



Department of Medicaid
Department of Mental Health and Addiction Services

201 Training and Feedback – Ohio’s Medicaid Behavioral Health Redesign

Opportunities

10/14, 10/18, 10/20, 10/27, 11/4, 11/14, 11/15, 11/21



Behavioral Health Redesign

Agenda

Welcome and Opening Remarks

Implementation and Training Schedule

January 1, 2017 Changes

January 1, 2017 OTP Manual

Respite Services

Mental Health Parity and Addiction Equity Act

July 1, 2017 Changes

Policy Updates: TBS; Benefit Administration; MH Day Treatment; SUD Intensive Outpatient and Partial Hospitalization;
Crisis Services

SUD ASAM Criteria

SRS Program

Evidence-Based or State-Best Practices for MH: ACT and IHBT

July 1, 2017 BH Manual

Rendering Practitioners

Coordination of Benefits

Coverage and Limitations Work Book

NCCI

Supervision Requirements

Interactive Complexity

Trading Partner Information

837P Companion Guide

Provider Enrollment Updates



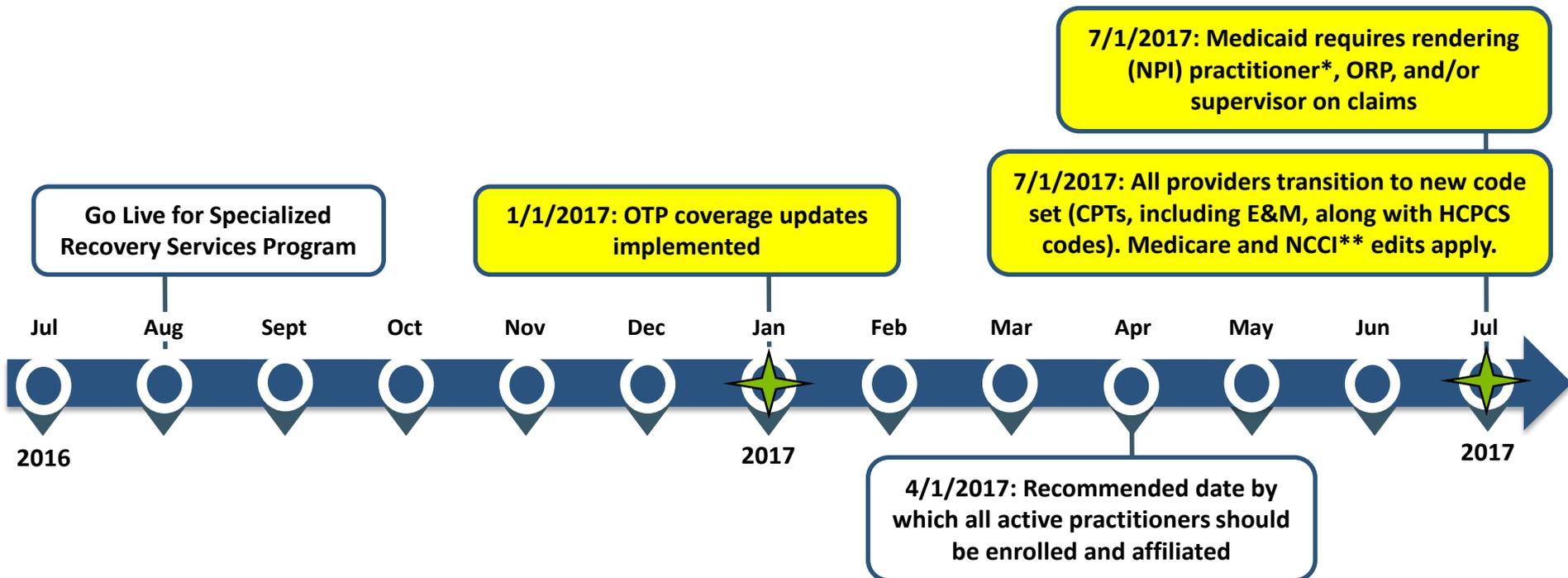
Department of Medicaid
Department of Mental Health and Addiction Services

Implementation and Training Schedule



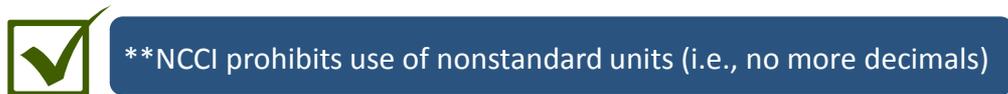
Behavioral Health Redesign

Implementation Schedule – BH Redesign



***Practitioners who must enroll with Ohio Medicaid:**

Physicians (MD/DO), Psychiatrists	Licensed Independent Social Workers
Advanced Practice Registered Nurses	Licensed Professional Clinical Counselors
Certified Nurse Practitioners	Licensed Independent Marriage and Family Therapists
Clinical Nurse Specialists	Licensed Independent Chemical Dependency Counselors (LICDC)
Physician Assistants	Registered Nurses
Licensed Psychologists	Licensed Practical Nurses



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 400,000 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.**

State Agency Goals for BH Redesign

Ensure Sustainability

All changes and stakeholder engagement are intended to ensure changes to the Behavioral Health program are sustainable into the future

Provide Training and Support

Numerous training and technical assistance opportunities have been provided to support the goal of sustainability

Encourage Organizational Awareness

Organizations must also be attentive to changes and adjust business models where necessary

Ensure Access

The state will collaborate with boards, providers, and other local entities to ensure ongoing access to services and continuity of care for individuals



Ongoing activities related to BH Redesign will continue throughout 2017



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START of January 1, 2017 Changes



Behavioral Health Redesign



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January 1, 2017 Opioid Treatment Program (OTP) Manual



Behavioral Health Redesign

January 1, 2017 OTP Manual



- *The 1/1 OTP Manual addresses for Opioid Treatment Programs (OTPs) changes that are being made in service coverage that will affect them with services provided on and after January 1, 2017.*
- *All other changes to the behavioral health system will be implemented July 1, 2017.*
- *All other MH/SUD services remain the same until July 1, 2017.*

January 1, 2017 OTP Manual is **now available** at <http://bh.medicareid.ohio.gov/manuals>

OhioMHAS Methadone License

Because you are licensed by OhioMHAS , including licensure by The State of Ohio Board of Pharmacy you can provide methadone administration/dispensing (H0020 [daily and/or weekly]). H0020 INCLUDES the cost of the methadone medication administered/dispensed.

John Kasich,
Governor

Ohio Department of
Mental Health and Addiction Services

Tracy Plouck,
Director



LICENSE TO OPERATE AN OPIOID AGONIST PROGRAM ISSUED TO :

Provider - 13732

Zepf Center, Inc.
2005 Ashland Avenue
Toledo, OH 43620
Lucas County

Owner

Zepf Center, Inc.
6605 West Central Avenue
Toledo, OH 43617
Lucas County

PROGRAM	Meth No.	Effective Date	Expiration Date
Methadone		8/24/2016	8/23/2017

Tracy Plouck, Director

In accordance with section 3793.06 of the Ohio Revised Code and section 3793.2-3-01 of the Ohio Administrative Code, this certificate is not assignable or transferable to any Owner or Provider other than those listed herein



Name and Address [back]	
Name	ZEPF CENTER
Public Address	2005 ASHLAND AVENUE TOLEDO, OH 43620
Business Phone	(419) 841-7701
County	Lucas

License and Registration Information				
License	First Issue Date	Current Issue Date	Expiration Date	Status
CL.022538000-03	08/03/2015	04/14/2016	03/31/2017	ACTIVE
License Type: Clinic - Category Three Responsible Party: KEVIN SCOTT KENDZIERSKI MD				

Formal Action Information
No formal action exists.

This data is an accurate representation of information currently maintained by the Ohio State Board of Pharmacy as of 8/16/2016.

This secure online license verification system conforms with The Joint Commission's current policy on "Primary Source Verification".

This information is otherwise provided as a public service and no user may claim detrimental reliance thereon.

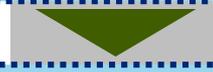
OhioMHAS Methadone License – New Services/Codes



OTPs may bill 99211 for the nasal administration of naloxone (J2310). This coding combination is only used when the naloxone is administered nasally on site.



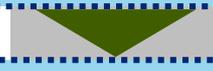
OTPs may bill 96372 for the injectable administration of naloxone (J2310). This coding combination is only used when the naloxone is administered by injection on site.



OTPs may bill for the dispensing of injectable/nasal naloxone (J2310) under their Ohio board of pharmacy license and in conformance with the Ohio board of pharmacy requirements.



OTPs may bill for the personal furnishing of injectable/nasal naloxone (J2310) when provided in accordance with Ohio Revised Code 4731.941.



OTPs may bill for the collection of blood using venipuncture (36415), per draw.



OTPs may administer/dispense oral naltrexone (J8499) under their Ohio board of pharmacy license.

SAMHSA OTP Certification

Because you are certified by SAMHSA as an OTP, including licensure by The State of Ohio Board of Pharmacy you can provide Buprenorphine administration/dispensing (T1502 [daily and/or weekly]). T1502 MUST be billed in combination with a Buprenorphine medication J-Code and the national drug code (NDC).

OPIOID TREATMENT PROGRAM CERTIFICATION

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, MD 20850

OTP NUMBER
OH-10123-M

EXPIRATION DATE
June 30, 2017

Sunrise Treatment Center - Forest Park
680 Northland Blvd.
Forest Park, OH 45240

This certificate is issued under authority of 42 CFR § 8.11 (21 U.S.C. 823(g)(1))



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov


Kimberly A. Johnson, PhD.
Director, Center for Substance Abuse Treatment

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY OR VALID AFTER EXPIRATION DATE



Name and Address		[back]
Name	SUNRISE TREATMENT CENTER	
Public Address	680 NORTHLAND BLVD. FOREST PARK, OH 45240	
Business Phone	(513) 941-4999	
County	Hamilton	

License and Registration Information				
License	First Issue Date	Current Issue Date	Expiration Date	Status
CL.022583650-03	01/21/2016	04/04/2016	03/31/2017	ACTIVE
License Type: Clinic - Category Three				
Responsible Party: CHRISTOPHER AVILES MD				

Formal Action Information
No formal action exists.

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This secure online license verification system conforms with The Joint Commission's current policy on "Primary Source Verification".

This information is otherwise provided as a public service and no user may claim detrimental reliance thereon.

SAMHSA OTP Certification – New Services/Codes

- ✓ OTPs may bill 99211 for the nasal administration of naloxone (J2310). This coding combination is only used when the naloxone is administered nasally on site.
- ✓ OTPs may bill 96372 for the injectable administration of naloxone (J2310). This coding combination is only used when the naloxone is administered by injection on site.
- ✓ OTPs may bill for the dispensing of injectable/nasal naloxone (J2310) under their Ohio board of pharmacy license and in conformance with the Ohio board of pharmacy requirements.
- ✓ OTPs may bill for the personal furnishing of injectable/nasal naloxone (J2310) when provided in accordance with Ohio Revised Code 4731.941.
- ✓ OTPs may bill for the collection of blood using venipuncture (36415), per draw.
- ✓ OTPs may administer/dispense oral naltrexone (J8499) under their Ohio board of pharmacy license.

Daily Buprenorphine/Methadone Example



DAILY EXAMPLE #1

A patient receiving a daily Buprenorphine based medication administration or daily methadone administration that has not yet been approved for take home use would attend a daily appointment at the OTP to receive their medication. The OTP would bill each day for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications.



DAILY EXAMPLE #2

A patient receiving a daily Buprenorphine based medication administration or daily methadone administration and is currently approved for two take home doses (the patient is in at least their second 90 days of treatment and receiving methadone or has been approved by the medical director independent of time in treatment for Buprenorphine based medications) would attend a daily appointment on a Monday at the OTP to have their Monday dose administered and receive the Tuesday and Wednesday take home doses on the same day (Monday). Because there is a national correct coding initiative (NCCI) medically unlikely edit (MUE) of 1 for H0020 (methadone administration) and 2 for T1502 (Buprenorphine based medication administration), the OTP would bill each day, Monday, Tuesday and Wednesday for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications.

Weekly Buprenorphine/Methadone Example



WEEKLY EXAMPLE #1

A patient receiving a weekly Buprenorphine based medication administration or weekly methadone administration on a Monday, they are currently approved for six take home doses (the patient is in at least their fourth 90 days of treatment and receiving methadone or has been approved by the medical director independent of time in treatment for Buprenorphine based medications) would attend a daily appointment on Monday at the OTP to have their Monday dose administered and receive the Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday take home doses on the same day (Monday). The OTP would bill on Monday (one unit) for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications **AND** the weekly modifier TV.



WEEKLY EXAMPLE #2

A patient receiving a two week Buprenorphine based medication administration or weekly methadone administration on a Monday, they are currently approved for six take home doses (the patient has at least one year of treatment and is receiving methadone or has been approved by the medical director independent of time in treatment for Buprenorphine based medications) would attend a daily appointment on Monday at the OTP to have their Monday dose administered and receive the remaining thirteen take home doses on the same day (Monday). The OTP would bill on Monday (one unit) for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications **AND** the weekly modifier TV and would bill on the following Monday (one unit) for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications **AND** the weekly modifier TV to cover the remaining seven take home doses.



Department of Medicaid
Department of Mental Health and Addiction Services

Respite Services

(scheduled for implementation January/February 2017)



Behavioral Health Redesign

Respite Services for Medicaid Managed Care Members



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.



Key Provisions

- 1 Respite services can be provided on a planned or emergency basis
- 2 Provider must be awake when the member is awake during the provision of respite services

Still under review pending finalization of Ohio Administrative Code

New Respite Eligibility for Children with MH Diagnoses



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;
- Enrolled in the managed care plan's care management program
- Have behavioral health needs as determined by the MCP through the use of a nationally recognized standardized functional assessment tool, and
 - (a) Be diagnosed with serious emotional disturbance as described in the appendix to this rule resulting in a functional impairment,
 - (b) Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to him or her self or others, and
 - (c) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's behavioral health needs, either:
 - (i) To prevent an inpatient, institutional or out-of-home stay; or
 - (ii) Because the member has a history of inpatient, institutional or out-of-home stays.

Still under review pending finalization of Ohio Administrative Code

Stakeholder Feedback Diagnoses



Several stakeholders noted that the substance use disorder (SUD) diagnoses originally included in the appendix would not likely rise to the level of requiring respite.

Conversely, there were several serious emotional disturbance (SED) related diagnoses that were not included, that stakeholders felt should be added to the appendix.



At the request of stakeholders, the SUD diagnoses were removed from the appendix and several new diagnoses were added.

Additions include Major Depressive Disorder, Generalized Anxiety Disorder, Oppositional Defiant Disorder, Anorexia Nervosa, Conduct Disorder and others.

Still under review pending finalization of Ohio Administrative Code

Provider Qualifications: New BH Respite Services

Behavioral health respite services must be provided by individuals employed by **OhioMHAS-certified** and medicaid enrolled agency providers that are also accredited by at least one of the following: the "Joint Commission", "Council on Accreditation" or "Commission on Accreditation of Rehabilitation Facilities".

Behavioral health respite providers must comply with the criminal records check requirements listed in OAC rule 5160-43-09 when the services are provided in an HCBS setting.

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



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

- **Either be credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board or received training for or education in mental health competencies and have demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency; 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 and a successful return demonstration of what was learned in the course.

- **Receive supervision from an independently licensed behavioral health professional credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board**

Still under review pending finalization of Ohio Administrative Code

**END of
January 1, 2017 Changes**



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Mental Health Parity and Addiction Equity Act



Behavioral Health Redesign

MHPAEA - Parity Guidance

A formal, methodical process with consultants to address parity with Medicaid services is ongoing.



