



Governor's Office of
Health Transformation

Benefit and Service Development Work Group

May 18th, 2016



Behavioral Health Redesign

Agenda

BH In Scope Topic Updates

- ✓ Respite Overview
 - ✓ Urinalysis
 - ✓ Opioid Treatment Program
 - ✓ SUD Residential
 - ✓ MH Day Treatment and MH Day Treatment TBS Per Diem Program
 - ✓ Coverage and Limitations Guidance
-

Douglas Day

Next Steps

- ✓ High Fidelity Wraparound
 - ✓ Mobile Crisis and BH Urgent Care
 - ✓ Budget Model and *Draft* Final Rates
 - ✓ Other Updates
-

Angie Bergefurd



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Topic:
In Scope Topics - Update



Behavioral Health Redesign

Behavioral Health Redesign Project Scope

The below table lists the key topics that are within scope for overall BH Redesign moving forward

Behavioral Health Redesign Scope

Solutions Identified

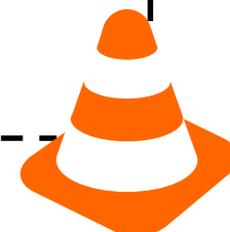
- ✓ ASAM Levels of Care
- ✓ Genetic Testing (E&M Services)
- ✓ Psychological Testing
- ✓ SBIRT
- ✓ School Psychologists
- ✓ Crisis
- ✓ Peer Recovery Support
- ✓ Opioid Treatment Programs
- ✓ Partial Hospitalization, Day Treatment and Intensive Outpatient
- ✓ SUD Group Counseling
- ✓ SUD Residential
- ✓ Early Childhood, Early Intervention
- ✓ Urinalysis
- ✓ High Fidelity Wraparound for Kids

Solutions Under Development

- Pharmacists
- MCP and Provider Interaction
- Benefit Packages, Prior Authorization and Continued Stay Criteria
- Care Coordination
- CPT Rate Adjustments
- ACT and IHBT



Additional information on topics in green are located in the appendix





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Topic:
Respite Overview



Behavioral Health Redesign

Current Medicaid Managed Care Waiver for Respite: Overview



What is Respite?

- "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of an individual under the age of twenty-one in order to support and preserve the primary caregiving relationship.
 - » The service provides general supervision of the child, and meal preparation and hands-on assistance with personal care that are incidental to supervision of the child during the period of service delivery.



Key Provisions*

- 1 Respite services can be provided on a planned or emergency basis
- 2 May only be furnished in the child's home
- 3 Provider must be awake during the provision of respite services
- 4 Services shall not be provided overnight

[*OAC 5160-26-03](#)

Current Provider Eligibility



Before commencing service delivery, the provider agency employee *must*:



After commencing service delivery, the provider agency employee *must*:

- Obtain a certificate of completion of either a competency evaluation program or a training and competency evaluation program, approved or conducted by the Ohio Department of Health* or the Medicare competency evaluation program for home health aides**, and
- Obtain and maintain First Aid certification from a class that is not solely Internet-based and that includes hands-on training by a certified First Aid instructor, with a successful return demonstration.

- Maintain evidence of completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation, and
- Receive supervision from an Ohio-licensed RN and meet any other additional supervisory requirements pursuant to the agency's certification or accreditation***.

* under Section [3721.31](#) of the Revised Code

** as specified in 42 CFR 484.36 (October 1, 2013)

*** respite services must not be delivered by the child's legally responsible family member or foster caregiver

Current Consumer Eligibility for Receiving Respite



To be eligible for respite services, the member must meet all of the following criteria*:

- Reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services;
- Not be residing in foster care;
- Under the age of 21 and **determined eligible for social security income for children with disabilities or supplemental security disability income;**
- Enrolled in the managed care plan's care management program;
- **The member must be determined by the MCP to meet an institutional level of care;**
- **Requires skilled nursing or skilled rehabilitation services at least once per week;**
- **Received at least 14 hours per week of home health aide services for at least six consecutive months immediately preceding the date respite services are requested, and**
- The managed care plan must have determined that the child's primary caregiver has a need for temporary relief from the care of the child as a result of the child's long term services and support needs/disabilities, or in order to prevent the provision of institution or out-of-home placement.

