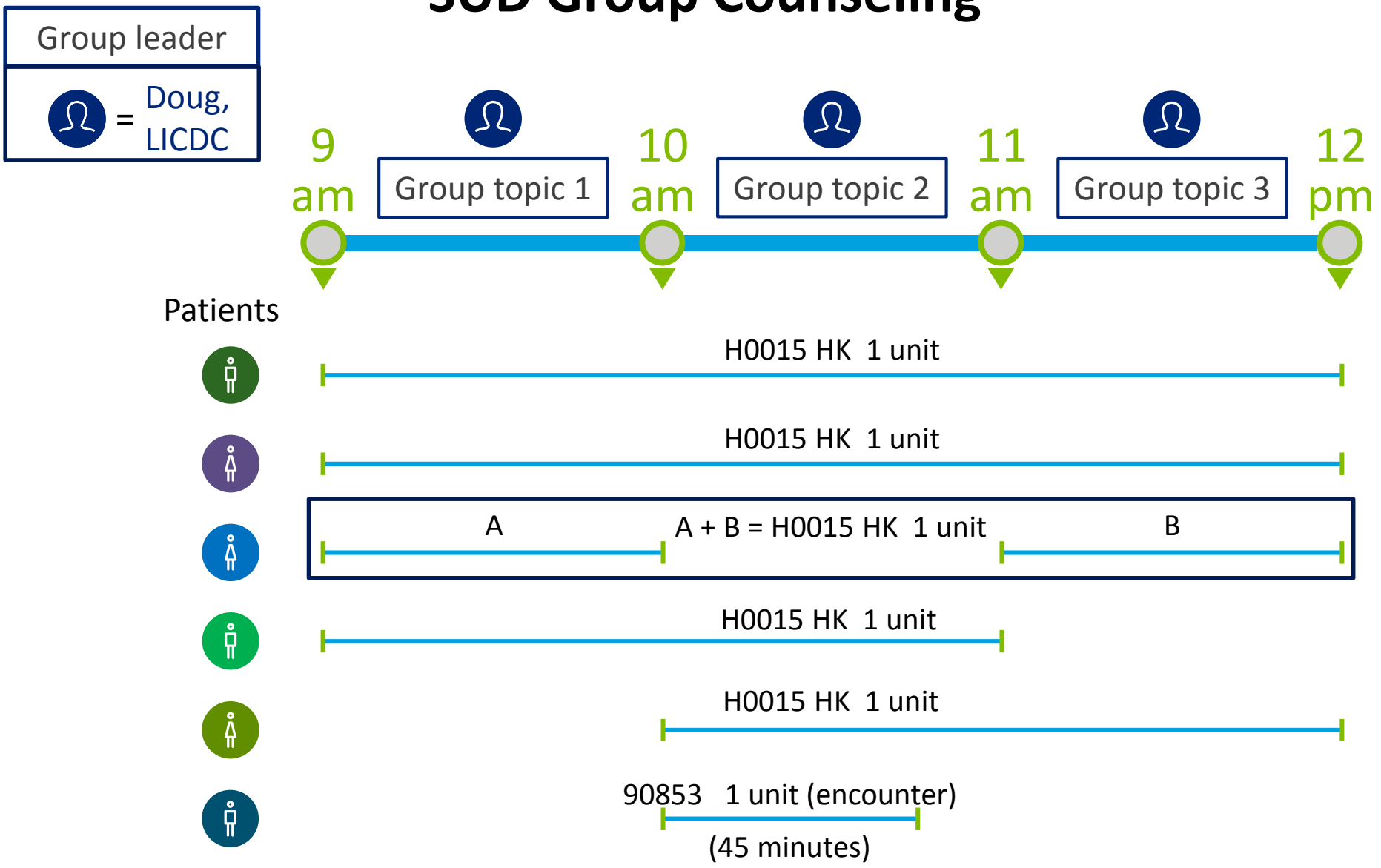
Refer to slide 9 – Policy Update #3

H0015	Per Diem - Assumed an average group size of three for an average duration of 4 hours for rate setting purposes with unlicensed practitioner leading	**$103.04** Per Diem Per Person
H0015 HK	Per Diem - Assumed an average group size of three for an average duration of 4 hours for rate setting purposes with licensed practitioner	**$149.88** Per Diem Per Person

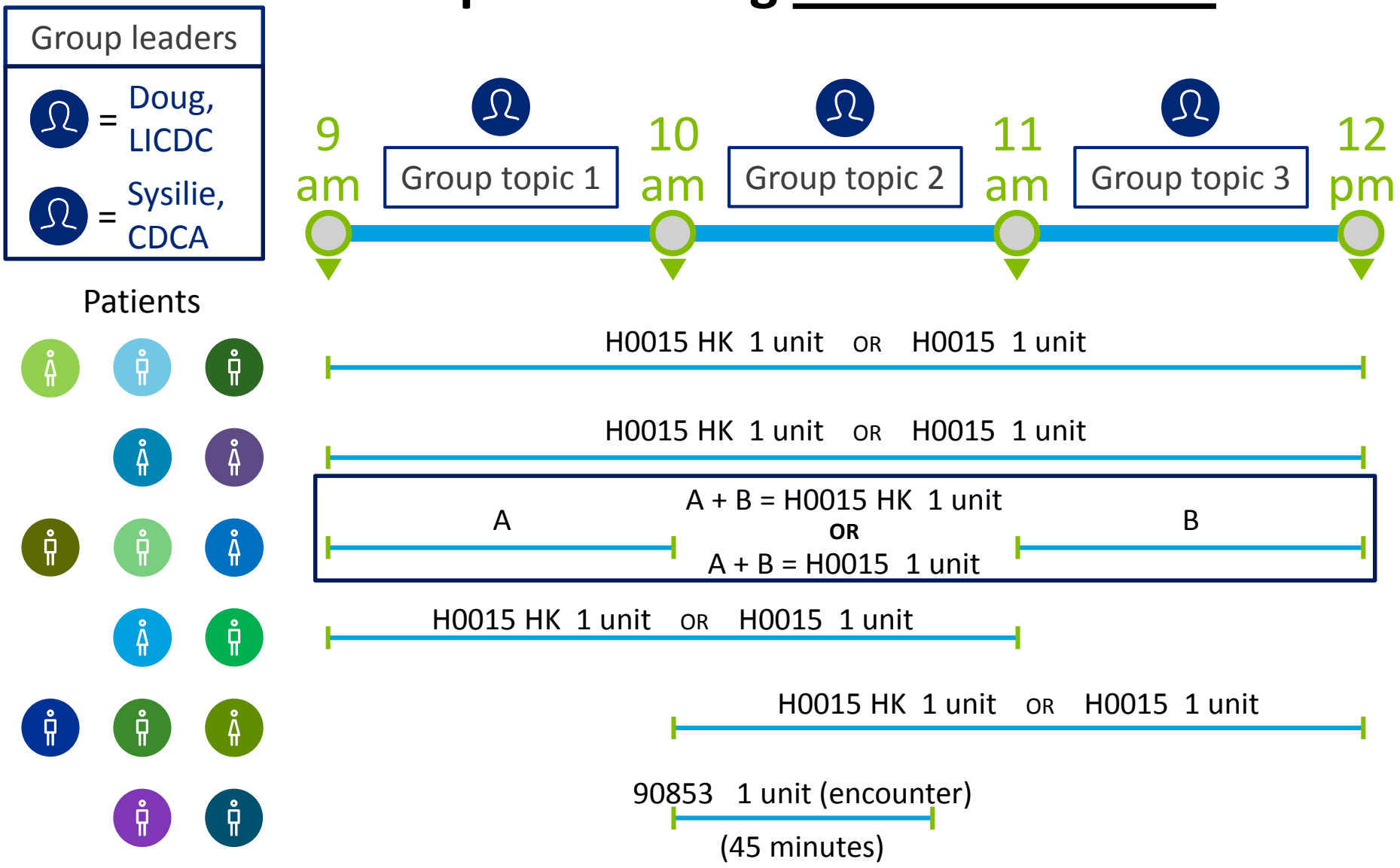
SUD Intensive Outpatient Group Counseling: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio.
2. Used at ASAM Level 2.1
   a. For IOP, only used if the person attends for the minimum needed to bill the per diem (2+ hours)
   b. If person doesn't meet the minimum 2+ hours, H0005 or 90853 may be used.
   c. Service is billed in whole unit only.
3. Other services must be billed in addition to H0015. H0015 can only be billed if the person attends the minimum amount of time (2+ hours) in a group which doesn't exceed the practitioner to client ratio.
4. Must be led by licensed practitioner to bill with HK modifier
5. ***Only one H0015 per diem, per patient, per day.***

Example: ASAM Outpatient Level of Care 2.1 IOP SUD Group Counseling



Example: ASAM Outpatient Level of Care 2.1 IOP SUD Group Counseling CO-FACILITATION



SUD Partial Hospitalization Level of Care: Group Counseling - Billing

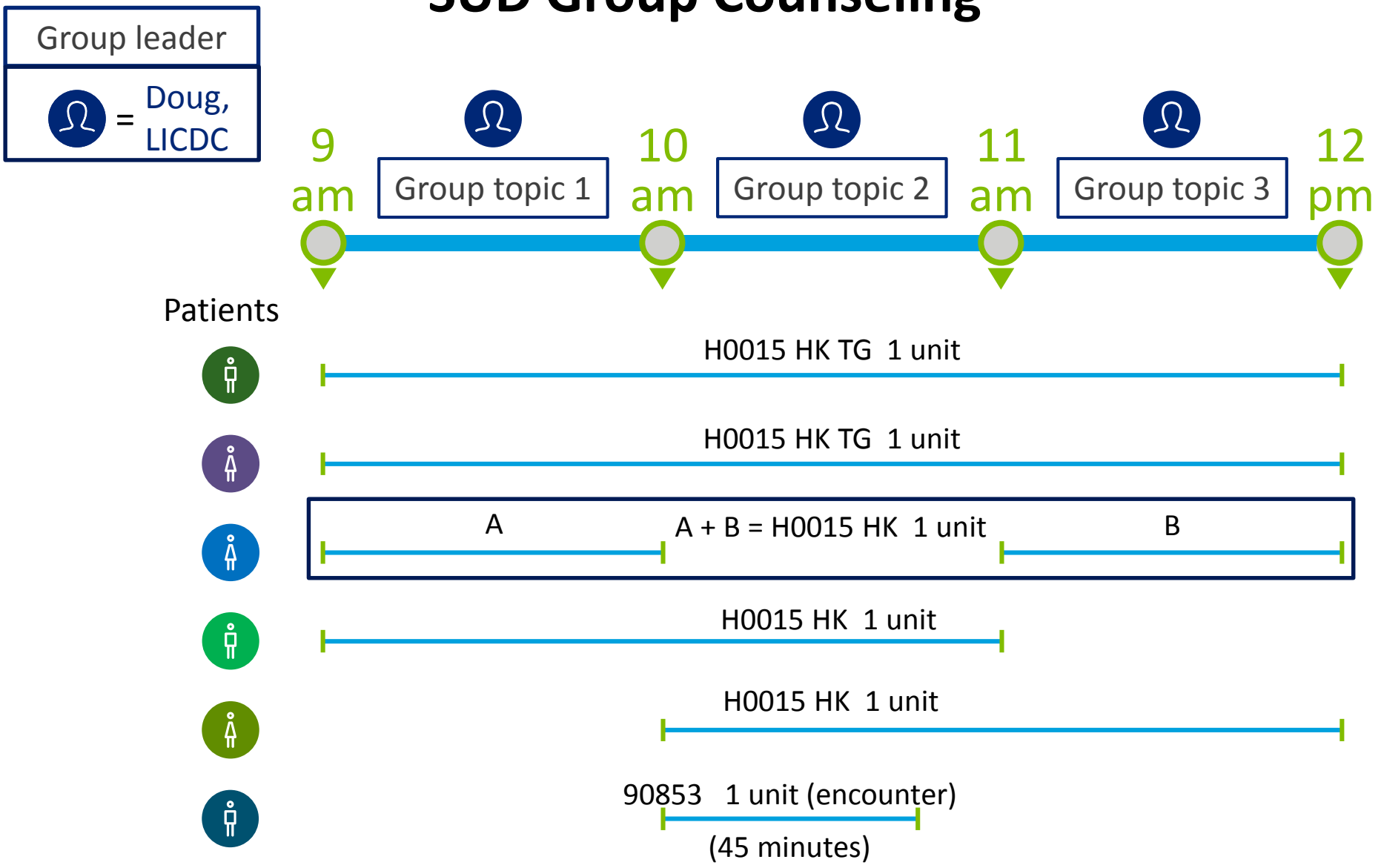
Refer to slide 9 – Policy Update #3

H0015 TG	Per Diem - Assumed an average group size of three for an average duration of 6 hours for rate setting purposes with unlicensed practitioner	$154.56 Per Diem Per Person
H0015 HK TG	Per Diem - Assumed an average group size of three for an average duration of 6 hours for rate setting purposes with licensed practitioner	$224.82 Per Diem Per Person

