301 Fundamentals of Behavioral Health Redesign

Opportunities
# Agenda

- Welcome and Opening Remarks
- BH Redesign and Managed Care
- BH Redesign Benefit Package: Mental Health
- H2017 and H2019: Different Uses
- Nursing Scope of Practice – RNs and LPNs
- Crisis Services
- BH Redesign Benefit Package: Substance Use Disorder (SUD) Services
- ASAM Outpatient Level of Care 1 SUD Group Counseling
- ASAM Outpatient Level of Care 2 Intensive Outpatient and Partial Hospitalization
- Staffing for ASAM Residential Levels of Care
- Benefit Administration Timeline, Policies, and Program Integrity
  - Services Which are - ALWAYS Prior Authorized -
  - Services With Prior Authorization - Billing Provider -
  - Services With Prior Authorization - Medicaid Enrollee -
  - Services With - No State-Defined Benefit Limits -
- Supervision Requirements
- Reporting Supervisor on Claims
- National Correct Coding Initiative (NCCI)
- Peer Recovery Support
- Medicaid-Funded Assertive Community Treatment (ACT)
- Intensive Home-Based Treatment (IHBT)
- Updates
  - Behavioral Health Redesign Work Book
  - Urine Drug Screening
  - Place of Service
  - Documentation Requirements
  - IT Resources and EDI File Testing (Fee for Service)
  - Rapid Response Team
  - BH Monitoring
- Behavioral Health Redesign Website
Qualified Mental Health Specialist (QMHS)+3 years may provide MH Day Treatment

- QMHSs with a minimum of 3 years of experience (without a Bachelor’s or Master’s degree) in a relevant field as determined by the employing agency may render MH Day Treatment.
- This includes MH Day Treatment per hour up to two hours – (H2012 UK HQ) and MH Day Treatment per diem (H2020 UK).

Medicaid Information Technology System (MITS) Trading Partner testing

- The timeline for trading partner EDI file testing has been expanded from two weeks to six weeks.
- Trading partners will be able to start testing in early May 2017.

Therapeutic Behavioral Service (TBS) and Psychosocial Rehabilitation (PSR)

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

Rapid Response Team

- State will establish a Rapid Response team that will be available beginning in July, 2017 to provide technical assistance 6 days a week for any issues related to claims payment or processing time.

Nursing Services

- There will be no limits to medically necessary nursing services.
- There will no longer be a limit of 24 hours (96 units) for Mental Health or SUD Nursing services per patient, per calendar year.

Monitoring Implementation

- ODM and OhioMHAS are implementing a plan to monitor the Behavioral Health Redesign. The State will monitor claims payment and processing times to ensure that a timely payment mechanism is in place when we transition to the new system in July, 2017.

Please refer to [http://bh.medicaid.ohio.gov/Newsletters](http://bh.medicaid.ohio.gov/Newsletters) for further details.
Ohio Medicaid Behavioral Health Redesign Initiative

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

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

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

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

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

- **Integration**
  Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.
Ohio Medicaid Behavioral Health Redesign Initiative - Where We Are Today

- **Elevation** – *Completed* as of July 1, 2012.
- **Expansion** – *Completed* as of January 1, 2014.

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

**Integration** – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. *Implementation on target for January 1, 2018.*
BH Redesign and Managed Care
Medicaid Managed Care Plans - Today

BH Services are “CARVED OUT” Until 1/1/18

- Ohio Medicaid recipients enrolled in a Medicaid managed care plan - Buckeye, CareSource, Molina Healthcare of Ohio, Paramount Advantage or UnitedHealthcare – can receive community behavioral health services through any participating Medicaid BH Provider agency.

- **One Exception: Respite**

- Coordinated or associated primary health care, (pharmacy, laboratory services) are the responsibility of MCPs. Check for any needed prior authorization.

*Paramount is a Medicaid Managed Care Plan but not a MyCare plan*
MyCare Ohio Managed Care Plans - Today

BH Services are “CARVED IN”

- Ohio *Medicare and Medicaid* recipients enrolled in a MyCare Ohio plan - Aetna, Buckeye, CareSource, Molina Healthcare of Ohio, or UnitedHealthcare - receive community behavioral health services through their MyCare Plan.

- Providers will need to be contracted with MyCare Plan and MAY need prior authorization for certain services

Aetna is a MyCare plan **but not** a Medicaid Managed Care Plan
BH Redesign Benefit Package: Mental Health
BH Redesign Changes Support the Treatment of Mental Illness

- Expanding MH Benefit package
- Adding family psychotherapy both with and without the patient
- Adding primary care services, labs & vaccines
- Adding coverage for psychotherapy, psychological testing
- Adding evidence based/state best practices:
  - Assertive Community Treatment - adults with SPMI
  - Intensive Home Based Treatment - youth at risk of out of home placement
- Expanding community based rehabilitation: Therapeutic Behavioral Services & Psychosocial Rehabilitation & maintaining coverage of CPST
- Maintaining prior authorization exemption for second generation antipsychotic medications when dispensed by physicians with a psychiatric specialty and in the standard tablet/capsule formulation
- Expanding eligibility for children’s respite care
Medicaid Mental Health Benefit – Pre July 1, 2017

- **Partial Hospitalization**: Teaching skills and providing supports to maintain community based care.
- **Crisis Intervention**: Services for people in crisis.
- **Psychiatric Diagnostic Evaluation w/ Medical**: Assessing treatment needs & developing a plan for care.
- **Mental health Assessment**: Assessing treatment needs & developing a plan for care.
- **Pharmacological Management**: Services provided by medical staff, directly related to MH conditions and symptoms.
- **CPST**: Care Coordination.
- **Mental health counseling**: Individual and group counseling may be provided by all credentialed practitioners.
- **Respite for Children and their Families**: Providing short term relief to caregivers.
- **Office Administered Medications**: Long Acting Psychotropics.
Medicaid Mental Health Benefit – July 1, 2017

**Psychotherapy CPT Codes**
 Individual, group, family and crisis

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

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

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

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

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

**Crisis Services**
 Covered under crisis psychotherapy and other HCPCS codes

**CPST**
 Care Coordination

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

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

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

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

**Office Administered Medications**
 Long Acting Psychotropics

**Psychological Testing**
 Neurobehavioral, developmental, and psychological
## MH Outpatient: Medical Services

### Medical Service CPT Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>Evaluation and Management, Office, New Patients</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Evaluation and Management, Office, Established Patients</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Evaluation and Management, Home, New Patients</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Evaluation and Management, Home, Established Patients</td>
</tr>
<tr>
<td>+99354</td>
<td>Prolonged service-first hour</td>
</tr>
<tr>
<td>+99355</td>
<td>Prolonged Service-each add. 30 mins</td>
</tr>
<tr>
<td>+90833</td>
<td>Psychotherapy add on, 30 min</td>
</tr>
<tr>
<td>+90836</td>
<td>Psychotherapy add on, 45 min</td>
</tr>
<tr>
<td>+90838</td>
<td>Psychotherapy add on, 60 mins</td>
</tr>
<tr>
<td>+90785</td>
<td>Interactive Complexity</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic Injection</td>
</tr>
</tbody>
</table>

All codes are subject to NCCI edits.
MH Group Day Treatment: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio
   a. For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the unit (30+ minutes). Service is billed in whole units only.
   b. If person doesn’t meet the minimum, 90853 or H2019 (HQ: Modifier for group) may be used.

