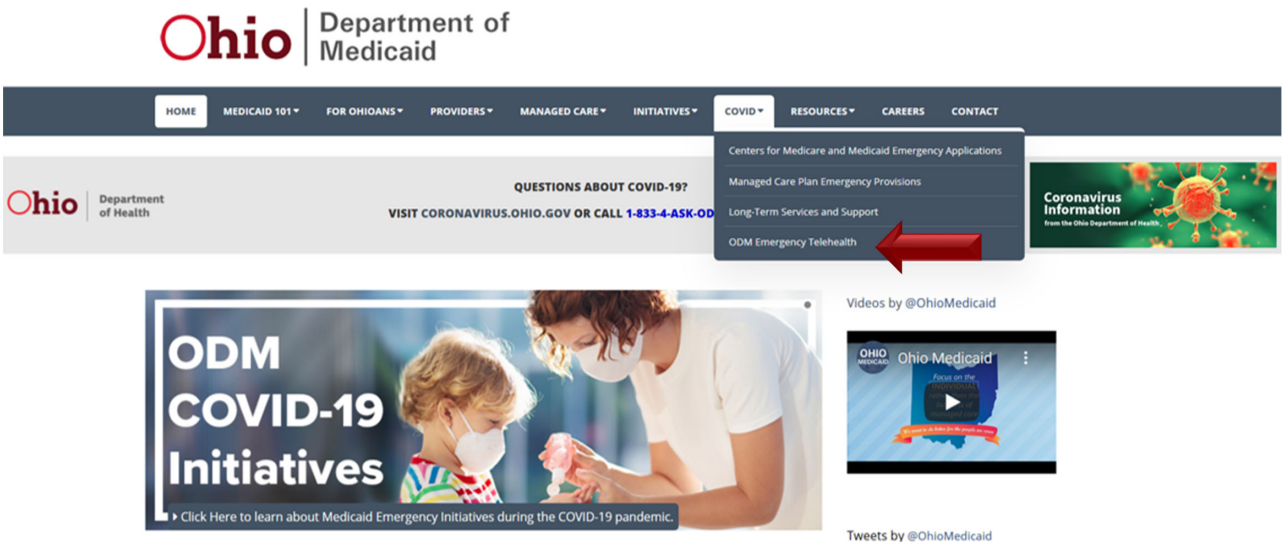
Policy

Ohio | Department of Medicaid

COVID-19



Ohio | Department of Medicaid

COVID-19, cont.

HOME | MEDICAID 101 | FOR OHIOANS | PROVIDERS | MANAGED CARE | INITIATIVES | COVID | RESOURCES | CAREERS | CONTACT

COVID > ODM Emergency Telehealth

Ohio | Department of Health

QUESTIONS ABOUT COVID-19?

VISIT CORONAVIRUS.OHIO.GOV OR CALL 1-833-4-ASK-ODH FOR ANSWERS.

The Ohio Department of Medicaid is working to make access to care easier and more flexible during the COVID-19 pandemic. The agency, in partnership with the Governor's office, our sister agencies as well as managed care plans, providers and consumers, has:

- Expanded telehealth services to include a wide array of medical, clinical and behavioral health providers and counselors
- Eased technology restrictions on patient-physician interaction to deliver telehealth services
- Reduced prior authorization requirements to for many medical and behavioral services
- Enhanced pharmacy benefits, eliminating in- and out-of-network restrictions, pharmaceutical co-pays while increasing pharmacy reimbursements for over the counter medications
- Enabled nursing home and congregate care members to access telehealth services with no prior authorization

Learn more about the emergency provisions now in place for Medicaid beneficiaries and their providers

OHIO MEDICAID EMERGENCY TELEHEALTH GUIDANCE

- Executive Order 2020-05D - ODM-OMAS Emergency Telehealth Guidance
- Updated list of COVID-19 Telehealth Rules Frequently Asked Questions (Version 2)
- Telehealth Billing Guidelines During COVID-19 State of Emergency
  Please Note: this document does NOT apply to OhioMHAS-certified providers.
- COVID-19 Telehealth Billing Desk Guide
- Ohio Medicaid Emergency Telehealth Infograph 04/13/2020
- ODM-OMAS Emergency Telehealth BH Provider Presentation Deck

Ohio | Department of Medicaid

COVID-19, cont.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC and FQHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.
- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.
- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/ FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

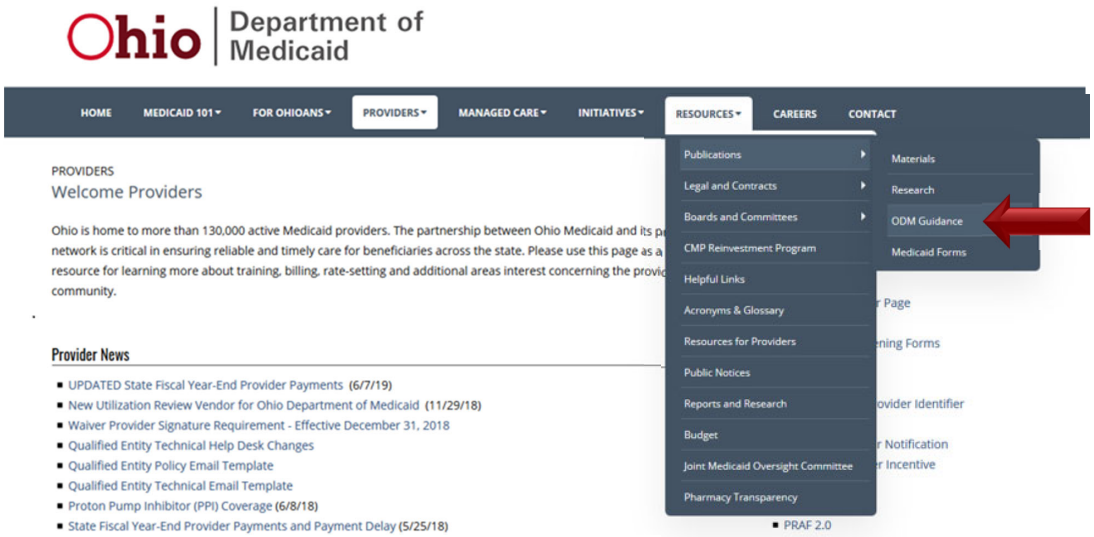
Ohio Medicaid announces changes to the Ohio Administrative Code and guidance/clarification that may affect providers via letters. There are two types of letters:

Medicaid Transmittal Letters (MTL)

Medical Assistance Letter (MAL)

Ohio | Department of Medicaid

Policy



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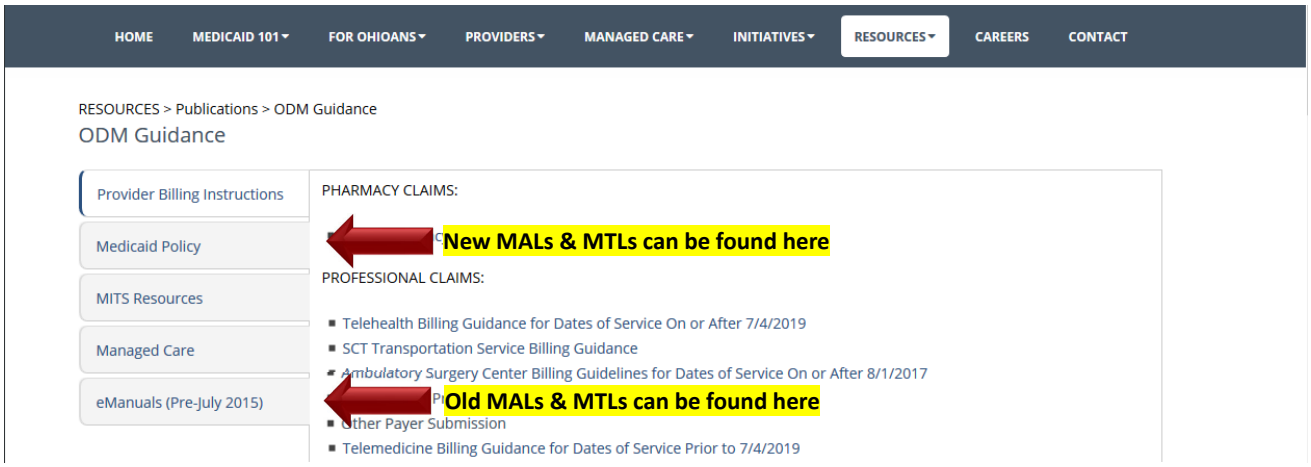

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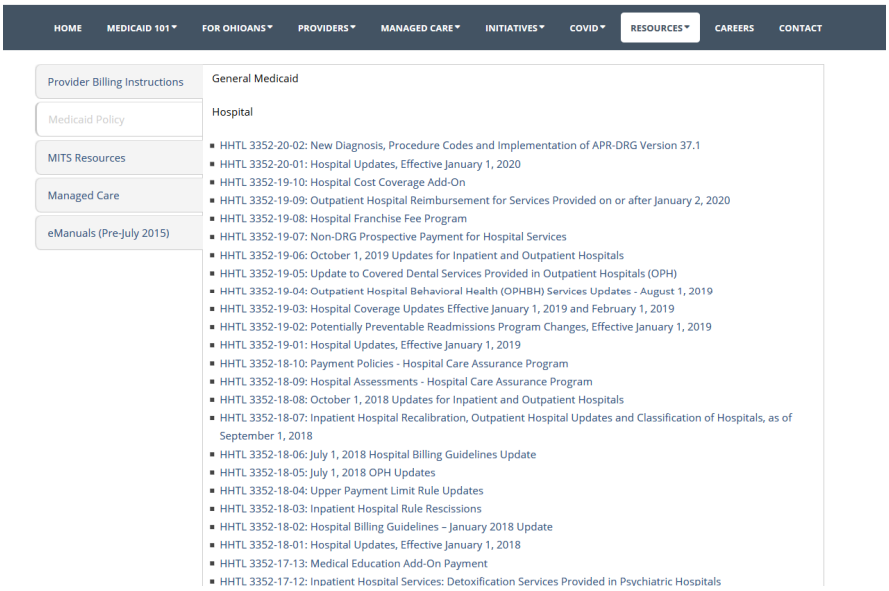

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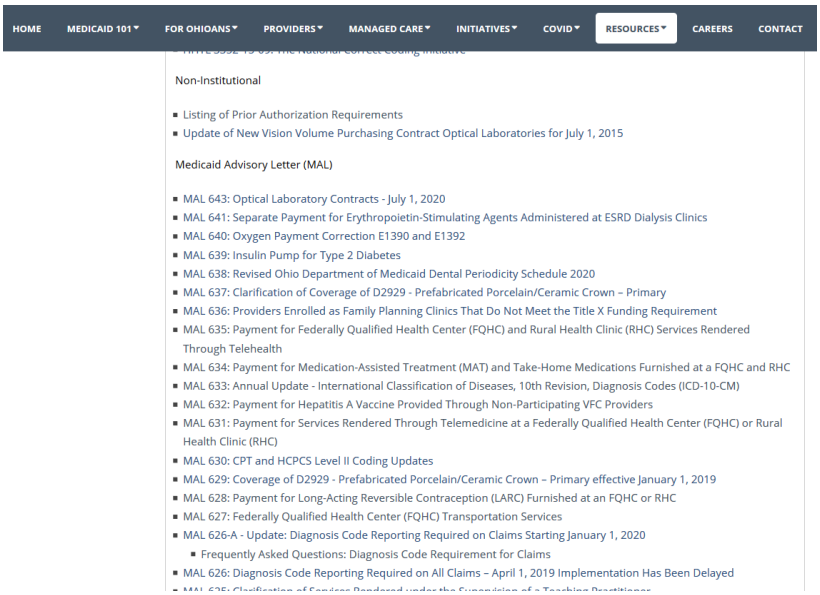