Red text indicates areas of upcoming changes.

Eligibility Criteria Under Revision

Consumer Eligibility criteria will be opened up. Criteria will include:



Those eligible for social security income for children with disabilities or supplemental security disability income

OR...



Those meeting diagnosis and functional criteria along with additional parameters (*TBD*)

Soliciting Feedback for Respite Eligibility

Topics for discussion



What are the key differences between in-home versus out-of-home respite services?



What accreditations could be accepted for certification?



Eligibility criteria will be modified to accommodate additional clinical diagnosis and criteria.



Overnight will be an available option.



Current limit of 250 hours annually (24 hours monthly) will be modified based on actuarial analysis.

Services for Children Including Early Intervention

Qualifying Diagnoses

✓ For behavioral health services provided by licensed practitioners to children (from birth to 21), there will be no claims edits in MITS on diagnosis.

✓ Services must be medically necessary.



✓ Diagnosis must be determined by a practitioner who is authorized to diagnose.

✓ Services may be subject to post-payment review.



Reminder: Recognized [ICD-10 codes](#) for behavioral health services will expand starting July 1, 2016.



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Topic:
Urinalysis



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Urinalysis

Billing H0048 allows providers increased flexibility to perform a urinalysis and review results in real time, instead of sending the results to a lab for analysis.



Key Considerations for Urinalysis

- H0048 (\$11.48) will replace H0003 (\$60.00), which includes the time associated with obtaining the sample and includes the cost of the collection materials. Lab testing will be billed directly by the lab.
- Urinalysis will be included as part of the SUD residential rate that providers will bill as a per diem; it cannot be billed separately.



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Topic:
Opioid Treatment Program



Behavioral Health Redesign

Opioid Treatment Program – Follow Up

The below rates have been aligned with the commercial pharmacy rates

J-code	Description	Price
J0571	BUPRENORPHINE ORAL 1MG	\$0.55
J0572	BUPRENORPHINE/NALOXONE, ORAL, LESS THAN OR EQUAL TO 3 MG BUPRENORPHINE	\$4.20
J0573	BUPRENORPHINE/NALOXONE, ORAL, GREATER THAN 3 MG, BUT LESS THAN OR EQUAL TO 3.1 TO 6 MG BUPRENORPHINE	\$7.53
J0574	BUPRENORPHINE/NALOXONE, ORAL, GREATER THAN 6 MG, BUT LESS THAN OR EQUAL TO 10 MG BUPRENORPHINE	\$10.33
J0575	BUPRENORPHINE/NALOXONE, ORAL, GREATER THAN 10 MG BUPRENORPHINE	\$15.82

Buprenorphine Treatment – Follow Up



Key Considerations



Bill unsupervised take-home doses on the day that they are dispensed



Additional clarification will be available in the Provider Manual

Methadone Treatment – Follow Up



Key Considerations



Do not bill unsupervised take-home doses on the day that they are to be taken



Unsupervised take-home doses are covered as part of the Methadone administration payment billed on the day they are dispensed



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Topics:
SUD Residential



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SUD Residential

The state and selected SUD providers met on April 6th, 2016, to review the SUD Residential budgeting data inputs. Based on this meeting and the last Benefit and Service Development Work Group meeting, providers returned an analysis of current staffing compared to the state's requirements.

Updates...

- ✓ Removing addiction accreditation for physicians.
- ✓ Based on feedback from the provider survey, current staffing levels are higher than the recommended staffing levels in the manual. Rates will remain "as is" based upon the recommended staffing levels.

Code	Modifier	Definition	Rate
H0010		Alcohol and/or drug services; sub acute detoxification (residential addiction program inpatient).	\$256.33
H0011		Alcohol and/or drug services; acute detoxification (residential addiction program inpatient).	\$392.86
H0012		Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)	\$360.36
H2034		Alcohol and/or drug abuse halfway house services, per diem.	\$158.99
H2036	HI	Alcohol and/or other drug treatment program, per diem. Cognitive Impairment.	\$152.57
H2036		Alcohol and/or other drug treatment program, per diem.	\$213.70
H2036	TG	Alcohol and/or other drug treatment program, per diem.	\$303.49