2. All other individual 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.

3. QMHSs+3 (H2012 UK HQ) are now able to bill for MH Group Day Treatment-hourly (new guidance in 3-17-17 newsletter).

Rate Development and Methodology

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Description</th>
<th>Rate Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlicensed BA</td>
<td>1 hour of unlicensed BA providing group activities in an average group size of four for rate setting purposes</td>
<td>$15.76</td>
</tr>
<tr>
<td>Unlicensed MA</td>
<td>1 hour of unlicensed MA providing group activities in an average group size of four for rate setting purposes</td>
<td>$18.54</td>
</tr>
<tr>
<td>Licensed Practitioner</td>
<td>1 hour of licensed practitioner providing group activities in an average group size of four for rate setting purposes</td>
<td>$21.05</td>
</tr>
<tr>
<td></td>
<td>85% of the BA rate</td>
<td>$28.10</td>
</tr>
</tbody>
</table>
MH Group Day Treatment - Per Diem

<table>
<thead>
<tr>
<th>Rate Development and Methodology</th>
<th>Per Diem Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2020 85% of the BA rate</td>
<td>$88.87</td>
</tr>
<tr>
<td>H2020 Assumes 5 hours of unlicensed BA providing group activities in an average group size of four for rate setting purposes</td>
<td>$104.55</td>
</tr>
<tr>
<td>H2020 Assumes 5 hours of unlicensed MA providing group activities in an average group size of four for rate setting purposes</td>
<td>$117.05</td>
</tr>
<tr>
<td>H2020 Assumes 5 hours of licensed practitioners providing group activities in an average group size of four for rate setting purposes</td>
<td>$140.51</td>
</tr>
</tbody>
</table>

MH Group Day Treatment: Additional Details

1. Maximum group size: 1:12 Practitioner to client ratio
   a. For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the per diem (2.5+ hours).
   b. If person doesn’t meet the minimum, 90853, H2019 HQ, or H2012 may be used.
   c. Service is billed in whole unit only.
   d. All other individual 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
5. QMHSs+3 (H2020 UK) are now able to bill for MH Group Day Treatment-per diem (new guidance in 3-17-17 newsletter).
On February 1, 2017, Medicaid respite services became available for children with mental health needs who are enrolled in Medicaid Managed Care. The definition of “respite services,” eligibility criteria and provider qualifications are described in Ohio Administrative Code rule 5160-26-03 which became effective February 1, 2017.

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

A MITS Bits detailing this update was released on Feb. 6th and can be found here.
H2017 and H2019: Different Uses
Mental Health Services-Therapeutic Behavioral Services (TBS) and Psychosocial Rehabilitation (PSR)

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

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

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

Therapeutic Behavioral Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Level of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019 HN – TBS, office (Bachelor’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 HO – TBS, office (Master’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 UK – TBS, office (QMHS: high school and 3 years+ experience)</td>
<td></td>
</tr>
<tr>
<td>H2019 HN HQ – TBS, office, group (Bachelor’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 HO HQ – TBS, office, group (Master’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 UK HQ – TBS, office, group (QMHS: high school and 3 years+ experience)</td>
<td></td>
</tr>
<tr>
<td>H2019 HN – TBS, home or community (Bachelor’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 HO – TBS, home or community (Master’s)</td>
<td></td>
</tr>
<tr>
<td>H2019 UK – TBS, home or community (QMHS: high school and 3 years+ experience)</td>
<td></td>
</tr>
</tbody>
</table>

Psychosocial Rehabilitation

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Level of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2017 HM – PSR, office, (less than a Bachelor’s/less than 3 years experience)</td>
<td></td>
</tr>
<tr>
<td>H2017 HM – PSR, home or community (less than a Bachelor’s/less than 3 years experience)</td>
<td></td>
</tr>
</tbody>
</table>
Unlicensed practitioners may only provide and bill Medicaid for TBS or PSR provided to a patient in a crisis only if the recipient of the intervention(s):

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

MH TBS or PSR Crisis Billing for Unlicensed Practitioners

**H2017**

Per 15 minutes: **Less than Bachelor’s Home/Cmty**
Per 15 minutes: **Less than Bachelor’s Office**

**H2019**

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

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

All codes are subject to NCCI edits.
MH Registered Nurse Providing Nursing Services to a Patient in a Crisis

Guidance for Registered Nurses Providing Crisis Services

Registered Nurses may provide crisis nursing services regardless of:
- Whether or not the individual is on their case load; or
- Whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).

H2019

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

Per 15 minutes: Home/Cmty
Per 15 minutes: Home/Cmty
Per 15 minutes: Office
Per 15 minutes: Office

All codes are subject to NCCI edits
# MH Nursing Services by Registered Nurses and Licensed Practical Nurses

## HCPCS Codes for Nursing Activities

### Registered Nurse

- **H2019** - Home/Community, per 15 minutes
- **H2019** - Office, per 15 minutes
- **H2019 HQ** - Office, Group, per 15 minutes

### Licensed Practical Nurse

- **H2017** - Home/Community, per 15 minutes
- **H2017** - Office, per 15 minutes
Update: TBS/PSR Reimbursement

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

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

All other places of services will be paid at 100% after 90 minutes.
Nursing Scope of Practice – RNs and LPNs
Ohio Medicaid follows the guidance of the Ohio Board of Nursing regarding the Scopes of Practice for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).

The Ohio Board of Nursing guidance on nursing scope is here: [http://www.nursing.ohio.gov/PDFS/Practice/RN_and_LPN_Scope_of_Practice.pdf](http://www.nursing.ohio.gov/PDFS/Practice/RN_and_LPN_Scope_of_Practice.pdf)

Questions regarding RN or LPN scope of practice should go to the Board of Nursing at practice@nursing.ohio.gov.