SUD Partial Hospitalization: Additional Details

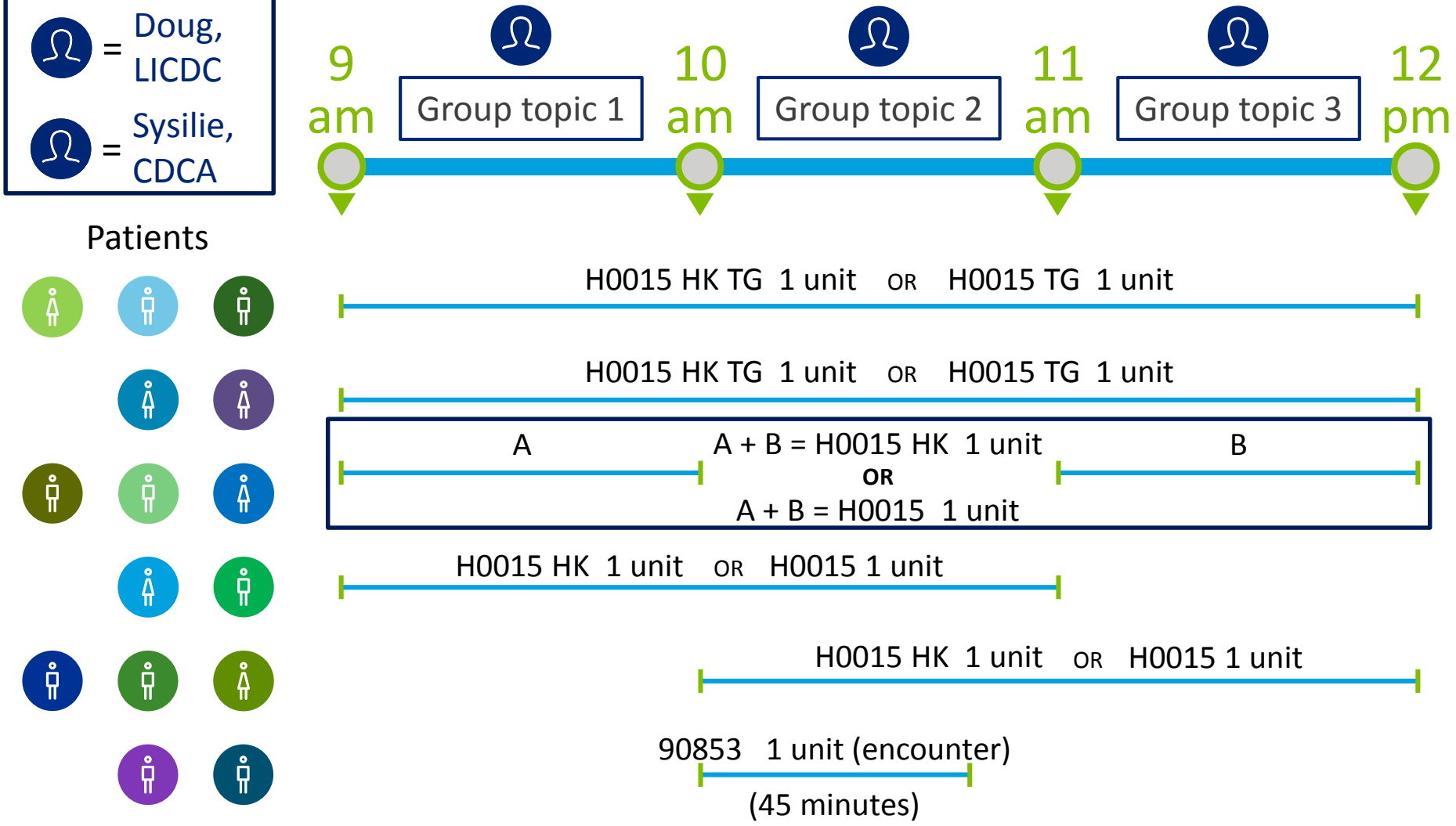
1. Maximum group size: 1:12 practitioner to client ratio
2. Only used at ASAM Level 2.5
   a. For PH, only used if the person attends for the minimum needed to bill the per diem (3+ hours)
   b. If person doesn't meet the minimum 3+ hours, H0015 (without TG, 2+ hours), H0005 or 90853 may be used.
   c. Service is billed in whole unit only.
3. Other services must be billed in addition to H0015 TG. H0015 TG can only be billed if the person attends the minimum amount of time (3+ hours) in a group which doesn't exceed the practitioner to client ratio.
4. Must be led by licensed practitioner to bill with HK modifier
5. ***Only one H0015 per diem, per patient, per day.***

Example: ASAM Outpatient Level of Care 2.5 PH SUD Group Counseling



Example: ASAM Outpatient Level of Care 2.5 PH SUD Group Counseling CO-FACILITATION

Group leaders	
=	Doug, LICDC
=	Sysilie, CDCA



Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Staffing for ASAM Residential Levels of Care

Behavioral Health Redesign

Staffing for American Society of Addiction Medicine (ASAM) Residential Levels of Care

Refer to slide 8 – Policy Updates #2

ASAM is a national model that improves individualized assessment and outcome-driven care. ASAM criteria is the clinical guide for OhioMHAS certification and Ohio Medicaid SUD benefit package.

ODM Rule 5160-27-09 clarifies the Medicaid staffing requirements for the ASAM residential levels of care.

SUD residential programs must provide comprehensive SUD, biomedical and co-occurring services to residents as medically necessary. Each per diem rate is based on this assumption.

Administration of medications by site based staff is covered within the SUD per diem residential rate, but the cost of the medication itself may be billed in addition to the per diem. If medication is administered by an agency other than the residential treatment agency, both administration and medication rates may be billed to Ohio Medicaid.

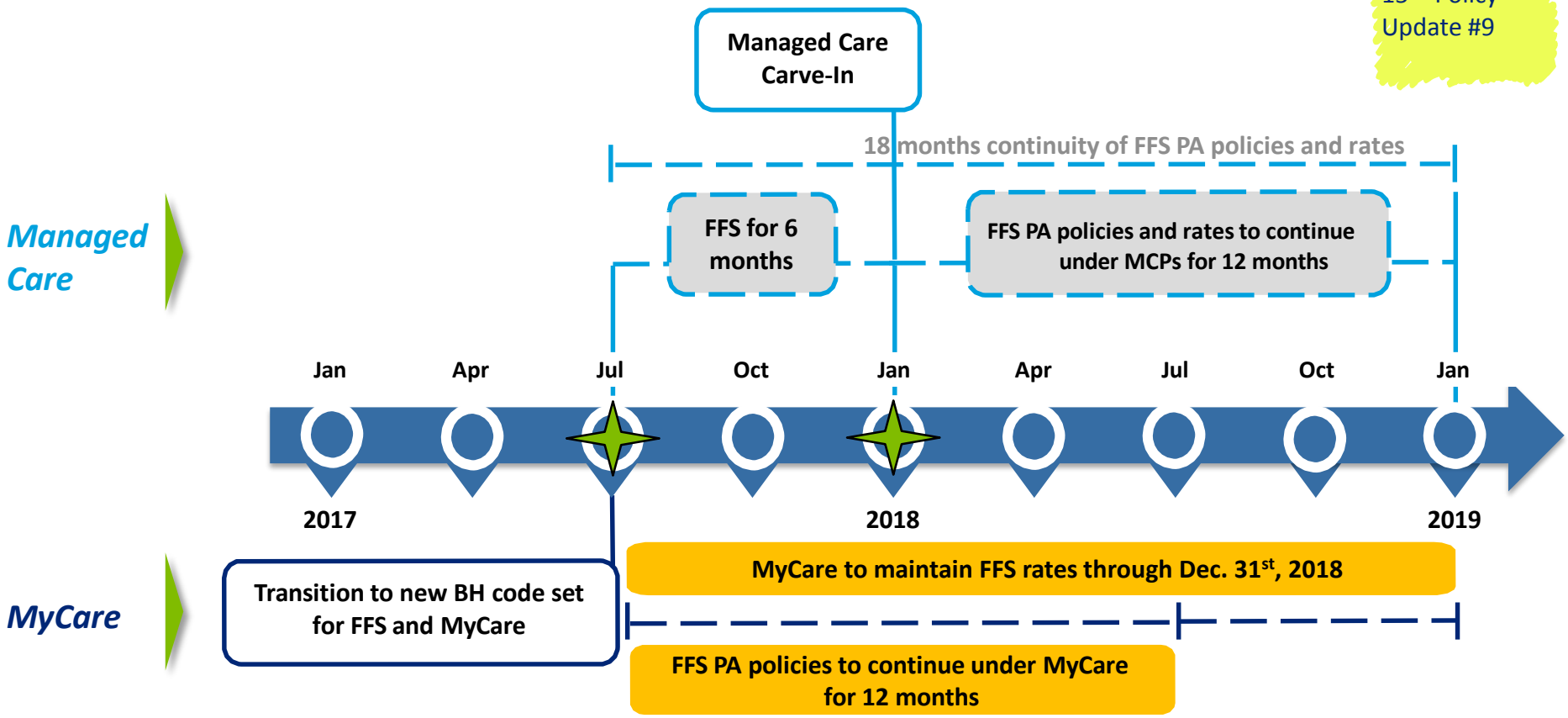
Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Benefit Administration Timeline, Policies, and Program Integrity

Behavioral Health Redesign

Updated Timeline: 2017 – 2019

Refer to slide 15 – Policy Update #9

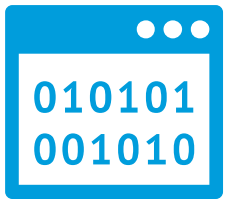


- Plans will follow state benefit administration policies for one year.
- MCP year is administered on a calendar year basis (Jan-Dec). Note: Benefit year is the calendar year (Jan-Dec).
- Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.

Milestone

Surveillance, Utilization and Review (SUR)
A Mandated Responsibility of Administering Medicaid

Federal law (CFR 42.456.25) requires state Medicaid programs to perform post-payment review of Medicaid claims - including recipient and provider profiles - to identify and fix any incorrect practices.



SUR activity is performed by Ohio Medicaid's Surveillance, Utilization and Review Section (SURS), which randomly samples Medicaid data to identify patterns that fall outside the mean.

Providers with outlier patterns may be contacted for post-payment review and possible recoupment of overpayments. Providers suspected of fraud, waste or abuse may be referred to the Attorney General's Medicaid Fraud and Control Unit.

- *Additional resources at bh.medicaid.ohio.gov*

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Services Which are
- ALWAYS Prior Authorized -

Behavioral Health Redesign

ALWAYS Prior Authorized:
Assertive Community Treatment (ACT)

DESCRIPTION	CODE
Assertive Community Treatment (ACT)	**H0040**

Prior Authorization Requirement

ACT must be prior authorized per person and all SUD services (except for medications) must be prior authorized for ACT enrollees.

