‘501’ Behavioral Health Redesign Webinar

December 5th, 2017
PLEASE NOTE:

Minor UPDATES have been made to the following slides since the December 5th BH Redesign “501” webinar recording:

- Slide 28 – Policy Reminder: SUD Intensive Outpatient and SUD Partial Hospitalization Group Services
- Slide 29 – Policy Reminder: MH TBS Day Treatment, additional same day services and additional same day group services
- Slide 65 – Prior Authorization Calendar

These individual slides are labeled with a ‘post-it’ note, and specific text will be marked in green for any additions and red for any strikethroughs.

Thank you.
Agenda

Welcome and Opening Remarks

Changes Already in Effect

BH Redesign Overview

State Readiness Checklist

Preparing for New BH Benefit Package: Now – 12/31/17
  - Policy Updates and Reminders
  - Rules Update
  - Testing
  - MyCare Ohio
  - Practitioner Enrollment and Affiliation
  - Coordination of Benefits
  - National Correct Coding Initiative (NCCI)
  - CNS/CNP Prior Authorization Exemption
  - BH Redesign Website

Prior Authorization under BH Redesign: Now – 7/1/19

Implementation of the New BH Benefit Package: 1/1/18 – 6/30/18
  - Are You Using the BH Benefit Package for Your Clients?
  - Monitoring Your Agency’s Claims
  - State Monitoring of BH Redesign Implementation
  - Enrolling Dependently Licensed and Paraprofessionals
  - Preparing for Managed Care Carve-In

Community BH Benefit Fully Integrated with Medicaid MCPs: 7/1/18 – Thereafter
  - Monitoring Your Agency’s Claims
  - Plan Requirements Post-Integration
  - Episode-Based Care
  - Care Coordination Workgroup Update

Medicaid Basic Billing Training for BH Provider Agencies (ODM ombuds staff)

LUNCH
Welcome and Opening Remarks
Changes Already in Effect
Opioid Treatment Programs (OTP) Benefit Updated January 1, 2017

• The OTP benefit was updated for January 1, 2017 to include Medicaid coverage of:
  
  ✓ Medications – Buprenorphine-based medications (SAMHSA certificate), injectable/nasal naloxone and oral naltrexone (Ohio Board of Pharmacy)
  ✓ Medication administration
  ✓ Collection of blood samples for external laboratory testing

OTP Licensure and Certification

**OTP Methadone License:** Ohio Medicaid recognizes and enrolls OTPs that are licensed by OhioMHAS under Ohio Administrative Code 5122-29-35. These OhioMHAS licensed programs are authorized to administer methadone.

**OTP Certification:** Ohio Medicaid recognizes and enrolls OTPs that are certified the by the Substance Abuse and Mental Health Services Administration (SAMHSA) under 42 CFR §8.11(21 U.S.C. 823(g)(1)). These SAMHSA certified programs are authorized to administer buprenorphine based medications.
On February 1, 2017, Medicaid respite services became available for children with mental health needs who are enrolled in Medicaid Managed Care. The definition of “respite services,” eligibility criteria and provider qualifications are described in Ohio Administrative Code rule 5160-26-03.

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

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

- The Institutions for Mental Disease (IMD) policy that went into effect July 1, 2017, allows MCPs to pay for inpatient psychiatric services to residents in an IMD.

- The IMD FAQs have been finalized and are now uploaded to the BH website under the Trainings tab at: http://bh.medicaid.ohio.gov/training
BH Redesign Overview
History of Ohio Medicaid Behavioral Health Services

Over the past 6 years, Ohio has redesigned the Medicaid behavioral health services delivery system and benefit package in the following four stages.

**Elevation:** Completed as of July 1, 2012
Financing of Medicaid behavioral health services moved from county administrators to the state.

**Expansion:** Completed as of January 1, 2014
Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 500,000 residents with behavioral health needs.

**Modernization:** Implementation on target for January 1, 2018
ODM and OhioMHAS are charged with modernizing the behavioral health benefit package to align with national standards and expand services to those in need.

**Integration:** Implementation on target for July 1, 2018
Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.
January 1, 2018: New behavioral health (BH) benefit begins.

- Ohio Administrative Code 5160-27 rules were filed October 1, 2017 to be effective January 1, 2018.
- MyCare Ohio plans administer the new benefit. (BH services are “carved in” to the MyCare Ohio benefit package today.)
- Traditional managed care plan members will continue to receive the new benefit through the fee-for-service delivery system for 6 months.

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 January 1, 2018.
Updated Timeline

10/1/17: Community BH rules & Manual finalized

1/1/18: Transition to new BH code set *

7/1/18: BH services carved into managed care

* BH Benefit remains “carved in” with MyCare Ohio plans

Milestone
State Readiness Checklist
1. Develop a centralized website dedicated to the education of providers and stakeholders, facilitating two-way communication about the Redesign process.

2. Utilize frequent and diverse communications to engage stakeholders and report progress on BH Redesign, allowing ample opportunity for stakeholders to participate in policy development.

3. Implement a robust training and technical assistance plan to ensure provider readiness.

4. Clarify schedule for the implementation of BH Redesign coding and rate changes, and full integration of the behavioral health benefit into Medicaid Managed Care.

5. By October 1, 2017 final file Ohio Administrative Code rules to authorize a January 1, 2018 effective date for the new Medicaid behavioral health benefit package.


7. MyCare Ohio Plans pass Readiness Reviews, deeming them ready for BH Redesign implementation.

8. Implement a beta test of the behavioral health coding and rate updates where at least half of the participating providers submit a clean claim for community behavioral health services that is properly adjudicated not later than thirty days after the date the clean claim is submitted. Participating providers must test with Ohio Medicaid as well as the MyCare Ohio Plans the provider does business with, if applicable.
Preparing for New BH Benefit Package: Now – 12/31/17
New BH Code Set Principles

• Mental health and substance use disorder coding and rates are aligned as much as possible, but there are still some unique codes.

• The practitioner rendering the service and the client’s primary condition being treated during the visit must be reflected in the claim.

• Matching scope of practice with the claim.
OhioMHAS Certification Process

What is NOT changing?

- OhioMHAS certifies community behavioral health agencies by types of service(s) and/or programs.
- Agencies with appropriate BH accreditation issued by TJC, CARF, COA, or DNV will be granted deemed status.
- For full deemed status, an agency must have all of its eligible services certified.
- ODM requires OhioMHAS provider certification as a condition of obtaining a Medicaid provider agreement.
- For agencies without accreditation, OhioMHAS will conduct a comprehensive certification review.
- OhioMHAS will continue to review and investigate complaints.
- Providers will continue to report MUIs.
- Providers will continue to report seclusion and restraint data.

What is changing?

- With Redesign, providers will determine billing codes used by Medicaid using ODM administrative rules and Manual.
- With Redesign, the rendering practitioner will be identified for each service.