**What services can a nurse perform?**

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

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

Each licensee is responsible for knowing and working within their scope of practice.
Registered Nurses and Licensed Practical Nurses

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

CPT/HCPCS Codes for Nursing Activities

<table>
<thead>
<tr>
<th>SUD</th>
<th>SUD &amp; MH</th>
<th>MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1002</td>
<td>99211</td>
<td>H2019</td>
</tr>
<tr>
<td>T1003</td>
<td></td>
<td>H2017</td>
</tr>
<tr>
<td>H0014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: used for Level 2 - Withdrawal Management

Key Takeaways

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

All codes are subject to NCCI edits.
Crisis Services
Psychotherapy for Crisis Situations*

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

90839

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

+90840

All codes are subject to NCCI edits

Psychotherapy for Crisis Services Defined*

Psychotherapy for Crisis Services Definition

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

Psychotherapy for Crisis Services*

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

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

Codes for crisis services CANNOT be reported in combination with:
- 90791, 90792 (diagnostic services)
- 90832-90838 (psychotherapy)
- +90785 (interactive complexity)

Psychotherapy for Crisis Services*

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

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

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Billable To</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>MD/DOs and psychologists, all other licensed practitioners*</td>
</tr>
<tr>
<td>+90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes</td>
<td>MD/DOs and psychologists, all other licensed practitioners*</td>
</tr>
<tr>
<td>90832</td>
<td>Based on Medicare, can be billed with a UT crisis modifier if crisis service does not reach 31 minutes</td>
<td>MD/DOs and psychologists, all other licensed practitioners*</td>
</tr>
</tbody>
</table>

* Review supervision requirements for billing guidance

All codes are subject to NCCI edits
MH and SUD Crisis Services by Unlicensed Practitioners

**Guidance for Unlicensed Practitioner Providing Crisis Services**

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

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

**SUD Crisis Billing for Unlicensed Practitioners**

- **H0004**
  - UT modifier will be used to differentiate a crisis service vs. a non-crisis service
  - Per 15 minutes

**MH Crisis Billing for Unlicensed Practitioners**

- **H2019**
  - UT modifier will be used to differentiate a crisis service vs. a non-crisis service
  - Per 15 minutes: Master's, Home/Cmty
  - Per 15 minutes: Bachelor's, Home/Cmty
  - Per 15 minutes: QMHS+3, Office
  - Per 15 minutes: Master's, Office
  - Per 15 minutes: Bachelor's, Office
  - Per 15 minutes: QMHS+3, Office

- **H2017**
  - UT modifier will be used to differentiate a crisis service vs. a non-crisis service
  - Per 15 minutes: Less than Bachelor’s Home/Cmty
  - Per 15 minutes: Less than Bachelor’s Office Setting

All codes are subject to NCCI edits.
RN Nursing Services Delivered to a Patient in Crisis

Guidance for Registered Nurses Providing Crisis Services

Registered Nurses may provide crisis care regardless of:
• Whether or not the individual is on their case load; or
• Whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).

Mental Health

<table>
<thead>
<tr>
<th>Code</th>
<th>Per 15 minutes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td></td>
<td>Home/Cmty</td>
</tr>
<tr>
<td></td>
<td>Office</td>
</tr>
<tr>
<td></td>
<td>Office</td>
</tr>
</tbody>
</table>

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

Substance Use Disorder

<table>
<thead>
<tr>
<th>Code</th>
<th>Per 15 minutes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1002</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td></td>
<td>Home/Cmty</td>
</tr>
<tr>
<td></td>
<td>Office</td>
</tr>
<tr>
<td></td>
<td>Office</td>
</tr>
</tbody>
</table>

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

All codes are subject to NCCI edits.
 BH Redesign Benefit Package: Substance Use Disorder (SUD) Services
## Medicaid Substance Use Disorder Benefit – Pre July 1, 2017

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ambulatory Detoxification</td>
<td>• Ambulatory Detoxification</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Assessment</td>
</tr>
<tr>
<td>• Case Management</td>
<td>• Case Management</td>
</tr>
<tr>
<td>• Crisis Intervention</td>
<td>• Crisis Intervention</td>
</tr>
<tr>
<td>• Group Counseling</td>
<td>• Group Counseling</td>
</tr>
<tr>
<td>• Individual Counseling</td>
<td>• Individual Counseling</td>
</tr>
<tr>
<td>• Intensive Outpatient</td>
<td>• Intensive Outpatient</td>
</tr>
<tr>
<td>• Laboratory Urinalysis</td>
<td>• Laboratory Urinalysis</td>
</tr>
<tr>
<td>• Medical/Somatic</td>
<td>• Medical/Somatic</td>
</tr>
<tr>
<td>• Methadone Administration</td>
<td></td>
</tr>
</tbody>
</table>
ASAM Levels of Care

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

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.
### Medicaid Substance Use Disorder Benefit – July 1, 2017

**Outpatient**
- Adolescents: Less than 6 hrs/wk
- Adults: Less than 9 hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy
  - Psychotherapy – Individual, Group, Family, and Crisis
  - Group and Individual (Non-Licensed)
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Level 1 Withdrawal Management (billed as a combination of medical services)

**Intensive Outpatient**
- Adolescents: 6 to 19.9 hrs/wk
- Adults: 9 to 19.9 hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy
  - Psychotherapy – Individual, Group, Family, and Crisis
  - Group and Individual (Non-Licensed)
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Additional coding for longer duration group counseling/psychotherapy
- Level 2 Withdrawal Management (billed as a combination of medical services)

**Partial Hospitalization**
- Adolescents: 20 or more hrs/wk
- Adults: 20 or more hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy
  - Psychotherapy – Individual, Group, Family, and Crisis
  - Group and Individual (Non-Licensed)
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Additional coding for longer duration group counseling/psychotherapy
- Level 2 Withdrawal Management (billed as a combination of medical services)

**Residential**
- Per Diems supporting all four residential levels of care including:
  - clinically managed
  - medically monitored
  - two residential levels of care for withdrawal management
- Medications
- Buprenorphine and Methadone Administration
- Medicaid is federally prohibited from covering room and board/housing
- Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem)
# SUD Outpatient: Medical Services

## Medical Service CPT Codes

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>Evaluation and Management, Office, New Patients</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Evaluation and Management, Office, Established Patients</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Evaluation and Management, Home, New Patients</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Evaluation and Management, Home, Established Patients</td>
</tr>
<tr>
<td>+99354</td>
<td>Prolonged service-first hour</td>
</tr>
<tr>
<td>+99355</td>
<td>Prolonged Service-each add. 30 mins</td>
</tr>
<tr>
<td>+90833</td>
<td>Psychotherapy add on, 30 min</td>
</tr>
<tr>
<td>+90836</td>
<td>Psychotherapy add on, 45 min</td>
</tr>
<tr>
<td>+90838</td>
<td>Psychotherapy add on, 60 mins</td>
</tr>
<tr>
<td>+90785</td>
<td>Interactive Complexity</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic Injection</td>
</tr>
</tbody>
</table>