- 1) Effective date for this is October 2, 2017. We are working with two time periods in this analysis:**
 - October 2 through December 31, 2017 (prior to carve-in)
 - January 1, 2018, and forward (carve-in)



- 2) MyCare is part of the CMS Financial Alignment Initiative. ODM is still researching how the parity requirements apply to MyCare and is seeking technical assistance from CMS.**

Quantitative Treatment Limit Template

Template below has been provided to the MCPs, which includes the type of information ODM/MHAS is expecting

Behavioral Health Parity FR/QTL Testing

[Name of Plan]

Benefit Package_1

Calendar Year 2018

[Enter Medicaid Eligibility Group]

[Enter Applicable Age Group/Gender]

[Enter additional comments regarding benefit package distinction]



Classification/Service	Financial Requirements					Quantitative Treatment Limitations (e.g., day/visit/hour limits, age limits, dollar limits)	Annual Dollar Limits or Lifetime Dollars Limits	Comments
	Deductible	Copay	Coinsurance	OOP Maximum	Other			
<i>Classification: Inpatient</i>								
<i><Insert additional rows above as needed></i>								
<i>Classification: Outpatient (PCP and Specialist Office Visit)</i>								
<i><Insert additional rows above as needed></i>								
<i>Classification: Outpatient (Non-Office Visit)</i>								
Ex. Eye exams	N/A	\$2 per examination	NA	NA	NA	One exam per calendar year		
Ex. Eyeglasses or contacts	N/A	\$1 per fitting	NA	NA	NA	One pair of glasses or retail allowance of \$125 toward any type of contacts per calendar year		
Ex. Chiropractic	N/A	N/A	N/A	N/A	N/A	15 visits per calendar year		
Ex. Physical and occupational therapy						30 visits per calendar year		
Ex. Dental	N/A	N/A	N/A	N/A	N/A	Two periodic oral exams and cleanings per calendar year		
<i><Insert additional rows above as needed></i>								



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START of July 1, 2017 Changes



Behavioral Health Redesign



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Policy Updates

INCLUDES:

- TBS Years of Experience
- Benefit Administration



Behavioral Health Redesign



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Therapeutic Behavioral Services (TBS) Years of Experience



Behavioral Health Redesign

TBS Years of Experience



Note:

- Not restricted to a single agency;
- Not contiguous;
- Must be documented in employment record
- Employer can be more restrictive



Current policy for practitioners providing TBS is below:

TBS can be performed by any unlicensed practitioner with a Bachelor's/Master's degree in a relevant field

Qualified mental health specialists who have a minimum of 3 years of experience on or before July 1, 2017, will be qualified to provide TBS



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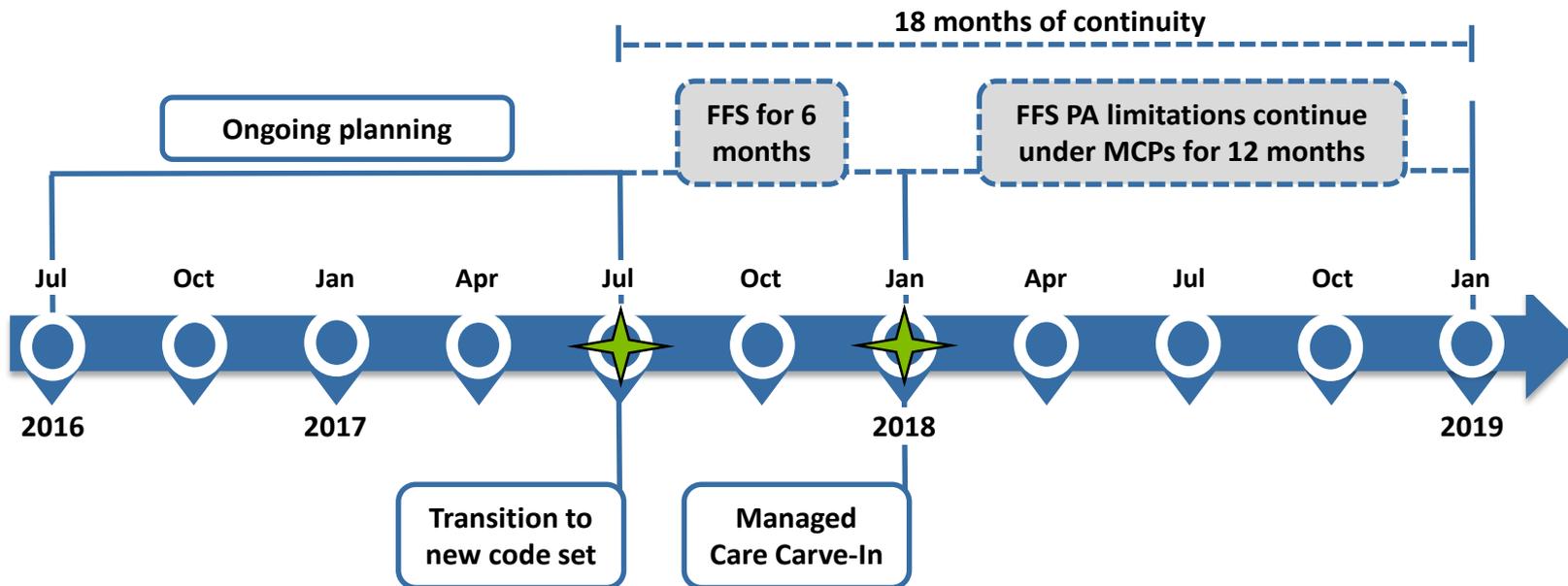
Benefit Administration



Behavioral Health Redesign

Timeline: 2016 – 2019

Transition of Care



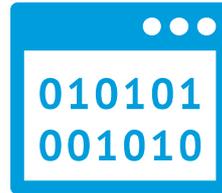
- Plans will abide by state benefit administration requirements for one year after carve-in and administer it on a calendar year basis (Jan-Dec).
- Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.



Surveillance, Utilization and Review Section (SURS)



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 correct any mis-utilization practices.



This 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 found to have outlier patterns may be contacted for post-payment review and possible recoupment of overpayments. In extreme cases, providers suspected of fraud, waste or abuse may be referred to the Attorney General's Medicaid Fraud and Control Unit.



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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.

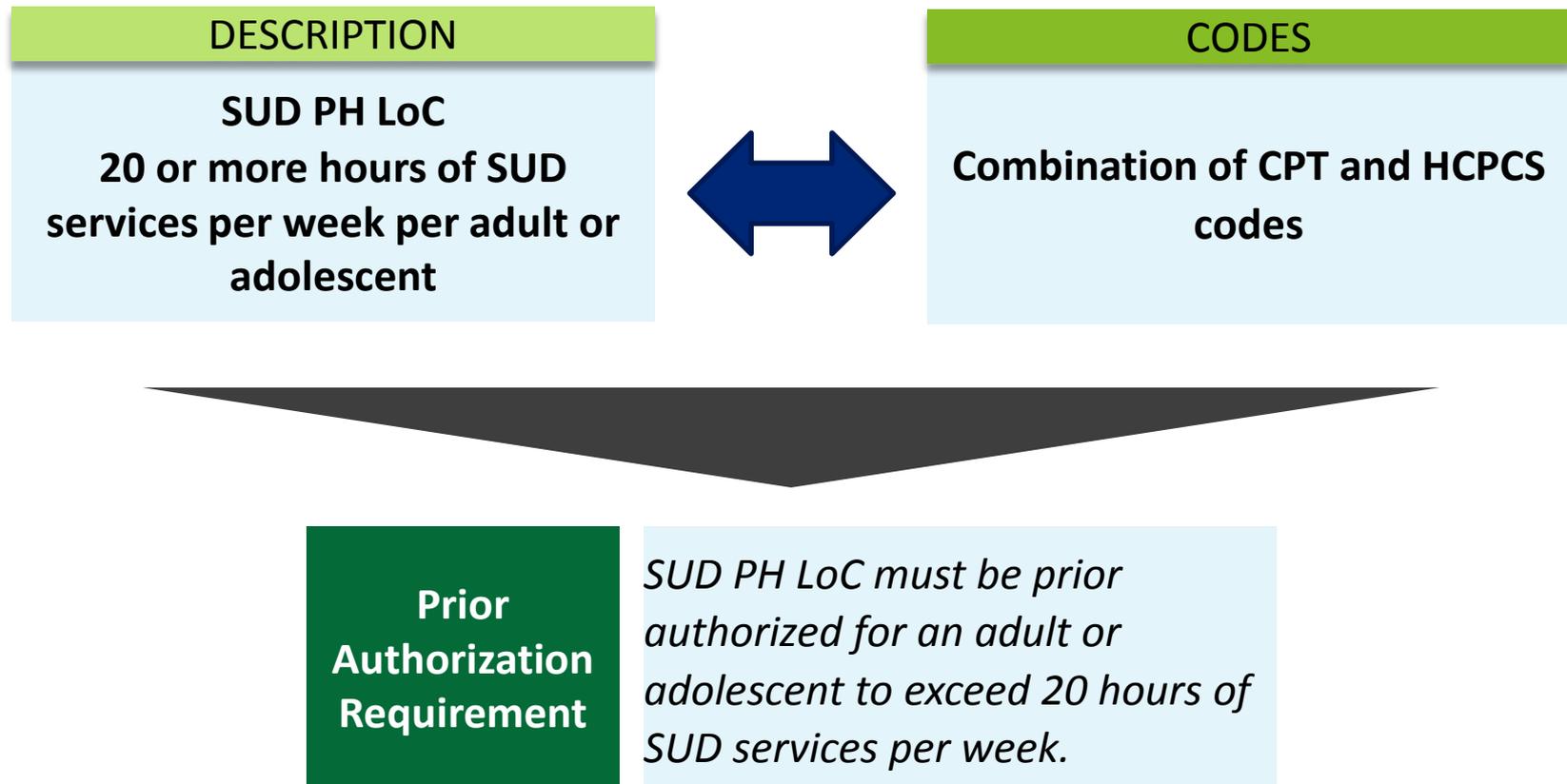
ALWAYS Prior Authorized: *Intensive Home Based Treatment (IHBT)*

DESCRIPTION		CODE
Intensive Home Based Treatment (IHBT)	↔	H2015

Prior Authorization Requirement

IHBT must be prior authorized per person.

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





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Services With Prior Authorization - Billing Provider -



Behavioral Health Redesign

Prior Authorization - Billing Provider: *Psychiatric Diagnostic Evaluations*

DESCRIPTION

Psychiatric Diagnostic
Evaluation



CODES

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.*

Prior Authorization - Billing Provider: *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)

Prior Authorization - Billing Provider: *Alcohol and/or Drug Assessment*

DESCRIPTION	CODE
Alcohol and/or Drug Assessment	H0001



Prior Authorization Requirement

*2 hours (8 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.*



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Services With Prior Authorization - Medicaid Enrollee -



Behavioral Health Redesign

Prior Authorization - Medicaid Enrollee: *Psychological Testing*

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



<p>Prior Authorization Requirement</p>	<p><i>Up to 12 hours/encounters per calendar year per Medicaid enrollee for 96101, 96111, and 96116.</i></p> <p><i>Up to 8 hours per calendar year per Medicaid enrollee for 96118.</i></p> <p><i>Prior authorization may be requested to exceed the annual limits.</i></p>
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Prior Authorization - Medicaid Enrollee: *RN/LPN Nursing Services*

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



Prior Authorization Requirement	<p><i>24 hours (96 units) combined per year per Medicaid enrollee.</i></p> <p><i>Prior authorization may be requested to exceed the annual limit.</i></p>
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Prior Authorization - Medicaid Enrollee: *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.



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Department of Mental Health and Addiction Services

Services with No Benefit Limits



Behavioral Health Redesign

No Benefit Limit: *TBS, PSR, and CPST*

DESCRIPTION		CODE
Therapeutic Behavioral Services	↔	H2019
DESCRIPTION		CODE
Psychosocial Rehabilitation	↔	H2017
DESCRIPTION		CODE
Community Psychiatric Support Treatment	↔	H0036

Provider(s) will receive an informational remark in remittance advice at and over 104 hours.

No Benefit Limit: *Psychotherapy*

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

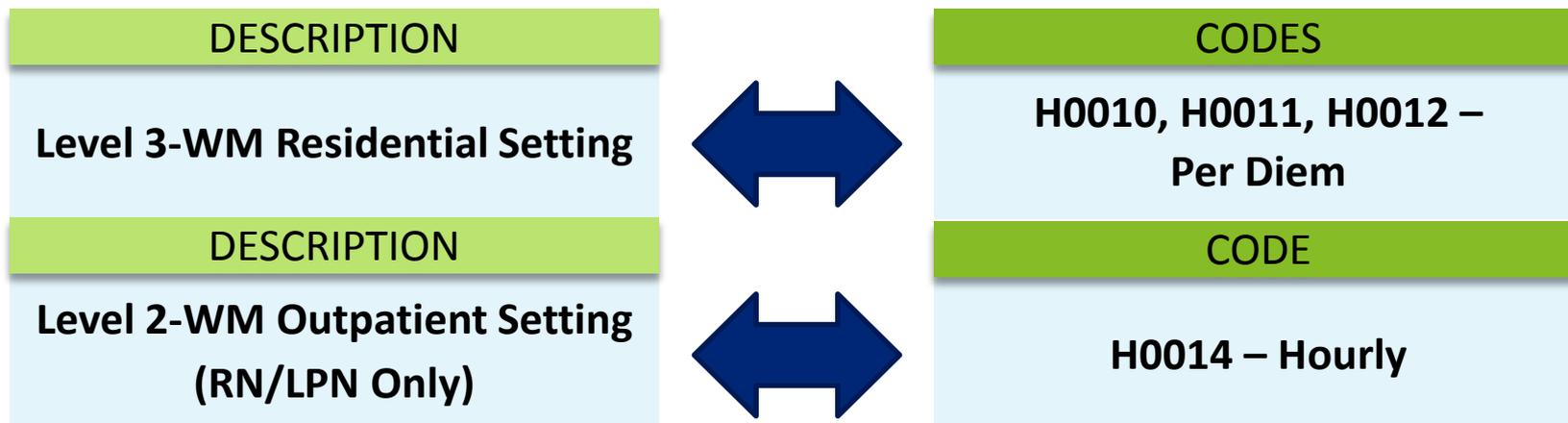
Services will accrue to ASAM outpatient, IOP, and PH levels of care.

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.