Continuity of Certification

- There will be continuity of certification on January 1, 2018.
- OhioMHAS issued a certification crosswalk between the current services and the new services and provided additional guidance on certification in relation to Redesign.
- If a provider intends to provide a new service, beyond a service that is being changed due to Redesign, then the existing process with the OhioMHAS Office of Licensure and Certification should be followed.
- Providers currently certified to provide CPST will also be certified for TBS and PSR on January 1, 2018.
- TCM certifications will remain unchanged.
# OhioMHAS Certification Crosswalk

<table>
<thead>
<tr>
<th>If You are Currently Certified for:</th>
<th>Current Rule Number</th>
<th>On January 1, 2018, Your Certification Will Transition to:</th>
<th>New Rule Number</th>
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<td>SUD Program Certification</td>
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<td>Residential and Inpatient Substance Use Disorder Services</td>
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<td>[SUD] Halfway House Treatment Program Certification</td>
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<td>Residential and Inpatient Substance Use Disorder Services</td>
<td>5122-29-09</td>
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<tr>
<td>MH Service Certification</td>
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<td>Mental Health Day Treatment Service</td>
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Sample of Crosswalk
## Medicaid Mental Health (MH) Benefit Through December 31, 2017

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Psychiatric Diagnostic Evaluation with Medical</td>
<td>Assessing treatment needs &amp; developing a plan for care</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Teaching skills and providing supports to maintain community based care</td>
</tr>
<tr>
<td>Mental Health Counseling</td>
<td>Individual and group counseling may be provided by all credentialed practitioners</td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>Assessing treatment needs &amp; developing a plan for care</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Services for people in crisis</td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>Services provided by medical staff directly related to MH conditions and symptoms</td>
</tr>
<tr>
<td>Community Psychiatric Supportive Treatment (CPST)</td>
<td></td>
</tr>
<tr>
<td>Office Administered Medications</td>
<td>Long Acting Psychotropics</td>
</tr>
<tr>
<td>Respite for Children and their Families</td>
<td>Providing short term relief to caregivers</td>
</tr>
<tr>
<td>Respite for Children and their Families</td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Substance Use Disorder (SUD) Benefit Through December 31, 2017

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

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

Clinical Nurse Specialist (CNS), Certified Nurse Practitioner (CNP), and Physician Assistant

Solution

- CNSs, CNPs, and physician assistants (not just physicians) can order RN and LPN services, and can also order other medical services, such as labs and x-rays
Policy Update

H0004: Behavioral Health Counseling Code for Mental Health

Solution

- For dates of service January 1, 2018, through June 30, 2018, ODM will implement a temporary solution for situations when the National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits would prevent more than one dependently licensed practitioner from providing psychotherapy services to the same client on the same day.

- ODM will address this issue by temporarily adding the H0004 BH Counseling code to the Mental Health Benefit. Beginning July 1, 2018, this solution will no longer be needed because dependently licensed practitioners must be enrolled in MITS.
Policy Update

Enrollment of Dependenty Licensed Practitioners and Paraprofessionals

Solution

- To comply with federal law, ODM will expand the types of practitioners required to enroll as Medicaid providers and be affiliated with their employing agency.

- This requirement will become effective on July 1, 2018, and will be applied to all Medicaid claims submitted for dates of service July 1, 2018, and thereafter.

- ODM and OhioMHAS have designed MITS provider types and specialties for the newly enrolling practitioner types (see slides 84 and 85).
Policy Reminder

Medicaid Coverage of a “Doctor and a Nurse on the Same Day”

Solution

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

SUD Residential Treatment Programs

Solution

- In order to bill Medicaid for SUD residential treatment, your agency needs the appropriate specialty in MITS.
- SUD residential treatment providers must bill the appropriate per diem code for level of care.
- If you bill services a la carte, you are misrepresenting the service and level of care.

Information on enrolling SUD residential treatment programs in MITS and adding the 954 specialty can be found here: [http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_7-31-2017.pdf](http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_7-31-2017.pdf)
Outpatient SUD Group Counseling

Solution

• There has been an update on SUD outpatient group counseling slides that reflect co-facilitated groups (see appendix).

• Practitioner modifiers have been added and highlighted to distinguish billing options and payment implications.

• This is a business decision to be made by every SUD provider that offers group counseling to balance productivity and payment.
SUD Intensive Outpatient and SUD Partial Hospitalization Group Services

Solution

- ODM has revised the reimbursement policy to allow a provider to be paid for SUD IOP group counseling (H0015 no TG modifier) and additional group counseling (H0005) and additional group psychotherapy (90853). Up to one hour or one encounter for an adult (21 and over) and all medically necessary for a child (under 21).

- Does not apply to SUD PH group counseling (H0015 with TG modifier)
Policy Reminder

MH TBS Day Treatment, additional same day services and additional same day group services

Solution

• ODM has revised the reimbursement policy to allow a provider to be paid for MH TBS day treatment and another group service (psychotherapy and/or CPST) on the same day. Up to one hour or one encounter for an adult (21 and over) and all medically necessary for a child (under 21).

• Two MH TBS day treatment services will be paid when they are provided on the same day to the same person by two DIFFERENT billing providers.
General Supervision vs. Direct Supervision

**Solution**

- Assistants and trainees are required to have supervision when providing services (not the same as board supervision) and to document it in the medical record.

- Payment rate will differ for assistants and trainees as follows:
  1. Assistants/Trainees: under general supervision will receive 85% of their supervisor’s rate
     - Psych assistants: 85% of 100%
     - Social worker trainees, marriage and family therapist trainees, counselor trainees, and chemical dependency counselor assistants: 85% of 85% (72.25%)
  2. Assistants/Trainees under direct supervision will receive their supervisor’s rate if the supervisor’s NPI is on the claim in the supervisor field and the assistant/trainee modifier is also reported.
Technical Update: Change Needed for UT Modifier for Crisis

Crisis Technical Update

• Several managed care plans have reported their IT system cannot accept the UT modifier as it is no longer HIPAA-compliant.

• The end result would have been denied claims for BH services submitted using the UT modifier indicating service was rendered to a recipient in crisis.

• To prevent this from happening, the UT modifier must be replaced with the new modifier KX to indicate a service has been provided to a recipient in crisis.
  • Important change needed in your IT system: Your IT system needs to be updated to replace UT with KX for services rendered on or after January 1, 2018.
  • For testing, on November 14th, the update was made to the test environment to replace UT with KX modifier. This will affect test claims submitted November 15, 2017, and later.
Lines Of Service (POS) 23 & 99

Solution

- ODM pays for certain behavioral health services when rendered in an emergency room setting (POS 23 with KX modifier indicating client is in crisis) or in the community (POS 99). See BH Provider Manual for specific guidance.

- POS 23 with KX modifier is needed for the following:
  - TBS/PSR by assistants/trainees;
  - RN – SUD or MH;
  - MH or SUD individual counseling (H0004);
  - Individual psychotherapy (90832)
    - Note: KX is NOT needed for crisis psychotherapy (90839/90840)

- Note: Federal law prohibits Medicaid payment for services rendered when someone is an inmate of a public institution (42 CFR 435.1009)
ODM modified its rules to clarify that transportation in and of itself is not reimbursable.