All codes are subject to NCCI edits
ASAM Outpatient Level of Care 1
SUD Group Counseling
ASAM Outpatient Level of Care 1 SUD Group Counseling by Licensed Practitioners

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

<table>
<thead>
<tr>
<th>Group psychotherapy (other than of a multiple-family group)</th>
<th>90853</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Service may be rendered by a licensed practitioner providing psychotherapy in a group setting.</td>
<td></td>
</tr>
<tr>
<td>• 90853 may be billed when the service provided complies with AMA/CMS billing guidance and the session is 52 minutes or less.</td>
<td></td>
</tr>
<tr>
<td>• $21.63 per encounter licensed practitioner and $25.45 per encounter SUD physician.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUD Group counseling 15-minute unit for SUD licensed practitioners who are not physicians</th>
<th>H0005 HK</th>
</tr>
</thead>
<tbody>
<tr>
<td>• H0005 may only be billed when a group session is 53 minutes or more and the practitioner bills for the correct number of 15-minute increments following AMA/CMS billing guidance.</td>
<td></td>
</tr>
<tr>
<td>• $7.21 per 15-minute unit.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUD Group counseling 15-minute unit for SUD physicians</th>
<th>H0005 AF</th>
</tr>
</thead>
<tbody>
<tr>
<td>• H0005 may only be billed when a group session led by a physician is 53 minutes or more and the practitioner bills for the correct number of 15-minute increments following AMA/CMS billing guidance.</td>
<td></td>
</tr>
<tr>
<td>• $8.48 per 15-minute unit.</td>
<td></td>
</tr>
</tbody>
</table>

All codes are subject to NCCI edits.
Example: ASAM Outpatient Level of Care 1
SUD Group Counseling

Group leader

 Doug, LICDC

9 am Group topic 1
10 am Group topic 2
11 am Group topic 3
12 pm

Patient

H0005 HK 12 units
H0005 HK 12 units
H0005 HK 12 units
A
B
A+B = H0005 HK 8 units
H0005 HK 8 units
H0005 HK 8 units

90853 1 encounter/unit
(45 minutes)
ASAM Outpatient Level of Care 2
Intensive Outpatient and Partial Hospitalization
**SUD Intensive Outpatient Level of Care: Group Counseling - Billing**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>Per Diem - Assumed an average group size of three for an average duration of 4 hours for rate setting purposes with unlicensed practitioner leading</td>
<td>$103.04 Per Diem Per Person</td>
</tr>
<tr>
<td>HK</td>
<td>Per Diem - Assumed an average group size of three for an average duration of 4 hours for rate setting purposes with licensed practitioner</td>
<td>$149.88 Per Diem Per Person</td>
</tr>
</tbody>
</table>

**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.
- Other services must be billed in addition to H0015. H0015 can only be billed if the person attends the minimum amount of time (2+ hours) in a group which doesn’t exceed the practitioner to client ratio.
- Must be led by licensed practitioner to bill with HK modifier.
- **Only one H0015 per diem, per patient, per day.**
SUD IOP Level of Care Example – 16 Hours

Scenario (patient-specific weekly IOP schedule)

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

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

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

Scenario is for **illustrative purposes only** for today’s training.
SUD Partial Hospitalization Level of Care: Group Counseling - Billing

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

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

SUD Partial Hospitalization: Additional Details

- 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.
- Other services must be billed in addition to H0015-TG. H0015-TG can only be billed if the person attends the minimum amount of time (3+ hours) in a group which doesn’t exceed the practitioner to client ratio.
- Must be led by licensed practitioner to bill with HK modifier
- Only one H0015 per diem, per patient, per day.
Staffing for ASAM Residential Levels of Care
Staffing for American Society of Addiction Medicine (ASAM) Residential Levels of Care

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

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

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

Administration of medications by site based staff is covered within the SUD per diem residential rate, but the cost of the medication itself may be billed in addition to the per diem. If medication is administered by an agency other than the residential treatment agency, both administration and medication rates may be billed to Ohio Medicaid.
Benefit Administration Timeline, Policies, and Program Integrity
Timeline: 2016 – 2019

- Plans will follow state benefit administration policies for one year.
- MCP year is administered 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.
Federal law (CFR 42.456.25) requires state Medicaid programs to perform post-payment review of Medicaid claims - including recipient and provider profiles - to identify and fix any incorrect practices.

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

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

ODM is developing a resource library of correct provider practices for coding, documentation, billing, etc. that will be posted on the bh.medicaid.ohio.gov website.
Services Which are
- ALWAYS Prior Authorized -
ALWAYS Prior Authorized: 
*Assertive Community Treatment (ACT)*

**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**

Intensive Home Based Treatment (IHBT)

**CODE**

H2015

**Prior Authorization Requirement**

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

All codes are subject to NCCI edits
ALWAYS Prior Authorized for a Medicaid Enrollee: *SUD Partial Hospitalization (PH) Level of Care (LoC)*

**DESCRIPTION**

SUD PH LoC
20 or more hours of SUD services per week per adult or adolescent

**CODES**

Combination of CPT and HCPCS codes

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

All codes are subject to NCCI edits.
Services With Prior Authorization
- Per Billing Provider -
Prior Authorization:
Psychiatric Diagnostic Evaluation

**DESCRIPTION**
Psychiatric Diagnostic Evaluation

**CODES**
- 90791 – with out medical
- 90792 – with medical

Prior authorization may be requested to exceed the annual limit.

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

All codes are subject to NCCI edits.
Prior Authorization:  
**Screening, Brief Intervention and Referral to Treatment (SBIRT)** *

**DESCRIPTION**  
Screening Brief Intervention and Referral to Treatment (SBIRT)

**CODES**  
G0396 – 15 to 30 minutes  
G0397 – greater than 30 minutes

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

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

All codes are subject to NCCI edits
Prior Authorization:
Alcohol and/or Drug Assessment

DESCRIPTION
Alcohol and/or Drug Assessment by an unlicensed practitioner

CODE
H0001

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

All codes are subject to NCCI edits
Services With Prior Authorization
- Per Medicaid Enrollee -
### Prior Authorization: Psychological Testing

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Testing</td>
<td>96101 – psychological testing by a psychologist/physician</td>
</tr>
<tr>
<td></td>
<td>96111 – developmental testing, extended</td>
</tr>
<tr>
<td></td>
<td>96116 – neurobehavioral status exam</td>
</tr>
<tr>
<td></td>
<td>96118 - neuropsychological testing by psychologist/physician</td>
</tr>
</tbody>
</table>

**Prior Authorization Requirement**

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

---

All codes are subject to NCCI edits
Prior Authorization:
**SUD Residential (Non-Withdrawal Management)**

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.