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Topics:
**MH Day Treatment & TBS Per Diem
Programs**



Behavioral Health Redesign

MH Day Treatment Group Activities

Rate Development and Methodology

H2012
Modifiers:
HN HQ

Assumes 1 hour of unlicensed BA⁺² in an average group size of 4

\$18.54
Hourly Per Person

H2012
Modifiers:
HO HQ

Assumes 1 hour of unlicensed MA⁺¹ in an average group size of 4

\$21.05
Hourly Per Person

H2012
Modifiers:
HK HQ

Assumes 1 hour of licensed practitioner in an average group size of 4

\$28.10
Hourly Per Person

Additional Details

1. Maximum group size: 1:12 Practitioner to client ratio
 - a. For MH 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 may be used for licensed practitioner or H2019 (HQ: Modifier for group) may be used for the BA⁺² and MA⁺¹.
2. All other services must be billed outside of 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.

Nationally Accredited and Clinically Supervised MH Day Treatment TBS Per Diem Program

Rate Development and Methodology

H2020
HQ Modifier
HN Modifier

Assumes 5 hours of unlicensed BA⁺² providing group counseling in an average group size of four

\$92.70*
Per Diem Per Person

H2020
HQ Modifier
HO Modifier

Assumes 5 hours of unlicensed MA⁺¹ providing group counseling in an average group size of four

\$105.25*
Per Diem Per Person

H2020
HQ Modifier
HK Modifier

Assumes 5 hours of licensed practitioners providing group counseling in an average group size of four

\$140.51
Per Diem Per Person

Additional Details

- Maximum group size: 1:12 Practitioner to client ratio
 - For Nationally Accredited and Clinically Supervised MH Day treatment TBS Per Diem Programs, only used if the person attends for the minimum needed to bill the per diem (2.5+ hours)
 - If the practitioner does not meet minimum qualifications or the beneficiary does not meet minimum admission criteria, H2019 (HQ: Modifier for group) may be used for the BA⁺² and MA⁺¹ - *See Current Partial Hospitalization Definition (Ohio)*.
 - Service is billed in whole unit only.
 - All other services must be billed outside of 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.
- Only one H2020 per diem, per patient, per day**
- Must be nationally accredited (COA, CARF or the Joint Commission)***
- Must be supervised by a licensed independent practitioner***

*Rates are under revision based upon the addition of the new criteria



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Topics:
Coverage and Limitations Guidance



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Coverage and Limitations Guidance

Topic	Current Coverage and Limitations
 <p>Nationally Accredited and Clinically Supervised MH Day treatment TBS Per Diem Program</p>	<ul style="list-style-type: none"> • One H2020 per diem, per patient, per day
 <p>ASAM: Outpatient</p>	<ul style="list-style-type: none"> • Adults: <9 hours per week of skilled treatment services • Adolescents: <6 hours per week of skilled treatment services
<p><u>H0015</u> Applies to Both IOP and PH – Billed Once Per Day, Per Patient</p>	
 <p>ASAM: Intensive Outpatient</p>	<ul style="list-style-type: none"> • Adults: 9-19.9 hours per week of skilled treatment services • Adolescents: 6-19.9 hours per week of skilled treatment services • One per diem, per patient, per day
 <p>ASAM: Partial Hospitalization</p>	<ul style="list-style-type: none"> • Adults and Adolescents: >20 hours per week • One per diem, per patient, per day

Coverage and Limitations Guidance

Topic	Current Coverage and Limitations
 <p>Psychological Testing</p>	<ul style="list-style-type: none"> 8 hours per calendar year (prior authorization to exceed)
 <p>Screening, Brief Intervention and Referral to Treatment</p>	<ul style="list-style-type: none"> One per patient, per provider, per code, per year (G0396 and G0397). Cannot be billed by provider type 95
 <p>Psychiatric Diagnostic Evaluation: 90791 & 90792</p>	<ul style="list-style-type: none"> 1 encounter per person per calendar year (90791 and for 90792). Prior Authorization after 1 encounter.
 <p>Evaluation and Management Codes (New and Existing Patient)</p>	<ul style="list-style-type: none"> 1 per day, per practitioner, per patient (NCCI) – may be subject to SURS review if in excess of 24 visits per calendar year across all billing providers
 <p>Specialized Recovery Services Program: Individualized Placement Support: Supported Employment</p>	<ul style="list-style-type: none"> Must be provided in accordance with the approved Person Centered Care Plan
 <p>Specialized Recovery Services Program: Peer Recovery Support</p>	<ul style="list-style-type: none"> No more than 4 hours daily; and Must be provided in accordance with the approved Person Centered Care Plan
 <p>Urinalysis – H0048</p>	<ul style="list-style-type: none"> 1 Per day