No Benefit Limit: *SUD Withdrawal Management*



No Benefit Limit: *MH Day Treatment*

DESCRIPTION

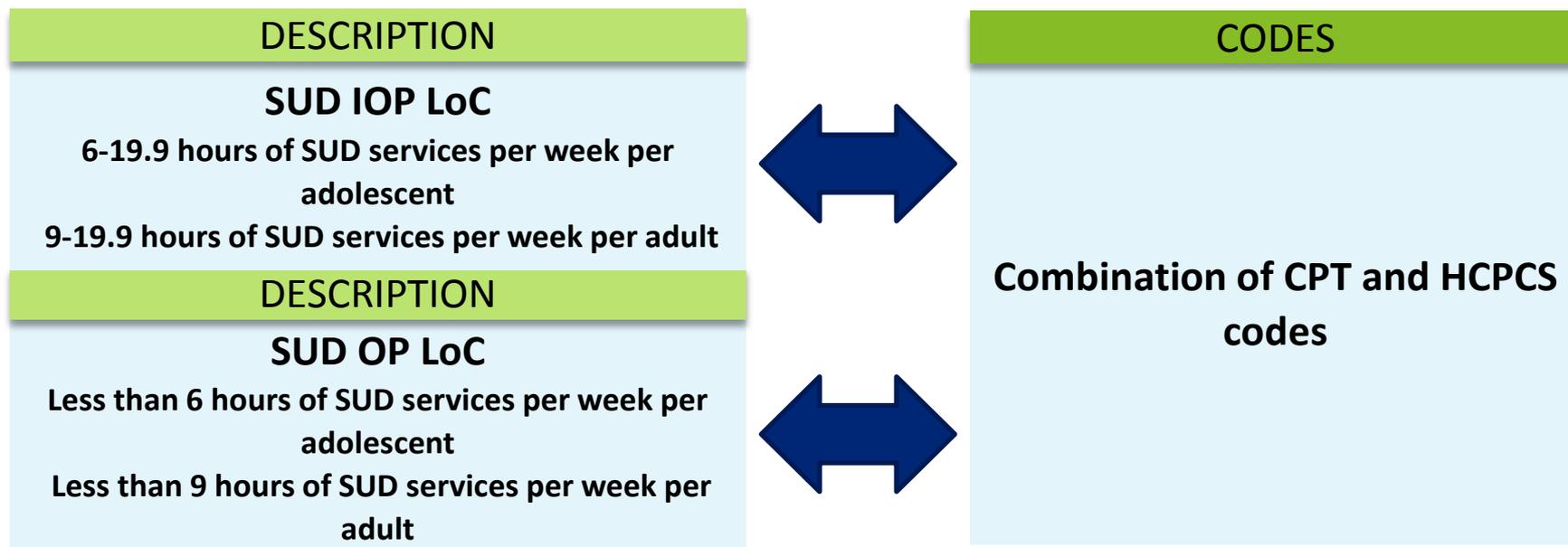
**MH Day Treatment
(Adult and Youth)**



CODES

**H2012 – Hourly
H2020 – Per Diem**

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



No Benefit Limit: *Crisis Services*

DESCRIPTION		CODES
Psychotherapy for Crisis	↔	90839, +90840, 90832 UT
DESCRIPTION		CODE
SUD Individual Counseling	↔	H0004 UT
DESCRIPTION		CODES
MH TBS or MH PSR	↔	H2019 UT or H2017 UT



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MH Day Treatment



Behavioral Health Redesign

MH Day Treatment Group Activities - Hourly

Rate Development and Methodology

H2012

Assumes 1 hour of unlicensed BA in an average group size of four

\$18.54
Hourly Per Person

H2012

Assumes 1 hour of unlicensed MA in an average group size of four

\$21.05
Hourly Per Person

H2012

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

\$28.10
Hourly Per Person

MH Day Treatment: 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 and MA.
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.

MH Day Treatment Group Activities - Per Diem

Rate Development and Methodology

H2020

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

\$104.55
Per Diem Per Person

H2020

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

\$117.05
Per Diem Per Person

H2020

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

\$140.51
Per Diem Per Person

MH Day Treatment: Additional Details

1. Maximum group size: 1:12 Practitioner to client ratio
 - a. For MH Day Treatment Services, 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: Modifier for group), and/or H2012 may be used.
 - c. Service is billed in whole unit only.
 - d. All other services must be billed outside of 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**



Department of Medicaid
Department of Mental Health and Addiction Services

SUD Intensive Outpatient and Partial Hospitalization



Behavioral Health Redesign

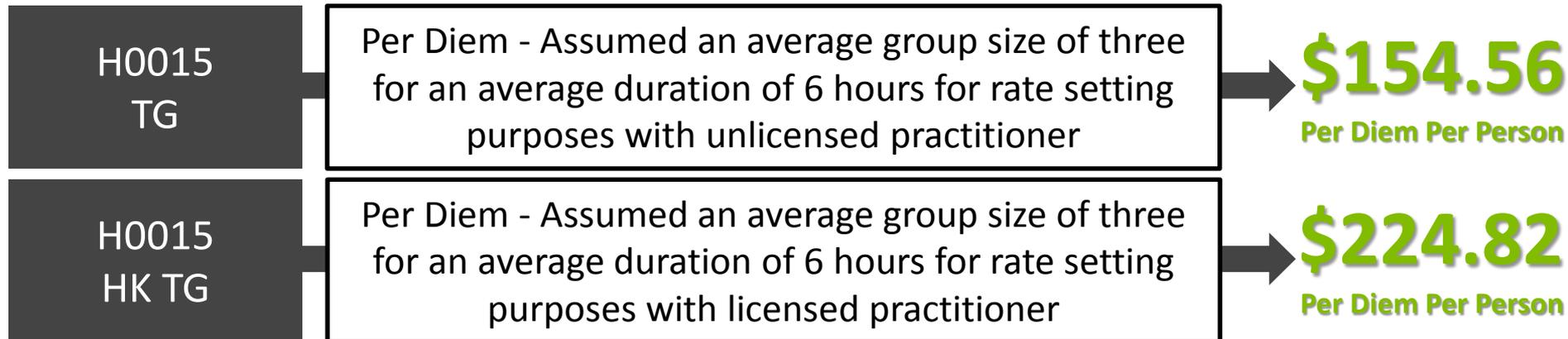
SUD Intensive Outpatient Level of Care: Group Counseling - Billing

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

- ✓ Maximum group size: 1:12 practitioner to client ratio.
- ✓ Used at ASAM Level 2.1
 - For IOP, only used if the person attends for the minimum needed to bill the per diem (2+ hours)
 - If person doesn't meet the minimum 2+ hours, H0005 may be used for unlicensed practitioners and 90853 may be used for licensed practitioners.
 - Service is billed in whole unit only.
- ✓ All other services must be billed outside of 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.
- ✓ Must be led by licensed practitioner to bill with HK modifier
- ✓ **Only one H0015 per diem, per patient, per day.**

SUD Partial Hospitalization Level of Care: Group Counseling - Billing



SUD Partial Hospitalization: Additional Details

- ✓ Maximum group size: 1:12 practitioner to client ratio
- ✓ Only used at ASAM Level 2.5
 - For PH, only used if the person attends for the minimum needed to bill the per diem (3+ hours)
 - If person doesn't meet the minimum 3+ hours, H0005 may be used for unlicensed practitioners and 90853 may be used for licensed practitioners.
 - Service is billed in whole unit only.
- ✓ All other services must be billed outside of 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.
- ✓ Must be led by licensed practitioner to bill with HK modifier
- ✓ **Only one H0015 per diem, per patient, per day.**



Department of Medicaid
Department of Mental Health and Addiction Services

Crisis Services



Behavioral Health Redesign

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



*** Review supervision requirements for billing guidance**

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:

- MH Crisis - TBS (H2019) or PSR (H2017)
- SUD Crisis - Individual counseling (H0004)

SUD Crisis Billing for Unlicensed Practitioners

H0004

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

BH counseling and therapy, per 15 minutes

MH Crisis Billing for Unlicensed Practitioners

H2019

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

TBS, per 15 minutes: **Master's, Home/Cmty**
 TBS, per 15 minutes: **Bachelor's, Home/Cmty**
 TBS, per 15 minutes: **Master's, Office**
 TBS, per 15 minutes: **Bachelor's, Office**



H2017

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

Psychosocial rehabilitation service: **Home/Cmty**, per 15 mins
 Psychosocial rehabilitation service: **Office Setting**, 15 minute units





Department of Medicaid
Department of Mental Health and Addiction Services

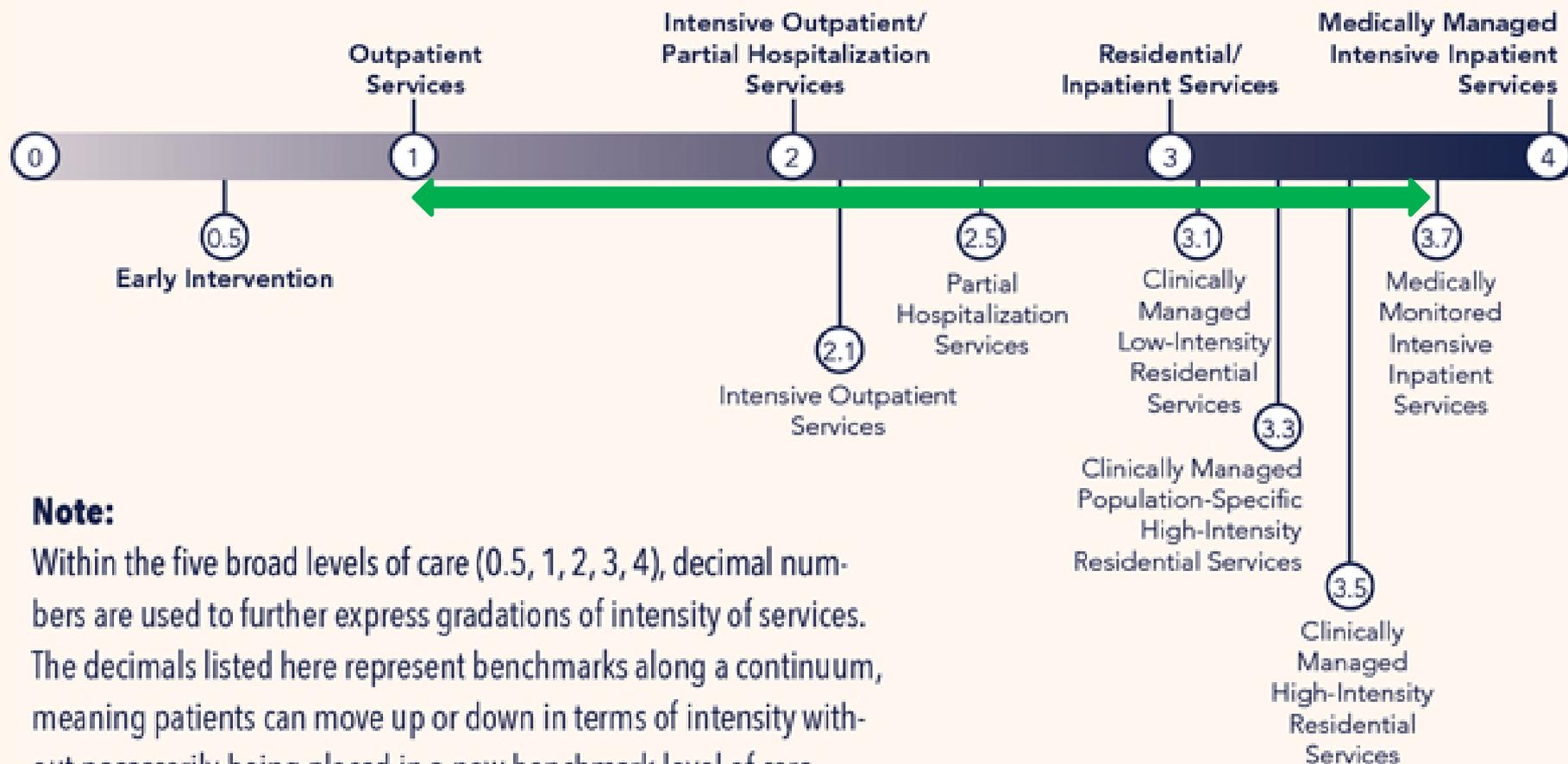
Substance Use Disorder (SUD) Benefit – ASAM Criteria



Behavioral Health Redesign

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

ASAM Levels of Care

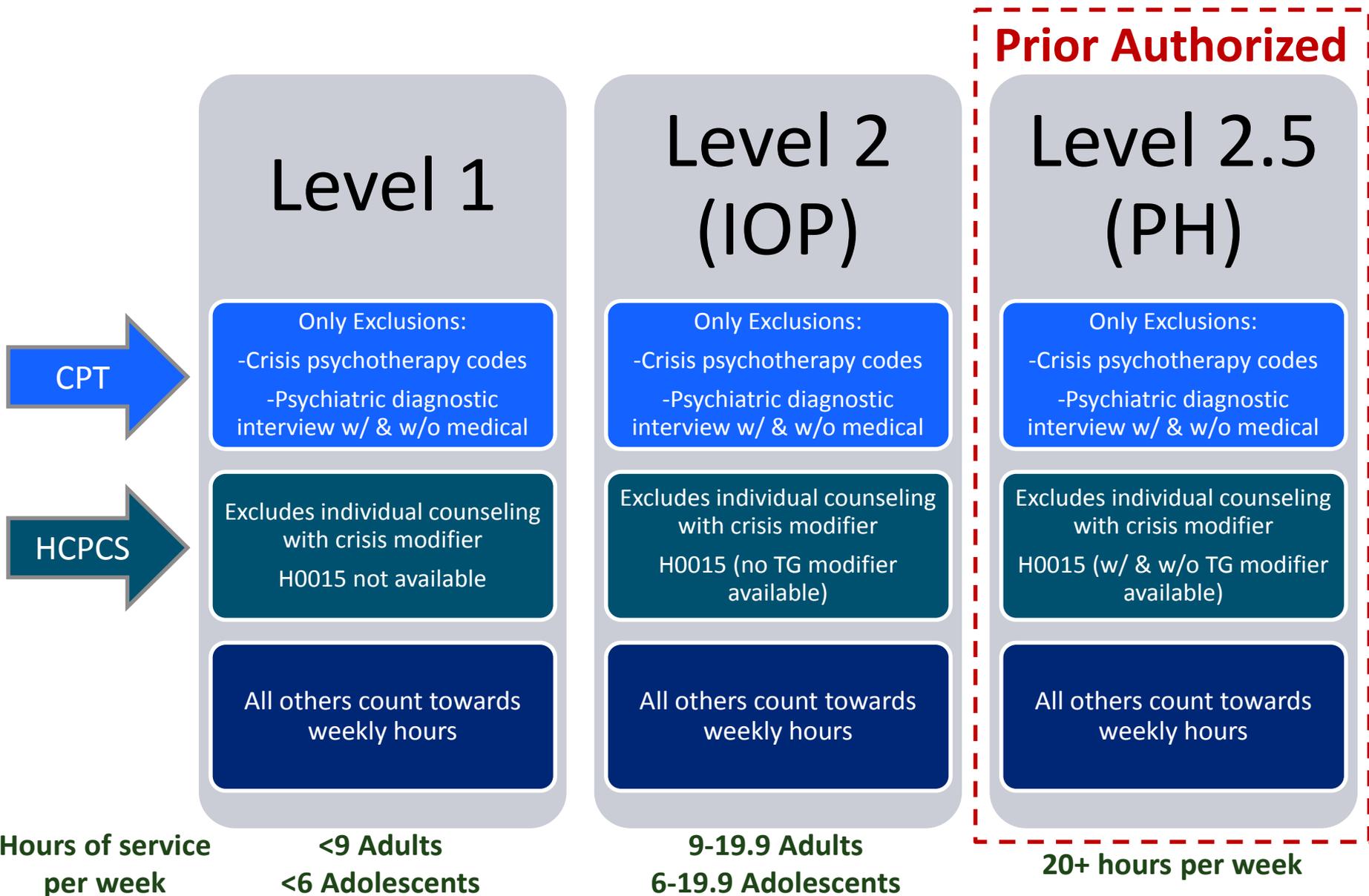
The provider manual contains information about each ASAM Level.