The expectation under general Medicaid rules applicable to all providers is that the nature of the services will be properly documented to support medical necessity.
Policy Reminder

Community Behavioral Health Center (CBHC) Laboratories

Solution

• When the MyCare Ohio or managed care plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare Ohio plan is directed to accept that laboratory into their panel.

• MyCare Ohio and managed care plans may negotiate the terms of the contract with CBHC laboratories, including rates.
Policy Reminder

Urine Drug Screening

**Solution**

- Aligning with industry practice for laboratory testing
- Covering sample collection and point of service testing for clinical use
- Sample collection and point of service testing limited to one per day
- Collection protocols should implement random and medically necessary screens
- Laboratories bill directly. Laboratory benefit managed by managed care plans (MyCare Ohio and Medicaid Managed Care).
Policy Reminder

Outpatient Hospital Clinics

Solution

• For dates of service on or after August 1, 2017, Provider Type 01 (general hospitals) and Provider Type 02 (psychiatric hospitals) may be reimbursed for community behavioral health services in accordance with OAC rule 5160-2-75 (G)(2)

• Hospitals will bill behavioral health services using Fee for Service until managed care carve-in on July 1, 2018 (except MyCare Ohio patients)

For additional information, utilize Outpatient Hospital BH resources: [www.Medicaid.Ohio.gov](http://www.Medicaid.Ohio.gov) > Providers > Fee Schedule & Rates > I Agree > Outpatient Hospital Behavioral Health Services
Rules Update
Rules Update

ODM Rules

- On September 18th, the Joint Legislative Committee on Agency Rule Review (JCARR) hearing included testimony on the ODM rules.
- That hearing cleared the way for final filing the rules for a January 1, 2018 effective date.
- ODM rules were final filed on September 29th.

OhioMHAS Rules

- The JCARR hearing for the OhioMHAS rules was held on May 30th.
- OhioMHAS rules were final filed on September 29th for a January 1, 2018 effective date.
- The certification crosswalk is complete and will be posted at http://mha.ohio.gov/Default.aspx?tabid=743

The final rules, effective January 1, 2018, are posted on Lawriter: http://codes.ohio.gov/oac/
Testing
Per the requirements set forth in House Bill 49, ODM and OhioMHAS conducted a beta test to demonstrate provider readiness to go-live with Behavioral Health Redesign on January 1, 2018.

- The beta test period was open from October 25th – November 30th.
- Scenarios that were used for beta testing were posted to the bh.medicaid.ohio.gov website on September 25th.
- Any provider who wished to participate was able to do so.
- The State is currently processing the results.
General EDI File Testing

General testing is still open until December 15th and will reopen after January 1st, 2018

Trading Partner Testing Support

For test files that fail EDI processing:
Trading partners should contact the DXC technology EDI Support Desk by calling the Medicaid Provider Hotline (1-800-686-1516) and selecting Option 4 for EDI related issues or by email at OhioMCD-EDI-Support@dxc.com.

EDI Support Desk will be available during the following times:
Monday-Friday 7:30 am – 7:00 pm

For test files with claims errors:
Trading partners can contact the ODM Policy “Rapid Response Team” by calling the Medicaid provider hotline 1-800-686-1516 and selecting Option 9 (behavioral health testing issues) OR send email to BH-Enroll@medicaid.ohio.gov.

Rapid Response Team will be available during the following times:
Monday-Friday 7:30 am – 7:00 pm
LISTED BELOW ARE SOME OF THE MORE COMMON REASONS FOR CLAIMS DENIALS:

- No indication of who rendered the service
  - No practitioner modifier or rendering NPI

- Rendering NPI not enrolled in Medicaid and/or affiliated with agency
  - Enrollment may still be pending. The practitioner would appear on provider panel for group members, but would not be actively enrolled in Medicaid.

- Fractional units on claims. These will no longer be accepted come January 1, 2018.

- Primary diagnosis not valid for service being rendered. For example, a mental health diagnosis for an SUD service.

- Use of modifiers that will no longer be used – HE, HF

- Recipients used in testing:
  - Have third party coverage – private insurance or Medicare. MITS test environment will look for indication other payers were billed. Better to use a person with no other coverage to have it process without TPL edits posting.
  - No longer eligible for Medicaid.

- Ordering NPI is required for all nursing services. A claim for nursing services will deny without the ordering practitioner’s NPI.

- Allowable places of service – make certain the places of service that are put on claims are included in the rate chart from the manual.
MyCare Ohio
MyCare Ohio Plans Map

• Individuals will have the ability to enroll by phone, online, or by mail.

<table>
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<tr>
<th>DEMONSTRATION REGION &amp; POPULATION</th>
<th>MANAGED CARE PLANS AVAILABLE</th>
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<tbody>
<tr>
<td>Northwest: 9,884 Fulton, Lucas, Ottawa, Wood</td>
<td>- Aetna - Buckeye</td>
</tr>
<tr>
<td>Southwest: 19,456 Butler, Clermont, Clinton, Hamilton, Warren</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>West Central: 12,381 Clark, Greene, Montgomery</td>
<td>- Buckeye - Molina</td>
</tr>
<tr>
<td>Central: 16,029 Delaware, Franklin, Madison, Pickaway, Union</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>East Central: 16,225 Portage, Stark, Summit, Wayne</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast Central: 9,234 Columbiana, Mahoning, Trumbull</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast: 31,712 Cuyahoga, Geauga, Lake, Lorain, Medina</td>
<td>- Buckeye - CareSource - United</td>
</tr>
</tbody>
</table>
MyCare Ohio Credentialing and Contracting

- MyCare Ohio Plans are credentialing at the agency level.
- Providers may reach out to MyCare Ohio Plans at any time to inquire about contracting.
- Beginning January 1, 2018, per federal regulation (42 CFR 438.602), managed care providers must also be Ohio Department of Medicaid providers.
- Plans and providers may negotiate contract terms, which may include payment arrangements.
Providers should begin testing the new BH Benefit Package with MyCare Ohio Plans as soon as they are able.

**IMPORTANT NOTES**

- **MyCare Ohio providers with established contracts should be testing now.**
- Testing can begin as soon as providers have contacted the plans and verified billing information to obtain testing access if necessary.
- Providers do not have to be fully credentialed to begin testing with the plans.
- Trading partners are not required to have an agreement with the plans in order to test as long as the MyCare Ohio Plan has accurate billing information from the provider.

Link to MITS Bits for MyCare Ohio Plan Testing Information:

http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf
Timely Filing

- Until December 31, 2018, the MyCare Ohio Plan must accept provider claims for community BH services described in OAC Chapter 5160-27 for no less than 180 days and not to exceed 365 days after the service is provided. A plan may negotiate timely filing requirements within these limitations through their contract with the community BH provider.