**Prior Authorization Requirement**

**DESCRIPTION**
- SUD Residential

**CODES**
- H2034
- H2036

All codes are subject to NCCI edits.
Services With No State-Defined Benefit Limits
No Benefit Limit:  
**RN/LPN Nursing Services***

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
</table>
| RN/LPN Nursing Services (MH) | H2019 (RN)  
H2017 (LPN) |

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
</table>
| RN/LPN Nursing Services (SUD) | T1002 (RN)  
T1003 (LPN) |

All codes are subject to NCCI edits

*This is a change according to March 17, 2017 newsletter (previous prior authorization guidance was set at 24 hours (96 units) combined per year per Medicaid enrollee)*
No Benefit Limit: *Mental Health*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Behavioral Services</td>
<td>H2019</td>
</tr>
</tbody>
</table>

All codes are subject to NCCI edits
No Benefit Limit: *Mental Health*

**DESCRIPTION**

Psychosocial Rehabilitation

**CODE**

H2017

All codes are subject to NCCI edits
No Benefit Limit: *Mental Health*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Psychiatric Support Treatment</td>
<td>H0036</td>
</tr>
</tbody>
</table>
## No Benefit Limit: Psychotherapy

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Psychotherapy</td>
<td>90832, 90834, 90837</td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>90853</td>
</tr>
<tr>
<td>Family Psychotherapy</td>
<td>90846, 90847, 90849</td>
</tr>
</tbody>
</table>

*Services will accrue to ASAM outpatient, IOP, and PH levels of care.*
# No Benefit Limit: E&M (Medical) Visits

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management – Office Visit</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td>Evaluation and Management – Home Visit</td>
<td>99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350</td>
</tr>
</tbody>
</table>

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

*All codes are subject to NCCI edits*
# No Benefit Limit: SUD Withdrawal Management

## Residential SUD Treatment Programs

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3-WM All Staff</td>
<td>H0010 or H0011 - Per Diem</td>
</tr>
<tr>
<td>Level 2-WM All Staff</td>
<td>H0012 – Per Diem</td>
</tr>
<tr>
<td>* Level 2-WM RN/LPN Services</td>
<td>H0014 – Hourly (up to 4 hours)</td>
</tr>
</tbody>
</table>

## Outpatient SUD Treatment Programs

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Level 2-WM RN/LPN Services</td>
<td>H0014 – Hourly (up to 4 hours)</td>
</tr>
<tr>
<td>* Level 1-WM RN Services</td>
<td>T1002 (RN)</td>
</tr>
<tr>
<td>* Level 1-WM LPN Services</td>
<td>T1003 (LPN)</td>
</tr>
</tbody>
</table>

---

* Note: Per diems cover all services provided by medical and clinical staff. When RN/LPN hourly or 15 minute services are provided, services provided by other medical staff are billed using evaluation and management coding. Services provided by clinical staff are billed accordingly. Level 1 RN/LPN services will be subject to prior authorization after 24 hours. All codes are subject to NCCI edits.
No Benefit Limit: **Group MH Day Treatment**

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

**CODES**
H2012/HQ – Hourly
H2020 – Per Diem

*Only one “per diem” day treatment unit will be paid per day per enrollee.*
No Benefit Limit:  
*SUD Intensive Outpatient (IOP) and Outpatient (OP)*  
*Levels of Care (LoC)*

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
</table>
| **SUD IOP LoC**  
6-19.9 hours of SUD services per week per adolescent  
9-19.9 hours of SUD services per week per adult | Combination of CPT and HCPCS codes |
| **SUD OP LoC**  
Less than 6 hours of SUD services per week per adolescent  
Less than 9 hours of SUD services per week per adult | |

All codes are subject to NCCI edits.
### No Benefit Limit: Crisis Services

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy for Crisis</td>
<td>90839, +90840, 90832 UT</td>
</tr>
<tr>
<td>SUD Individual Counseling provided to Patients in Crisis</td>
<td>H0004 UT</td>
</tr>
<tr>
<td>MH TBS or PSR provided to Patients in Crisis</td>
<td>H2019 UT or H2017 UT</td>
</tr>
<tr>
<td>RN services provided to Patients in Crisis</td>
<td>MH - H2019 UT, SUD - T1002 UT</td>
</tr>
</tbody>
</table>

All codes are subject to NCCI edits
# Medicaid Covered Behavioral Health Practitioners *

<table>
<thead>
<tr>
<th>Medical BHPs</th>
<th>Licensed BHPs</th>
<th>BHPs</th>
<th>BHP-Paraprofessionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (MD/DO)</td>
<td>Licensed Independent Chemical Dependency Counselors</td>
<td>Licensed Independent Social Workers</td>
<td>Chemical Dependency Counselor Assistants</td>
</tr>
<tr>
<td>Certified Nurse Practitioners</td>
<td>Licensed Chemical Dependency Counselors</td>
<td>Licensed Social Workers</td>
<td>Counselor Trainees</td>
</tr>
<tr>
<td>Clinical Nurse Specialists</td>
<td>Licensed Independent Marriage and Family Therapists</td>
<td>Licensed Professional Clinical Counselors</td>
<td>Marriage and Family Therapist Trainees</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Licensed Marriage and Family Therapists</td>
<td>Licensed Professional Counselors</td>
<td>Psychology Assistants, Interns or Trainees</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>Licensed Psychologists</td>
<td></td>
<td>Social Work Assistants</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td></td>
<td></td>
<td>Social Worker Trainees</td>
</tr>
</tbody>
</table>

* When employed by or contracted with an OhioMHAS certified agency/program
Rendering Practitioners Required to Enroll in Ohio Medicaid, Effective For Dates of Service On and After July 1, 2017

<table>
<thead>
<tr>
<th>Rendering Practitioners</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (MD/DO), Psychiatrists</td>
<td>Licensed Independent Social Workers</td>
</tr>
<tr>
<td>Certified Nurse Practitioners</td>
<td>Licensed Professional Clinical Counselors</td>
</tr>
<tr>
<td>Clinical Nurse Specialists</td>
<td>Licensed Independent Marriage and Family Therapists</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Licensed Independent Chemical Dependency Counselors (LICDC)</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>Licensed Psychologists</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td></td>
</tr>
</tbody>
</table>

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

**ADDITIONAL GUIDANCE**

- Practitioners must be affiliated with their employing/contracted agency or agencies; either the agency or practitioner may perform the affiliation in MITS
- Practitioner or agency/agencies may “un-affiliate” rendering practitioners listed above when necessary
Medicare Participation Rendering Practitioners