All codes are subject to NCCI edits

ALWAYS Prior Authorized:
Intensive Home-Based Treatment (IHBT)

DESCRIPTION	CODE
Intensive Home-Based Treatment (IHBT)	**H2015**

Prior Authorization Requirement

IHBT must be prior authorized and a maximum of 72 hours can be authorized per authorization.

All codes are subject to NCCI edits

ALWAYS Prior Authorized for a Medicaid Enrollee: *SUD Partial Hospitalization (PH) Level of Care (LoC)*

DESCRIPTION	CODES
SUD PH LoC **20 or more hours of SUD services per week per adult or adolescent**	**Combination of CPT and HCPCS codes**

Prior Authorization Requirement

SUD PH LoC must be prior authorized for an adult or adolescent to exceed 20 hours of SUD services per week.

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Services With Prior Authorization
<u>- Per Billing Provider -</u>

Behavioral Health Redesign

Prior Authorization:
Psychiatric Diagnostic Evaluation

DESCRIPTION	CODES
Psychiatric Diagnostic Evaluation	**90791 – with out medical** **90792 – with medical**

Prior Authorization Requirement

*1 encounter per person per calendar year per code **per billing provider** for 90791 and 90792. Prior authorization may be requested to exceed the annual limit.*

All codes are subject to NCCI edits

Prior Authorization:
*Screening, Brief Intervention and Referral to Treatment (SBIRT)**

DESCRIPTION	CODES
Screening Brief Intervention and Referral to Treatment (SBIRT)	**G0396 – 15 to 30 minutes** **G0397 – greater than 30 minutes**

Prior Authorization Requirement

*One of each code (G0396 and G0397), **per billing provider**, per patient, per calendar year. Prior authorization may be requested to exceed the annual limit.*

*Can not be billed by provider type 95 (SUD treatment programs)

All codes are subject to NCCI edits

Prior Authorization:
Alcohol and/or Drug Assessment

DESCRIPTION	CODE
Alcohol and/or Drug Assessment by an unlicensed practitioner	**H0001**

Prior Authorization Requirement

*2 hours (2 units) per person per calendar year **per billing provider**. Does not count toward ASAM level of care benefit limit. Prior authorization may be requested to exceed the annual limit.*

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Services With Prior Authorization
- Per Medicaid Enrollee -

Behavioral Health Redesign

Prior Authorization:
Psychological Testing

DESCRIPTION	CODES
Psychological Testing	**96101 – psychological testing by a psychologist/physician** **96111 – developmental testing, extended** **96116 – neurobehavioral status exam**
	CODE
	96118 – neuropsychological testing by psychologist/physician

Prior Authorization Requirement	*Up to 12 hours/encounters per calendar year **per Medicaid enrollee** for 96101, 96111, and 96116.* *Up to 8 hours per calendar year **per Medicaid enrollee** for 96118.* *Prior authorization may be requested to exceed the annual limits.*

All codes are subject to NCCI edits

Prior Authorization:
SUD Residential (Non-Withdrawal Management)

DESCRIPTION	CODES
SUD Residential	**H2034** **H2036**

Prior Authorization Requirement

*Up to 30 consecutive days without prior authorization **per Medicaid enrollee**.*

Prior authorization then must support the medical necessity of continued stay; if not, only the initial 30 consecutive days are reimbursed.

Applies to first two stays; any stays after that would be subject to prior authorization.

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Services With No State-Defined Benefit Limits

Behavioral Health Redesign

No Benefit Limit:
*RN/LPN Nursing Services**

DESCRIPTION	CODES
RN/LPN Nursing Services (MH)	**H2019 (RN)** **H2017 (LPN)**
RN/LPN Nursing Services (SUD)	**T1002 (RN)** **T1003 (LPN)**

*This is a change according to March 17, 2017 newsletter (previous prior authorization guidance was set at 24 hours (96 units) combined per year per Medicaid enrollee)

All codes are subject to NCCI edits

No Benefit Limit: *Mental Health*

DESCRIPTION	CODE
Therapeutic Behavioral Services	**H2019**

All codes are subject to NCCI edits

No Benefit Limit: *Mental Health*

DESCRIPTION	CODE
Psychosocial Rehabilitation	**H2017**

All codes are subject to NCCI edits

No Benefit Limit: *Mental Health*

DESCRIPTION	CODE
Community Psychiatric Support Treatment	**H0036**

All codes are subject to NCCI edits

No Benefit Limit: *Psychotherapy*

DESCRIPTION	CODES
Individual Psychotherapy	**90832, 90834, 90837**
DESCRIPTION	**CODE**
Group Psychotherapy	**90853**
DESCRIPTION	**CODES**
Family Psychotherapy	**90846, 90847, 90849**

Services will accrue to ASAM outpatient, IOP, and PH levels of care.

All codes are subject to NCCI edits

No Benefit Limit: *E&M (Medical) Visits*

DESCRIPTION	CODES
Evaluation and Management – Office Visit	**99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215**
DESCRIPTION	**CODES**
Evaluation and Management – Home Visit	**99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350**

Services will accrue to ASAM outpatient, IOP, and PH level of care hours.

All codes are subject to NCCI edits

No Benefit Limit: *SUD Withdrawal Management*

Residential SUD Treatment Programs

DESCRIPTION	CODES
Level 3-WM All Staff	**H0010 or H0011 – Per Diem**

DESCRIPTION	CODE
Level 2-WM All Staff	**H0012 – Per Diem**
*** Level 2-WM RN/LPN Services**	**H0014 – Hourly (up to 4 hours)**

Outpatient SUD Treatment Programs

DESCRIPTION	CODE
*** Level 2-WM RN/LPN Services**	**H0014 – Hourly (up to 4 hours)**

DESCRIPTION	CODE
*** Level 1-WM RN Services**	**T1002 (RN)**
*** Level 1-WM LPN Services**	**T1003 (LPN)**

* Note: Per diems cover all services provided by medical and clinical staff. When RN/LPN hourly or 15 minute services are provided, services provided by other medical staff are billed using evaluation and management coding. Services provided by clinical staff are billed accordingly. Level 1 RN/LPN services will be subject to prior authorization after 24 hours.

All codes are subject to NCCI edits

No Benefit Limit: *Group MH Day Treatment*

DESCRIPTION	CODES
Group MH Day Treatment (Adult and Youth)	**H2012/HQ – Hourly** **H2020 – Per Diem**

Only one "per diem" day treatment unit will be paid per day per enrollee.

All codes are subject to NCCI edits

No Benefit Limit:
SUD Intensive Outpatient (IOP) and Outpatient (OP) Levels of Care (LoC)

DESCRIPTION		CODES
SUD IOP LoC **6-19.9 hours of SUD services per week per adolescent** **9-19.9 hours of SUD services per week per adult**		**Combination of CPT and HCPCS codes**
DESCRIPTION		
SUD OP LoC **Less than 6 hours of SUD services per week per adolescent** **Less than 9 hours of SUD services per week per adult**		

All codes are subject to NCCI edits

No Benefit Limit: *Crisis Services*

DESCRIPTION	CODES
Psychotherapy for Crisis	90839, +90840, 90832 UT
DESCRIPTION	**CODE**
SUD Individual Counseling provided to Patients in Crisis	H0004 UT
DESCRIPTION	**CODES**
MH TBS or PSR provided to Patients in Crisis	H2019 UT or H2017 UT
DESCRIPTION	**CODES**
RN services provided to Patients in Crisis	MH – H2019 UT SUD – T1002 UT

All codes are subject to NCCI edits

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Coordination of Benefits

Behavioral Health Redesign

Medicare Participation Rendering Practitioners

Rendering Practitioner	Guidance
Physician Advanced Practice Registered Nurse Physician Assistant Psychologist Licensed Independent Social Worker	A CBHC employing or contracting with any of these rendering providers **must bill the Medicare program prior to billing Medicaid if the service is covered by Medicare.**
Licensed Professional Clinical Counselor Licensed Independent Marriage and Family Therapist Licensed Independent Chemical Dependency Counselor Licensed Professional Counselor Licensed Marriage and Family Therapist Licensed Chemical Dependency Counselor Licensed Social Worker Licensed School Psychologists	A CBHC employing or contracting with any of these rendering providers **may submit the claim directly to Medicaid**.

Medicare Certification vs. Medicare Participation

Medicare Certification

- ✓ CMHCs have the option to enroll as an institutional provider to deliver Medicare services such as partial hospitalization.
- ✓ Certification requires accreditation or survey performed by the CMS designated state survey agency (In Ohio, ODH).

Dates of Service
July 1, 2017

Medicare Participation

- ✓ CBHCs (MH, SUD or both) have the option to enroll as a group practice.
- ✓ Eligible practitioners employed by CBHCs should also enroll as individual practitioners (to be listed as the rendering provider on claim).
- ✓ Once the Medicare Administrative Contractor (MAC) has received an application it has 60 days to review and approve or deny it. In Ohio, the MAC is CGS Administrators LLC.

Third Party Liability

GUIDANCE

- Third Party Liability will be enforced on all claims, assuring Medicaid is the last payer;
- The codes found in the document “Final Services Billable to Medicare” at this link, www.bh.Medicaid.ohio.gov/manuals, must be billed to Medicare and must also be billed to commercial payors;
- All practitioners providing those services must bill commercial payors;
- IF the commercial payor does not pay for those practitioners and/or those services, the agency will need to get a denial code to put on the claim and then bill Medicaid.

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

Refer to slide 10 – Policy Update #4

Supervision Requirements

Behavioral Health Redesign

Supervision Types

Types of Supervision
• ***General supervision:*** Supervising practitioner must be available by telephone to provide assistance and direction if needed. • ***Direct supervision:*** Supervising practitioner must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

Minimum Supervision Requirements for CPT

Practitioner Providing the Service:	Type of Supervision
Licensed professional counselor	***General***
Licensed chemical dependency counselor II or III	***General***
Licensed social worker	***General***
Licensed marriage and family therapist	***General***
Psychology assistant, intern, trainee	***General***
Chemical dependency counselor assistant	***General***
Counselor trainee	***General***
Social worker trainee	***General***
Marriage and family therapist trainee	***General***

Optional Direct Supervision

Guidance
• Trainees or assistants registered/credentialed with a professional board in the state of Ohio are authorized to practice under ***Direct or General*** clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions. • This includes: o Psychology assistants, interns, trainees; o Chemical dependency counselor assistants; o Counselor trainees; o Social worker trainees; o Marriage and family therapist trainees.

CPT General and Direct Supervision Example

Example: CPT Codes

General Supervision: A social worker trainee (SW-T) conducts a psychotherapy session with a patient with their supervising practitioner (LISW) available by phone. The claim would be submitted with the U9 modifier (representing the SW-T credential). ***The rendering field MUST BE blank and the billing field will contain the agency NPI.*** MITS will adjudicate the claim using the SW-T rate (85% of their supervisor's rate).

Direct Supervision: A SW-T conducts a psychotherapy session with a patient, and their supervisor (LISW) is immediately available and interruptible if the social worker trainee needs direction while providing this session. The claim would be submitted with the U9 modifier (representing the SW-T credential) with the supervisor's NPI in the supervisor field. ***The rendering field MUST BE blank and the billing field will contain the agency NPI.*** The supervisor takes the responsibility for the service. MITS will adjudicate the claim using the LISW rate.

Minimum Supervision Requirements for HCPCS

Practitioner Providing the Service:	Type of Supervision
Psychology assistant, intern, trainee	***General***
Chemical dependency counselor assistant	***General***
Counselor trainee	***General***
Social worker assistant	***General***
Social worker trainee	***General***
Marriage and family therapist trainee	***General***
Qualified Mental Health Specialist	***General***
Care Management Specialist	***General***
Peer Recovery Supporters	***General***

HCPCS General Supervision Example

Example: HCPCS Codes

General Supervision: A SW-T provides Psychosocial Rehabilitation to a patient in their home with their supervising practitioner available by phone. The claim would be submitted with the U9 modifier (representing the SW-T credential). ***The rendering field MUST BE blank and the billing field will contain the agency NPI.*** MITS will adjudicate the claim using the SW-T rate.