Prior Authorization

- MyCare Ohio Plans will prior authorize the new behavioral health benefit package beginning January 1, 2018, using ODM established criteria until December 31, 2018. As of January 1, 2019, plans may establish plan-specific authorization criteria.

Rates

- MyCare Ohio Plans must maintain FFS rates as a floor for community BH providers through December 31, 2018, when the MyCare Ohio Plan and provider contract pays on a FFS basis.
Practitioner Enrollment and Affiliation
Practitioners must be enrolled in MITS and affiliated with their employing/contracted agency or agencies effective for dates of service on or after those listed above.
Practitioners Required to Enroll in Ohio Medicaid, Effective For Dates of Service On and After January 1, 2018

<table>
<thead>
<tr>
<th>Medical and Licensed Independent Practitioners</th>
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<tbody>
<tr>
<td>Physicians</td>
<td>Licensed Independent Social Workers</td>
</tr>
<tr>
<td>Certified Nurse Practitioners</td>
<td>Licensed Professional Clinical Counselors</td>
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<tr>
<td>Clinical Nurse Specialists</td>
<td>Licensed Independent Marriage and Family Therapists</td>
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<tr>
<td>Physician Assistants</td>
<td>Licensed Independent Chemical Dependency Counselors</td>
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<tr>
<td>Registered Nurses</td>
<td>Licensed Psychologists</td>
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<td>Licensed Practical Nurses</td>
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Exception: Prescribers already registered with ODM as Ordering, Referring or Prescribing providers need not re-enroll. ORP is no longer a valid provider status so no new enrollments

**ADDITIONAL GUIDANCE**

- Practitioners must be affiliated with their employing/contracted agency or agencies; either the agency or practitioner may perform the affiliation in MITS
- Practitioner or agency/agencies may “un-affiliate” rendering practitioners listed above when necessary
- BH Provider Affiliation Report MITS Bits was released on April 11th and can be found at: [HTTP://MHA.OHIO.GOV/PORTALS/0/ASSETS/FUNDING/MACSIS/MITS-BITS/BH-MITS-BITS-BH-REDESIGN-UPDATE_4-11-17.PDF](HTTP://MHA.OHIO.GOV/PORTALS/0/ASSETS/FUNDING/MACSIS/MITS-BITS/BH-MITS-BITS-BH-REDESIGN-UPDATE_4-11-17.PDF)
- See section below on Enrolling Dependently Licensed and Paraprofessionals (slide 82)
Coordination of Benefits
## 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>Licensed 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>Licensed 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>A CBHC employing or contracting with any of these rendering providers <strong>may</strong> submit the claim directly to Medicaid.</td>
</tr>
<tr>
<td>Licensed School Psychologists</td>
<td></td>
</tr>
</tbody>
</table>
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
January 1, 2018

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.
MyCare Ohio Members

NOTE

1. Submit claims to the MyCare Ohio plan for opt in members **OR** submit claims to Medicare intermediary (currently CGS) or Medicare Advantage Plan for opt out members

2. The rate the provider will be paid is the Medicare rate

3. When the Medicaid rate is higher than Medicare, there is no additional payment from Medicaid

Opt In Example

CareSource MyCare Ohio Medicare-Medicaid Member ID Card:

Opt Out Example

CareSource MyCare Ohio Medicaid Only Member ID Card:

Back of CareSource MyCare Ohio Medicare-Medicaid Member ID Card:

Back of CareSource MyCare Ohio Medicaid Only Member ID Card:
Non-MyCare Medicare/Medicaid Members

**NOTE**

1. Submit claims to Medicare intermediary (currently CGS). When applicable, CGS will cross over the claim to Medicaid.

2. The rate the provider will be paid is the Medicare rate

3. When the Medicaid rate is higher than Medicare, there is no additional payment from Medicaid

CGS Medicare Part B contact information:
https://www.cgsmedicare.com/partb/cs/contactinfo.html
Third Party Liability – Commercial Insurance

GUIDANCE

• Third Party Liability will be enforced on all claims, assuring Medicaid is the last payer;

• The codes found in the document “Final Services Billable to Medicare” at this link, bh.Medicaid.ohio.gov/manuals, must be billed to Medicare and must also be billed to commercial payors;

• All practitioners providing those services must bill commercial payors;

• IF the commercial payor does not pay for those practitioners and/or those services, the agency will need to get a denial code to put on the claim and then bill Medicaid.
National Correct Coding Initiative (NCCI)
Remember that Medicaid NCCI edits will be effective January 1, 2018
Two types of edits:
- Procedure to Procedures (PTP) and Medically Unlikely Edits (MUEs)
Providers should check NCCI quarterly updates (Jan, Apr, Jul, Oct)
NCCI edits are active in the MITS testing environment
Due to NCCI edits and timing of enrollment of dependently licensed practitioners, the State will allow H0004 to be used until July 1, 2018, for mental health individual and group counseling services. This will allow payment when the service is rendered by two dependently licensed practitioners, on the same day, to the same client, at the same agency. *(reference back to slide 23)*

For more information on NCCI, reference the CMS site here: [https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html](https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html)
Clinical Nurse Specialist (CNS) / Certified Nurse Practitioner (CNP) Prior Authorization Exemption
CNS and CNP Prior Authorization Exemption

Language set forth in Am. Sub. House Bill 49, ORC Sec. 5167.12:
The department shall not permit a health insuring corporation to impose a prior authorization requirement when the drug (as described in ORC) is prescribed by:

“(c) A certified nurse practitioner, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code;

(d) A clinical nurse specialist, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code.”

The three qualifying national certifications from the American Nurses Credentialing Center include:

- Psychiatric-Mental Health NP
- Adult Psychiatric-Mental Health CNS
- Child-Adolescent Psychiatric-Mental Health CNS

UPDATE:

ODM has obtained a list from the Ohio Board of Nursing and is working with the Medicaid managed care plans on ongoing implementation.
BH Redesign Website
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Preparing for BH Redesign

Please utilize the ‘Preparing for BH Redesign’ section found on the home page of the BH Redesign website for latest updates as we approach 1/1/18 BH Redesign implementation.