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Topic:
Next Steps



Behavioral Health Redesign

Therapeutic Behavioral Services Small Group Debrief

Bill: CPT Codes

Physicians (Or
equivalent)



CPT Codes Would Include the Following Types of Services:

1. Assessments
2. Psychological Testing
3. Individual/Group/ Family Therapy
4. Crisis



Gap Identified for Licensed Practitioners:

- ✓ Behavioral Health Intervention / Skills Development (when not considered Psychotherapy by practitioner)

Licensed
Practitioners



Bill: HCPCS Codes – Unlicensed Practitioners

Unlicensed
TBS (H2019)

MAs⁺¹
BAs⁺²



HCPCS Code Would Include the Following Types of Services:

1. Development of Treatment plan
2. Service Planning
3. Care coordination
4. Collateral contacts
5. Identify triggers/Interventions
6. Individual/Group/Family Therapy



Key Consideration for Unlicensed Practitioners:

- ✓ Collateral contacts are allowed and billable under TBS (H2019)

Unlicensed
PSR (H2017)

HS, Assoc., Bach, or
Masters gaining
experience



HCPCS Code Would Include the Following Types of Services:

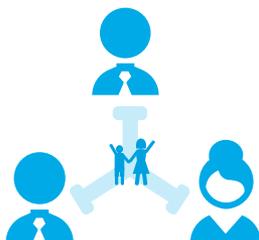
1. Implement the plan established

Key Topics: Next Steps



Budget Model

- *Budget Model and *Draft* Final Rates will be shared at the June 15 stakeholder meeting*



High Fidelity Wraparound

- *Work Group kick off meeting: Summer 2016*
 - *Meeting will be used to identify timeline for implementation*



Mobile Crisis and BH Urgent Care

- *Mobile Crisis and BH Urgent Care Work Group kick off meeting: Late Summer 2016*
 - Meeting will be used to identify timeline for implementation and identification of all payers involved

Next Steps and Schedule

Core Team/Benefit and Service Development Work Group Was Combined as of March 9th, 2016

- Next Benefit and Service Development Work Group
 - ✓ June 15th All meetings 10:00am – 12:00pm (unless otherwise specified)

Upcoming Benefit and Service Development Work Groups:

June 29th, 2016



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Topic: Appendix



Behavioral Health Redesign

Conversion Charts

Conversion Chart 15 Minute Based Services Reported in 15 Minute Increments		
Minimum Minutes	Maximum Minutes	Billing Unit(s)
Hour 1		
0	7	N/A
8	22	1
23	37	2
38	52	3
53	67	4
Hour 2		
68	82	5
83	97	6
98	112	7
113	127	8
Hour 3		
128	142	9
143	157	10
158	172	11
173	187	12
Hour 4		
188	202	13
203	217	14
218	232	15
233	247	16

Conversion Chart Hour Based Services Reported in Whole Unit Increments		
Minimum Minutes	Maximum Minutes	Billing Increment
1	30	N/A
31	90	1
91	150	2
151	210	3
211	270	4
271	330	5
331	390	6
391	450	7
451	510	8
511	570	9

School Psychologists

 Education	ODE Certification	Psychology Board Licensure
	<p>Must have a Master's Degree in School Psychology</p>	<p>Must meet the following criteria: 4 years of experience as a school psychologist (which can include master's program internship year), Pass the PRAXIS exam and Pass the Ohio Board of Psychology Oral Exam</p>
 Scope/Location	<p>Limited to school psychology within the scope of employment by a board of education or by a private school meeting the standards under division (D) of section 3301.07 of the Revised Code, or while acting as a school psychologist in a program for children with disabilities established under ORC Chapter 3323 or 5126.</p>	<p>Can practice school psychology independently under ORC 4732.01 (E)</p> <ul style="list-style-type: none"> Examples: Private practice, independently in a CMHC, hospital, etc.
 Psychologist and CBHC Interaction	<p>ADDITIONALLY – School Psychologists may work as a School Psychology Assistant, Trainee, or Intern when working in the community under the supervision of a Board Licensed School Psychologist or Psychologist. Psychologist must be registered with the Psychology Board.</p>	<p>Board Licensed Independent School Psychologist</p>