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Reporting Supervisor

Behavioral Health Redesign

General Supervision

Refer to slide 10 – Policy Update #4

Listing Supervisor on Claims

In response to stakeholder feedback, for practitioners working under general supervision, identification of a practitioner's supervisor on a Medicaid claim will be OPTIONAL.

Practitioners for CPT/HCPCS:
Licensed professional counselor
Licensed chemical dependency counselor II or III
Licensed social worker
Licensed marriage and family therapist
Psychology assistant, intern, trainee
Chemical dependency counselor assistant
Counselor trainee
Social worker assistant
Social worker trainee
Marriage and family therapist trainee
Qualified mental health specialist
Care management specialist
Peer recovery supporters

Note: Appropriate supervision must be provided and documented in the medical record

Guidance on How to Report Supervisor NPI

ODM Guidance at this Point in Time:

- Report supervising practitioner at the header level only: Loop 2310D
- Do not report supervisor at the detail level: Loop 2420D
- Report only one supervisor per claim at the header. Any detail lines under this header must have been directly supervised by this supervisor.
- On this claim only report services that are directly supervised by this supervisor

Billing Example: Correct Reporting of Supervisor

- Supervisor reported at header applies to all detail lines
- Claim will pay based on the supervisor's rate

Header Level		
Supervisor	**Rendering**	**Billing Provider**
Supervisor NPI	-	Agency NPI

Detail Level								
Line #:	**DOS**	**Code**	**Units**	**Modifiers**	**Rendering**	**Supv**	**Ordering**	**Prior Authorization**
1	7-2-17	90839	1	U9	-	-	-	-
2	7-2-17	90840	2	U9	-	-	-	-
3	7-10-17	90839	1	U9	-	-	-	-

Billing Example: Incorrect Reporting of Supervisor

- Supervisor reported at the header applies to all detail lines
- Services that are not performed under supervision should not be reported on the same claim – the claim may adjudicate incorrectly

Header Level

Supervisor	Rendering	Billing Provider
Supervisor NPI	-	Agency NPI

Detail Level

Line #:	DOS	Code	Units	Modifiers	Rendering	Supv	Ordering
1	7-2-17	90839	1	U9	-	-	-
2	7-2-17	90840	2	U9	-	-	-
3	7-10-17	90839	1	U9	-	-	-
4	7-11-17	90839	1	-	LISW NPI	-	
5	7-12-17	90839	1	-	RN NPI	-	Ordering NPI

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Practitioner Enrollment and Affiliation

Behavioral Health Redesign

Medicaid Covered Behavioral Health Practitioners *

Behavioral Health Professionals (BHPs)				
Medical BHPs	**Licensed BHPs**		**BHPs**	**BHP-Paraprofessionals**
Physicians (MD/DO)	Licensed Independent Chemical Dependency Counselors	Licensed Independent Social Workers	Chemical Dependency Counselor Assistants	Care Management Specialists
Certified Nurse Practitioners	Licensed Chemical Dependency Counselors	Licensed Social Workers	Counselor Trainees	Peer Recovery Supporters
Clinical Nurse Specialists	Licensed Independent Marriage and Family Therapists	Licensed Professional Clinical Counselors	Marriage and Family Therapist Trainees	Qualified Mental Health Specialists
Physician Assistants	Licensed Marriage and Family Therapists	Licensed Professional Counselors	Psychology Assistants, Interns or Trainees	
Registered Nurses	Licensed Psychologists		Social Work Assistants	
Licensed Practical Nurses			Social Worker Trainees	

* When employed by or contracted with an OhioMHAS certified agency/program

Rendering Practitioners Required to Enroll in Ohio Medicaid, Effective For Dates of Service On and After July 1, 2017

Rendering Practitioners	
Physicians	Licensed Independent Social Workers
Certified Nurse Practitioners	Licensed Professional Clinical Counselors
Clinical Nurse Specialists	Licensed Independent Marriage and Family Therapists
Physician Assistants	Licensed Independent Chemical Dependency Counselors
Registered Nurses	Licensed Psychologists
Licensed Practical Nurses	

Exception: Prescribers already registered with ODM as Ordering, Referring or Prescribing providers need not re-enroll.

ADDITIONAL GUIDANCE

- Practitioners must be affiliated with their employing/contracted agency or agencies; either the agency or practitioner may perform the affiliation in MITS
- Practitioner or agency/agencies may “un-affiliate” rendering practitioners listed above when necessary
- BH Provider Affiliation Report MITS Bits was released on April 11th and can be found at: HTTP://MHA.OHIO.GOV/PORTALS/0/ASSETS/FUNDING/MACSIS/MITS-BITS/BH-MITS-BITS-BH-REDESIGN-UPDATE_4-11-17.PDF

Practitioner Modifiers

Practitioner Providing the Service	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2
Licensed chemical dependency counselor III	LCDC III	U3
Licensed chemical dependency counselor II	LCDC II	U3
Licensed social worker	LSW	U4
Licensed marriage and family therapist	LMFT	U5
Psychology assistant, intern, trainee	PSY assistant	U1
Chemical dependency counselor assistant	CDC-A	U6
Counselor trainee	C-T	U7
Social worker assistant	SW-A	U8
Social worker trainee	SW-T	U9
Marriage and family therapist trainee	MFT-T	UA
QMHS – high school	QMHS	HM
QMHS – Associate's	QMHS	HM
QMHS – Bachelor's	QMHS	HN
QMHS – Master's	QMHS	HO
QMHS – 3 years' experience	QMHS	UK
Care management specialist – high school	CMS	HM
Care management specialist – Associate's	CMS	HM
Care management specialist – Bachelor's	CMS	HN
Care management specialist – Master's	CMS	HO
Peer recovery supporter	PRS	HM

Provider Enrollment Applications and Revalidations

Status

- ODM staff has been working through any remaining backlog to prepare for July 1st
- As of May 15th: 175 agencies had no affiliated practitioners
- Remittance advice includes a message for all 84s and 95s
- BH Provider Affiliation Report MITS Bits was released on April 11th and can be found at: http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-BH-Redesign-Update_4-11-17.pdf
- Report of Affiliated Practitioners by agency is posted on the BH Redesign site at: http://bh.medicaid.ohio.gov/manuals

Medicaid Provider Enrollment Webinar can be found **http://bh.medicaid.ohio.gov/training**

Provider Enrollment Applications and Revalidations

Statistics

Enrollment status as of May 10th:

	Enrollments			Applications		
Provider Types	Total enrolled as of 04/10/17	Total enrolled as of 4/26/2017	Total enrolled as of 5/10/2017	Oldest dated application	Applications in "Submit Status"	Applications Returned to Provider
LISW (Type 37)	1,887	1,982	2,059	4/20/2017	12	115 2/27/2017
LPCC (Type 47)	1,973	2,108	2,207	4/20/2017	30	119 01/09/2017
LIMFT (Type 52)	44	51	52	N/A	0	1 04/17/2017
LICDC (Type 54)	296	336	344	4/26/2017	25	29 02/13/2017
Nurses (Type 38)	897	915	1,018	4/3/2017	68	175 03/22/2017
	5,097	5,392	5,680		135	439

* Provider enrollment concentrating efforts on getting RTP and Nurse applications processed

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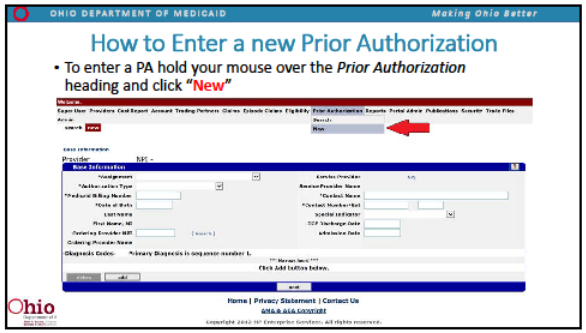
Resources on How to Enter a Prior Authorization

Behavioral Health Redesign

Resources on How to Enter a Prior Authorization

- To view the PA webinar, please go to http://medicaid.ohio.gov/PROVIDERS/Training/BasicBilling.aspx



ODM MITS PA functionality overview: http://www.medicaid.ohio.gov/PROVIDERS/Training/MITSOnlineTutorialsforProviders/WebPortalFundamentals.aspx#Submit%20a%20Prior%20Authorization

Submit a Prior Authorization Request

Overview

In this topic, you learn how to submit a prior authorization (PA) request. You can submit three PA request types:

- Prior Auth
- Prior Auth--Hospital
- Pre-Cert--Hospital

Who

Providers and their designated agents can submit a prior authorization request.

When

Based on the type of prior authorization a patient needs, the answer from ODJFS could arrive the same day or take several days--depending on how complex the case is. Thus, it is important to submit the prior authorization request in time to receive an answer when needed for the patient's condition.

Relevance

Submitting a prior authorization request directly in Ohio MITS can save time for you and the patient.

Guidelines

When you submit a prior authorization request, these guidelines can help:

- The choice you make in the Assignment Type field determines what is available in the Authorization Type drop-down list: Prior Auth, Prior Auth--Hospital, or Pre-Cert--Hospital.
- The amount you request to be paid for the procedure may or may not be granted by ODJFS.
- If a message displays stating you might not need a prior authorization, and you want to proceed, you must select the **Ignore** checkbox and then click **Continue** to go to the next panel.

May 23rd – Behavioral Health Prior Authorization Webinar

Information

- ODM is hosting a training webinar on May 23rd from 1-3 p.m. that will provide step-by-step instructions on how community behavioral health agencies can submit requests for prior authorization for services such as ACT, IHBT, SUD Partial Hospitalization, SUD Residential, etc.
- Click on this link to register: https://register.gotowebinar.com/register/8342927488327893763
- After registering, you will receive a confirmation email containing information about joining the webinar.

Note: The webinar will be recorded. The recording and slide presentation will be posted to the BH.Medicaid.Ohio.Gov website.

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National Correct Coding Initiative (NCCI)

Behavioral Health Redesign

National Correct Coding Initiative

National Correct Coding Initiative Overview

- Required by the Affordable Care Act
- Goals: Assure practitioners work within scope, control improper coding, prevent inappropriate payment by Medicare and Medicaid.
- Implemented, governed and regularly updated by Centers for Medicare & Medicaid Services (CMS)
- **Providers should check NCCI quarterly updates and adjust IT and billing systems accordingly (next quarterly update April 1)**
- Implemented October 1st, 2010, in rest of Ohio's Medicaid program – not in BH
- To be implemented July 1st, 2017, for Ohio Medicaid BH providers

What Does This Mean For You?

- NCCI policies are applied as edits (claims denials) to Medicaid health care claims
- Two types of edits:
  - Procedure to procedure edits: Pairs of codes that may not be reported together when delivered by the same provider for the same recipient on the same date of service. Applied to current and historic claims.
  - Medically unlikely edits: These edits define the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same recipient on the same date of service.

Procedure to Procedure (PTP) Edits Overview

PTP Edits Overview

Defines HCPCS and CPT codes that should not be reported together for a variety of reasons. **The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported**.

Medicaid PTP (including those that can be overridden by specific modifiers), MUE edits and other relevant information can be found at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/ national-correct-coding-initiative.html

What Does This Mean For You?

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers.

Where services are "separate and distinct." it may be necessary to override the procedure-to-procedure edit using a specific modifier. Documentation must support "separate and distinct" services.

What is an example?

Example 1: The same physician performs a psychotherapy service and E&M service on the same day to the same client (significant and separately identifiable services). NCCI will not allow the psychotherapy code 90834 to be billed with an E&M office visit code 99212, as there are separate add-on codes (+90833, +90836, and +90838) for psychotherapy services provided in conjunction with E&M services. This cannot be overridden with the modifier.

NCCI Medically Unlikely Edits (MUEs)

NCCI MUEs

MUEs define, for each HCPCS / CPT code, **the maximum units of service (UOS) that a provider would report** under most circumstances for a single beneficiary on a single date of service.

What Does This Mean For You?

Medically Unlikely Edits will review anything that, from a medical standpoint, is unlikely to happen. MUEs **cannot be overridden** with the 59, XE, XS, XP, XU modifiers.