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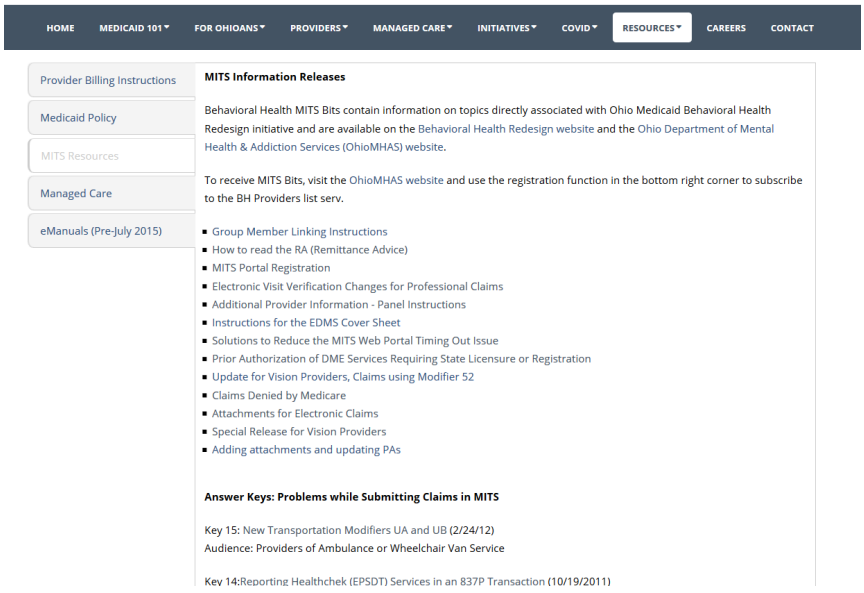

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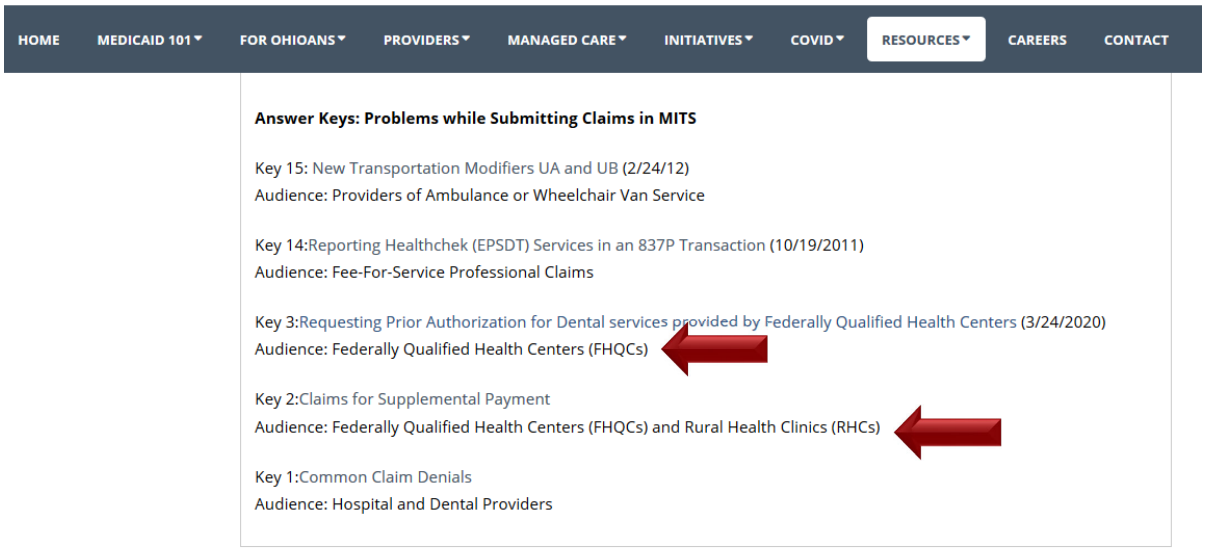

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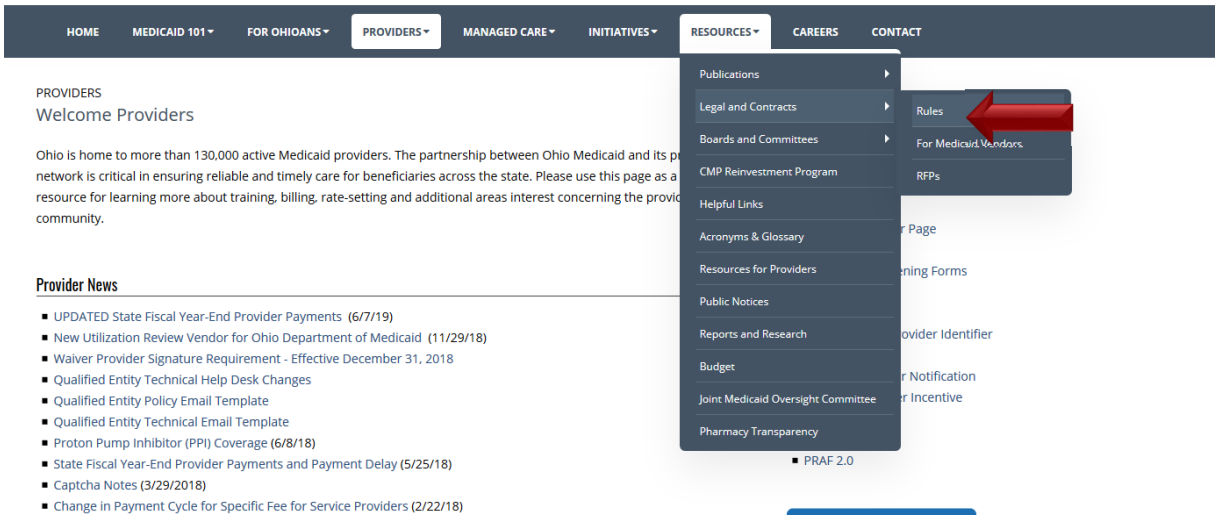