<table>
<thead>
<tr>
<th>Rendering Practitioner</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>A CBHC employing or contracting with any of these rendering providers <strong>must</strong> bill the Medicare program prior to billing Medicaid if the service is covered by Medicare.</td>
</tr>
<tr>
<td>Advanced Practice Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>Licensed Independent Social Worker</td>
<td></td>
</tr>
<tr>
<td>Licensed Professional Clinical Counselor</td>
<td></td>
</tr>
<tr>
<td>Independent Marriage and Family Therapist</td>
<td></td>
</tr>
<tr>
<td>Licensed Independent Chemical Dependency Counselor</td>
<td></td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td></td>
</tr>
<tr>
<td>Marriage and Family Therapist</td>
<td></td>
</tr>
<tr>
<td>Licensed Chemical Dependency Counselor</td>
<td></td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td></td>
</tr>
<tr>
<td>School Psychologists</td>
<td>A CBHC employing or contracting with any of these rendering providers <strong>may</strong> submit the claim directly to Medicaid.</td>
</tr>
</tbody>
</table>
## Medicare Certification vs. Medicare Participation

<table>
<thead>
<tr>
<th>Medicare Certification</th>
<th>Medicare Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ CMHCs have the option to enroll as an institutional provider to deliver Medicare services such as partial hospitalization.</td>
<td>✓ CBHCs (MH, SUD or both) have the option to enroll as a group practice.</td>
</tr>
<tr>
<td>✓ Certification requires accreditation or survey performed by the CMS designated state survey agency (In Ohio, ODH).</td>
<td>✓ Eligible practitioners employed by CBHCs should also enroll as individual practitioners (to be listed as the rendering provider on claim).</td>
</tr>
<tr>
<td></td>
<td>✓ 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.</td>
</tr>
</tbody>
</table>
Supervision Requirements
Supervision Types

<table>
<thead>
<tr>
<th>Types of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General supervision:</strong> Supervising practitioner must be available by telephone to provide assistance and direction if needed.</td>
</tr>
<tr>
<td><strong>Direct supervision:</strong> 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.</td>
</tr>
</tbody>
</table>
Minimum Supervision Requirements for CPT

<table>
<thead>
<tr>
<th>Practitioner Providing the Service:</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed professional counselor</td>
<td>General</td>
</tr>
<tr>
<td>Licensed chemical dependency counselor II or III</td>
<td>General</td>
</tr>
<tr>
<td>Licensed social worker</td>
<td>General</td>
</tr>
<tr>
<td>Licensed marriage and family therapist</td>
<td>General</td>
</tr>
<tr>
<td>Psychology assistant, intern, trainee</td>
<td>General</td>
</tr>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>Direct</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>Direct</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>Direct</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>Direct</td>
</tr>
</tbody>
</table>
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. *The rendering field MUST BE blank and the billing field will contain the agency NPI.* The supervisor takes the responsibility for the service. MITS will adjudicate the claim using the LISW rate.
Minimum Supervision Requirements for HCPCS

<table>
<thead>
<tr>
<th>Practitioner Providing the Service:</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology assistant, intern, trainee</td>
<td>General</td>
</tr>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>General</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>General</td>
</tr>
<tr>
<td>Social worker assistant</td>
<td>General</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>General</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>General</td>
</tr>
<tr>
<td>Qualified Mental Health Specialist</td>
<td>General</td>
</tr>
<tr>
<td>Care Management Specialist</td>
<td>General</td>
</tr>
<tr>
<td>Peer Recovery Supporters</td>
<td>General</td>
</tr>
</tbody>
</table>
### 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). **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 and then the service would be billed using CPT code.
Reporting Supervisor on Claims
## General Supervision

### Reporting Supervisor on Claims

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

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

*Note: Appropriate supervision must be provided and documented in the medical record*
## Unlicensed Practitioners Under Direct Supervision Providing CPT-Coded Services

<table>
<thead>
<tr>
<th>Practitioner Providing the Service</th>
<th>Billing Provider Field</th>
<th>Supervisor Field</th>
<th>Rendering field</th>
<th>Practitioner Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>Agency NPI</td>
<td>Direct Supervisor NPI</td>
<td>Blank</td>
<td>U6</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>Agency NPI</td>
<td>Direct Supervisor NPI</td>
<td>Blank</td>
<td>U7</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>Agency NPI</td>
<td>Direct Supervisor NPI</td>
<td>Blank</td>
<td>U9</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>Agency NPI</td>
<td>Direct Supervisor NPI</td>
<td>Blank</td>
<td>UA</td>
</tr>
</tbody>
</table>

In these instances, Medicaid claims must include the supervisor's NPI in the supervisor field on the claim in order for payment to be processed for the CPT code. The practitioners listed above are unable to perform these services without the direct supervision of an independently licensed practitioner.
National Correct Coding Initiative (NCCI)
National Correct Coding Initiative

Overview

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

What Does This Mean For You?

- NCCI policies are applied as edits (claims denials) to Medicaid health care claims
- Two types of edits:
  - Procedure to procedure edits: Pairs of codes that may not be reported together when delivered by the same provider for the same recipient on the same date of service. Applied to current and historic claims.
  - Medically unlikely edits: These edits define the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same recipient on the same date of service.
 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](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html)

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.

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)

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.

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)

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.
Peer Recovery Support
### Peer Recovery Support Service

#### Mental Health Benefit

<table>
<thead>
<tr>
<th>Program</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialized Recovery Services</strong></td>
<td></td>
</tr>
<tr>
<td>Authorized by Person Centered Care Plan</td>
<td>Act service is prior authorized by Medicaid</td>
</tr>
<tr>
<td>No more than 4 hours per day</td>
<td></td>
</tr>
<tr>
<td><strong>Billing</strong></td>
<td></td>
</tr>
<tr>
<td>Only for individuals eligible for SRS</td>
<td>Peer recovery supporter is a full member of the ACT team, a face to face contact can be used for a monthly “billing event”</td>
</tr>
<tr>
<td>H0038 - Individual</td>
<td></td>
</tr>
<tr>
<td>H0038/HQ - Group</td>
<td></td>
</tr>
</tbody>
</table>

#### Substance Use Disorder Benefit

<table>
<thead>
<tr>
<th>Program</th>
<th>SUD Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUD Residential</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Authorization</strong></td>
<td></td>
</tr>
<tr>
<td>Discrete service as medically necessary</td>
<td>SUD residential service is prior authorized by Medicaid</td>
</tr>
<tr>
<td><strong>Billing</strong></td>
<td></td>
</tr>
<tr>
<td>Peer recovery supporter is part of clinical team</td>
<td>Available to all residents when peer recovery supporter is part of clinical team</td>
</tr>
<tr>
<td>H0038 - Individual</td>
<td>Covered as part of the per diem</td>
</tr>
<tr>
<td>H0038/HQ - Group</td>
<td></td>
</tr>
</tbody>
</table>
Medicaid-Funded Assertive Community Treatment (ACT)
Behavioral Health Timeline: Focus on ACT

1/1/2017: Agencies with ACT teams can begin requesting CWRU Fidelity Reviews

6/1/2017: Agencies may begin submitting PA requests via MITS Portal

April/May 2017: Training on PA functionality in MITS Portal

7/1/2017: Transition to new BH codes & Rates including ACT

- Beginning Jan 1, 2017, agencies employing ACT team(s) may begin requesting CWRU to perform Fidelity Review (DACTS Scale) for Medicaid enrollment.
- Once an agency ACT team has met minimum fidelity, they may be enrolled in Ohio Medicaid and begin submitting prior authorization requests for consumers in their ACT caseload.
- Medicaid billable ACT services begin July 1, 2017
Why Initiate Medicaid Payment for ACT?