Registered Nurses and Licensed Practical Nurses

For services provided on and after January 1, 2017, three 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, there will be no exceptions:

Behavioral Health Codes for Nursing Activities

H2017

99211

H2019



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 Rendering type and education will be what drives this rate
- 3 These codes and the associated rates will be used during rate setting methodology

Added to State Plan Amendment (TBS): Nursing assessments and group medication education may only be performed by a registered nurse or a licensed nurse practicing with a Bachelor's degree within their current scope of practice.

CPT and HCPCS – Nursing Activities by RNs and LPNs

The below matrix provides examples of how components of nursing activities rendered by LPNs and RNs can be coded. LPNs must be supervised by a higher level medical practitioner.

Nursing Activity	Behavioral Health Interaction
Nursing Assessment (RN Only) 	<p>RN: 99211 should be used if the activity meets the criteria. Only use H2019 when 99211 is not appropriate or services are delivered outside of the office setting.</p> <p>LPN: 99211 should be used if the activity meets the criteria. Only use H2017 when 99211 is not appropriate or services are delivered outside of the office setting.</p>
Medication Assessment and Education 	
Symptom Management 	

Psychological Testing

The following codes were added to the rate chart and are currently covered under Medicaid, today (will continue post January 2017):

96101

96111

96116

96118

Additional Rate and Limitation Guidance

Code	Description	Limitation	Rate
96101	Psychological testing with interpretation and report, per hour.	8 hours per calendar year, any combination of the four psychological testing codes	\$59.26
96111	Developmental testing; extended with interpretation and report		\$56.11
96116	Neurobehavioral status exam per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report		\$64.10
96118	Neuropsychological testing battery with interpretation and report, per hour		\$78.31

Genetic Testing



Physician determines genetic testing is necessary and orders it



Collection of cheek cell sample is obtained as part of a medical service appointment (Evaluation and Management Office Visit)