- Manuals, Rates & Resources
- Training Opportunities
- MITS Bits Provider Information Releases
Prior Authorization under BH Redesign: Now – 7/1/19
## Prior Authorization under BH Redesign

<table>
<thead>
<tr>
<th>Description and Code</th>
<th>Benefit Period</th>
<th>Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment (ACT) H0040</td>
<td>Based on prior authorization approval</td>
<td>ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees. See service description for additional information.</td>
</tr>
<tr>
<td>Intensive Home Based Treatment (IHBT) H2015</td>
<td>Based on prior authorization approval</td>
<td>IHBT must be prior authorized. See service description for additional information.</td>
</tr>
<tr>
<td>SUD Partial Hospitalization (20 or more hours per week)</td>
<td>Calendar year</td>
<td>Prior authorization is required for this level of care for adults and adolescents.</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluations 90791, 90792</td>
<td>Calendar year</td>
<td>1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Psychological Testing 96101, 96111, 96116, 96118</td>
<td>Calendar year</td>
<td>Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397</td>
<td>Calendar year</td>
<td>One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Alcohol or Drug Assessment H0001</td>
<td>Calendar year</td>
<td>2 hours per patient per calendar year per billing agency. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>SUD Residential H2034, H2036</td>
<td>Calendar year</td>
<td>Up to 30 consecutive days without prior authorization. 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 full prior authorization.</td>
</tr>
</tbody>
</table>

Any service or ASAM level of care not listed in this table is not subject to prior authorization.
Prior Authorization Calendar

- Plans will follow state benefit administration policies for one year.
- Medicaid benefit year is the calendar year (Jan-Dec).
- Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.
Submitting FFS Prior Authorization Requests in MITS

- ODM hosted a training webinar on December 4th that provided step-by-step instructions on how community behavioral health agencies can submit requests for prior authorization for services such as ACT, IHBT, SUD Partial Hospitalization, SUD Residential, etc.

- The webinar recording and slide presentation will be posted to the BH Redesign website at: http://bh.medicaid.ohio.gov/training.
## Managed Care Prior Authorization for BH Redesign

### MyCare Ohio Plans, Effective January 1, 2018

- MyCare Ohio Plans will begin prior authorizing the behavioral health services with implementation of redesign on January 1, 2018.

### Managed Care Plans, Effective July 1, 2018

- Managed Care Plans will begin prior authorizing the behavioral health services with implementation of carve-in on July 1, 2018.
- Approved FFS prior authorizations will be honored until the prior authorization expires.

### Both MyCare Ohio Plans and Managed Care

- Both MyCare Ohio and Managed Care Plans will be required to follow behavioral health coverage policies as established through redesign for 12 months (including prior authorization and rates).
  - MyCare Ohio until December 31, 2018
  - Managed Care until June 30, 2019
The Ohio MyCare plans have developed uniform prior authorization form for community BH services. This form is now available at: http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans.
Implementation of the New BH Benefit Package: 1/1/18 – 6/30/18
New BH Code Set

NOTES ON CODING & BILLING GUIDANCE:

Providers must consult OAC rules, the BH Provider Manual and BH Workbook Code Chart for complete policy guidance on Medicaid behavioral health service definitions, client eligibility requirements, standards for medical record documentation and when prior authorization is required. However, neither these resources nor ODM staff can provide coding and billing guidance specific to individual provider business models or clinical circumstances. Providers should seek qualified billing guidance from certified coders, CPT/HCPCS code books, and professional associations to determine the most appropriate coding and billing logic for each individual situation.
Are You Using the BH Benefit Package for Your Clients?
Consumer Experience

How is your agency utilizing the new community BH benefit package to meet each of the client’s needs?

Introspective Questions For Your Agency:

- Are your clients getting the right services at the right time?
- If staff transitions are needed, have you worked with your clients so they understand and make the transition?
- How are you assisting and supporting staff in implementing the new services?
- Are you incorporating these new services into your treatment planning?
- How are you incorporating these esoteric changes into clinical care?
- Are your clinicians working at the top of, and within, their scope of practice?

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

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

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

**MHAS Resources:**

**Local Resources:**
- National Alliance on Mental Illness helpline: 1-800-686-2646

**MCP Resources:**
- Medicaid Consumer hotline: 1-800-324-8680
- See consumer’s Medicaid card
Monitoring Your Agency’s Claims
# Monitoring Your Agency’s Claims

## Things you should be monitoring

1. **837P/835:** HIPAA standardized inbound and outbound claim EDI transactions

2. **MITS portal-entered claims/remittance advice - DON’T show up in the 835**

3. Pay attention to denial reasons

4. See [www.bh.medicaid.ohio.gov](http://www.bh.medicaid.ohio.gov) under the IT Resources section for ‘MITS to HIPAA Explanation of Benefits (EOB) Crosswalk’

5. Modifying claims as needed in MITS (*stay for ombuds training for more information*)

6. Call MITS provider hotline at 1-800-686-1516 or contact the appropriate MyCare Ohio plan
Timely Filing for FFS: Claim Submission

OAC 5160-1-19

Providers have 365 days to submit FFS claims.

During that 365 days providers can attempt to submit the claim for payment (if receiving a denial) or adjust it as many times as they need to.

An additional 180 days from the date of a claim denial are given, even when the date is beyond 365 days from the original DOS.

There are exceptions to the 365 day rule. Stay for ombuds training for more information.
MyCare Points of Contact

Aetna
- 24/7 Notification Phone Line: 1-855-364-0974
- 24/7 Notification Phone Line: 1-855-364-0974, option 2, then 4
- 24/7 Notification Fax Line: 1-855-734-9393
- Escalation/Other Questions: KilincA@AETNA.com

CareSource
- 24/7 Notification Phone Line: 1-800-488-0134
- 24/7 Notification Fax Line: 1-937-487-1664
- 24/7 Notification Email: mm-bh@caresource.com
- Escalation/Other Questions: Julie.Curtis@caresource.com

UnitedHealthcare
- 24/7 Notification Phone Line: 1-800-600-9007
- 24/7 Provider Line to request authorizations: 1-866-261-7692
- 24/7 Submit online authorization requests via Provider Portal: www.providerexpress.com and www.UnitedHealthcareOnline.com
- Escalation/Other Questions: tracey.izzard-everett@optum.com

Buckeye
- 24/7 Notification Phone Line: 1-866-296-8731
- 24/7 Nursewise Line 1-800-244-1991
- 24/7 OH Notification Fax Line 1-866-535-6974
- Escalation/Other Questions: Amber.Bundy@envolvehealth.com

Molina
- 24/7 Notification Phone Line: 1-855-322-4079
- 24/7 Notification Fax Line: 1-877-708-2116
- 24/7 Notification Email: OHBehavioralHealthReferrals@MolinaHealthcare.com
- Escalation/Other Questions: Emily.Higgins@MolinaHealthcare.com
Reporting Problems with MyCare Ohio Plans

How to Contact ODM

• If you have concerns regarding the MyCare Ohio Plans, please submit your inquiry or complaint by using the online form at: [http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx](http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx) (Scroll to the bottom of the page)

• Please also specify which plan(s) your inquiry is concerning. This will ensure that your complaint is routed to the correct individual(s) for resolution.
State Monitoring of BH Redesign Implementation
State Monitoring of BH Redesign Implementation

**GOAL:**

ODM and OhioMHAS have developed a plan to monitor continuity of care for consumers, access to and utilization of services, number of participating providers, and accurate, prompt provider payment.