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

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)
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.
   - TM ACT 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 120.

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

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

For additional reference on TM ACT:
Tool for Measurement of Assertive Community Treatment (TM ACT) Summary Scale Version 1.0
ACT Policy Update Cont’d

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.

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

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

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

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0
Role and Responsibilities of the ACT Team Leader

Operate as the point of contact for ODM and their PA vendor

Will be the “clinician of record” that links an ACT enrollee with an ACT team

Be listed as the “Rendering” or “Supervising” practitioner on claims as appropriate

ODM requires that a team leader:
• Lead only one ACT team and
• Be licensed (preferably licensed independent with a supervisory endorsement)
ACT Team Monthly Billing Example – Physician Prescriber

**DACTS (w/ 2 BAs):**

- **Code - H0040**
- **MD/DO**
  - Unit Rate: $615.64
  - Total: $1,266.95
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Bachelor’s**
  - Unit Rate: $199.70
  - Total: $1,266.95

**DACTS (w/ 1 BA, 1 PRS):**

- **Code - H0040**
- **MD/DO**
  - Unit Rate: $615.64
  - Total: $1,226.49
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Bachelor’s**
  - Unit Rate: $199.70
- **Peer Recovery Supporter**
  - Unit Rate: $159.24
  - Total: $1,186.03

**DACTS (w/ 2 PRSs):**

- **Code - H0040**
- **MD/DO**
  - Unit Rate: $615.64
  - Total: $1,266.95
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Bachelor’s**
  - Unit Rate: $199.70
- **Peer Recovery Supporter**
  - Unit Rate: $159.24
  - Total: $1,186.03

**ACT is a fully prior authorized service**
ACT Team Monthly Billing Example – APRN/PA Prescriber

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

**Unit Rates**
- APRN/PA: $251.91
- Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Peer Recovery Supporter: $159.24

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

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

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

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

Scenario is for illustrative purposes only.
<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unlicensed BA Visit</td>
<td></td>
<td></td>
<td>Unlicensed BA Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td>Unlicensed BA Visit</td>
<td></td>
<td></td>
<td>Unlicensed BA Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td>Psychiatrist Visit</td>
<td></td>
<td></td>
<td>LPN Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td></td>
<td>LPN Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACT Policy Summary

1. ACT Fidelity Review
2. ACT Prior Authorization and Eligibility
3. ACT is a “Lock In” BH Benefit
4. ACT Billable Events
5. ACT Services to Hospitalized Enrollees
The Ohio Department of Medicaid has contracted with Case Western Reserve University to perform fidelity reviews for Medicaid payment.

To qualify for Medicaid payment, ACT Teams must achieve a minimum average score of 3 on the DACTS fidelity scale. Once an ACT Team has met minimum fidelity, they will be authorized to begin using the ACT billing model (see slides 99-100).

Teams who fail to achieve a minimum fidelity score of 3 are not penalized.

These teams may seek technical assistance from Case Western under the OhioMHAS funded component of CWRU CEBP*

Periodicity of ACT team fidelity review is still under discussion:

- 12 months
- ODM reserves the right to have additional fidelity reviews conducted as may be necessary

*see next slide for further detail
Free technical assistance is available for provider agencies interested in or providing ACT (but not yet ready for Medicaid fidelity review) from CWRU via OhioMHAS financing.
ACT Prior Authorization and Eligibility

- Medicaid recipients may only be enrolled with ACT teams after they have been prior authorized by the ODM designated PA entity.
- ACT teams must submit clinical documentation of each potential Medicaid enrollee’s eligibility for ACT.

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

- Age 18 or over
- Diagnosis of schizophrenia spectrum, bipolar spectrum, or major depressive disorder with psychosis
- Functional limitation(s) measured by the Adult Needs and Strengths Assessment (ANSA)
  - Teams will need competency to administer ANSA
- One of the following risk factors:
  - At risk of psych inpatient psych hospitalization
  - One or more previous inpatient psych admissions
3) When a person is enrolled on an ACT team, no other Medicaid BH services will be paid except recovery management through the SRS program or SUD services that are prior authorized

- BH medications will be covered outside of ACT; this includes physician administered medications and methadone/buprenorphine administration by OTPs

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

- Inpatient and emergency room visits
- Physician services (e.g. OBGYN, cardiac, and other specialties)
- Prescription and over the counter (OTC) medications
4) All ACT billable events must be rendered “face to face” and must be at least 15 minutes in duration
• ACT services rendered via telephone or video conference are allowable, but they do not qualify as a billing event
• See slides 99 – 102 for more detail on billable ACT events
5) ACT teams are expected to maintain contact with their enrollees if they are hospitalized

- ACT teams should assist with admission and discharge planning
  - However, these are not billable events
- Depending on length of stay, the ACT team may want to consider the clinical appropriateness of maintaining the individual on the case load until they are discharged
Disenrollment from ACT

**Planned Disenrollment**

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

**Unplanned Disenrollment**

- ACT enrollees may lose touch with the team for some period of time
- It is recommended ACT teams disenroll the consumer after a month of no communication
- This will allow the consumer to receive BH services outside the ACT team
- The ACT team may pursue expedited re-enrollment once the consumer is found
<table>
<thead>
<tr>
<th>ACT CHECKLIST</th>
<th>TO DO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Prescriber must be enrolled in Ohio Medicaid as either a ORP or a billing provider</td>
</tr>
<tr>
<td></td>
<td>2. Team leader must be enrolled in Ohio Medicaid</td>
</tr>
<tr>
<td></td>
<td>3. Contact CWRU to schedule fidelity review</td>
</tr>
<tr>
<td></td>
<td>4. Team should have a member competent in conducting the ANSA</td>
</tr>
<tr>
<td></td>
<td>5. Agency must have an IT system that supports medical documentation plus clinical and billing nuances</td>
</tr>
<tr>
<td></td>
<td>6. Attend training on use of the MITS PA functionality</td>
</tr>
<tr>
<td></td>
<td>7. Team must prepare to submit PA requests for potential ACT enrollees, including documentation of their eligibility for ACT</td>
</tr>
</tbody>
</table>
ACT and Coordination of Benefits

- ODM assumes that Assertive Community Treatment is not a service covered by Medicare or commercial insurers.