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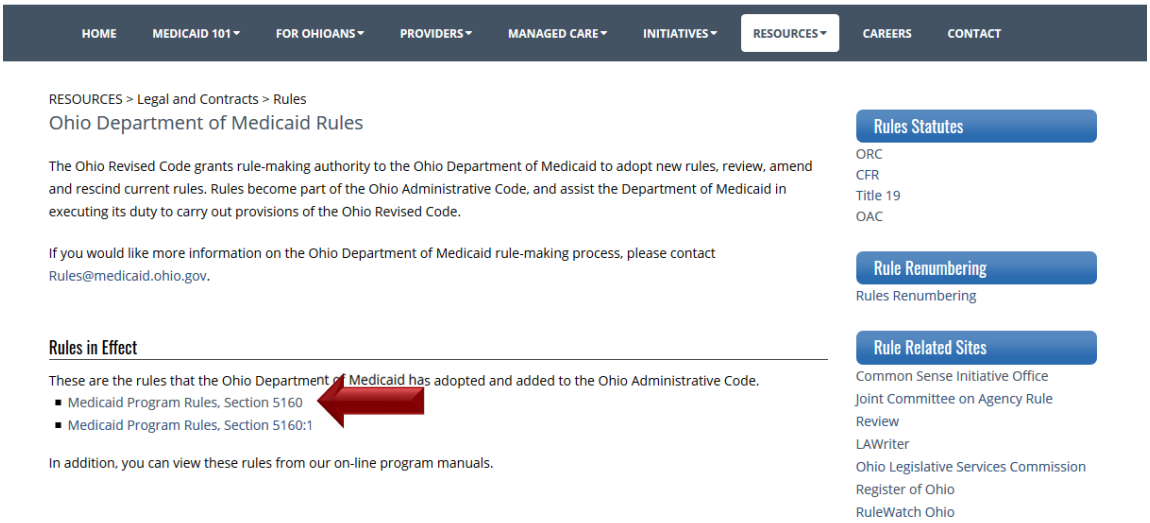

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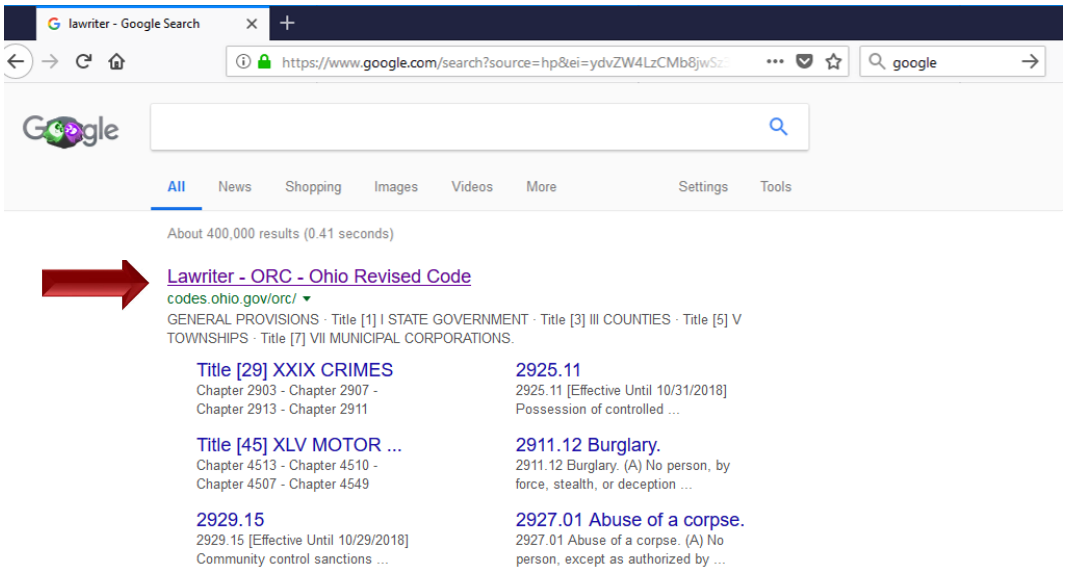

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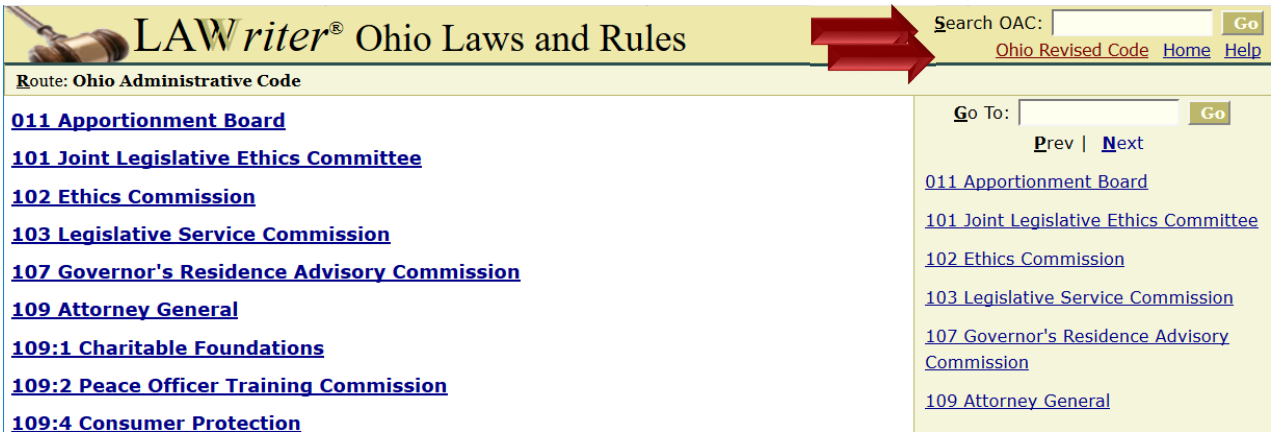