For more information:
August 2010 (Questions and Answers Section 6507 of the ACA, NCCI Methodologies)
September 1, 2010 (State Medicaid Director Letter [SMD] 10-017)
September 29, 2010 (CMS letter to The National Medicaid EDI Healthcare Workgroup)
April 22, 2011 (SMD 11-003)
CMS website: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html

What is an example?

Example 1: The same licensed independent social worker (LISW) performs two diagnostic evaluations (2 units of 90791) with the same client on the same day. NCCI will deny the second evaluation, as it is medically unlikely that one client would need two complete diagnostic evaluations in the same day.

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Peer Recovery Support

Behavioral Health Redesign

Peer Recovery Support Service

Mental Health Benefit

Program

Specialized Recovery Services		ACT

Authorization

Authorized by Person Centered Care Plan		Act service is prior authorized by Medicaid
No more than 4 hours per day		

Billing

Only for individuals eligible for SRS		Peer recovery supporter is a full member of the ACT team, a face to face contact can be used for a monthly "billing event"
H0038 - Individual H0038/HQ - Group		

Substance Use Disorder Benefit

Program

SUD Outpatient		SUD Residential

Authorization

Discrete service as medically necessary		SUD residential service is prior authorized by Medicaid

Billing

Peer recovery supporter is part of clinical team		Available to all residents when peer recovery supporter is part of clinical team
H0038 - Individual H0038/HQ - Group		Covered as part of the per diem

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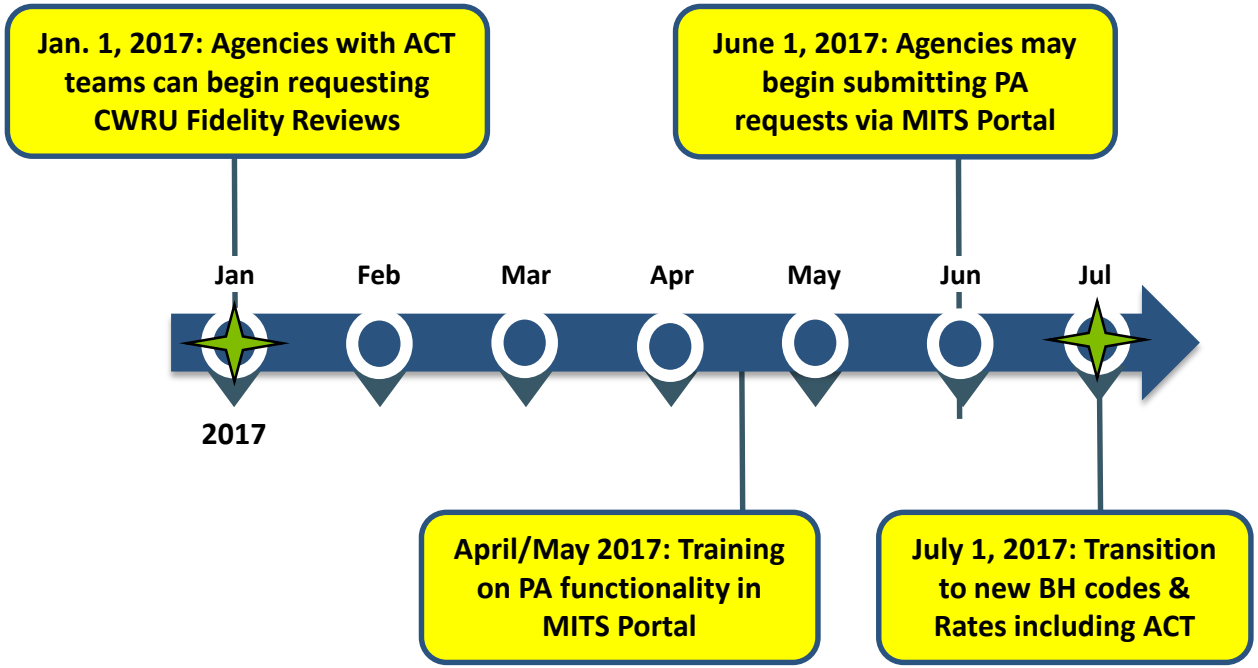
Department of Mental Health and Addiction Services

Medicaid-Funded Assertive Community Treatment (ACT)

Behavioral Health Redesign

Behavioral Health Timeline: Assertive Community Treatment



- As of January 1, 2017, agencies employing ACT team(s) may begin requesting CWRU to perform Fidelity Review (DACTS Scale) for Medicaid enrollment.
- Once an agency ACT team has met minimum fidelity, they may be enrolled in Ohio Medicaid and begin submitting prior authorization requests for consumers in their ACT caseload.
- Agency begins using the Medicaid ACT billing model July 1, 2017.

Milestone

Why Initiate Medicaid Payment for ACT?

1. Investing in "what works" – an evidence-based practice
2. Improve health outcomes
3. Reduce use of emergency room and inpatient hospital admissions
4. Improve stability of community living & quality of life
5. Available to Medicaid enrollees with the most complex mental health conditions who meet eligibility criteria
6. Only ACT teams who meet and maintain minimum fidelity to the model may bill Medicaid for ACT intervention

ACT – Fidelity Measurement

Please click on the ACT Fidelity Rating Tool image for reference and review:

ACT Fidelity Measurement

Fidelity Measures to qualify for ACT billing methodology were built on recommendations and discussions from November 2015

SAMHSA-approved ACT Fidelity Scale Toolkit

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

ACT Policy Summary

1. ACT team fidelity measurement will be based on DACTS until carve in to managed care.
   - Team Fidelity must be measured by CWRU Center for Evidence Based Practice under contract with ODM.
   - TMACT fidelity measurement encouraged post carve in.

2. ACT enrollment and caseload:
   - All ACT enrollees must be prior authorized by ODM PA vendor regardless of previous ACT enrollment
   - Caseload may include both Medicaid and non-Medicaid enrollees; Teams must assure that total caseload size doesn't exceed FTE capacity noted at time of Fidelity rating
   - Agencies may have more than one ACT Team

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0

ACT Policy Summary Cont'd

3 Requirements for ACT Team Leaders:

- Must be dedicated to only one team.
- Must be licensed (preferably licensed independent with a supervisory endorsement)
- Be enrolled in MITS as an active Medicaid provider

4 No Medicaid payment for supported employment /vocational rehabilitation services unless the person is enrolled in SRS program.

5 ACT team members responsible for providing ASAM Level 1 services to enrollees as part of the ACT service.

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0

ACT Team Monthly Billing Example – Physician Prescriber

DACTS (w/ 2 BAs): Code - H0040	Unit Rates
MD/DO	$615.64
Master's/ RN/LPN	$251.91
Bachelor's	$199.70
Bachelor's	$199.70
Total: $1,266.95	

DACTS (w/ 1 BA, 1 PRS): Code - H0040	Unit Rates
MD/DO	$615.64
Master's/ RN/LPN	$251.91
Bachelor's	$199.70
Peer Recovery Supporter	$159.24
Total: $1,226.49	

DACTS (w/ 2 PRSs): Code - H0040	Unit Rates
MD/DO	$615.64
Master's/ RN/LPN	$251.91
Peer Recovery Supporter	$159.24
Peer Recovery Supporter	$159.24
Total: $1,186.03	

ACT is a fully prior authorized service – ACT billable events must occur in person face-to-face for minimum of 15 minutes

ACT Team Monthly Billing Example – APRN/PA Prescriber

DACTS (w/ 2 BAs): Code - H0040	Unit Rates
APRN/PA	$352.75
Master's/ RN/LPN	$251.91
Bachelor's	$199.70
Bachelor's	$199.70
Total: $1,004.06	

DACTS (w/ 1 BA, 1 PRS): Code - H0040	Unit Rates
APRN/PA	$352.75
Master's/ RN/LPN	$251.91
Bachelor's	$199.70
Peer Recovery Supporter	$159.24
Total: $963.60	

DACTS (w/ 2 PRSs): Code - H0040	Unit Rates
APRN/PA	$352.75
Master's/ RN/LPN	$251.91
Peer Recovery Supporter	$159.24
Peer Recovery Supporter	$159.24
Total: $923.14	

ACT is a fully prior authorized service – ACT billable events must occur in person face-to-face for minimum of 15 minutes

ACT Team Patient Scenario

Scenario Example

A 57-year-old client, Mary, is receiving services from an ACT team. She has Schizophrenia with a long history of multiple inpatient hospitalizations due to chronic paranoia, hallucinations, disorganized and delusional thinking. She has been able to maintain community living since initiating services with the ACT team 2 months ago. However, she continues to have poor medication compliance with her recently prescribed Clozapine, poor hygiene skills and overall poor ADLs and IADLs. She receives multiple services throughout the month to help her maintain in independent living and to reduce periods of decompensation.

- Mary has a monthly visit with her psychiatrist. At this visit, medications are reviewed to assure there are no needed adjustments/adverse interactions as well as providing psychotherapy as needed.
- Weekly, an RN medically monitors Mary by taking vitals and drawing blood. The RN educates Mary re: the importance of taking Clozapine as prescribed and the need for regular lab work to monitor blood levels and prevent possible side effects. The RN encourages Mary to take her daily medication to increase optimal thinking levels and to increase performance of ADLs and IADLs.
- Every evening and twice a day on weekends, an unlicensed BA staff member (acting as a medication monitor) goes to Mary's home to prompt and monitor her self-administration of medication. The BA staff member reminds Mary about the importance of medication compliance.
- Weekly, an LPN provides verbal direction and supervision when Mary fills her weekly medication box. The LPN educates Mary about the side effects of Clozapine and how medication compliance can reduce and stabilize her Schizophrenia, as well as helping her to maintain independent living in her own apartment.
- Weekly, a peer recovery supporter works with Mary overcome her disorganized thinking by helping her at her home and in other community settings with money management and healthy nutrition. The peer recovery supporter redirects Mary and keeps her focused on ADLS and IADLs as reflected on her care plan.

Scenario is for **illustrative purposes only**

Service Event

ACT Services/Billing Events: November 2016

Billable Event

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 Unlicensed BA Visit	2 Unlicensed BA Visit	3 LPN Visit	4	5
6 Peer Recovery Supporter Visit Unlicensed BA Visit	7 RN Visit Unlicensed BA Visit	8 Unlicensed BA Visit	9 Unlicensed BA Visit	10 LPN Visit Unlicensed BA Visit	11 Unlicensed BA Visit	12 Unlicensed BA Visit
13 Peer Recovery Supporter Visit Unlicensed BA Visit	14 RN Visit Unlicensed BA Visit	15 Unlicensed BA Visit	16 Psychiatrist Visit Unlicensed BA Visit	17 LPN Visit Unlicensed BA Visit	18 Unlicensed BA Visit	19 Unlicensed BA Visit
20 Peer Recovery Supporter Visit Unlicensed BA Visit	21 RN Visit Unlicensed BA Visit	22 Unlicensed BA Visit	23 Unlicensed BA Visit	24 LPN Visit Unlicensed BA Visit	25 Unlicensed BA Visit	26 Unlicensed BA Visit
27 Peer Recovery Supporter Visit Unlicensed BA Visit	28 RN Visit Unlicensed BA Visit	29 Unlicensed BA Visit	30 Unlicensed BA Visit			

ACT and Coordination of Benefits

- ODM assumes that Assertive Community Treatment is not a service covered by Medicare or commercial insurers.
- Therefore, H0040 “billable events” may be submitted directly to Medicaid without first submitting to Medicare or commercial plans to obtain a denial code.