- ✓ **Opioid Treatment Services: Opioid Treatment Programs (OTPs) and Medically Managed Opioid Treatment (MMOT)**
- ✓ **ASAM Level 1- Outpatient Services**
- ✓ **ASAM Level 2- WM Ambulatory Withdrawal Management with Extended Onsite Monitoring**
- ✓ **ASAM Level 2.1- Intensive Outpatient Services**
- ✓ **ASAM Level 2.5- Partial Hospitalization Services**
- ✓ **ASAM Level 3.1- Clinically Managed Low-Intensity Residential Treatment (Halfway House)**
- ✓ **ASAM Level 3.2- WM Clinically Managed Residential Withdrawal Management**
- ✓ **ASAM Level 3.3- Clinically Managed Population-Specific High Intensity Residential Treatment**
- ✓ **ASAM Level 3.5- Clinically Managed High Intensity Residential Treatment**
- ✓ **ASAM Level 3.7- Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent)**
- ✓ **ASAM Level 3.7- WM Medically Monitored Inpatient Withdrawal Management**

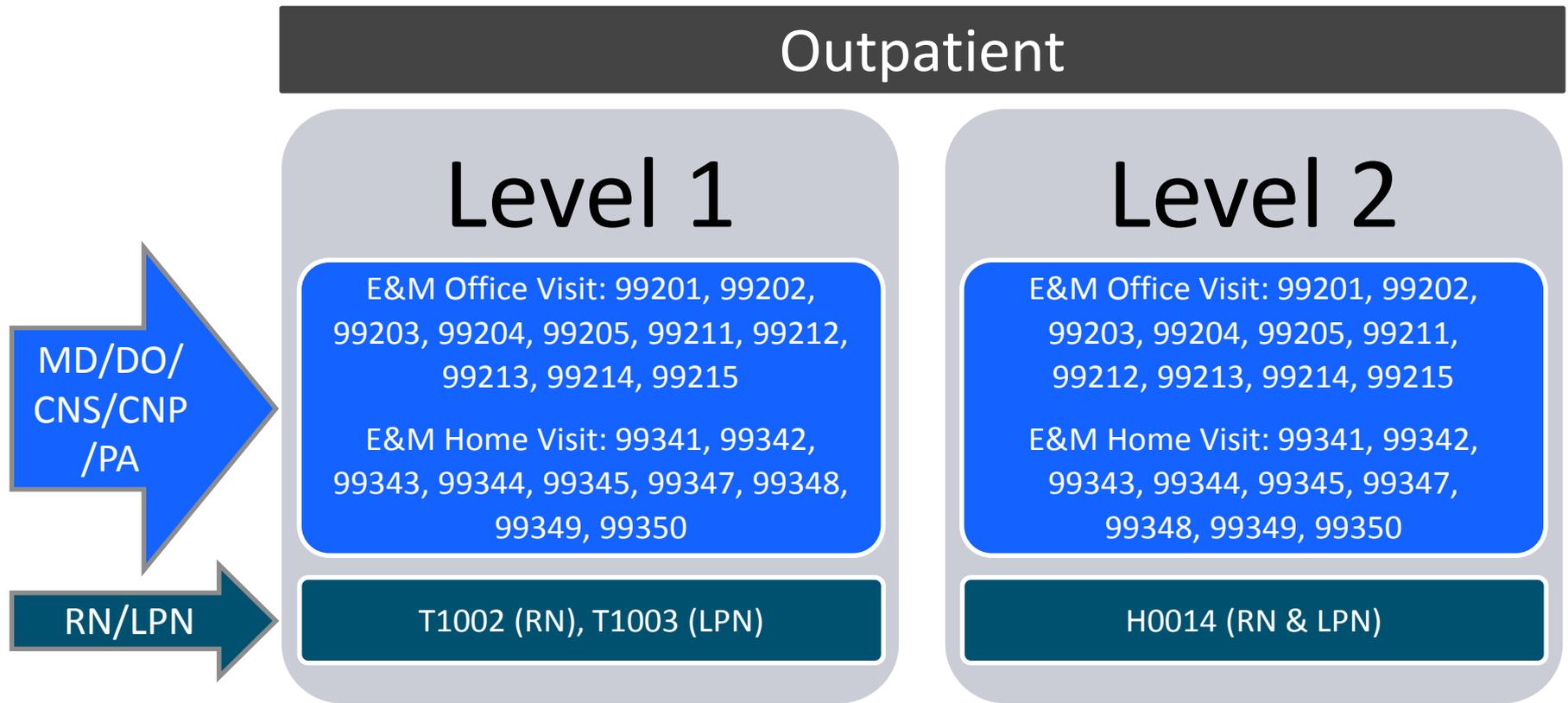
Substance Use Disorder Benefit

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
<ul style="list-style-type: none"> • Assessment • Psychiatric Diagnostic Interview • Counseling and Therapy <ul style="list-style-type: none"> • Psychotherapy – Individual, Group, Family, and Crisis • Group and Individual (Non-Licensed) • Medical • Medications • Buprenorphine and Methadone Administration/Dispensing • Urine Drug Screening • Peer Recovery Support • Case Management • Withdrawal Management Level 1 (Detoxification) 	<ul style="list-style-type: none"> • Assessment • Psychiatric Diagnostic Interview • Counseling and Therapy <ul style="list-style-type: none"> • Psychotherapy – Individual, Group, Family, and Crisis • Group and Individual (Non-Licensed) • Medical • Medications • Buprenorphine and Methadone Administration/Dispensing • Urine Drug Screening • Peer Recovery Support • Case Management • Additional coding for longer duration group counseling/psychotherapy • Withdrawal Management Level 2 (Detoxification) 	<ul style="list-style-type: none"> • Assessment • Psychiatric Diagnostic Interview • Counseling and Therapy <ul style="list-style-type: none"> • Psychotherapy – Individual, Group, Family, and Crisis • Group and Individual (Non-Licensed) • Medical • Medications • Buprenorphine and Methadone Administration/Dispensing • Urine Drug Screening • Peer Recovery Support • Case Management • Additional coding for longer duration group counseling/psychotherapy • Withdrawal Management Level 2 (Detoxification) 	<ul style="list-style-type: none"> • Per Diems ranging from clinical managed to medically monitored • Medications • Buprenorphine and Methadone Administration/Dispensing • Urine Drug Screening 

ASAM Levels 1 & 2: Outpatient Services



ASAM Level 1 & 2: Withdrawal Management Medical Services



NOTE: Withdrawal Management is not subject to prior authorization

ASAM Level 3: Withdrawal Management

Residential (per diem codes)

Level 3

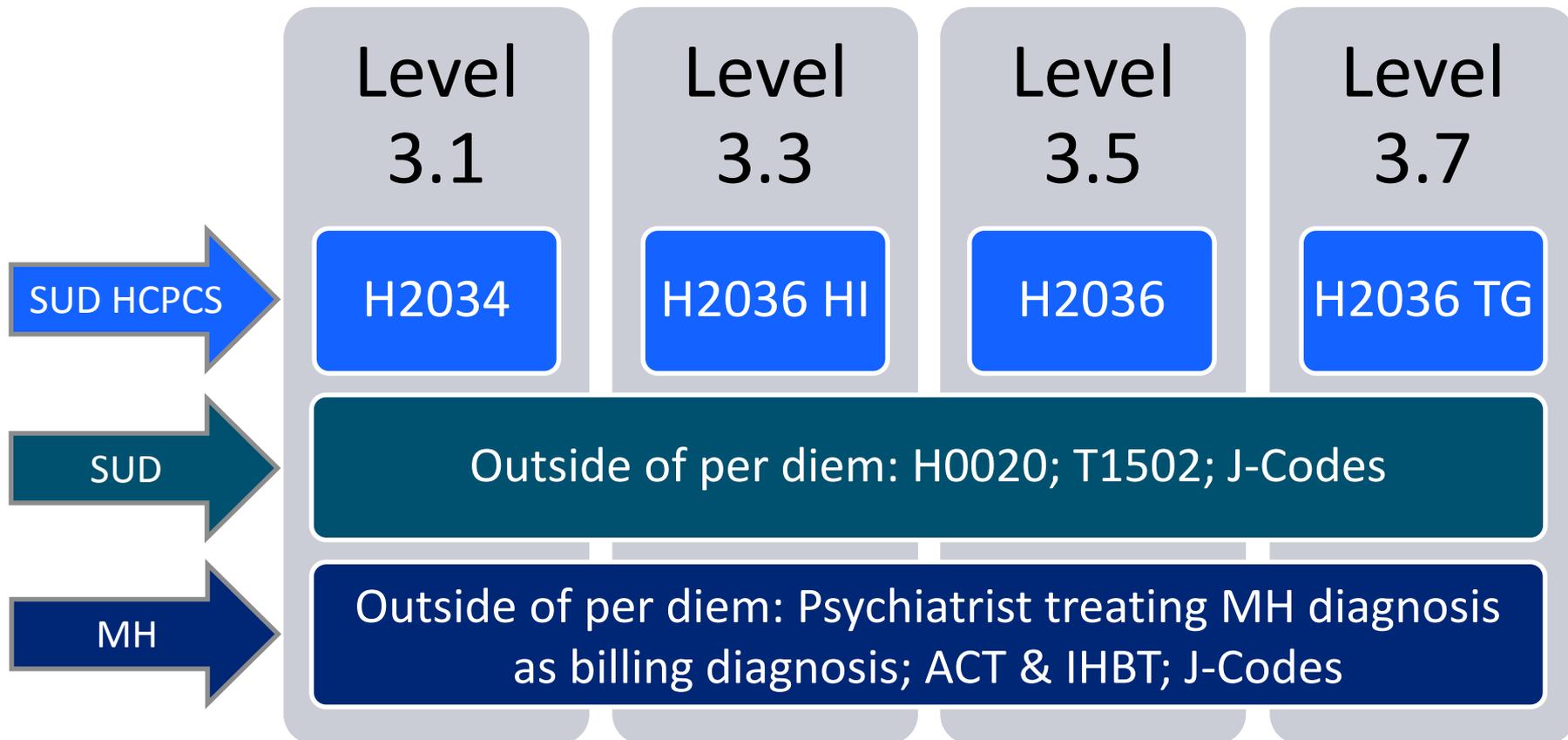
H0010
(clinically managed)

OR

H0011
(medically monitored)

NOTE: Withdrawal Management is not subject to prior authorization

ASAM Level 3: Residential Treatment (Non-Withdrawal Management)



Prior Authorization - Medicaid Enrollee: *SUD Residential (Non-Withdrawal Management)*

DESCRIPTION		CODES
SUD Residential		H2034 H2036



<p>Prior Authorization Requirement</p>	<p><i>Up to 30 consecutive days without prior authorization per Medicaid enrollee.</i></p> <p><i>Prior authorization then must support the medical necessity of continued stay; if not, only the initial 30 consecutive days are reimbursed.</i></p> <p><i>Applies to first two stays; any stays after that would be subject to prior authorization.</i></p>
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Department of Medicaid
Department of Mental Health and Addiction Services

Specialized Recovery Services (SRS) Program



Behavioral Health Redesign

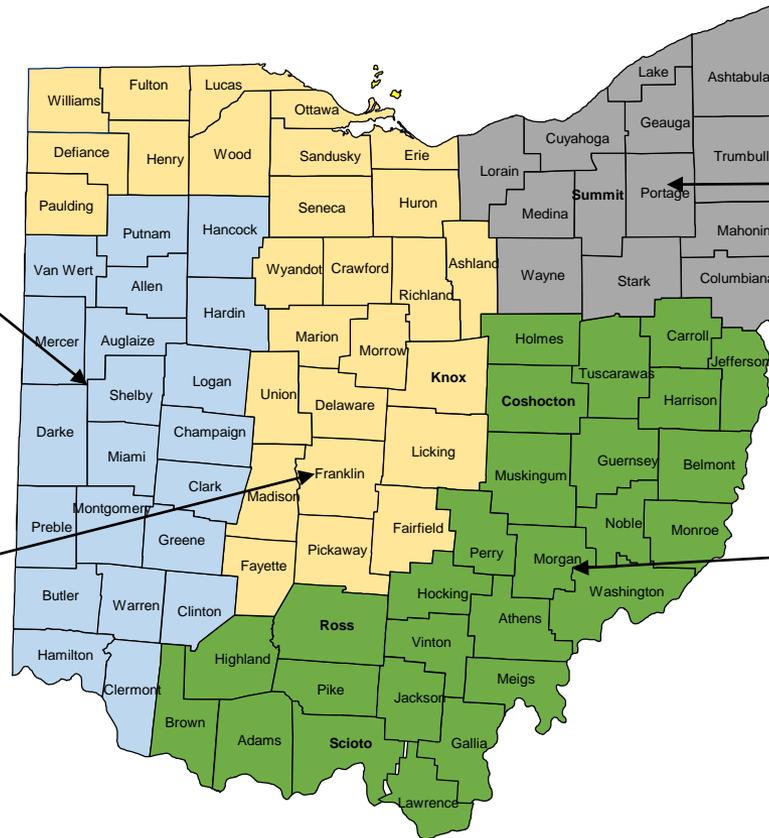
SRS Program- Ohio Home Care Case Management

Cincinnati Region – Available Recovery Management

Council on Aging
(855) 372-6176
CareStar
(800) 616-3718

Cleveland Region – Available Recovery Management:

CareSource
(877) 209-3154
CareStar
(800) 616-3718



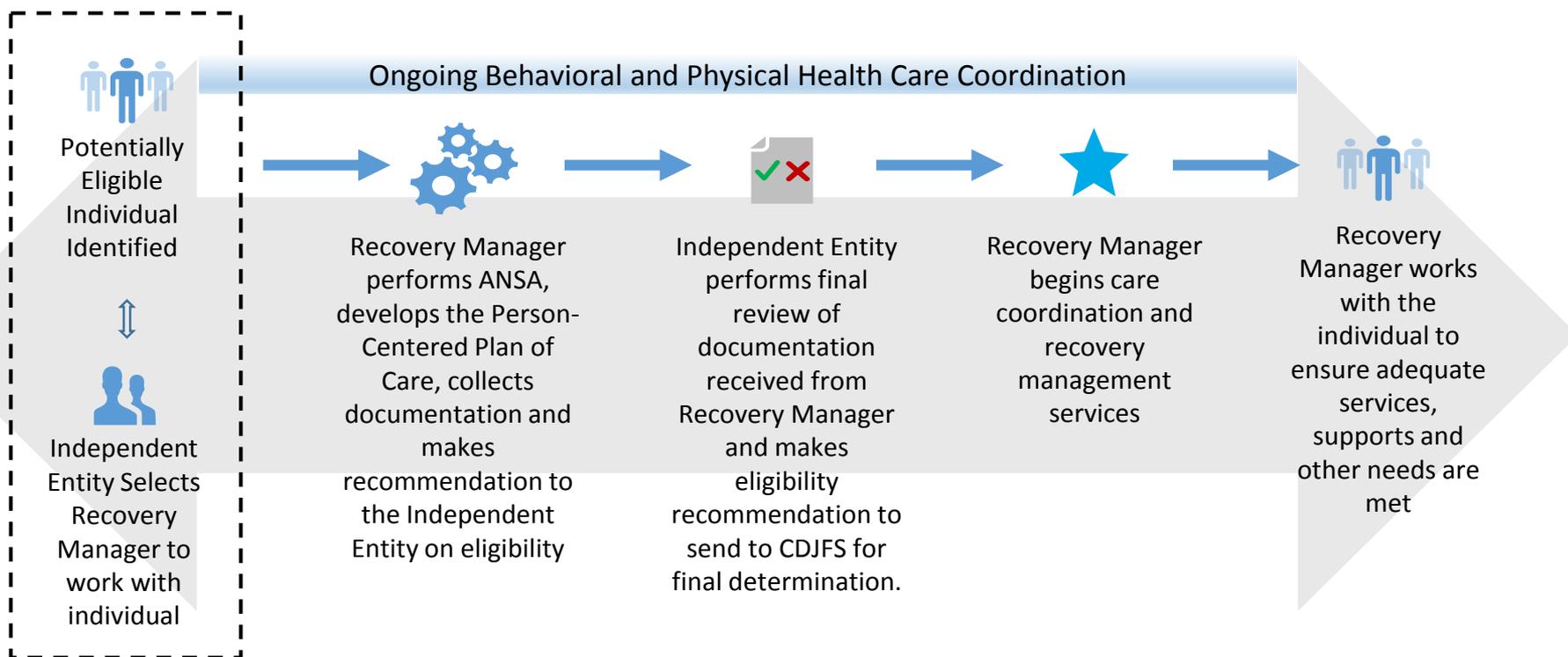
Columbus Region – Available Recovery Management