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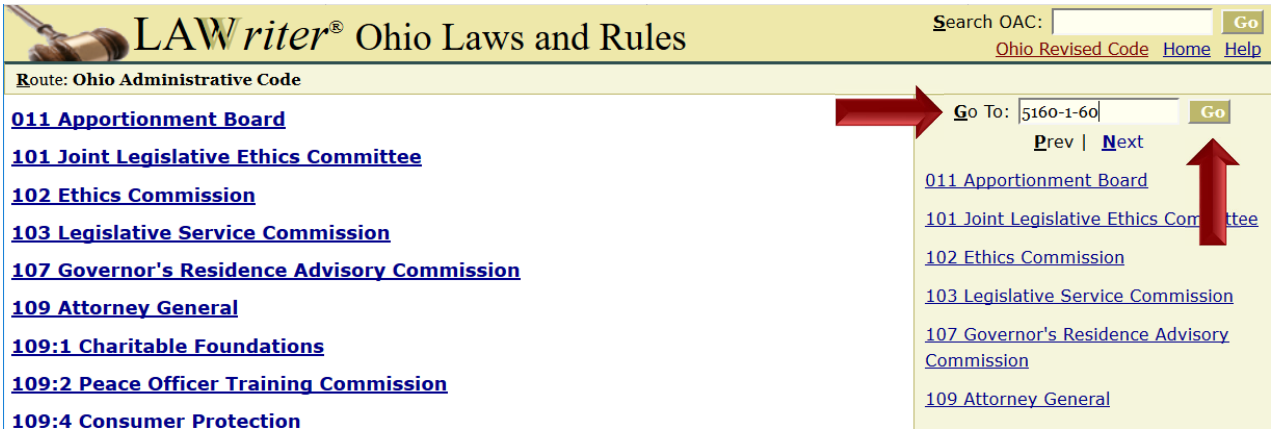

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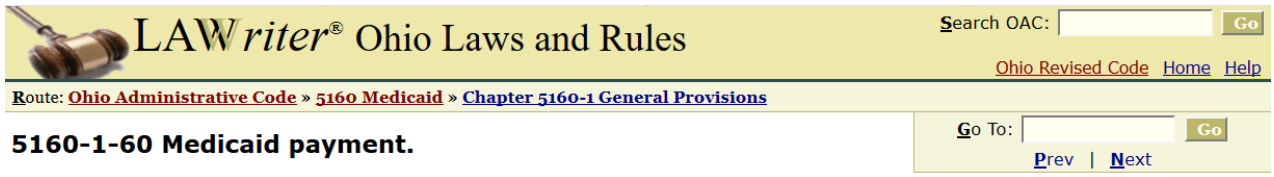
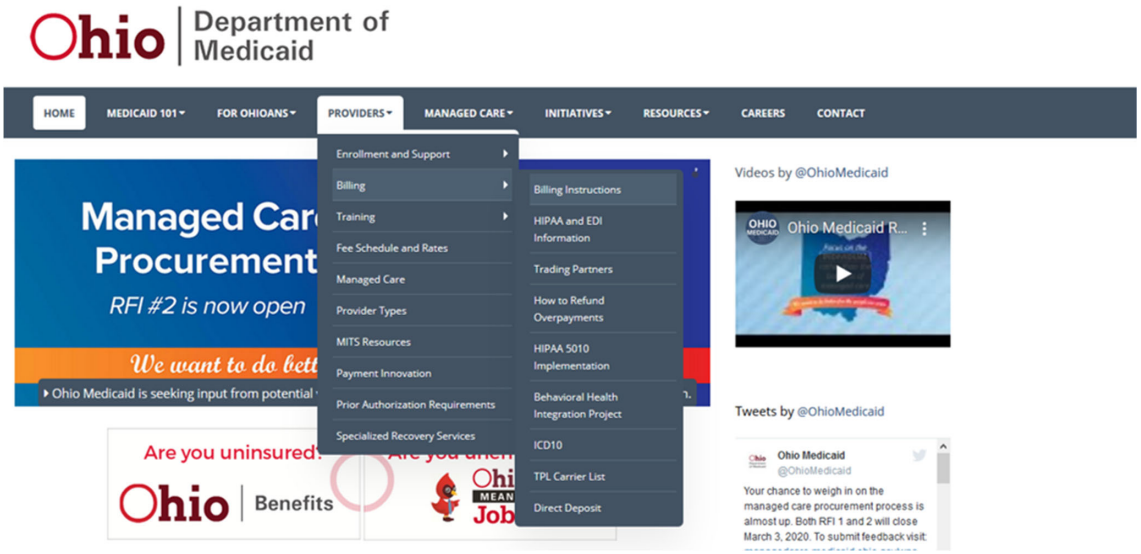


5160-1-60 Medicaid payment.

(A) The medicaid payment for a covered procedure, service, or supply constitutes payment in full and may not be construed as a partial payment when the payment amount is less than the provider's submitted charge. A provider may not collect from a medicaid recipient nor bill a medicaid recipient for any difference between the medicaid payment and the provider's submitted charge, nor may a provider ask a medicaid recipient to share in the cost through a deductible, coinsurance, copayment, or other similar charge other than medicaid copayments as defined in rule 5160-1-09 of the Administrative Code. Nothing in agency 5160 of the Administrative Code, however, precludes a provider from requesting payment, collecting, or waiving the collection of medicare copayments from a medicaid recipient for medicare part D services. Medicaid recipient liability provisions set forth in rule 5160-1-13.1 of the Administrative Code do not apply to medicare part D services.