ACT Fidelity Review

- The Ohio Department of Medicaid has contracted with Case Western Reserve University to perform fidelity reviews for Medicaid
- ACT Teams must achieve a minimum average score of 3 on the DACTS fidelity scale. Once an ACT Team has met minimum fidelity, they will be authorized to begin using the ACT billing model *(see slides 132-133)*.
- Teams who fail to achieve a minimum fidelity score of 3 are not penalized
  - These teams may seek technical assistance from Case Western under the OhioMHAS funded component of CWRU CEBP*
- ACT teams must renew and pass fidelity review every 12 months

*see next slide for further detail

ACT Technical Assistance

Technical Assistance Guidance

- Free technical assistance is available for provider agencies interested in or providing ACT (but not yet ready for Medicaid fidelity review) from CWRU via OhioMHAS financing

ACT Prior Authorization and Eligibility

Refer to slide 14 – Policy Update #8

- Medicaid recipients may only be enrolled with ACT teams after they have been prior authorized by the ODM designated PA entity.
- Prior Authorization requests must be submitted via MITS
- **Webinar tomorrow, May 23rd on submitting BH Prior Authorization Requests –**
  - **Link:** https://attendee.gotowebinar.com/register/8342927488327893763

Draft ACT Eligibility Criteria (Draft OAC 5160-27-04):

- Age 18 or over
- Diagnosis of schizophrenia spectrum, bipolar spectrum, or major depressive disorder with psychosis
- Functional limitation(s) measured by:
  - Adult Needs and Strengths Assessment (ANSA), or
  - SSI/SSDI determination
- One of the following risk factors:
  - At risk of psych inpatient psych hospitalization
  - One or more previous inpatient psych admissions

ACT is a "Lock In" BH Benefit

When a person is enrolled on an ACT team, no other Medicaid BH services will be paid

Exceptions:

- BH medications including physician administered medications and methadone/buprenorphine administration by OTPs
- recovery management through the SRS program
- SUD services that are prior authorized

ACT enrollees may receive other non-BH Medicaid services like:

- Inpatient and emergency room visits
- Physician services (e.g. OBGYN, cardiac, and other specialties)
- Prescription and over the counter (OTC) medications

ACT Services to Hospitalized Enrollees

ACT teams are expected to maintain contact with their enrollees if they are hospitalized

- ACT teams should assist with admission and discharge planning, However, these are not billable events while a hospital is being paid for Medicaid inpatient stay
- Depending on length of stay, the ACT team may want to consider the clinical appropriateness of maintaining the individual on case load until they are discharged

Note: Crisis services will be covered when provided by another agency for an ACT enrollee

Disenrollment from ACT

Planned Disenrollment

- ACT teams must develop a transition plan in partnership with the consumer for disenrollment

Unplanned Disenrollment

- ACT enrollees may lose touch with the team for some period of time
- It is recommended ACT teams disenroll the consumer after a month of no communication
- This will allow the consumer to receive BH services outside the ACT team
- The ACT team may pursue expedited re-enrollment once the consumer is found

ACT CHECKLIST

TO DO

Refer to slide 14 – Policy Update #8

- ❑ All independently licensed members of ACT team (Prescriber, LISW, LPCC, LIMFT, LICDC, Psychologist, RN/LPN, Team Leader) must be enrolled in Ohio Medicaid and affiliated with the billing agency
- ❑ Contact CWRU to schedule fidelity review
- ❑ Team should have a member competent in conducting the ANSA
- ❑ Team should be able to verify SSI/SSDI status
- ❑ Agency must have an IT system that supports medical documentation plus clinical and billing nuances
- ❑ Attend training on use of the MITS PA functionality and prepare to submit PA requests for potential ACT enrollees, including documentation of their eligibility for ACT

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Intensive Home-Based Treatment (IHBT)

Behavioral Health Redesign

IHBT Provider Requirements

1. Team must meet or exceed fidelity scores *(see slide 147 for IHBT Fidelity Rating Tool)*
2. Employing/contracting agency must be certified by OhioMHAS for the IHBT service
3. Team members must be licensed by either Psychology or Counselor, Social Worker & Marriage and family therapy board

IHBT Prior Authorization Requirements

1. IHBT is fully prior authorized from Day 1
2. Maximum amount authorized for a PA is 72 hours within a 6 month date span. More than 72 hours within the 6 month span will require additional PA request

IHBT Consumer Eligibility

1. Younger than 18 unless SED onset occurs before age 18; then 18-21 year olds may receive IHBT
   - At risk of out of home placement or
   - Returned within last 30 days from out of home or
   - Requiring highly intense MH intervention to remain safely at home
2. SED diagnosis
3. CANS functional scale
4. A family member or other responsible adult who authorizes and participates in IHBT

Note: Crisis services will be covered when provided by another agency for an IHBT enrollee

IHBT – Fidelity Measurement

Please click on the IHBT Fidelity Rating Tool image for reference and review:

IHBT Fidelity Measurement

Fidelity Measures to qualify for the IHBT billing methodology were built on premises similar to ACT

IHBT Fidelity Document

Ohio Department of Mental Health and Addiction Services Intensive Home-Based Treatment Fidelity Rating Tool

Rating	1	2	3	4	5
1) Intensity of service	Averages one or less service hour per week and less than 1 contact per week for each IHBT consumer. Intensity is not sufficient in meeting the behavioral health needs of the youth and family.	Averages 2 or less service hours per week and 1 face-to-face contact per week for each IHBT consumer. Intensity is not sufficient in meeting the behavioral health needs of the youth and family.	Averages 3 service hours per week and 2 face-to-face contacts per week during the intensive phase, one of which has to be with the youth and family. Intensity matches presenting behavioral health needs of the youth and family and is modified during course of treatment as needed.	Averages 4 service hours per week and a minimum of 2 face-to face contacts with the youth and family and collaterals per week during the intensive phase. Intensity matches presenting behavioral health needs of youth and family and is modified during course of treatment as needed.	Averages 5 or more service hours per week and 3 or more face-to-face contacts with the youth, family, and collaterals per week during the intensive phases of IHBT. Intensity matches presenting behavioral health needs of youth and family and is modified during course of treatment as needed.
2) Location of service	49% or less of IHBT service is delivered in home and community settings.	50% to 74% of IHBT service is delivered in home and community settings.	75% to 89% of IHBT service is delivered in home and community settings.	90% to 99% of IHBT service is delivered in home and community settings.	100% of IHBT service is delivered in home and community settings.
3) Caseload	For single provider: Caseload averages 12 or greater youth/families. For team of two: Averages 20 or greater youth/families. Mixed caseloads (non-IHBT and IHBT)	For single provider: Caseload averages 9 to 11 youth/families. For team of two: Averages 17 to 19 youth/families. Mixed caseloads (non-IHBT and IHBT)	For single provider: Caseload averages 8 youth/families. For team of two: Averages 15 to 16 youth/families. Staff serve IHBT cases only.	For single provider: Caseload averages 7 youth/families. For team of two: Averages 13 to 14 youth/families. Staff serve IHBT cases only.	For single provider: Caseload averages 4 to 6 youth/families. For team of two: Caseload averages 8 to 12 youth/families. Staff serve IHBT cases only.

OhioMHAS Intensive Home-Based Treatment Fidelity Rating Tool Last Updated 9-23-2016 Page 1 of 7

IHBT Billing Structure

Code - H2015	Unit Rate (15 minute)
Licensed clinician (modifier or NPI) 	$33.26

Although services delivered via telephone or video conference are not prohibited, only face to face, in person services are billable

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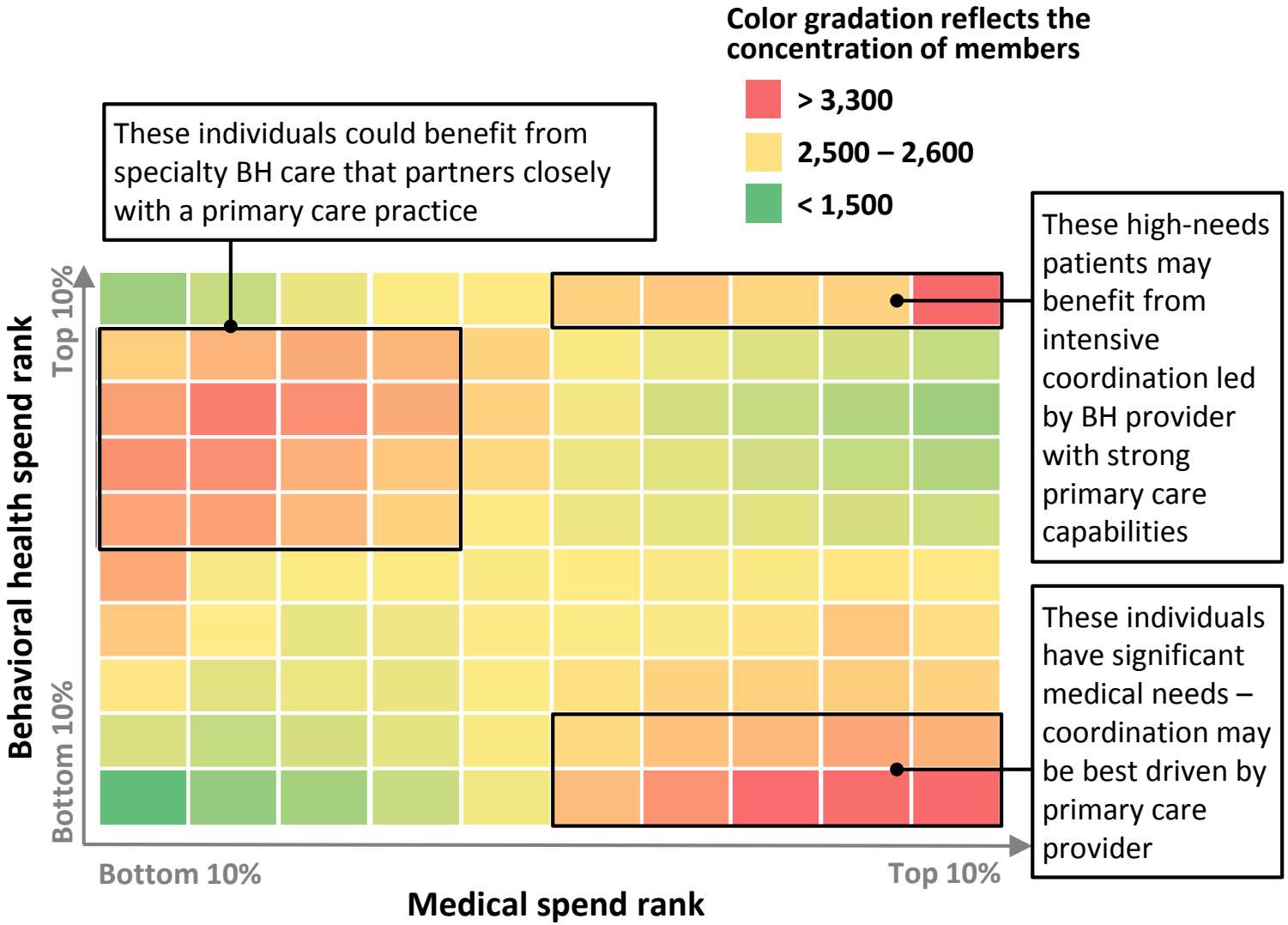
Care Coordination

Behavioral Health Redesign

Opportunities for Care Coordination

Sources of Value and Spend Vary by Segment

Heat map of behavioral health members as a function of behavioral health and medical spend ranks

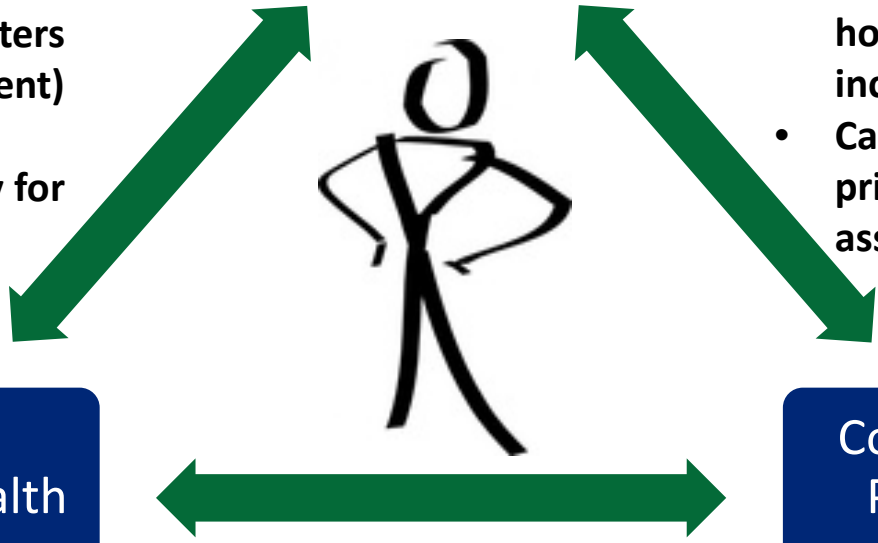


Accountability for Care Coordination

- **Require health plans to delegate components of care coordination to qualified behavioral health centers ("Model 2" commitment)**
- **Care management identification strategy for high risk population**