CareSource
(844) 832-0159
CareStar
(800) 616-3718

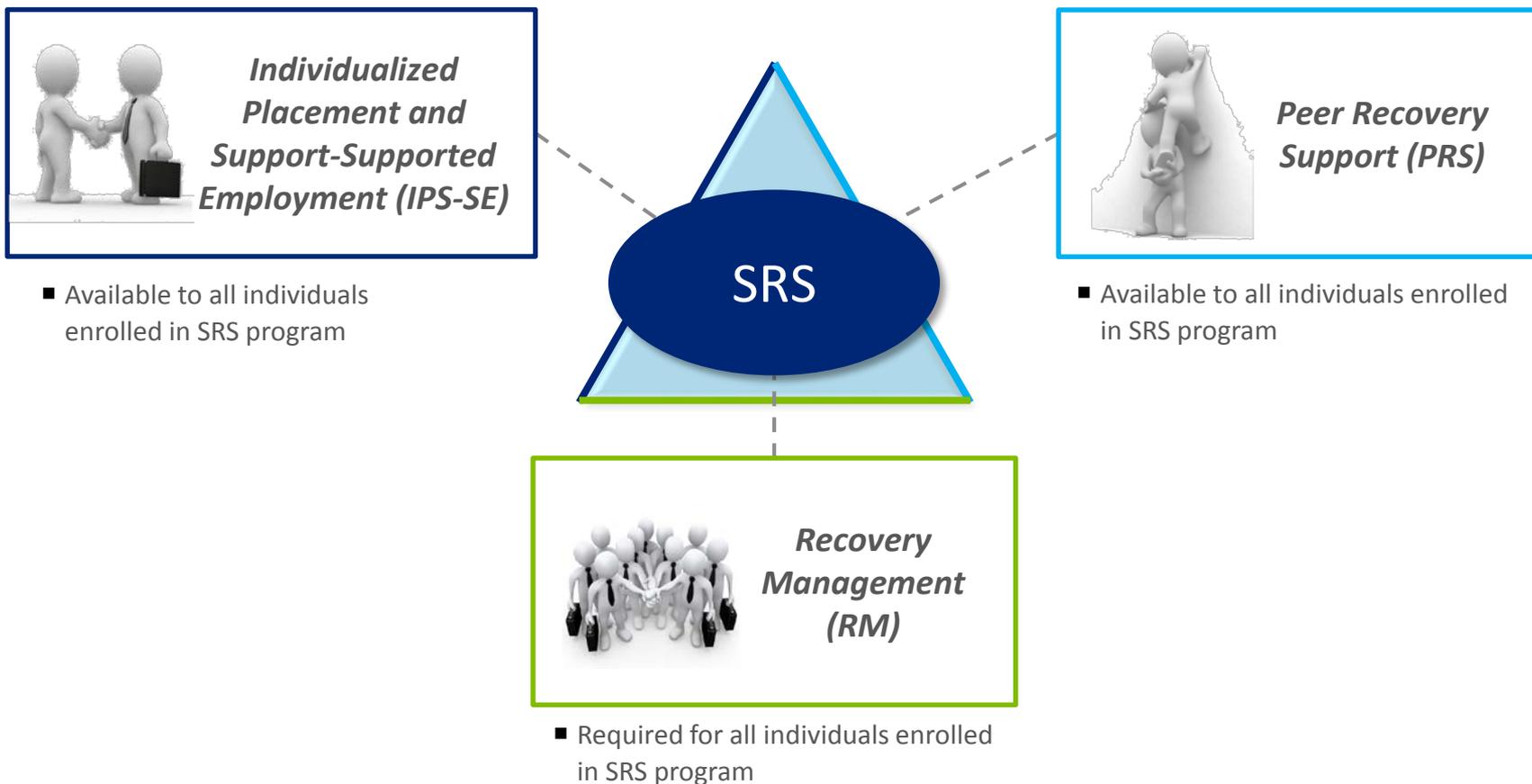
Marietta Region – Available Recovery Management:

CareSource
(855) 288-0003
CareStar
(800) 616-3718

Recovery Manager and Independent Entity Interaction



Specialized Recovery Services Program



Specialized Recovery Services Program

To be eligible for enrollment an individual must:

- Be at least 21 years of age
- Be determined financially eligible for Medicaid
- Receive Social Security Disability Benefits
- Be diagnosed with a severe and persistent mental illness as set forth in the attachment to rule 5160-43-02 of the OAC
- Score at least a 2 in one of the items in the “mental health needs” or “risk behaviors” section or score a 3 on at least one of the items in “life domains section” of the ANSA
- Demonstrate needs related to the management of the behavioral health condition

Specialized Recovery Services Program

To be eligible for enrollment an individual must:

- Have at least one of the following risk factors prior to enrollment:
 - One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
 - A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that facility; or
 - Two or more emergency department visits with a psychiatric diagnosis; or
 - A history of treatment in an intensive outpatient rehab program for greater than ninety days. The ninety days does not need to be contiguous.

Specialized Recovery Services Program

To be eligible for enrollment an individual must:

- Reside in an HCBS setting
- Demonstrate a need for SRS, and not otherwise receive those services
- Have needs that can be safely met in a HCBS setting
- Participate in the development of a person-centered care plan

Specialized Recovery Services Program

To be eligible for enrollment an individual must:

- Meet at least one of the following:
 - Have a need for a SRS to maintain stability, improve functioning, prevent relapse, be maintained in the community and if not for the provision of the SRS the individual would decline to a prior level of need; or
 - Previously have met the eligibility criteria and but for the provision of the SRS, would decline to a prior level of need

Specialized Recovery Services Program

Listed below is the explanation of how identification and outreach will occur for individuals impacted by the SRS Program

Identification

- ODM identifies potentially eligible individuals **OR** Behavioral health providers refer potentially eligible individuals
- Individuals cannot be enrolled in both the SRS program and a 1915 (c) waiver

Communications

- Individual receives SRS program “educational” letter from ODM
- Individual’s primary behavioral health provider notified of potential eligibility

Recovery Manager Outreach

- Individual randomly assigned to 1 of 2 Independent Entities(IE) in their region
- Individual can select the other (IE) if they so choose

Ongoing Identification and Outreach

Supporting Individuals to Enroll

During the week of May 9th 2016, the Ohio Department of Medicaid began contacting potentially eligible individuals to provide information on the SRS program and their assigned recovery management agency.

Be prepared to assist with the enrollment process by identifying individuals likely to be eligible for SRS and ensuring that they are connected to a recovery manager.

If you believe an individual may be eligible for the SRS program, but that person has not been contacted, contact the Ohio Department of Medicaid via secure email at BHCP@medicaid.ohio.gov, subject line: *SRS Program Referrals*

- the individual's Medicaid ID (if on Medicaid)
- name
- address
- telephone number
- and email address

You are encouraged to prioritize referrals based on the criteria below. Please only refer individuals who:

- Are 21 or older;
- Are diagnosed with a serious and persistent mental illness as listed in the [appendix](#) of Rule 5160-43-02; and
- Have received Medicaid through spenddown at least once in the last 12 months (indicating the most recent month in which the client met spend down within the past 12 months).

Ohio Medicaid will connect the person to a recovery manager to begin program enrollment.

To help determine an individual's eligibility and for other helpful information, visit <https://benefits.ohio.gov/ddr.html>.

More information on the SRS referral process can be found in the [May 23rd issue of MITS Bits](#).

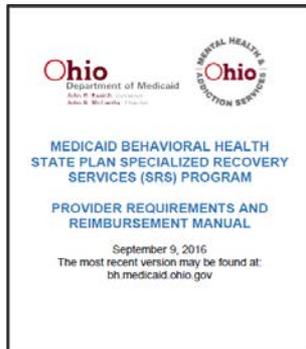
Supporting Individuals to Enroll

Educational Resources

The Ohio Departments of Medicaid and Mental Health and Addiction Services have developed a number of educational resources about the SRS program, including:

- **Educational video** explaining the program and its benefits:
<https://www.youtube.com/watch?v=fZW4p1fOmWM>
- **Frequently Asked Questions:**
<http://www.medicaid.ohio.gov/Portals/0/Initiatives/DDR/FAQ-SRS.pdf>
- **Sample letter** sent to individuals who may be eligible for the SRS program:
<http://www.medicaid.ohio.gov/Portals/0/Initiatives/DDR/Letter-SRS-2016-04.pdf>

SRS Program Manual



UPDATE

- ✓ The 9/9 release of the [Specialized Recovery Services \(SRS\) Program Manual](#) is to help providers understand how to provide and be reimbursed for SRS by Ohio Medicaid.
- ✓ The manual includes information on services offered through the SRS program, eligibility requirements, the provider enrollment process, billing codes and rates, guidance on enrolling individuals and more.

The SRS Program Manual is **now available** at:

<http://bh.medicareid.ohio.gov/Providers1#42721-specialized-recovery-services>



Department of Medicaid
Department of Mental Health and Addiction Services

Evidence-Based or State-Best Practices for Mental Health



Behavioral Health Redesign



Department of Medicaid
Department of Mental Health and Addiction Services

Assertive Community Treatment (ACT)



Behavioral Health Redesign

ACT – Fidelity Measurement

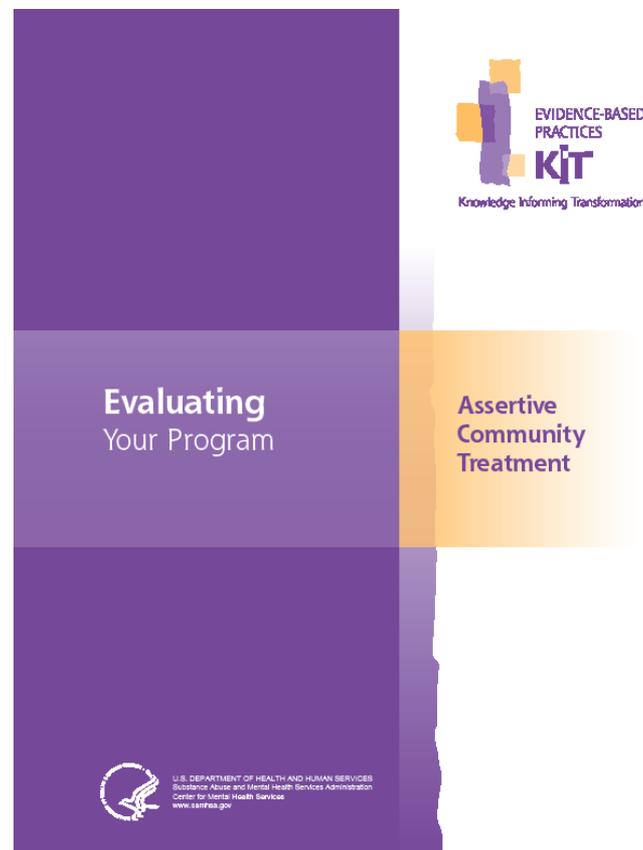
Please click on the ACT Fidelity Rating Tool image for reference and review:

ACT Fidelity Measurement

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

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

SAMHSA-approved ACT Fidelity Scale Toolkit



ACT Policy Update

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 payment rates set at the Medium caseload size regardless of the actual caseload size. Caseloads may not exceed 100.

3

ACT enrollment and caseload:

- All ACT enrollees must be prior authorized by ODM entity 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 Update Cont'd

4

Requirements for ACT Team Leaders:

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

5

No Medicaid payment for supported employment/vocational rehabilitation services unless the person is enrolled in SRS program – this is because supported employment/vocational rehabilitation can only be covered by Medicaid as a home and community based service (HCBS).



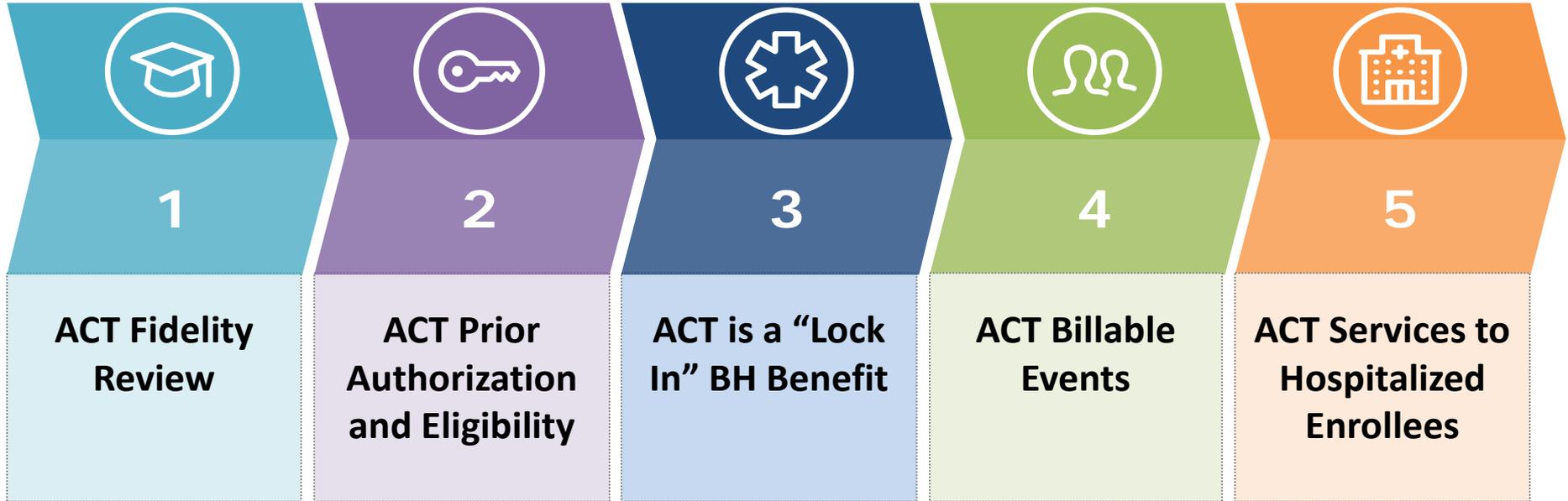
For additional reference on DACTS:

[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



ACT Medium Team Monthly Billing Example

DACTS (w/ 2 BAs): Code - H0040		Unit Rates	DACTS (w/ 1 BA, 1 PRS): Code - H0040		Unit Rates	DACTS (w/ 2 PRSs): Code - H0040		Unit Rates
MD/DO		\$615.64	MD/DO		\$615.64	MD/DO		\$615.64
Licensed/ Master's/ RN/LPN		\$251.91	Licensed/ Master's/ RN/LPN		\$251.91	Licensed/ Master's/ RN/LPN		\$251.91
Bachelor's		\$199.70	Bachelor's		\$199.70	Peer Recovery Supporter		\$159.24
Bachelor's		\$199.70	Peer Recovery Supporter		\$159.24	Peer Recovery Supporter		\$159.24
Total: <u>\$1,266.95</u>			Total: <u>\$1,226.49</u>			Total: <u>\$1,186.03</u>		

ACT is a fully prior authorized service

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 her 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**

**Billable
Event**

ACT Services/Billing Events: November 2016

**Service
Event**

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



Department of Medicaid
Department of Mental Health and Addiction Services

Intensive Home-Based Treatment (IHBT)



Behavioral Health Redesign

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

Intensive Home-Based Treatment Fidelity Rating Tool
 Minimum Rating to Qualify for Medicaid Billing: **Case Recommendations**
State Recommendations

Rating	1	2	3	4	5
1) Intensity of service	Averages one or less service hours 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.	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.	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 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 services delivered in home & community.	50% to 74% of IHBT delivered in home and community.	75% to 89% of IHBT service is delivered in home & community.	90% to 99% of IHBT service is delivered in home & community.	100% of IHBT service is delivered in home & community.
3) Caseload	For single provider: Averages 12 or greater For team of two: Averages 20 or greater Mixed caseloads (non-IHBT and IHBT)	For single provider: Averages 9 to 11 For team of two: Averages 17 to 19 Mixed caseloads (non-IHBT & IHBT)	For single provider: Averages 8 cases For team of two: Averages 15 to 16 Staff serve IHBT cases only.	For single provider: Averages 7 cases For team of two: Averages 13 to 14 Staff serve IHBT cases only.	Small caseloads. Staff serve IHBT cases only. For single provider: Caseload averages 4 to 6 youth/families. For team of two: Caseload averages 8 to 12.