**Metrics for Pre and Post BH Redesign Implementation:**

1. Number, type, and location of providers rendering behavioral health services.
2. Number, type and cost of behavioral health services rendered to Medicaid consumers.
3. Number, location, and array of Medicaid consumers receiving behavioral health services.
Monitoring of MyCare Ohio Plans

- ODM continually monitors the MyCare Ohio plans for program compliance.
- In addition, ODM performed a readiness review process with the plans beginning in October and will be ongoing.
Enrolling Dependenty Licensed and Paraprofessionals
## Begin Enrolling Behavioral Health Practitioners During this Time Period *

### Behavioral Health Practitioners (BHPs)

<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>Chemical Dependency Counselor Assistants</td>
<td>Care Management Specialists</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>Social Work Assistants</td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>Social Worker Trainees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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### Enrolment Requirements

- Practitioners must be enrolled and affiliated by July 1, 2018, and any new practitioners must be enrolled and/or affiliated thereafter.
- Practitioners will be able to enroll in MITS by early 2018.
- Once enrolled, practitioners can be affiliated.
Dependently Licensed Practitioners

<table>
<thead>
<tr>
<th>Type &amp; Specialty</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>SOCIAL WORKER</td>
</tr>
<tr>
<td>37/371</td>
<td>LICENSED SOCIAL WORKER</td>
</tr>
<tr>
<td>37/372</td>
<td>SOCIAL WORKER TRAINEE</td>
</tr>
<tr>
<td>37/373</td>
<td>SOCIAL WORKER ASSISTANT</td>
</tr>
<tr>
<td>47</td>
<td>CLINICAL COUNSELOR</td>
</tr>
<tr>
<td>47/471</td>
<td>LICENSED PROFESSIONAL COUNSELOR</td>
</tr>
<tr>
<td>47/472</td>
<td>COUNSELOR OR TRAINEE</td>
</tr>
<tr>
<td>54</td>
<td>CHEMICAL DEPENDENCY</td>
</tr>
<tr>
<td>54/541</td>
<td>CHEMICAL DEPENDENCY COUNSELOR III</td>
</tr>
<tr>
<td>54/542</td>
<td>CHEMICAL DEPENDENCY COUNSELOR II</td>
</tr>
<tr>
<td>54/543</td>
<td>CHEMICAL DEPENDENCY COUNSELOR ASSISTANT</td>
</tr>
</tbody>
</table>

**Additional Information**

- Dependently licensed practitioners can begin the process by obtaining an NPI now if they do not currently have one by using [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov).
- Information on timeline for enrolling in MITS will be announced in a future MITS Bits.
Paraprofessional Practitioners

<table>
<thead>
<tr>
<th>Type &amp; Specialty</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96</td>
<td>BEHAVIORAL HEALTH PARAPROFESIONAL</td>
</tr>
<tr>
<td>96/960</td>
<td>QUALIFIED MENTAL HEALTH SPECIALIST</td>
</tr>
<tr>
<td>96/961</td>
<td>QUALIFIED MENTAL HEALTH SPECIALIST III</td>
</tr>
<tr>
<td>96/962</td>
<td>CARE MANAGEMENT SPECIALIST</td>
</tr>
<tr>
<td>96/963</td>
<td>PEER RECOVERY SUPPORTER</td>
</tr>
<tr>
<td>96/964</td>
<td>INDIVIDUALIZED PLACEMENT AND SUPPORT-SUPPORTED EMPLOYMENT (IPS-SE)</td>
</tr>
</tbody>
</table>

Additional Information

- Paraprofessional practitioners can begin the process by obtaining an NPI now if they do not currently have one by using [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov).
- Information on timeline for enrolling in MITS will be announced in a future MITS Bits.
How to Obtain a National Provider Identifier

### STEPS


2. Choose the health care taxonomy that best fits the activities of the person enrolling: [http://codelists.wpc-edi.com/nucc_taxonomy.asp](http://codelists.wpc-edi.com/nucc_taxonomy.asp) (see next slide if you cannot find an acceptable taxonomy, and therefore do not have an NPI).

3. Complete enrollment

4. If enrollment status fails to update within 2-4 days, follow the steps below to update:
   - Go to NPPES and log in as the provider
   - On the home screen, select “Manage Provider Information” to show application status
   - If it shows “Change in Progress”, click the pencil option
   - make sure all steps of the application process are completed
   - Click through each screen to verify the information
   - Click next at the bottom of each screen
   - On the final page, click submit
   - Enrollment status then should change
Paraprofessionals Must Have an NPI: Recommendations

1. Taxonomy codes are self-selected by the health care practitioner and describe the health care provider’s work activities plus any required education, licensure and/or certifications.

2. Review the following taxonomy categories:
   - Behavioral Health and Social Service Providers, or
   - Other Service Providers

3. Two possible taxonomies:
   - Case manager (taxonomy code 171M00000X) is “a person who provides case management services and assists an individual in gaining access to needed social, educational, and/or other services.”
   - Peer specialist (taxonomy code 175T00000X) is an “individual certified to perform peer support services through a training process defined by a government agency, such as...a state mental health department/certification/licensing authority.”

4. Practitioners who do not find an acceptable matching taxonomy code, may choose a taxonomy code that links to the work of the organization that employs them:
   - Mental health clinic, including a community mental health center (taxonomy code 261QM0801X), or
   - Community/behavioral health agency (taxonomy code 251S00000X).

Regardless of the taxonomy chosen, paraprofessionals must obtain an NPI and be enrolled in Ohio Medicaid no later than June 30, 2018. More specific information will be provided via MITS BITS.
Preparing for Managed Care Carve-In
Preparing for Managed Care Carve-In

Providers should begin testing the new BH Benefit Package with Managed Care Plans as soon as they are able.

**IMPORTANT NOTES**

☑ Behavioral health providers should begin contracting with the managed care plans now to prepare for carve-in if they have not already done so.

☑ Testing can begin as soon as providers have contacted the plans and verified billing information to obtain testing access if necessary.

☑ Providers do not have to be fully credentialed to begin testing with the plans.

☑ Trading partners are not required to have an agreement with the plans in order to test as long as the managed care plan has accurate billing information from the provider.

*Note: Managed care plans will have to close their testing sometime before July 1, 2018*
Monitoring

- **Behavioral Health (BH) Carve-in Testing.** In preparation for BH Carve-in implementation, the MCP must provide ODM a bi-weekly report on testing outcomes for test claims submitted by contracted BH providers. Failure to meet the testing standards will result in the assessment of a noncompliance penalty.

  a. 50% of test claims submitted correctly by contracted BH providers must adjudicate correctly through the system by April 15, 2018.

  b. 75% of test claims submitted correctly by contracted BH providers must adjudicate correctly through the system by May 31, 2018.
The plans have developed a managed care information grid with important information related to carve-in. This document addresses point of contacts, operations, billing, prior authorization, and pharmacy. This document is available at:

http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans.
Community BH Benefit Fully Integrated with Medicaid MCPs: 7/1/18 – Thereafter
Integration – The community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. Implementation on target for July 1, 2018.