Medicaid Managed Care Plan

- **Require health plans to financially reward practices that keep people well and hold down total cost of care, including behavioral health**
- **Care coordination defaults to primary care unless otherwise assigned by the plan**



Qualified Behavioral Health Center

Comprehensive Primary Care (CPC)

- **Mutual Accountability**
- **Alignment on care plan, patient relationship, transitions of care, etc.**
- **Common identification of needs and assignment of care coordination**

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ODM and OhioMHAS Rules Update

Behavioral Health Redesign

ODM and OhioMHAS Rules Timeline

2017

February

- Updates shared with Benefit & Service Development Workgroup, February 15

March

- CSIO public comment, March 17 – March 31

April

Original file submitted, April 14

- Updates shared with Benefit & Service Development Workgroup, April 19

Rule updates following stakeholder feedback, including review of 300+ comments

May

- Public hearings on Rules: ODM, May 15; OhioMHAS, May 17

JCARR hearing, May 30

June

- Final file date, June 21

July

- Rules take effect, July 1

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Stakeholder Resources

Behavioral Health Redesign

Available Resources

Ohio's transition to the new BH benefit package should be seamless for individuals who access these critical services. Current BH services should not be impacted by BH Redesign, and new services (e.g., ACT/IHBT) will be available to individuals with high intensity needs.

The resources below can help individuals in accessing current or new services:

ODM Resources:

- Medicaid Consumer hotline: 1-800-324-8680
- Beneficiary Ombudsman: Sherri Warner (Phone: 614-752-4599; Email: Sherri.Warner@medicaid.ohio.gov)

MHAS Resources:

- Client Rights and Advocacy Resources (http://mha.ohio.gov/Default.aspx?tabid=270)

Local Resources:

- National Alliance on Mental Illness helpline: 1-800-686-2646
- Ohio Association of County Behavioral Health Authorities, Board Directory (http://www.oacbha.org/mappage.php)

MCP Resources:

- Medicaid Consumer hotline: 1-800-324-8680

SRS Resources:

For questions related to the Specialized Recovery Services program, please contact your RM agency:

- CareSource SRS Program Manager: Dawn Rist-Opal (Phone: 216-618-8124; Email: Dawn.RistOpal@CareSource.com)
- Council on Aging SRS Program Manager: Christy Nichols (Phone: 513-592-2779; Email: Cnichols@help4seniors.com)
- CareStar SRS Program Manager: Mary Farrell (Phone: 614-729-6319; Email: Mfarrel@CareStar.com)

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Behavioral Health Redesign Work Book Updates

Behavioral Health Redesign

What has changed with the BH Redesign Work Book?

		CPT/HCPCS	Pricing Modifier(s)		Description		Medical Behavioral Health (BH) Practitioners						Licensed BH Pract						
Unit of Measure	ASAM	Procedure Code	1	2		Per Diem Rate	MD/DO	CNS	CNP	PA	RN	LPN	Independent BH Professionals PSY	LISW	LIMFT	LPCC/ LPCC-S	LICDC	LI School PSY** (HB)	LPC
Encounter		+90785			Interactive Complexity Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350], and group psychotherapy [90853]	NA	$13.81	$11.74	$11.74	$11.74	NA	NA	NA	NA	NA	NA	NA	NA	NA	N
Encounter		+90785			Interactive Complexity-non E/M use (Use 90785 in conjunction with codes for psychotherapy [90832, 90834, 90837], and group psychotherapy [90853])	NA	NA	NA	NA	NA	NA	NA	$13.81	$11.74	$11.74	$11.74	$11.74	$11.74	$11
Encounter		90791			Psychiatric diagnostic evaluation.	NA	$130.72	$111.11	$111.11	$111.11	NA	NA	$130.72	$111.11	$111.11	$111.11	$111.11	$111.11	$11
Encounter		90792			Psychiatric diagnostic evaluation - includes	NA	$126.50	$107.53	$107.53	$107.53	NA	NA	NA	NA	NA	NA	NA	NA	N
Encounter		90832			Psychotherapy, 30 minutes with patient and/or family member.	NA	$63.11	$53.64	$53.64	$53.64	NA	NA	$63.11	$53.64	$53.64	$53.64	$53.64	$53.64	$53
Encounter		+90833			Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure). (Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350).	NA	$65.37	$55.56	$55.56	$55.56	NA	NA	NA	NA	NA	NA	NA	NA	N
Encounter		90834			Psychotherapy, 45 minutes with patient and/or family member.	NA	$82.05	$69.74	$69.74	$69.74	NA	NA	$82.05	$69.74	$69.74	$69.74	$69.74	$69.74	$69
Encounter		+90836			Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M services (list separately in addition to the code for primary procedure). (Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350).	NA	$83.03	$70.58	$70.58	$70.58	NA	NA	NA	NA	NA	NA	NA	NA	N
Encounter		90837			Psychotherapy, 60 minutes with patient and/or														

Changes Made to the Coding Chart Since March 20, 2017

- ✓ Aligned Direct Supervision for CPT codes
- ✓ Aligned General Supervision for CPT/HCPCS codes
- ✓ Aligned H0012 to allow medical staff only as rendering
- ✓ Removed SBIRT from CDCA tab
- ✓ Increased H0048
- ✓ Psych testing rate at 100%
- ✓ Corrected Psych Testing Limitations language
- ✓ Correct QMHS Associates and QMHS High School modifiers on tabs
- ✓ Removed Modifier HO from H2015
- ✓ Updated all internal links

Version 9.0 of the BH Redesign Work Book is now available on the at www.bh.medicaid.ohio.gov

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Urine Drug Screening Recent Update

Behavioral Health Redesign

Urine Drug Screening Recent Update

$ Rate Update $

Urine drug screening (UDS) collection and handling (H0048):

Based on stakeholder feedback, the payment rate for UDS has increased from $11.48 to $14.48.

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Place of Service Recent Updates

Behavioral Health Redesign

Recent Update on Services Rendered in the Emergency Room

Refer to slide 12 – Policy Update #6

Place of Service 23: Emergency Room - Hospital

1. ODM and OhioMHAS have received questions regarding crisis services provided to clients in emergency rooms, specifically when the hospital is not staffed to respond to a behavioral health related crisis.
2. Past versions of BH Redesign Provider Manual and BH Redesign Coding Workbook do not allow place of service 23 Emergency Room – Hospital for crisis services.
3. In response to stakeholder feedback, ODM and OhioMHAS have updated policy and both of these resources to include place of service 23 as allowable for crisis services.

Recent Update on Services Rendered in "Other" Place of Service 99

Refer to slide 12 – Policy Update #6

ODM Will Define Place of Service 99 as "Community"

1. ODM and OhioMHAS have received questions regarding Medicaid coverage of behavioral health services rendered in a community location not otherwise defined in the place of service listing in the current BH Provider Manual.

2. Past versions of the BH Provider Manual and the BH Redesign Coding Workbook do not allow Place of Service 99

3. In response to stakeholder feedback, ODM and OhioMHAS has permitted appropriate use of place of service 99. From Rule 5160-27-02: "Place of service 99 is defined as 'community,' and may only be used when a more specific place of service is not available. Place of service 99 shall not be used to provide services to an recipient of any age if the recipient is in custody and is held involuntarily through the operation of law enforcement authorities in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016)."

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Documentation Requirements Recent Update

Behavioral Health Redesign

Documentation Requirements Recent Update

Refer to slide 11 – Policy Update #5

Update

- ✓ ODM and OhioMHAS fully support the use of electronic health records (EHRs) by community behavioral health providers. Providers may use structured "drop down" and "check list" options that support individualized clinical documentation.
- ✓ Please keep in mind that cloning is not an acceptable documentation practice.
- ✓ Reference https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf for additional Federal information on EHRs.

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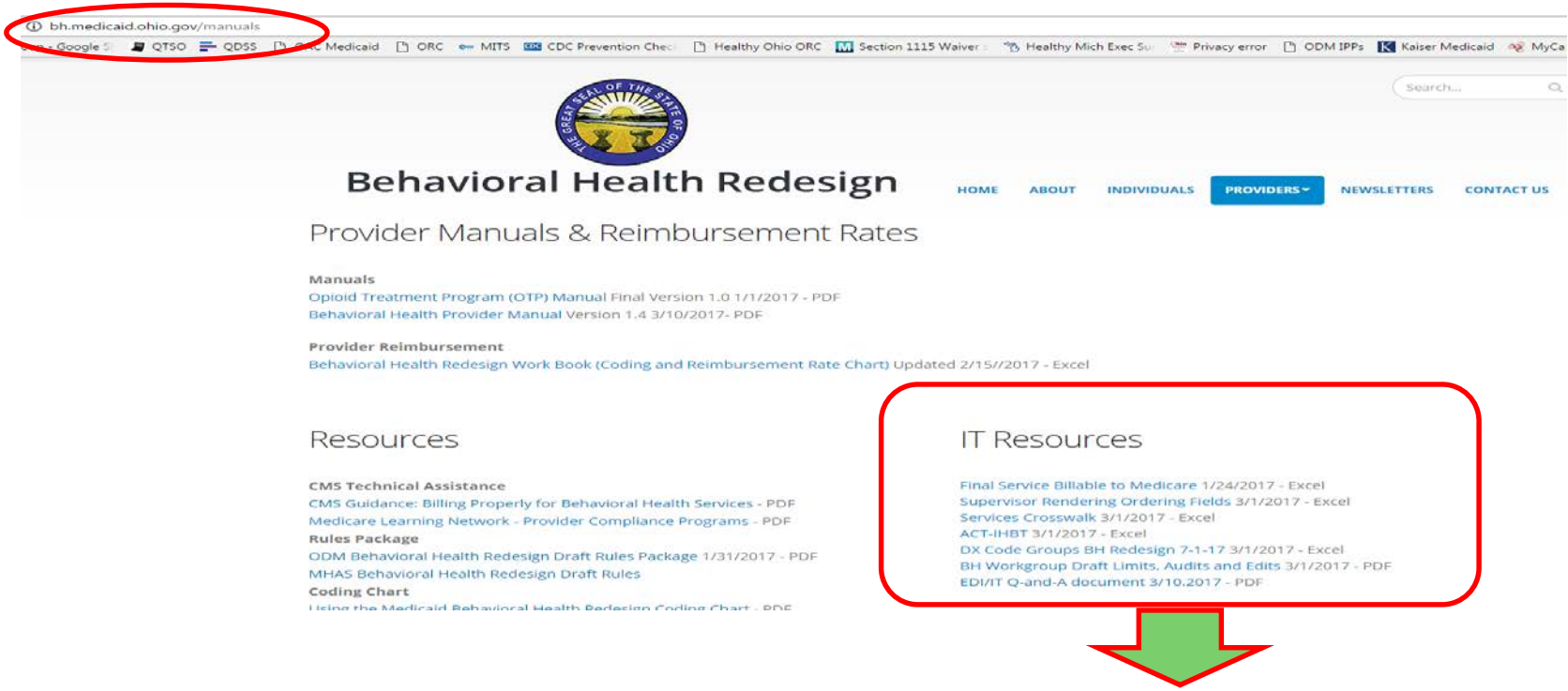
IT Resources and EDI File Testing (Fee for Service)