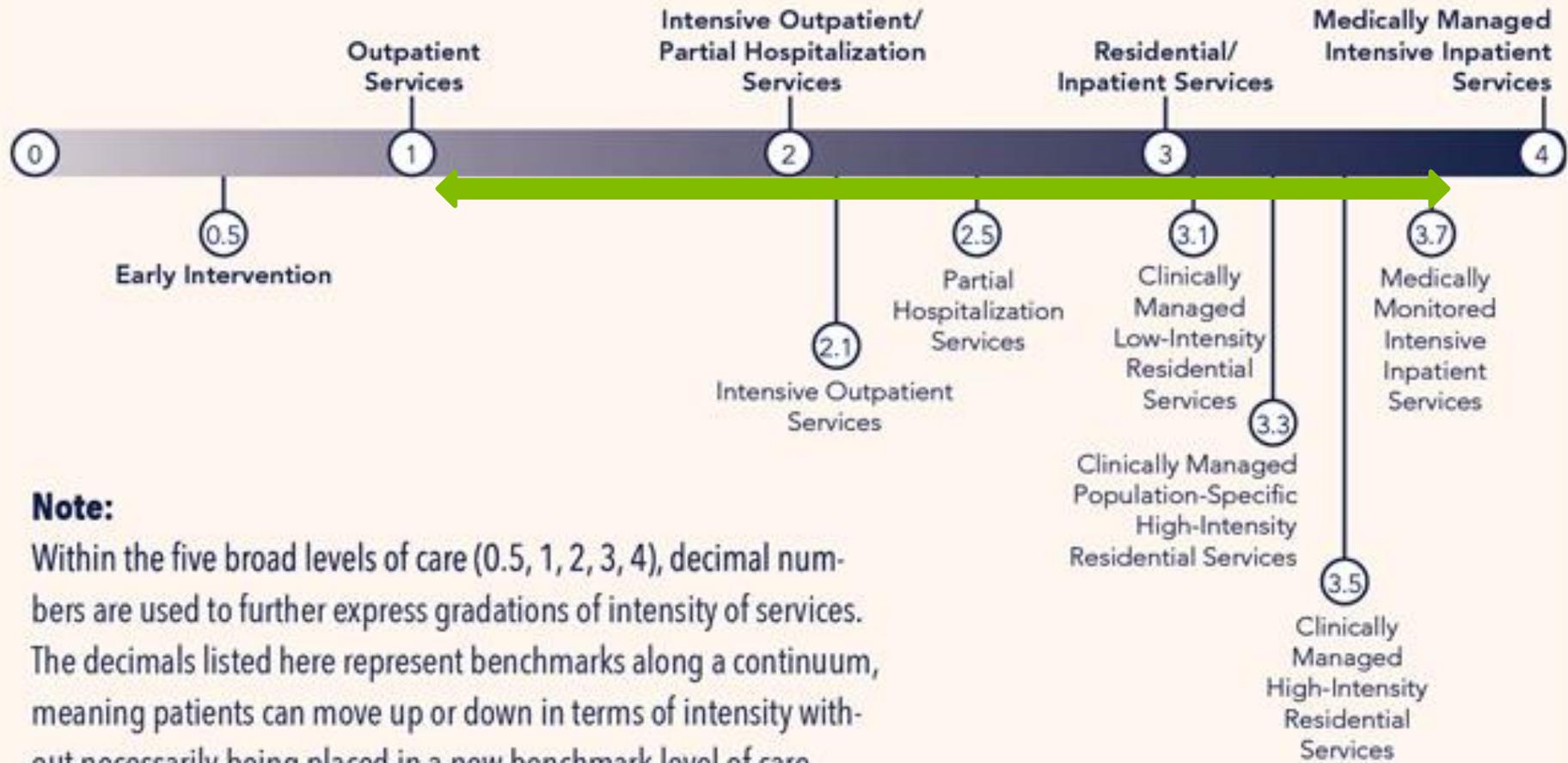


Sample sent to and analyzed by a CLIA certified lab (not waived)

Collection of the cheek swab that is needed to perform genetic testing does not have a separate code.