- Therefore, H0040 “billable events” may be submitted directly to Medicaid without first submitting to Medicare or commercial plans to obtain a denial code.
Additional Resources for ACT Teams

1. Updated July 1, 2017 BH Redesign Manual – Posted to bh.medicaid.ohio.gov website
   - Shorter
   - More user friendly
   - Coordinates with OAC Rules

2. DRAFT OAC rules defining ACT – Posted to bh.medicaid.ohio.gov website
   - Service definition
   - Consumer eligibility
   - Provider eligibility and team composition
   - Fidelity rating requirements
   - Documentation standards
   - Billing guidance

3. ODM: Informal comment period on ODM rule was open through COB Monday Feb 20th. Rule review continues via the CSIO and JCARR public process.

OhioMHAS: Comments on OhioMHAS rule continues via JCARR public hearing process.
Intensive Home-Based Treatment (IHBT)
Fidelity Measures to qualify for the IHBT billing methodology were built on premises similar to ACT.
IHBT Billing Structure

Code - H2015

Licensed clinician (modifier or NPI)

Unit Rate (15 minute)

$33.26

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

IHBT is a fully prior authorized service
Behavioral Health Redesign Work Book Updates
What has changed with the BH Redesign Work Book?

- TBS/PSR moved out of the counseling/therapy tab to the other services tab
- Added QMHS+3 for MH Day Treatment (H2012 UK HQ, H2020 UK)
- 99211 – $22.31 across for all providers
- Updated PSY Assistant to general supervision
- H0048 rate increased to $14.48
- Updated all internal links

Version 8.0 of the BH Redesign Work Book is now available on the BH Redesign site
Urine Drug Screening Update
Urine Drug Screening Update

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

Based on stakeholder feedback, the payment rate for UDS will be increased from $11.48 to $14.48.
Place of Service Updates
Update on Services Rendered in the Emergency Room

Place of Service 23: Emergency Room - Hospital

1. ODM and OhioMHAS have received questions regarding crisis services provided to clients in emergency rooms, specifically when the hospital is not staffed to respond to a behavioral health related crisis.

2. Current versions of BH Redesign Provider Manual and BH Redesign Coding Workbook do not allow place of service 23 Emergency Room – Hospital for crisis services.

3. In response to stakeholder feedback, ODM and OhioMHAS will update policy and both of these resources to include place of service 23 as allowable for crisis services.
Update on Services Rendered in “Other” Place of Service 99

ODM Will Define Place of Service 99 as “Community”

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

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

3. In response to stakeholder feedback, ODM and OhioMHAS will permit appropriate use of place of service 99. From Rule 5160-27-02: “Place of service 99 is defined as ‘community,’ and may only be used when a more specific place of service is not available. Place of service 99 shall not be used to provide services to an recipient of any age if the recipient is in custody and is held involuntarily through the operation of law enforcement authorities in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016).”
Documentation Requirements Update
ODM and OhioMHAS fully support the use of electronic health records (EHRs) by community behavioral health providers. Providers may use structured “drop down” and “check list” options that support individualized clinical documentation.

Please keep in mind that cloning is not an acceptable documentation practice.

Reference [https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf) for additional Federal information on EHRs.
IT Resources and EDI File Testing
(Fee for Service)
IT Resources

bh.medicaid.ohio.gov/manuals

Behavioral Health Redesign

Provider Manuals & Reimbursement Rates

Manuals
- Opioid Treatment Program (OTP) Manual Final Version 1.0 1/1/2017 - PDF
- Behavioral Health Provider Manual Version 1.4 3/10/2017 - PDF

Provider Reimbursement
- Behavioral Health Redesign Work Book (Coding and Reimbursement Rate Chart) Updated 2/15/2017 - Excel

Resources

CMS Technical Assistance
- CMS Guidance: Billing Properly for Behavioral Health Services - PDF
- Medicare Learning Network - Provider Compliance Programs - PDF
- Rules Package
- ODM Behavioral Health Redesign Draft Rules Package 1/31/2017 - PDF
- MHAS Behavioral Health Redesign Draft Rules Coding Chart

IT Resources

Final Service Billable to Medicare 1/24/2017 - Excel
Supervisor Rendering Ordering Fields 3/1/2017 - Excel
Services Crosswalk 3/1/2017 - Excel
ACT-IHBT 3/1/2017 - Excel
DX Code Groups BH Redesign 7-1-17 3/1/2017 - Excel
BH Workgroup Draft Limits, Audits and Edits 3/1/2017 - PDF
EDI/IT Q-and-A document 3/10/2017 - PDF

• **Services Billable to Medicare (Final Version)** - Identifies those codes that require third party billing as well as those that do not

• **Supervisor Rendering Ordering Fields** - Identifies what information is in these fields for all CPT and HCPCS codes

• **Services Crosswalk** - Details what codes can be billed on same date of service

• **ACT-IHBT** - What is allowed to be billed with these two new services, what is not allowed and what requires prior authorization

• **Dx Code Groups** - Allowable diagnoses for behavioral health services

• **Limits, Audits and Edits** - Includes benefit limits as well as audits to limit some combination of services on same day

• **EDI/IT Q-and-A** - Contains responses to questions received from EDI/IT work group
EDI File Testing

*Early May:*
Trading partners can begin testing EDI file submissions to MITS.
MyCare Plans open testing.

*May-June:*
Providers continue preparation for go live.

More detailed information will be forthcoming via MITS Bits
Ensuring Success: BH Redesign Rapid Response Team

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

GOAL:

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

Example metrics to begin monitoring

July 1, 2017 –

Provider Network Adequacy

Claims Paid / Denied (reason codes for denials)
BH Monitoring Mission – **Long Term** Objectives

**GOAL:**

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

*Example metrics to monitor after July 1, 2017 –*

- Members Served
- System & Service-Level Spending
Checklist for July 1, 2017

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

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

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

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

☑ Train all levels of staff on BH Redesign changes
  - Attend trainings
  - Watch webinars
  - Study documents at BH.Medicaid.Ohio.gov
Behavioral Health Redesign Website
**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](http://mha.ohio.gov/Default.aspx?tabid=154) and use the “BH Providers Sign Up” in the bottom right corner to subscribe to the BH Providers List serve.
Questions?