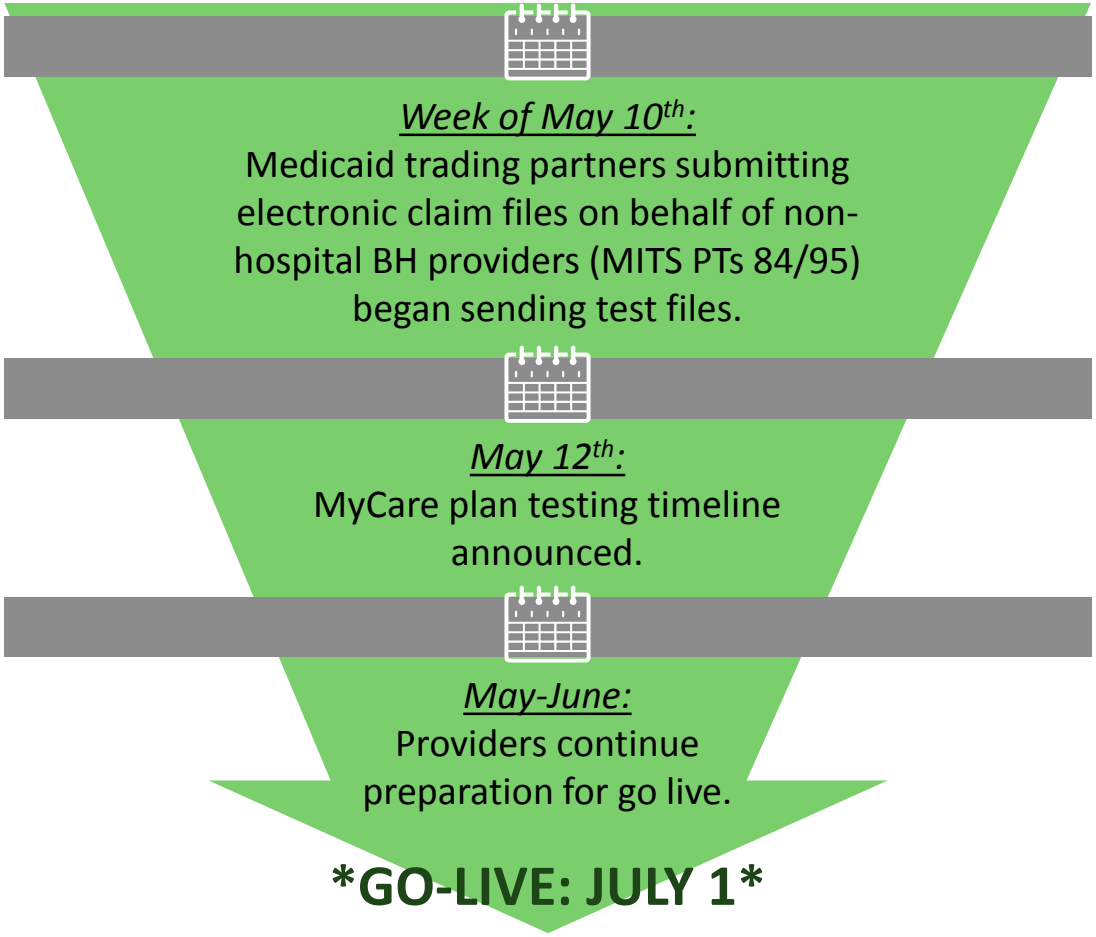
Behavioral Health Redesign

IT Resource Documents – *BH.Medicaid.Ohio.Gov*



- ✓ **Services Billable to Medicare (Final Version)** - Identifies those codes that require third party billing as well as those that do not
- ✓ **Supervisor Rendering Ordering Fields** - Identifies what information is in these fields for all CPT and HCPCS codes
- ✓ **Services Crosswalk** - Details what codes can be billed on same date of service
- ✓ **ACT-IHBT** - What is allowed to be billed with these two new services, what is not allowed and what requires prior authorization
- ✓ **Dx Code Groups** - Allowable diagnoses for behavioral health services
- ✓ **Limits, Audits and Edits** - Includes benefit limits as well as audits to limit some combination of services on same day
- ✓ **EDI/IT Q-and-A** - Contains responses to questions received from EDI/IT work group

EDI File Testing



Please refer to the two Trading Partner Testing MITS Bits for more details:

1. http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits%205-1-17_Medicaid-Trading-Partner-Testing.pdf
2. http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf

Ensuring Success: BH Redesign Rapid Response Team

A Rapid Response team will be available to provide technical assistance six days a week to ensure a successful transition to the new code set and BH benefit package.

"Rapid Response" ***Team A***

May – June

- Respond to trading partner-identified issues
- Communicate ODM-identified issues

"Rapid Response" ***Team B***

July – end date determined based on need

- Respond to provider-identified issues regarding claims processing

Information on how to contact the Rapid Response team can be found in the May 1st issue of MITS BITS

EDI File Testing

Trading Partner Testing Support

For test files that fail EDI processing:
Trading partners should contact the DXC technology EDI Support Desk by calling the Medicaid Provider Hotline (1-800-686-1516) and selecting Option 4 for EDI related issues or by email at OhioMCD-EDI-Support@dxc.com
EDI Support Desk will be available the following times:
Monday-Friday 7:30am-7:00 pm
Saturday 8 am – 1:00 pm

For test files with claims errors:
Trading partners can contact the ODM Policy "Rapid Response Team" by calling the Medicaid provider hotline 1-800-686-1516 and selecting Option 9 (behavioral health claims issues) OR send email to BH-Enroll@medicaid.ohio.gov.
Rapid Response Team will be available the following times:
Monday-Friday 7:30am-7:00 pm
Saturday 8am-1pm

Checklist for July 1, 2017

BH Providers should complete these steps prior to Go Live for BH Redesign:

☑ **Practitioners Required to Enroll in Medicaid**

- Obtain NPI
- Complete your Ohio Medicaid enrollment application by April 2017 – see instructions and webinar training on this posted here http://bh.medicaid.ohio.gov/training
- Respond quickly to any communication from Ohio Medicaid regarding your application
- Once enrolled, the practitioner must be "affiliated" with their employing agency
- **Enroll by April 1, 2017 to guarantee completion by July 1, 2017**

☑ **Medicare: Agencies and Practitioners** should enroll no later than May 2017 to ensure readiness for the July 1, 2017. See MITS BITS here: http://mha.ohio.gov/Portals/0/assets/Planning/MACSISorMITS/REVISED-mits-bits-medicare-enrollment-4-22-16_rev.pdf

☑ **IT Systems**

- Existing trading partners may begin submitting test EDI files in early May.
- New trading partners will be accepted after the migration has been completed.
- Trading partner testing region will be open 24/7.
- See extensive IT guidance on BH.Medicaid.Ohio.gov and
- Provider staff and your IT System Designers should participate in IT Work Group Meetings

☑ **Train all levels of staff on BH Redesign changes**

- Attend trainings
- Watch webinars
- Study documents at BH.Medicaid.Ohio.gov

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Behavioral Health Monitoring

Behavioral Health Redesign

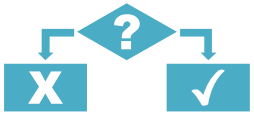
BH Monitoring Mission – Short Term Objectives

GOAL:

The State is implementing a plan to monitor the BH redesign changes. Short-term, the state will monitor claims payment and processing times to ensure continuity of care during the transition period.

Example metrics to begin monitoring July 1, 2017 –

Provider Network Adequacy



Claims Paid / Denied
(reason codes for denials)

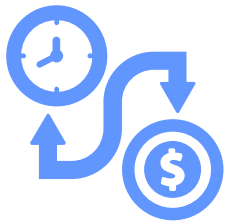
BH Monitoring Mission – Long Term Objectives

GOAL:

The State is implementing a plan to monitor the BH redesign changes. Long-term, the state will monitor overall spending to ensure our commitment to invest into the system is realized.

Example metrics to monitor after July 1, 2017 –

Members Served



System & Service-Level Spending

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Behavioral Health Redesign Website

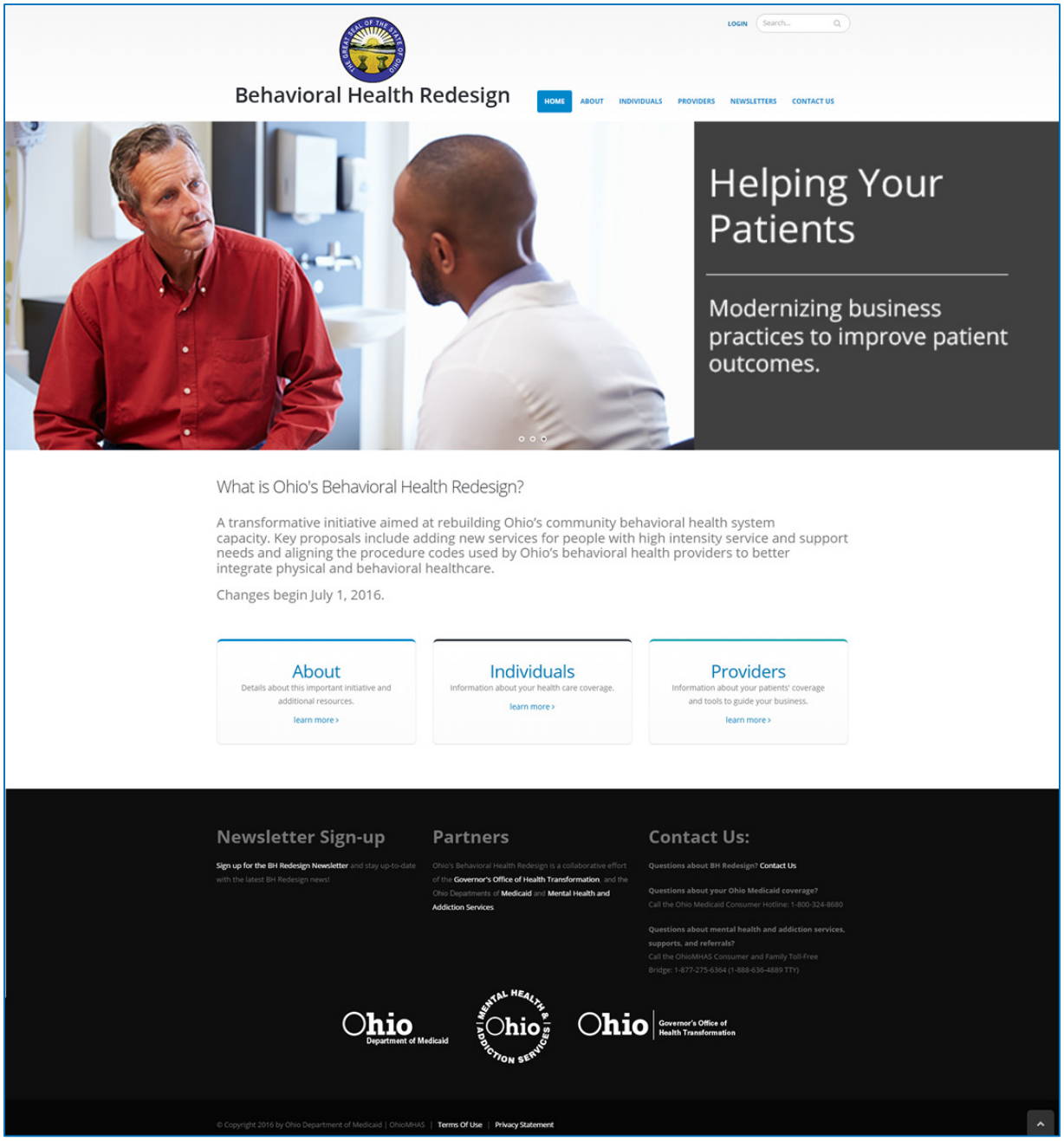
Behavioral Health Redesign

Behavioral Health Redesign Website

Go To:
bh.medicaid.ohio.gov

Sign up online for the ***BH Redesign Newsletter.***

Go to the following OhioMHAS webpage: http://mha.ohio.gov/Default.aspx?tabid=154 and use the "BH Providers Sign Up" in the bottom right corner to subscribe to the BH Providers List serve.



Questions?