IHBT Billing Structure

Code - H2015

Unit Rate (15 minute)

Licensed clinician
(modifier or NPI)



\$33.26

Medicaid will only cover when the service is provided by at least a licensed clinician

IHBT is a fully prior authorized service



Department of Medicaid
Department of Mental Health and Addiction Services

July 1, 2017 BH Manual



Behavioral Health Redesign

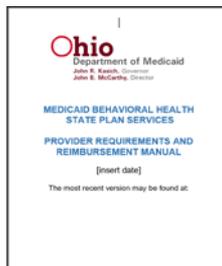
July 1, 2017 BH Manual

i

PLEASE READ

i

Please understand that this is not a ‘final’ BH manual and is in **DRAFT** format. Updates are being made and version control notation is included.



FOR BILLING GUIDANCE: Providers should review CPT/HCPCS code books, the finalized provider manual, and other materials available (e.g., NCCI, additional professional guidance).



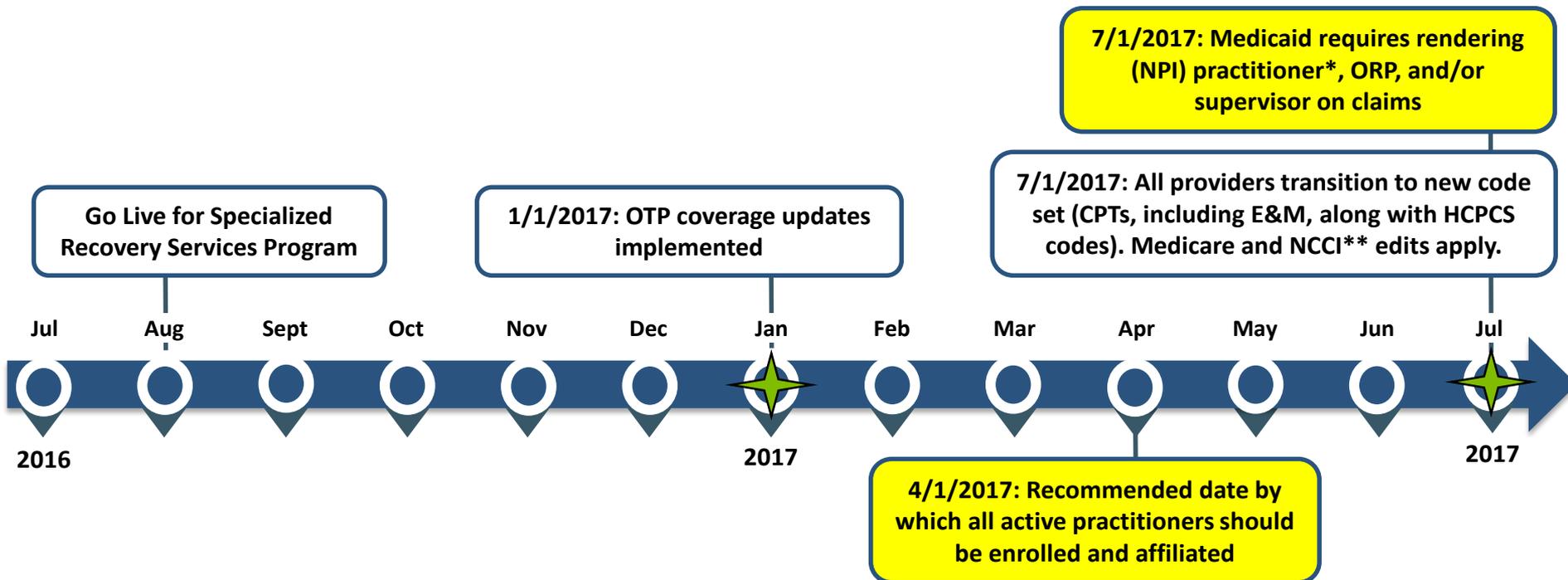
Department of Medicaid
Department of Mental Health and Addiction Services

Rendering Practitioners



Behavioral Health Redesign

Implementation Schedule – BH Redesign



***Practitioners who must enroll with Ohio Medicaid:**

Physicians (MD/DO), Psychiatrists	Licensed Independent Social Workers
Advanced Practice Registered Nurses	Licensed Professional Clinical Counselors
Certified Nurse Practitioners	Licensed Independent Marriage and Family Therapists
Clinical Nurse Specialists	Licensed Independent Chemical Dependency Counselors (LICDC)
Physician Assistants	Registered Nurses
Licensed Psychologists	Licensed Practical Nurses

 Milestone

 **NCCI prohibits use of nonstandard units (i.e., no more decimals)

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

Rendering Practitioners	
Physicians (MD/DO), Psychiatrists	Licensed Independent Social Workers
Advanced Practice Registered Nurses	Licensed Professional Clinical Counselors
Certified Nurse Practitioners	Licensed Independent Marriage and Family Therapists
Clinical Nurse Specialists	Licensed Independent Chemical Dependency Counselors (LICDC)
Physician Assistants	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 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

April 1, 2017 Checklist

PROVIDER CHECKLIST

The following checklist provides steps for providers to complete prior to full implementation of Behavioral Health Redesign on July 1, 2017



- ❖ Enrollment: Practitioners will be enrolled on a first-come, first-served basis. Enrollments submitted on or after April 1, 2017, cannot be guaranteed to be processed before July 1, 2017.
 - Obtain NPI if required to enroll in Ohio Medicaid
 - If you are a practitioner: Complete your Ohio Medicaid enrollment application before April 1, 2017 – be sure to include all required documents and affiliate with the agency or agencies you work for
 - If you are an agency: Ensure your providers complete the enrollment and affiliation process before April 1, 2017
 - Need to affiliate with provider type 84 (MH provider) and 95 (SUD provider) lines of business

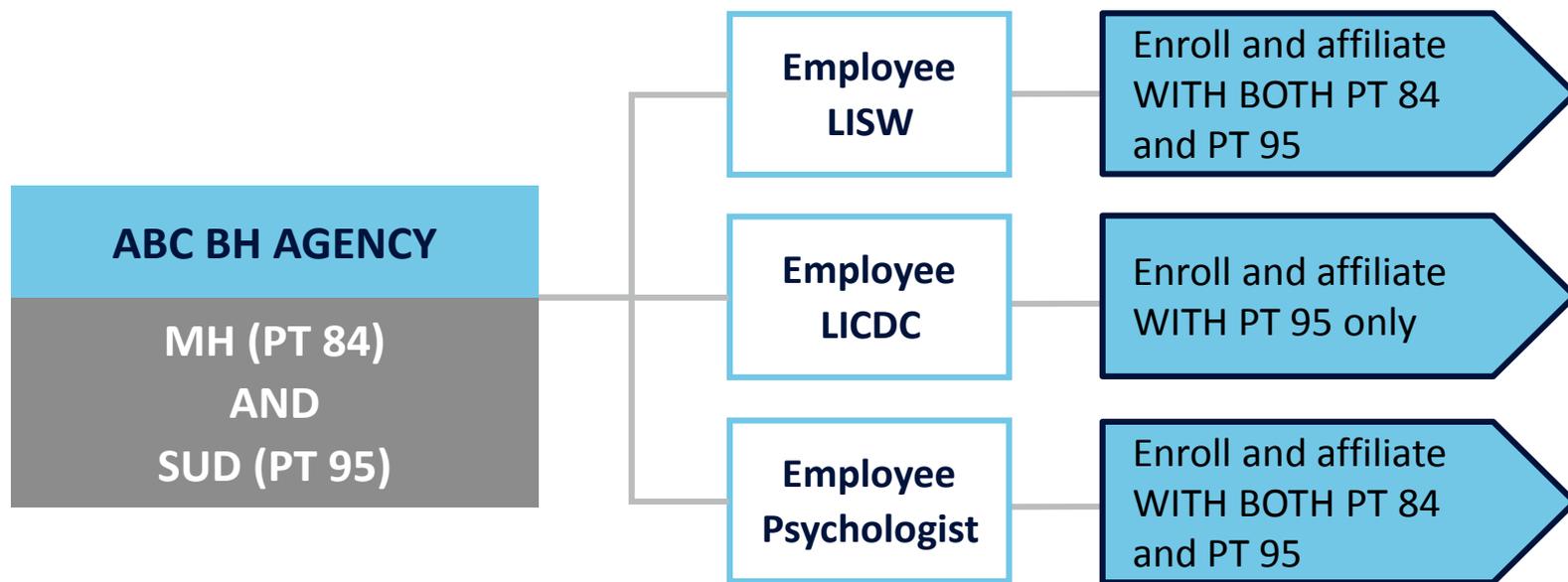


- ❖ Medicare: Enrollment takes approximately 60 days to process – enroll no later than May 1, 2017, to ensure readiness for the July 1, 2017 coordination of benefits requirement.
 - If you are an agency and serve Medicare patients, enroll with Medicare no later than May 1, 2017
 - If you are a practitioner who can bill Medicare and serves Medicare patients, enroll with Medicare no later than May 1, 2017

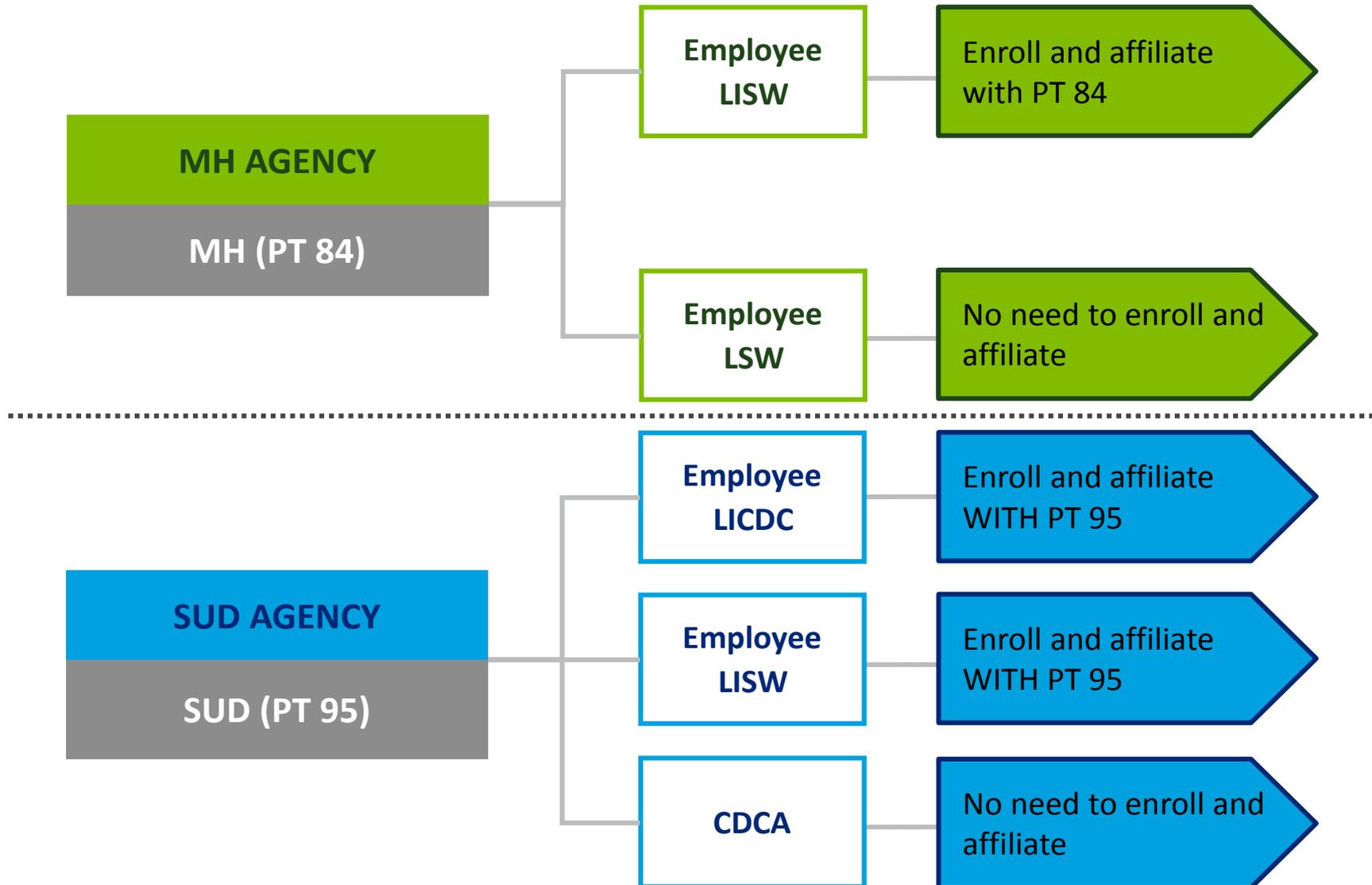


- ❖ IT Systems: Trading Partner testing of new coding.
 - Estimated date trading partners can begin testing new coding: April 1, 2017
 - Complete testing prior to July 1, 2017, to ensure claim processing is not disrupted

BH Agency (PT 84 AND PT 95) Provider Enrollment and Practitioner Enrollment and Affiliation



MH Agency (PT 84) or SUD Agency (PT 95) Provider Enrollment and Practitioner Enrollment and Affiliation





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 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 Independent Marriage and Family Therapist Licensed Independent Chemical Dependency Counselor Licensed Professional Counselor Marriage and Family Therapist Licensed Chemical Dependency Counselor Licensed Social Worker School Psychologists Registered Nurse Licensed Practical Nurse	A CBHC employing 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.



Department of Medicaid
Department of Mental Health and Addiction Services

Coverage and Limitations Work Book



Behavioral Health Redesign

C&L Work Book Clarification – 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

SUD**T1002****T1003****H0014**

*Note: used for Level 2-
Withdrawal Management*

SUD & MH**99211****MH****H2019****H2017**

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.

What has changed with the C&L Work Book?