July 1, 2018: Behavioral health benefit incorporated into managed care: AKA “Carve-In”

- Medicaid managed care plans become responsible for the financing and delivery of behavioral health benefits for all members. (Brings BH in line with the rest of Medicaid health care services.)
- Approximately 13% of Medicaid enrollees will continue to receive their benefits through fee-for-service Medicaid.
Monitoring Your Agency’s Claims
Monitoring Claims Submitted to the Managed Care Plans

<table>
<thead>
<tr>
<th>Things you should be monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 837P/835: HIPAA standardized inbound and outbound claim EDI transactions</td>
</tr>
<tr>
<td>2. MCP portal-entered claims</td>
</tr>
<tr>
<td>3. Pay attention to denial reasons</td>
</tr>
<tr>
<td>4. Talk to MCPs about explanation of benefit coding and modifying and adjusting claims</td>
</tr>
</tbody>
</table>
Plan Requirements
Post-Integration
Plans are Required to Follow ODM Policy Post-Integration

Timely Filing
- Until June 30, 2019 the managed care plan must accept provider claims for community BH services described in OAC Chapter 5160-27 for no less than 180 days and not to exceed 365 days after the service is provided. A plan may negotiate timely filing requirements within these limitations through their contract with the community BH provider.

Prior Authorization
- Managed care plans are required to accept and continue ODM prior authorizations until they expire.
- Plans are required to use ODM’s prior authorization criteria for one year after integration through June 30, 2019.
- See prior authorization slides in this presentation for additional details.

Rates
- Managed Care Plans must maintain FFS rates as a floor for community BH providers through June 30, 2019, when the Managed Care Plan and provider contract pays on a FFS basis.

Continuity of Care
- The continuity of care period is from July 1, 2018, until September 30, 2018. Therefore, contracts with Managed Care Plans should be in place before July 1, 2018. If a provider/MCP contract has not been executed by September 30, 2018, the provider and the plan may enter into a single case agreement or may transition the member to an in-network provider to assure continuity of care for the Medicaid enrollee.
Managed care plans are required to meet network adequacy and prompt pay standards as outlined in the Managed Care Plan Provider Agreement (ODM – MCP Contract.)

Network adequacy – Plans are required to meet the minimum standards by county. Plans may be fined if out of compliance with network adequacy standards.

Prompt pay – In accordance with 42 CFR 447.46, MCPs shall pay 90% of clean claims within 30 days, and 99% of clean claims within 90 days. This is a minimum standard.
Managed Care Plan Points of Contact

Buckeye
- 24/7 Notification Phone Line: 1-866-296-8731
- 24/7 Nursewise Line 1-800-244-1991
- 24/7 OH Notification Fax Line 1-866-535-6974
- Escalation/Other Questions: Amber.Bundy@envolvehealth.com

CareSource
- 24/7 Notification Phone Line: 1-866-296-8731
- 24/7 Nursewise Line 1-800-244-1991
- 24/7 OH Notification Fax Line 1-866-535-6974
- Escalation/Other Questions: Julie.Curtis@caresource.com

Paramount
- 24-hour Call Center: 1-419-887-2557 or 1-888-891-2564
- PHCReferralManagement@ProMedica.org
- Escalation/Other Questions: hy.kisin@promedica.org
Behavioral Health fax: 1-567-661-0841

Molina
- 24/7 Notification Phone Line: 1-855-322-4079
- 24/7 Notification Fax Line: 1-877-708-2116
- 24/7 Notification Email: OHBehavioralHealthReferrals@MolinaHealthcare.com
- Escalation/Other Questions: Emily.Higgins@MolinaHealthcare.com

UnitedHealthcare
- 24/7 Notification Phone Line: 1-800-600-9007
- 24/7 Provider Line to request authorizations: 1-866-261-7692
- 24/7 Submit online authorization requests via Provider Portal: www.providerexpress.com and www.UnitedHealthcareOnline.com
- Escalation/Other Questions: tracey.izzard-everett@optum.com
Reporting Problems with Managed Care Plans

**How to Contact ODM**

- If you have concerns regarding the Managed Care Plans, please submit your inquiry or complaint by using the online form at: [http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx](http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx). (Scroll to the bottom of the page)

- Please also specify which plan(s) your inquiry is concerning. This will ensure that your complaint is routed to the correct individual(s) for resolution.
Episode-Based Care
Retrospective episode model mechanics

1. **Patients** seek care and select providers as they do today

2. **Providers** submit claims as they do today

3. **Payers** reimburse for all services as they do today

### 4. Calculate incentive payments based on outcomes after close of 12 month performance period

Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode

### 5. Payers calculate **average risk-adjusted reimbursement per episode** for each PAP

Compare to predetermined “commendable” and “acceptable” levels

### 6. Providers may:

- **Share savings**: if average costs below commendable levels and quality targets are met
- **Pay negative incentive**: if average costs are above acceptable level
- **See no impact**: if average costs are between commendable and acceptable levels

Patients and providers continue to deliver care as they do today

Payers calculate average risk-adjusted reimbursement per episode for each PAP
Ohio’s episode timeline by wave

Wave 1
- Acute PCI, Asthma, COPD, Non-acute PCI, Perinatal, Total joint replacement

Wave 2
- Appendectomy, Cholecystectomy, Colonoscopy, EGD, GI bleed, URI, UTI

Wave 3
- Ankle sprain/strain, ADHD, Breast biopsy, Breast cancer surgery, Breast medical oncology, CABG, Cardiac valve, CHF exacerbation, Dental: tooth extraction (in progress), Diabetic ketoacidosis (DKA) / hyperosmolar hyperglycemic state, Headache, Hip/pelvic fracture procedure, HIV, Hysterectomy, Knee arthroscopy, Knee sprain/strain, Low back pain, Neonatal (high-risk), Neonatal (low-risk), Neonatal (moderate-risk), ODD, Otitis media, Pancreatitis, Pediatric acute lower respiratory infection, Shoulder sprain/strain, Skin and soft tissue infection, Spinal decompression (without fusion), Spinal fusion, Tonsillectomy, Wrist sprain/strain

1 Reporting for Wave 3 episodes extended to CY2018 given need to incorporate physician feedback through reactive provider engagement process into episode design prior to performance periods (Wave 3 episodes designed and launched on accelerated timelines without Clinical Advisory Groups)

ADHD and ODD are in Wave 3
This is an example of an episodes performance report

Later this year, the first reports for the two behavioral health episodes – ADHD and ODD – will be delivered

Note that these reports are for information only at this point; the episodes are not yet linked to payment.
Additional episode details can be found online

The Ohio Department of Medicaid website includes links to the following documents for each episode (http://www.medicaid.ohio.gov/Providers/PaymentInnovation/Episodes.aspx):

- **Concept paper**: Overview of episode definition including clinical rationale for the episode, patient journey, sources of value, and episode design dimensions
- **Detailed business requirements (DBR)**: Description of episode design details and technical definitions by design dimensions
- **Code sheet**: Medical, pharmacy, and other related codes needed to build the episode, to be referenced with the DBR

There is also a ‘How to read your report’ guide available for providers on the same site.