(B) Providers are expected to submit their usual and customary charge (the amount charged to the

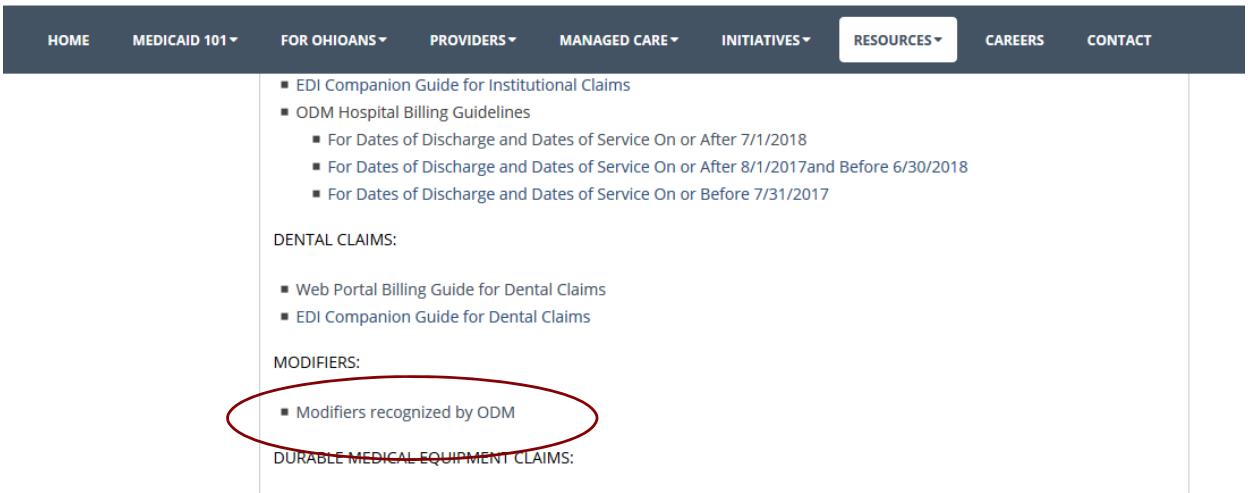
How to Find Modifiers Recognized by Ohio Medicaid



Ohio | Department of Medicaid

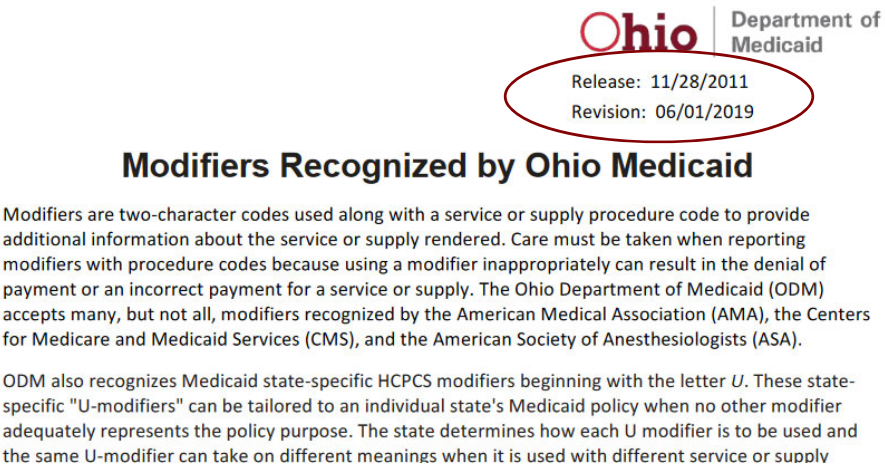
How to Find Modifiers Recognized by Ohio Medicaid

- Scroll to the bottom of the page



❑ Modifiers Recognized by Ohio Medicaid

Medicaid.ohio.gov -> Providers -> Billing -> Billing Instructions



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Release: 11/28/2011
Revision: 06/01/2019

Modifiers Recognized by Ohio Medicaid

Modifiers are two-character codes used along with a service or supply procedure code to provide additional information about the service or supply rendered. Care must be taken when reporting modifiers with procedure codes because using a modifier inappropriately can result in the denial of payment or an incorrect payment for a service or supply. The Ohio Department of Medicaid (ODM) accepts many, but not all, modifiers recognized by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and the American Society of Anesthesiologists (ASA).

ODM also recognizes Medicaid state-specific HCPCS modifiers beginning with the letter *U*. These state-specific "U-modifiers" can be tailored to an individual state's Medicaid policy when no other modifier adequately represents the policy purpose. The state determines how each U modifier is to be used and the same U-modifier can take on different meanings when it is used with different service or supply

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Prospective Payment System (PPS)

- ODM complies with provisions set forth in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)
  - Requires states to establish a PPS for FQHCs and RHCs
  - A separate all-inclusive per-visit payment amount (PVPA) is established for each FQHC or RHC service provided at a FQHC or RHC service site
  - PVPAs are specific to an FQHC or RHC service site
  - No FQHC or RHC service site may submit claims based on the PVPAs of another service site

MAL No. 621

- Prohibition of commingling in FQHCs and RHCs
  - RHC and FQHC practitioners may not render or separately submit claims for FQHC or RHC covered services as another type of provider in the FQHC or RHC, or in an area outside of the certified FQHC or RHC space such as a treatment room adjacent to the FQHC or RHC, during FQHC or RHC hours of operation
  - FQHC and RHC providers may only submit claims for non-FQHC and RHC services if the service cannot be claimed as an FQHC or RHC service as set forth in paragraph (B) of OAC rule 5160-28-03.1