ASAM Levels of Care

REFLECTING A CONTINUUM OF CARE

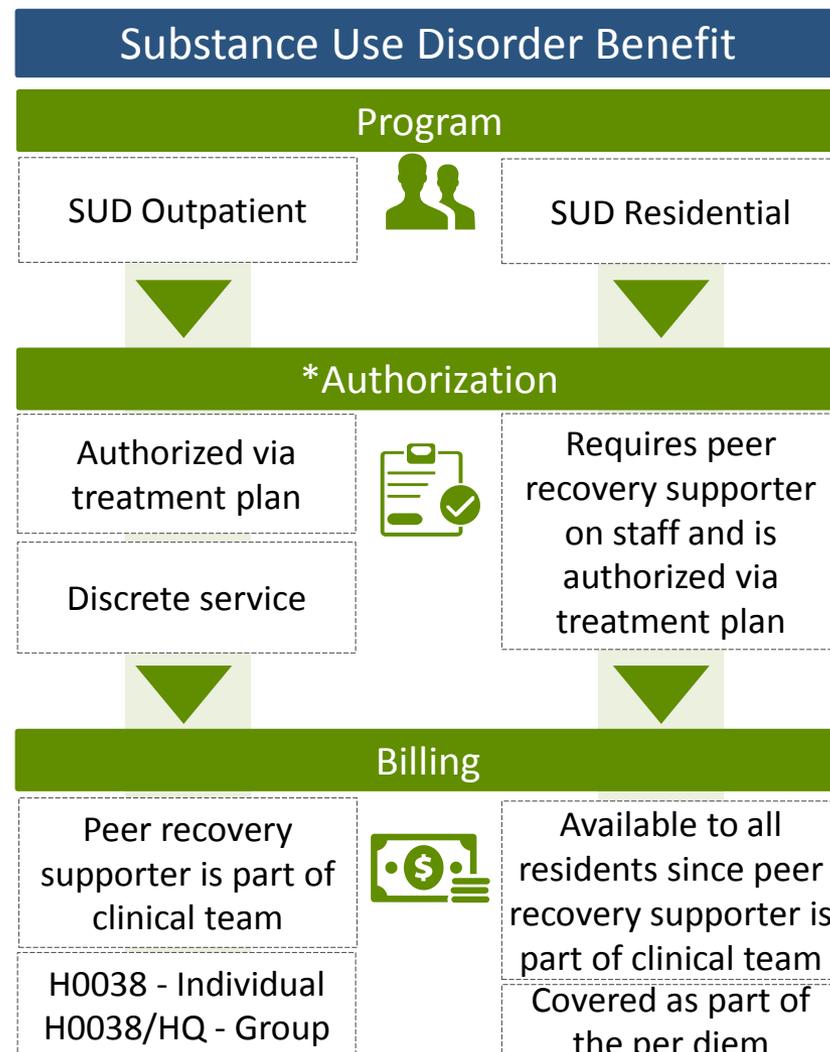
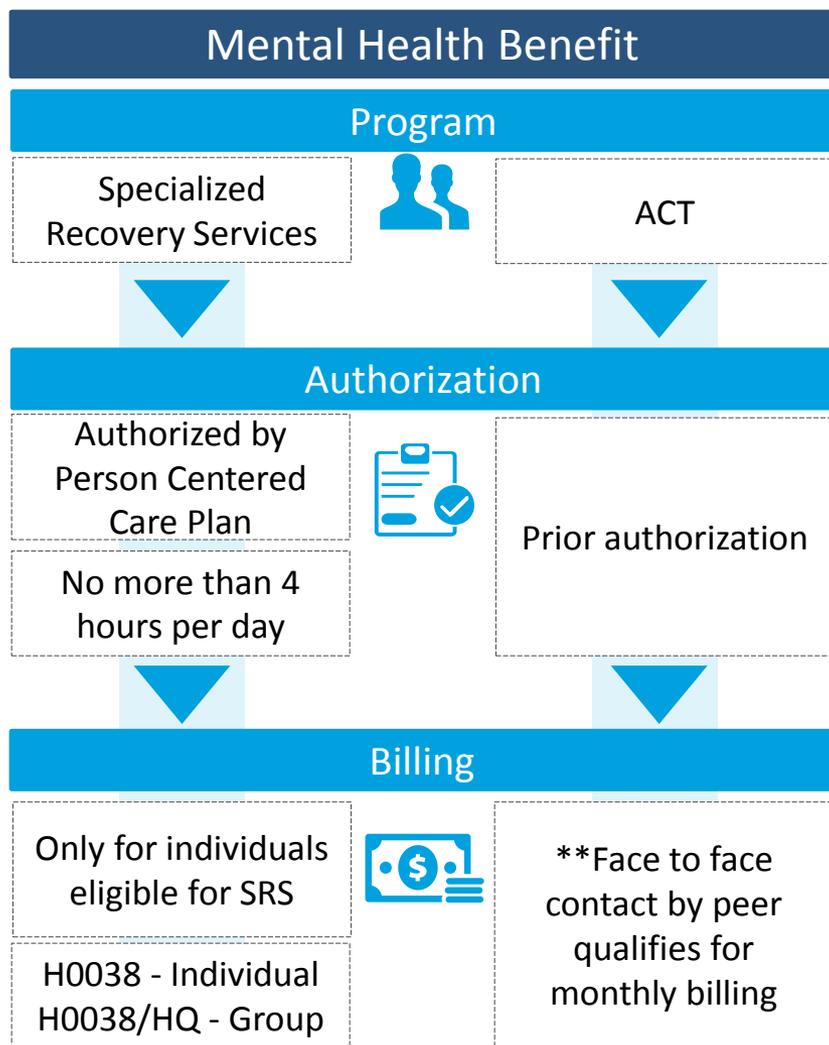


Note:

Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

The green double ended arrow represents scope of Levels of Care in Redesign.

Peer Recovery Support Coverage



*Please keep in mind that the SUD State Plan affords the State the ability to prior authorize SUD services.

**See previous ACT billing guidance provided on February 12, 2016 for additional clarification