Unit of Measure	ASAM	CPT/HCPCS Procedure Code	Pricing Modifier(s)		Description	Medical Behavioral Health (BH) Practitioners							Licensed BH Pract							
			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** (HS)	LPC	
Encounter		+90785			Interactive Complexity Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90781, 90782], psychotherapy [90824, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 90201-90205, 90904-90927, 90941-90950], and group psychotherapy [90853]	N/A	\$13.81	\$11.74	\$11.74	\$11.74	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Encounter		+90785			Interactive Complexity-non ERM use (Use 90785 in conjunction with codes for psychotherapy [90832, 90834, 90837], and group psychotherapy [90853])	N/A	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
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	\$111.11	\$111.11
Encounter		90792			Psychiatric diagnostic evaluation - includes	NA	\$126.50	\$107.53	\$107.53	\$107.53	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
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	\$53.64	\$53.64
Encounter		+90833			Psychotherapy, 30 minutes with patient and/or family member when performed with an ERM service (list separately in addition to the code for primary procedure). (Use 90833 in conjunction with 90201-90205, 90904-90927, 90941-90950).	NA	\$65.37	\$55.56	\$55.56	\$55.56	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Encounter		90834			Psychotherapy, 45 minutes with patient and/or family member.	NA	\$82.05	\$68.74	\$68.74	\$68.74	NA	NA	\$82.05	\$68.74	\$68.74	\$68.74	\$68.74	\$68.74	\$68.74	\$68.74
Encounter		+90836			Psychotherapy, 45 minutes with patient and/or family member when performed with an ERM service (list separately in addition to the code for primary procedure). (Use 90836 in conjunction with 90201-90205, 90904-90927, 90941-90950).	NA	\$83.03	\$70.58	\$70.58	\$70.58	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Encounter		90837			Psychotherapy, 50 minutes with patient and/or															

Changes Made to the Coding Chart Since June 15, 2016

- ✓ Updated Assistants and Trainee cells in CPT codes to say "See Supervisor Rate" for direct supervision.
- ✓ Updated rates for: H0014; H2017 (PSR); H2017 (LPN Services); H2019 (TBS); H2019 (RN Services); H2019 (Group)
- ✓ Replaced H0016 with T1002 and T1003 for SUD nursing codes and aligned rates with above
- ✓ Updated Crisis modifier to "UT"
- ✓ Added physician assistants to methadone and buprenorphine administration
- ✓ Added physician assistants to psychotherapy and psychotherapy add-on's
- ✓ Removed the requirements for years of experience for Bachelor's and Master's TBS
- ✓ Updated IHBT to MH licensed practitioners
- ✓ Assured all rates are not higher than 100% of Medicare
- ✓ Changed APRN modifier to match rest of Medicaid (SA/UC)
- ✓ Added HI (Cognitive Impairment), SA (CNP), UC (CNS), TV (Weekly Administration) modifiers to modifier table in "Overall Coding_Rate Sheet"
- ✓ Added ACT, IHBT, SUD Residential, and SUD Withdrawal Management services to "All Services" tab
- ✓ Updated all internal links
- ✓ Updated benefit limits



Coverage and Limitations Work Book

Version Control

Behavioral Health Coverage and Limitations Work Book			
Current Version	Description of Changes	Last Editor	Release Date
Version 1.0	Initial DRAFT Version	State Policy Team	6/14/2016
Version 2.0	General Updates: 1. SUD Residential Rate - error in code chart 2. Added in LPNs able to bill OTP codes 3. All services tab was added (all services, codes and coverage and limitations - excluding ACT, IHBT, SUD Residential and SUD Withdrawal Management on this tab) 4. Added in Time Conversion Charts 5. Added Case Management to 'all practitioners' within overall coding chart	State Policy Team	6/23/2016
Version 3.0	General Updates: 1. Physician Assistants are eligible to bill CPT codes as well as Interactive Complexity 2. SUD TCM is added to all practitioner tabs as eligible to bill (previously was only on coding chart)	State Policy Team	NA
Version 4.0	General Updates: 1. Physician Assistants are eligible to bill psychotherapy 2. Incident to language was removed from the code chart 3. Psych. Assistants supervision requirements updated to reflect only a need for general supervision 4. Removed IHBT Bachelor's	State Policy Team	NA
Version 5.0	General Updates: 1. Updated Assistants and Trainee cells in CPT codes to say "See Supervisor Rate" for direct supervision 2. Increased rates for: H0014, H2017 (PSR), H2017 (LPN Service), H2019 (TBS), H2019 (RN Services), H2019 (Group) 3. Replaced H0016 with T1002 and T1003 for SUD nursing Codes 4. Updated Crisis Modifier to UT 5. Added Physician Assistants to Methadone and BUP 6. Added Physician Assistants to Psychotherapy and Psychotherapy add-ons 7. Removed the requirements for years of experience for Bachelor's and Master's TBS 8. Updated IHBT to Licensed Practitioners 9. Decreased the following rates to 100% of Medicare: 90791, 90839, 90840, 90863 10. Changed APRN modifier to match rest of Medicaid (SA/UC) 11. Added HI (Cognitive Impairment), SA (CNP), UC (CNS), TV (Weekly Administration) modifiers to modifier table in "Overall Coding_Rate Sheet" 12. Added ACT, IHBT, SUD Residential, and SUD Withdrawal Management services to "All Services" tab 13. Updated all internal links 14. Updated Benefit Limits to new proposals 15. General aesthetic changes	State Policy Team	8/23/2016

- ✓ Version updates are noted on a separate tab sheet
- ✓ New Version releases will be uploaded onto the Ohio Behavioral Health Redesign website

Version 5.0 of the Coverage and Limitations Work Book is **now available** at
<http://bh.medicaid.ohio.gov/manuals>



Department of Medicaid
Department of Mental Health and Addiction Services

National Correct Coding Initiative (NCCI)



Behavioral Health Redesign

National Correct Coding Initiative

National Correct Coding Initiative Overview



- Required by 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)
- 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.



Department of Medicaid
Department of Mental Health and Addiction Services

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	<i>General</i>
Licensed chemical dependency counselor II or III	<i>General</i>
Licensed social worker	<i>General</i>
Licensed marriage and family therapist	<i>General</i>
Psychology assistant, intern, trainee	<i>General</i>
Chemical dependency counselor assistant	<i>Direct</i>
Counselor trainee	<i>Direct</i>
Social worker trainee	<i>Direct</i>
Marriage and family therapist trainee	<i>Direct</i>

CPT General and Direct Supervision Example

Example: CPT Codes

General Supervision: An LSW conducts a psychotherapy session with a patient with their supervising practitioner available by phone. The claim would be submitted with the U4 modifier (representing the LSW 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.** MITS will adjudicate the claim using the LSW rate.

Direct Supervision: A social worker trainee 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 social worker trainee credential) with the supervisor's NPI in the supervisor field and the rendering field is blank. 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	<i>General</i>
Chemical dependency counselor assistant	<i>General</i>
Counselor trainee	<i>General</i>
Social worker assistant	<i>General</i>
Social worker trainee	<i>General</i>
Marriage and family therapist trainee	<i>General</i>
Qualified Mental Health Specialist	<i>General</i>
Care Management Specialist	<i>General</i>
Peer Recovery Supporters	<i>General</i>

HCPCS General and Direct Supervision Example

Example: HCPCS Codes

General Supervision: A SWT 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 SWT 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.** MITS will adjudicate the claim using the SWT rate.

Direct Supervision: Not likely to occur because the direct supervisor would have to be present with the supervised clinician.



Department of Medicaid
Department of Mental Health and Addiction Services

Interactive Complexity



Behavioral Health Redesign

Interactive Complexity

Interactive Complexity

- Interactive complexity is an add-on code which may be reported in conjunction with Psychiatric Diagnostic Evaluation (90791, 90792), Psychotherapy (90832, 90834, and 90837), Psychotherapy add-ons (90833, 90836, and 90838) and Group Psychotherapy (90853).
- Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur *during* the delivery of the service. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients.



Recent Guidance: Interactive complexity was added for physician assistants to bill standalone psychotherapy and psychotherapy add-ons.

Interactive Complexity Base Codes

Relevant Codes
90791 – Psychiatric Diagnostic Evaluation
90792 – Psychiatric Diagnostic Evaluation – Includes Medical
90832 – Psychotherapy, 30 minutes (16-37)
90834 – Psychotherapy, 45 minutes (38-52)
90837 – Psychotherapy, 60 minutes (53+)
+90833 – Psychotherapy, 30 minutes, with E&M (16-37)
+90836 – Psychotherapy, 45 minutes, with E&M (38-52)
+90838 – Psychotherapy, 60 minutes, with E&M (53+)
90853 – Group Psychotherapy

Note: Report 90785 in addition to the primary procedure, when certain communication factors are present during the visit. Please see the Provider Manual for further details.

Interactive Complexity Cont'd

Interactive Complexity can be added on to the following codes per practitioner:

	MD/DO	CNS	CNP	PA	PSY	LISW	LIMFT	LPCC	LICDC	LI School PSY	LSW	LMFT	LPC	LCDC II/III	Train/ Assist*
PDE	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791	90791
	90792	90792	90792	90792	90792										
Psychotherapy	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832	90832
	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834	90834
	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837	90837
	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853	90853
	+90833	+90833	+90833	+90833											
	+90836	+90836	+90836	+90836											
	+90838	+90838	+90838	+90838											

* under direct supervision

Interactive Complexity Professional Guidance Example



Interactive Complexity

Revised 11/3/12

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
www.aacap.org

Definition A new concept in 2013, interactive complexity refers to 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code 90785.

Code Type Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.

Replaces Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.

Use in Conjunction With The following psychiatric "primary procedures":

- Psychiatric diagnostic evaluation, 90791, 90792
- Psychotherapy, 90832, 90834, 90837
- Psychotherapy add-on codes, 90833, 90836, 90838, when reported with E/M
- Group psychotherapy, 90853

When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work intensity of the psychotherapy service, and does not change the time for the psychotherapy service.

May Not Report With

- Psychotherapy for crisis (90839, 90840)
- E/M alone, i.e., E/M service not reported in conjunction with a psychotherapy add-on service
- Family psychotherapy (90846, 90847, 90849)

Typical Patients Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Report 90785

When at least one of the following communication factors is present during the visit:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.

Complicating Communication Factor Must Be Present During the Visit

The following examples are **NOT** interactive complexity:

- Multiple participants in the visit with straightforward communication
- Patient attends visit individually with no sentinel event or language barriers
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors

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LINK:

[https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/Interactive Complexity Guide 2012.pdf](https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/Interactive_Complexity_Guide_2012.pdf)

For additional AACAP CPT & Reimbursement language, click [here](#)

Interactive Complexity Professional Guidance Example



Interactive Complexity

Revised 11/3/12

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

www.psychiatry.org

Definition	A new concept in 2013, interactive complexity refers to 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code 90785.
Code Type	Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.
Replaces	Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.
Use in Conjunction With	<p>The following psychiatric "primary procedures"</p> <ul style="list-style-type: none"> • Psychiatric diagnostic evaluation, 90791, 90792 • Psychotherapy, 90832, 90834, 90837 • Psychotherapy add-on codes, 90833, 90838, 90838, when reported with E/M • Group psychotherapy, 90853 <p>When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work intensity of the psychotherapy service, and does not change the time for the psychotherapy service.</p>
May Not Report With	<ul style="list-style-type: none"> • Psychotherapy for crisis (90839, 90942) • E/M alone, i.e., E/M service not reported in conjunction with a psychotherapy add-on service • Family psychotherapy (90846, 90847, 90849)
Complicating Communication Factor Must Be Present During the Visit	<p>The following examples are NOT interactive complexity:</p> <ul style="list-style-type: none"> • Multiple participants in the visit with straightforward communication • Patient attends visit individually with no sentinel event or language barriers • Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors

Report 90785 When at least one of the following communication factors is present during the visit:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.

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Typical Patients

Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
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- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Interactive Complexity Professional Guidance Example



Interactive Complexity

Revised 11/3/12

AMERICAN ACADEMY OF
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PSYCHIATRY

www.psychiatry.org

<p>Definition</p> <p>A new concept in 2013, interactive complexity refers to 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code 90785.</p>	<p>Typical Patients</p> <p>Interactive complexity is often present with patients who:</p> <ul style="list-style-type: none"> • Have other individuals legally responsible for their care, such as minors or adults with guardians, or • Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or • Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools. <p>Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.</p>	<p style="text-align: center; color: green; font-weight: bold;">Report 90785</p> <p>When at least one of the following communication factors is present during the visit:</p> <ol style="list-style-type: none"> 1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care. 2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan. 3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants. 4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language. <p style="font-size: x-x-small;">Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.</p>	<p>Code Type</p> <p>Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.</p>	<p>Replaces</p> <p>Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.</p>	<p>Use in Conjunction With</p> <p>The following psychiatric "primary procedure" codes:</p> <ul style="list-style-type: none"> • Psychiatric diagnostic evaluation, 90761, 90792 • Psychotherapy, 90832, 90834, 90837 • Psychotherapy add-on codes, 90833, 90835, 90838, when reported with E/M • Group psychotherapy, 90853 <p>When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work intensity of the psychotherapy service, and does not change the time for the psychotherapy service.</p>	<p>May Not Report With</p> <ul style="list-style-type: none"> • Psychotherapy for crisis (90830, 90942) • E/M alone, i.e., E/M service not reported in conjunction with a psychotherapy add-on service • Family psychotherapy (90846, 90847, 90849)
<p>Complicating Communication Factor Must Be Present During the Visit</p> <p>The following examples are NOT interactive complexity:</p> <ul style="list-style-type: none"> • Multiple participants in the visit with straightforward communication • Patient attends visit individually with no sentinel event or language barriers 		<p>Report 90785</p> <p>When at least one of the following communication factors is present during the visit:</p> <ol style="list-style-type: none"> 1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care. 2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan. 3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants. 4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language. <p style="font-size: x-x-small;">Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.</p>				

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Report 90785

When at least one of the following communication factors is present during the visit:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.



Department of Medicaid
Department of Mental Health and Addiction Services

Trading Partner Information



Behavioral Health Redesign

Trading Partner Information & File Testing



- EDI services are being transitioned from the Ohio Department of Administrative Services (DAS) to Hewlett Packard Enterprise (HPE)
- June 2016: Trading partner testing began for the new system
- Transition to be complete by end of 2016
- BH trading partners who have not been contacted with transition information should ensure MITS contact information is accurate or contact DAS-EDI-Support@das.ohio.gov as soon as possible

Existing Trading Partner Resources

The following can be accessed here:

- ✓ Important updates
- ✓ Transition webinar
- ✓ Enrollment and testing information
- ✓ EDI Processing calendars
- ✓ MITS provider portal
- ✓ 5010 Companion guides
- ✓ FAQs for EDI
- ✓ HPE information

HOME	MEDICAID 101	FOR OHIOANS	PROVIDERS	INITIATIVES	NEWS
RESOURCES	CAREERS	CONTACT			

PROVIDERS > Billing > Trading Partners

ODM Trading Partners

This information is intended to assist organizations who facilitate electronic Medicaid claims reimbursement on behalf of Ohio Medicaid providers.

NOTICE: Due to the migration of the EDI Services from the Ohio Department of Administrative Services to Hewlett Packard Enterprise, the Ohio Department of Medicaid has temporarily suspended the enrollment of new Trading Partners as of Wednesday June 29, 2016.

ALERT: In June 2016, the Ohio Department of Medicaid began testing a new system and processes for all EDI transactions. All current Ohio Medicaid Trading Partners should have received related communications via email. Additional communications will be sent on a regular basis as we continue to roll out testing opportunities for the new system. All trading partners **WILL** be transitioned to the new system before the end of the calendar year. Please watch your email for updates. If any of the contacts for your company change please ensure that you notify the DAS-EDI-Support@das.ohio.gov. Contact updates after your company transitions please notify OhioMCD-EDI-Support@hpe.com. For more information please visit the Hewlett Packard Enterprise Information link under Features.