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MAL No. 622

- Effective July 1, 2018
- FQHCs and RHCs must report on their claim individual practitioners' National Provider Identifiers (NPIs) in the rendering provider field
- For Electronic Data Interchange (EDI) submissions, the individual rendering providers' NPIs will be reported in the 2310B Rendering Provider loop
- Claims will be rejected if they do not include the individual practitioner's NPI

MAL No. 622-A

- Update to MAL No.: 622
- Services rendered by mid-level health care workers (e.g, registered nurses) and unlicensed dependent practitioners (i.e., behavioral health trainees) should continue to be reported under the overseeing practitioner's NPI
- Transportation, DME, laboratory, and radiology should continue to be reported under the organizational NPI

Ohio | Department of Medicaid

MAL No. 624

- Group therapy services do not meet the criteria for a face-to-face encounter in a FQHC or RHC
- FQHCs and RHCs may submit claims for group therapy using their ambulatory health care clinic (AHCC - provider type 50) number

MAL No. 627

- Transportation services
- FQHCs are allowed up to 4 transports on the same date of service for the same individual
- Example:
  - Trip to one FQHC for medical service
  - Trip to another FQHC for mental health service
  - Trip back to first FQHC for pick-up of medications
  - Trip home
- T1015 U9 with up to 4 units and T2003 with up to 4 units

Ohio | Department of Medicaid

MAL No. 628

- Payment for Long-Acting Reversible Contraception (LARC) furnished at a FQHC or RHC
- In addition to submitting a claim for a medical visit for a LARC insertion procedure, separate payment may be made for a LARC device or implant
  - Claim may be submitted using the AHCC (provider type 50) number

MAL No. 632

- Payment for Hepatitis A Vaccine Provided Through Non-Participating VFC Providers
  - ODM developed an avenue to provide a Hepatitis A vaccination to high risk or exposed individuals as quickly as possible
  - Enables providers to be reimbursed for both the administration and the vaccine toxoid component
  - Effective May 1, 2019, non-participating VFC providers can also be reimbursed for administration code (CPT 90471) and the Hepatitis A vaccines (CPT codes 90633 and 90634)
  - The **SK** modifier must be reported with the appropriate vaccine code

Ohio | Department of Medicaid

MAL No. 634

- Separate payment will be made for Medication-Assisted Treatment (MAT) and take-home medications furnished at a FQHC or RHC
- In order to be paid, practitioners must submit the Drug Addiction Treatment Act of 2000 (DATA 2000) waiver and obtain the provider specialty 704 in MITS

MAL No. 634, cont.

- FQHC or RHC may be paid for evaluation & management (E&M) service associated with the MAT and the administered pharmaceutical(s)
  - J0571 – J0575, J8499
- In addition a separate claim for the dispensing of the medication may be submitted under the AHCC (provider type 50) number
  - T1502 – Dispensing of the medication
  - S5000, S5000 HD, S5001 – Take home medication

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MAL No. 631

- Telehealth services rendered at a FQHC or RHC
  - Payment (including wraparound payment) is made under the prospective payment system (PPS) of the FQHC or RHC
    - Modifier GT must be appended to the procedure code

MAL No. 635

- Payment for FQHC and RHC Services Rendered Through Telehealth
  - FQHCs and RHCs must follow the claims submission guidance in "Telehealth Billing Guidance for Dates of Service On or After 7/4/19"
  - Payment (including wraparound payment) for covered FQHC and RHC services listed in OAC rules 5160-28-03.1 and 5160-28-3.3 is made under the prospective payment system (PPS)

Ohio | Department of Medicaid

Qualified entity requirements and responsibilities for determining presumptive eligibility: 5160-1-17.12

- Effective 11/9/2019
- To become a Qualifying Entity (QE) a facility must:
  - Have an active provider agreement
  - Read the presumptive eligibility (PE) training guide found on ODM's website
  - Attest that it will meet the terms and conditions as a QE by reading, signing, and sending form ODM 10252

Qualified entity requirements and responsibilities for determining presumptive eligibility: 5160-1-17.12, cont.

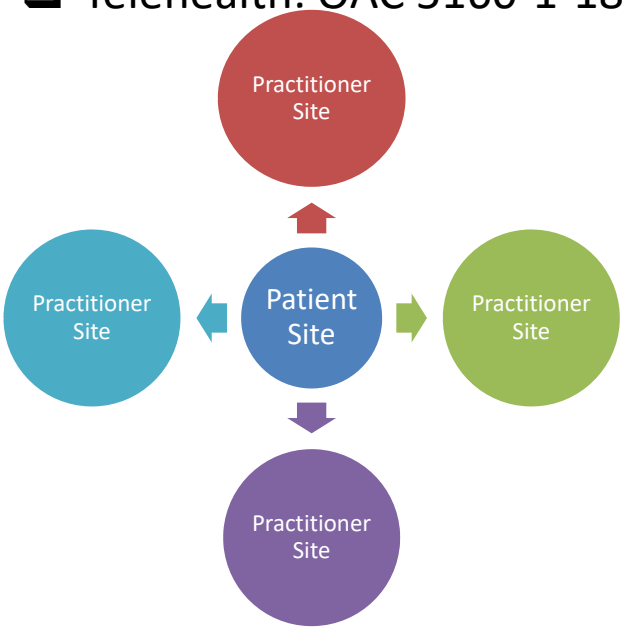
- Once designated as a QE, a facility must:
  - Remain in good standing as an ODM provider
  - Follow OAC 5160:1-2-13 & all applicable federal & state laws when determining Medicaid PE
  - Verify the individual is not already enrolled
  - Without compensation, agree to perform all of the administrative functions associated with PE

Ohio | Department of Medicaid

Qualified entity requirements and responsibilities for determining presumptive eligibility: 5160-1-17.12, cont.