Latest news for ODM Trading Partners

- Initial EDI Transition Communication
- Update to Medicaid Crossover Claims
- Important Notice about 837P Claims
- EDI Adjustment Instructions

Need technical assistance?
Provider Hotline:
(800) 686-1516

Access the
MITS Portal

Trading Partner Forums

MyCareOhio for BH providers
ORP FAQs
5/27/15 ICD-10 Webinar for TPs
5/27/15 ICD-10 Webinar for TPs Q&A
Transition Webinar
EDI Transition FAQs

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

New Trading Partner Resources

- To help in transitioning to the new EDI system, user guides and testing information can be found here
- ODM will provide web site for submission of test claims at a later date

HOME	MEDICAID 101	FOR OHIOANS	PROVIDERS	INITIATIVES	NEWS
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PROVIDERS > Billing > Trading Partners > HP Vendor Information

Hewlett Packard Enterprises (HPE) Vendor Information

HPE is an information services company that provides HIPAA EDI transaction communication, processing and security services for Ohio Medicaid. The software utilized by HPE is optimized for healthcare transactions as defined by HIPAA Transaction and Code Sets standards.

All transactions are moved via secure Internet transmission channels using encryption as approved by the Centers for Medicare and Medicaid Services (CMS).

HPE offers several ways for trading partners to connect to submit their EDI transactions to Ohio Medicaid. HTTPS, FTPS, SFTP and Web Service Definition Language (WSDL) and MIME as required by the ACA 1104. User manuals can be found below.

Helpful Links:

- Web File Transfer Information
- FTPS Protocol Information
- WEDI SNIP Testing Types
- HTTPS Portal User Guide (Updated 09/12/2016)
- SFTP User Guide (Updated 09/12/2016)

} Current user guides

} Post-transition user guides

Need technical assistance?
Provider Hotline:
(800) 686-1516

Access the
MITS Portal

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners/HPVendorInformation.aspx>



Department of Medicaid
Department of Mental Health and Addiction Services

837P Companion Guide



Behavioral Health Redesign

IT Workgroup Changes for July 1, 2017



Initial meeting May 31,
2016

Met October 3, 2016

- [Link to presentation](#)
- Future dates: November 9
and December 6, 2016

Reviewing companion
guides to identify updates
needed to support
upcoming changes

Electronic Data Interchange:

Updates will be made to EDI Companion Guides for 7/1/2017

- ODM is identifying the page numbers, loops and segments in the Companion Guides that will be affected by these changes
- ODM will issue updated Companion Guides with clarifications for the 7/1/2017 changes and will be communicated to the field



837P Companion Guide – Overview

Document Information			
Document Title:	837 Professional Encounter Claims		
Document ID:	Ohio 837P Enc CG Book		
Version:	1.2		
Owner:	Ohio MIT's Team		
Author:	Ohio Department of Medicaid & Hewlett Packard Enterprise EDI Team		

Amendment History			
Version	Date	Modified By	Modifications
1.0	05/11/2014	ODM & HP EDI Team	Initial Creation
1.1	04/08/2016	ODM & HP EDI Team	Updated notes around Check or Remittance Date sent in Loop 2330B or 2430
1.2	12/02/2016	ODM & HP EDI Team	Minor Updates

837P GUIDANCE

- Does not replace the HIPAA Implementation guide.
- Guide for **specific or additional** EDI claim requirements to ODM.
- Fields reported on the 837P will be populated in the 835 and sent back to the provider.



Ongoing Activities



- ODM will continue to share draft 837P FFS Companion Guide changes with the IT workgroup.
- Anticipate all changes to be identified by January 2017 and final operating draft issued.
- Final version will be posted to the ODM website on July 1, 2017, to coincide with the implementation effective date.

837P Companion Guide

INPUT

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
262	2310B	NM1	Rendering Provider Name			<p>The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.</p> <p>If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.</p> <p>An encounter that contains an NPI that does not pass check digit validation WILL REJECT.</p>
264	2310B	NM109	Rendering Provider Identifier			Provider NPI

<http://medicaid.ohio.gov/Portals/0/Providers/MITS/HIPAA%205010%20Implementation/CompanionGuide/Ohio837P-FFS.pdf>

837P Companion Guide – DRAFT for July

**** Proposed additions in red ****

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
90	2010AA	NM109	Billing Provider identifier			Provider NPI. For provider types 84 and 95, this would be the agency NPI
264	2310B	NM109	Rendering Provider Number			Provider NPI. For provider types 84 and 95 if the practitioner is enrolled in Medicaid, use practitioner’s NPI. Otherwise leave field blank.
456	2420E	NM109	Ordering Provider Identifier			Provider NPI For provider types 84 and 95 , when an RN or LPN provides the service, this field must have NPI of ordering practitioner

837P Companion Guide – DRAFT Cont’d.

**** Proposed additions in red ****

This next loop, Rendering Provider, would only be used IF there were multiple detail lines on the claim and the individual rendering this particular service line was different than what was sent in the 2310B:

432	2420A	NM109	Rendering Provider Number		Provider NPI For provider types 84 and 95 if the practitioner is enrolled in Medicaid , use practitioner’s NPI. Otherwise leave field blank.
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Subject to UAT results, may need to add language to Supervisor field

**END of
July 1, 2017 Changes**



Department of Medicaid
Department of Mental Health and Addiction Services

Provider Enrollment Updates



Behavioral Health Redesign

BH Provider Enrollment Support



The mailbox address is
bh-enroll@medicaid.ohio.gov

The Ohio Department of Medicaid has established a Medicaid mailbox to collect and respond to questions from behavioral health providers.

- Providers should email this mailbox when they have questions regarding MITS enrollment of rendering practitioners
- OR agency revalidation

Provider Enrollment for Type 84 and Type 95 Providers



A provider must be certified by OhioMHAS as a provider of Mental Health services or SUD treatment program before they can enroll in Medicaid.

To complete the MITS enrollment application the following documents are necessary:



An agency National Provider Identifier number (NPI) from the National Plan and Provider Enumeration System (NPPES)

- If applying as both provider types, the agency must have two NPIs



A signed copy of the IRS W-9 form for the applicant MH or SUD agency



And verification of an application fee payment

- If the provider is a Medicare provider, they may use the Medicare payment confirmation **BUT** the NPI number and address must match the Medicaid application

Information on OhioMHAS mental health services or SUD treatment program certification can be obtained from the OhioMHAS Bureau of Licensure & Certification by calling 614-752-8880 or by visiting the OhioMHAS licensure and certification webpage here:

<http://mha.ohio.gov/Default.aspx?tabid=123>.



Department of Medicaid
Department of Mental Health and Addiction Services

Next Steps and Schedule



Behavioral Health Redesign

Key Topics: Next Steps



Mobile Crisis and BH Urgent Care

Mobile Crisis and BH Urgent Care Work Group will reconvene in the fall of 2016



High Fidelity Wraparound

Work Group will reconvene in the fall of 2016



Payment Innovation

*Design and implement new health care delivery payment systems to reward the value of services, not volume.
Develop approach for introducing episode based payment for BH services.*

- Focusing on ADHD and ODD



Managed Care Transition

Working with stakeholders to prepare for January 2018



Department of Medicaid
Department of Mental Health and Addiction Services

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.

Behavioral Health Redesign

HOME ABOUT INDIVIDUALS PROVIDERS NEWSLETTERS CONTACT US

Helping Your Patients

Modernizing business practices to improve patient outcomes.

What is Ohio's Behavioral Health Redesign?

A transformative initiative aimed at rebuilding Ohio's community behavioral health system capacity. Key proposals include adding new services for people with high intensity service and support needs and aligning the procedure codes used by Ohio's behavioral health providers to better integrate physical and behavioral healthcare.

Changes begin July 1, 2016.

About
Details about this important initiative and additional resources.
[learn more >](#)

Individuals
Information about your health care coverage.
[learn more >](#)

Providers
Information about your patients' coverage and tools to guide your business.
[learn more >](#)

Newsletter Sign-up
Sign up for the BH Redesign Newsletter and stay up-to-date with the latest BH Redesign news!

Partners
Ohio's Behavioral Health Redesign is a collaborative effort of the Governor's Office of Health Transformation and the Ohio Departments of Medicaid and Mental Health and Addiction Services.

Contact Us:
Questions about BH Redesign? [Contact Us](#)
Questions about your Ohio Medicaid coverage?
Call the Ohio Medicaid Consumer Hotline: 1-800-324-8680
Questions about mental health and addiction services, supports, and referrals?
Call the OhioMHAS Consumer and Family Toll-Free Bridge: 1-877-275-4364 (1-888-436-4889 TTY)

Ohio Department of Medicaid | Ohio Department of Mental Health and Addiction Services | Ohio Governor's Office of Health Transformation

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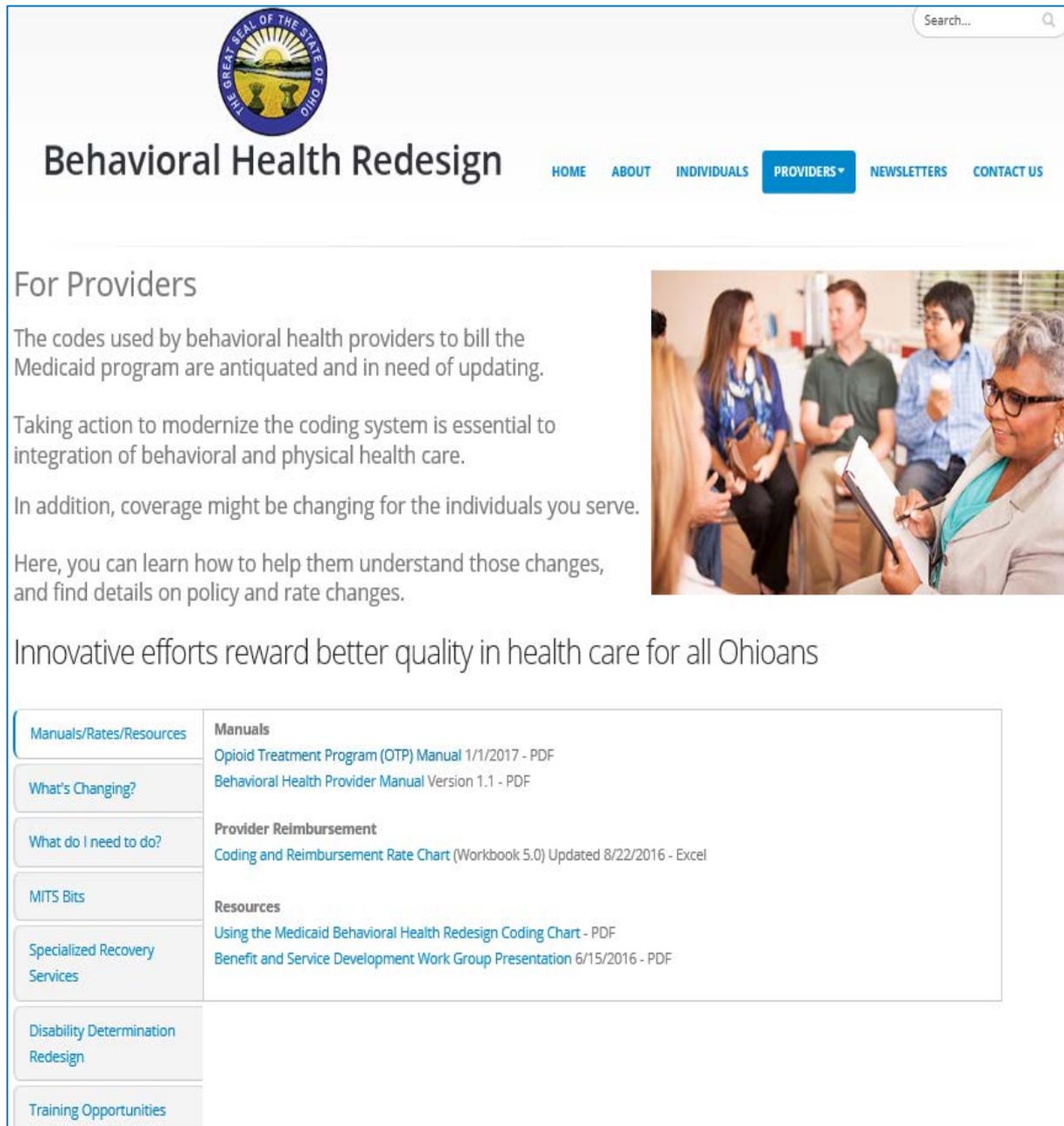
Behavioral Health Redesign Website

Go To:

bh.medicaid.ohio.gov

Click on the
PROVIDERS tab.

Scroll through this webpage to find updated materials for BH providers. Materials include such topics as trainings, manuals, the Rate Chart, MITS Bits uploads, and new program information.



Behavioral Health Redesign

HOME ABOUT INDIVIDUALS **PROVIDERS** NEWSLETTERS CONTACT US

For Providers

The codes used by behavioral health providers to bill the Medicaid program are antiquated and in need of updating.

Taking action to modernize the coding system is essential to integration of behavioral and physical health care.

In addition, coverage might be changing for the individuals you serve.

Here, you can learn how to help them understand those changes, and find details on policy and rate changes.



Innovative efforts reward better quality in health care for all Ohioans

Manuals/Rates/Resources	Manuals Opioid Treatment Program (OTP) Manual 1/1/2017 - PDF Behavioral Health Provider Manual Version 1.1 - PDF
What's Changing?	
What do I need to do?	Provider Reimbursement Coding and Reimbursement Rate Chart (Workbook 5.0) Updated 8/22/2016 - Excel
MITS Bits	Resources Using the Medicaid Behavioral Health Redesign Coding Chart - PDF Benefit and Service Development Work Group Presentation 6/15/2016 - PDF
Specialized Recovery Services	
Disability Determination Redesign	
Training Opportunities	



Questions?

Reference Links

LINK	TOPIC	SLIDE
http://bh.medicaid.ohio.gov/manuals	January 1, 2017 OTP Manual	10
BHCP@medicaid.ohio.gov	SRS Program Referrals	80
http://bh.medicaid.ohio.gov/Providers1#42721-specialized-recovery-services	SRS Program Manual	82
http://www.dartmouth.edu/~implementation/page15/page4/files/dacts_protocol_1-16-03.pdf	Dartmouth Act Fidelity Scale	85
http://www.ct.gov/dmhas/lib/dmhas/publications/ACT-TMACT.pdf	TMACT Summary Scale V.1.	86
http://bh.medicaid.ohio.gov/manuals	Coverage & Limitations Work Book	109
https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html	NCCI Initiative	112
https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/Interactive_Complexity_Guide_2012.pdf	Interactive Complexity	124
http://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/CPT_and_Reimbursement.aspx?hkey=e53bd2fa-d1f9-4db5-bbfa-17f48bec4e35	CPT & Reimbursement	124
DAS-EDI-Support@das.ohio.gov	Trading Partner Contact Info	128
http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx	Existing Trading Partner Resources	129
OhioMCD-EDI-Support@hpe.com	New Trading Partner Contact Info	129
http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners/HPVendorInformation.aspx	New Trading Partner Resources	130
http://bh.medicaid.ohio.gov/Portals/0/Users/008/08/8/20161003-EDI-IT-meeting.pdf?ver=2016-10-05-164148-253	10-3 EDI/IT Workgroup Meeting	132
http://medicaid.ohio.gov/Portals/0/Providers/MITS/HIPAA%205010%20Implementation/CompanionGuide/Ohio837P-FFS.pdf	837P Companion Guide	134
bh-enroll@medicaid.ohio.gov	BH Provider Enrollment Mailbox	139
http://mha.ohio.gov/Default.aspx?tabid=123	Enrollment Application	140
http://mha.ohio.gov/Default.aspx?tabid=154	BH Providers List Serve	144