- Guidelines to remain a QE:
  - If the QE is a FQHC and is able to do so, provide thirty-six hours' worth of medically necessary medications to any person enrolled presumptively by the QE at the time of determination if such needs are determined during a medical visit
  - At least eighty-five percent of all persons enrolled presumptively by the QE have completed application for full Medicaid
  - At least eighty-five percent of individuals completing application for full Medicaid result in an awarding of Medicaid eligibility

❑ Telehealth: OAC 5160-1-18



NEW

- Terminology changed from Telemedicine to Telehealth
- Patient location is flexible (includes home or school)
- No Distance Requirement between patient and practitioner site
- Practitioner location is flexible (includes home under certain circumstances)
- No originating site or patient site fee can be billed

Ohio | Department of Medicaid

❑ Telehealth: OAC 5160-1-18, cont.

➢ Expanded Practitioner type to include:

- Physician Assistant
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Podiatrist
- Licensed Independent Behavioral Health Providers (LISW, LICDC, LIMFT, LPCC)

❑ Telehealth: OAC 5160-1-18, cont.

- Practitioner Locations include:
  - No restriction on practitioner's location if patient is *active* or if provider working for a Comprehensive Primary Care (CPC) practice
  - If patient is not *active* or practice is not a CPC practice, practitioner location must be office

* At least one in person exam or assessment of the patient by the telehealth practice within the previous twelve month period

Ohio | Department of Medicaid

Ambulatory Health Care Clinic (AHCC) – Provider Type 50

- FQHCs/RHCs may use a second Medicaid provider number to submit claims for non-FQHC/RHC services
- Examples of AHCC services:
  - Inpatient hospital surgery, visits, or consultations
  - Medicare crossover claims
  - Durable Medical Equipment
  - Group Therapy Services
  - Chronic Care Management
  - Take home drugs billed through pharmacy program per OAC 5160-9
  - Medical nutrition therapy services when rendered by a registered dietitian
  - Acupuncture when rendered by an acupuncturist

Cost-based clinics: definitions and explanations: 5160-28-01

- (P)(2) Multiple encounters with one or multiple health professionals constitute a single visit if all of the following conditions are satisfied:
  - (a) All encounters take place on the same day
  - (b) All contact involves a single cost-based clinic service; and
  - (c) The service rendered is for a single purpose, illness, injury, condition, or complaint
- (3) Multiple encounters constitute separate visits if one of the following conditions is satisfied:
  - (a) The encounters involve different cost-based clinic services; or
  - (b) The services rendered are for different purposes, illnesses, conditions, or complaints or for additional diagnosis and treatment

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Cost-based clinics: submission and payment of FQHC claims: 5160-28-08.1

- (A) Claims for services provided to managed care organization (MCO) enrollees, including requests for prior authorization by an MCO of a Federally Qualified Health Center (FQHC) service, must be submitted in accordance with Chapter 5160-26 of the Administrative Code
- (B) In claims submitted to the department for all other services, an FQHC must include the following data:
  - (1) procedure code for an encounter;
  - (2) appropriate modifier to specify the FQHC service; and
  - (3) additional codes representing all procedures performed during the encounter, along with any required modifiers

Cost-based clinics: submission and payment of FQHC claims: 5160-28-08.1, cont.

- (C) In claims submitted to the department for supplemental payment for services provided to an MCO enrollee, an FQHC must also include the following data:

  (1) The name of the MCO that paid for the FQHC service;
  (2) The identification code of the MCO, assigned by the department;
  (3) The MCO payment plus amounts received from any other third party payers; and
  (4) Any other information, such as an adjustment reason code, that is necessary for the coordination of benefits

Ohio | Department of Medicaid

Dental Services: 5160-5-01

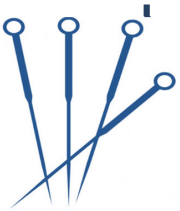
- Some dental services require tooth or quadrant number distinction (extractions, crowns, scaling & planning etc.)

- There is not a place on the professional claim form to notate this information

- FQHCs and RHCs cannot use the tooth or quadrant number fields on the prior authorization
  - This information should be entered in the Provider Notes
  - You should also enter a comment stating you are a FQHC or RHC

Acupuncture Services: OAC 5160-8-51

- Providers eligible to receive payment for acupuncture:
  - An acupuncturist
  - A recognized acupuncture provider
  - Ambulatory health care clinic as defined in OAC 5160-13
  - FQHCs and RHCs
  - Professional medical group



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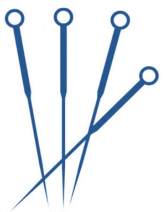
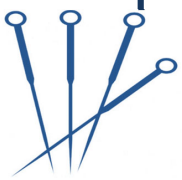
Acupuncture Services: OAC 5160-8-51, cont.

- Payment may be made for service that meets the following:
  - Is medically necessary per OAC 5160-1-01
  - Is performed at the written order of a practitioner, during the one year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code
  - Is rendered by a practitioner who is enrolled in the Medicaid program
  - Is rendered for treatment of:
    - Low back pain
    - Migraine
- Payment for more than 30 visits per benefit year requires prior authorization



Acupuncture Services: OAC 5160-8-51, cont.

- No separate payment will be made for both an evaluation & management service and acupuncture service rendered by the same provider to the same individual on the same day
- No separate payment is made for services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
- No separate payment will be made for additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period
  - Symptoms worsen over a course of treatment



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❑ Other Policy Updates, cont.

- Effective 7-1-2019
- ODM replaced McKesson ClaimCheck
- Change Healthcare ClaimsXten Select (CXT-S) is now utilized
  - ODM implemented a fix on 10/25/19 to allow payments of preventive visit and the office visit procedures together
  - This fix also corrected smoking cessation denials*

    * Modifier 25 must be appended to the denied detail

- Policy Next Steps

Five Year Rule Review

Ohio | Department of Medicaid

Questions?