Wave 3: The following episodes are also planned for release in 2017:

- Attention deficit and hyperactivity disorder (concept paper, DBR, code sheet)
- Breast biopsy (concept paper, DBR, code sheet)
- Breast cancer surgery (concept paper, DBR, code sheet)
- Breast medical oncology (concept paper, DBR, code sheet)
- Coronary artery bypass graft (concept paper, DBR, code sheet)
- Cardiac valve (concept paper, DBR, code sheet)
- Congestive heart failure exacerbation (concept paper, DBR, code sheet)
- Diabetic ketoacidosis/ hyperosmolar hyperglycemic state (concept paper, DBR)
- Headache (concept paper, DBR, code sheet)
- HIV (concept paper, DBR, code sheet)
- Hysterectomy (concept paper, DBR, code sheet)
- Low back pain (concept paper, DBR, code sheet)
- Neonatal (high-risk) (concept paper, DBR, code sheet)
- Neonatal (low-risk) (concept paper, DBR, code sheet)
- Neonatal (moderate-risk) (concept paper, DBR, code sheet)
- Oppositional defiant disorder (concept paper, DBR, code sheet)
Care Coordination Workgroup Update
Context: Accountability for care coordination

Reminder: We are designing a BH care coordination that fulfills the “Model 2” design

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

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

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

<table>
<thead>
<tr>
<th>Phase</th>
<th>Duration</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design phase</strong></td>
<td>2 weeks</td>
<td>Align on care delivery model and sources of value</td>
</tr>
<tr>
<td></td>
<td>3 weeks</td>
<td>Determine target population and scope of activities</td>
</tr>
<tr>
<td></td>
<td>3 weeks</td>
<td>Align on accountability and provider eligibility</td>
</tr>
<tr>
<td></td>
<td>2 weeks</td>
<td>Determine framework for incentive structure and considerations for implementation</td>
</tr>
<tr>
<td></td>
<td>3-6 months</td>
<td>Detailed design and launch</td>
</tr>
</tbody>
</table>

**Align on care delivery model and sources of value**
- Prioritize design decisions
- Share case studies from other states
- Review member journeys to align on sources of value

**Determine target population and scope of activities**
- Create definition for high-needs BH population
- Test activities required to support care coordination and address sources of value
- Develop hypotheses for which providers are well positioned to fulfill care coordination

**Align on accountability and provider eligibility**
- Determine split of accountability between CPC and BH providers
- Outline activities to be driven by BH provider
- Build member journeys to test “edge cases” and points of potential entry / exit to BH care coordination

**Determine framework for incentive structure and considerations for implementation**
- Align on high-level care team requirements (to support care coordination requirements)
- Outline potential incentive streams
- Outline considerations for detailed design and implementation

**Detailed design and launch**
- Determine provider assessment and enrollment process
- Finalize member eligibility and attribution logic
- Finalize payment model
- Determine reporting, infrastructure & regulatory requirements
Questions?
Medicaid Basic Billing Training for BH Provider Agencies
External Business Relations Team

Sarah Bivens
Ava Cottrell
Laura Gipson
Ed Ortopan
Janene Rowe
Chezré Willoughby

Manager - Meagan Grove
Medicaid Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice
Traditional fee-for-service (FFS) Medicaid card is issued on a month to month basis to individuals.
Ohio Medicaid Categories

**Supplemental Security Income (SSI)**
- Automatically eligible for Medicaid as long as eligible for SSI

**Modified Adjusted Gross Income (MAGI)**
- Children, parents, caretakers, and expansion

**Aged, Blind, and/or Disabled (ABD)**
- 65+, or blind/disabled with no SSI
Presumptive Eligibility

- Covers children up to age 19, pregnant women, parents and caretaker relatives, and extension adults
- Coverage under this category is *time limited* to allow time for a full eligibility determination
Presumptive Eligibility Letter

If a state qualified entity determines presumptive eligibility, the individual will receive a letter
Inpatient Hospital Services Plan (IHSP)

- Specialized benefit plan for incarcerated individuals
- For inmates who are admitted to the hospital for at least 24 hours
- Only coverage for inpatient and associated professional services
Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to their actual release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan
Qualified Medicare Beneficiary (QMB)

- Issued to qualified consumers who receive Medicare
- Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid
- Reimbursement policy is set in Chapter 5160-1 and this can result in a payment of zero dollars
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

Medicaid **ONLY** pays their Medicare Part B premium
This is **NOT** Medicaid eligibility
There is **NO** cost-sharing eligibility
Conditions of Eligibility and Verifications

OAC 5160:1-2-10

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage.
- Individuals must cooperate with requests from a Medicaid provider for information which is needed in order to bill third party insurance appropriately.
- Providers may contact the local CDJFS office to report non-cooperative individuals.
- CDJFS may terminate eligibility.
Managed Care Enrollment

How do you know someone is enrolled?

Providers need to check the MITS provider portal each time BEFORE providing services

MITS will show if the individual is enrolled in a Managed Care Plan for the dates of service entered

For individuals enrolled in a MyCare Ohio Managed Care Plan, MITS will show if they are enrolled for Dual Benefits or Medicaid Only
Managed Care Enrollment in MITS

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
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<tr>
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Case/Cat/Seq Spenddown

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Managed Care

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<th>Plan Description</th>
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<th>Managed Care Benefits</th>
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<td>HMO, CFC</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
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</table>
Managed Care Sample Card

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Buckeye for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Buckeye NurseWise toll-free at 1-866-246-4358 and follow the prompt for ‘Nurse’ or TTY at 1-800-750-0750. NurseWise is open 24 hours per day.
MyCare Ohio Overview

- Demonstration project to integrate Medicare and Medicaid services into one program
- Operates in seven geographic regions, 29 counties
- Project was extended for 2 additional years
MyCare Ohio Eligibility

In order to be eligible for MyCare Ohio, an individual must be:

* Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
* Over the age of 18
* Reside in one of the demonstration project regions
### MyCare Ohio Enrollment in MITS

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<thead>
<tr>
<th>Benefit / Assignment Plan</th>
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### Lock-In

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<td>PART B</td>
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<td>PART D</td>
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<td>01/31/2017</td>
<td>^H8452/001</td>
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<td>001</td>
</tr>
</tbody>
</table>

**Dual Benefits** = Claim submission only to the MCP

**Medicaid Only** = Claim submission to Medicare then secondary claim to MCP for Medicaid portion
MyCare Ohio Opt-In Sample Card

Member Name: Jason Doe
Member ID: (Amisys MC Member #)
Health Plan: Buckeye Community Health Plan – MyCare Ohio
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
Plan Contract: H0022 001

RxBin: <RxBin #>
RxPCN: <RxPCN#>
RxBin: 012353
RxPCN: 06241400
RxID: <MC Amisys#-01>

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service: 866-549-8289 (TDD/TTY 800-750-0750)
Behavioral Health Crisis: 866-549-8289
Care Management: 866-549-8289
24-Hour Nurse Advice: 866-246-4358 Option 7)
Website: www.bchpohio.com

Send claims to: Buckeye Community Health Plan
P.O. Box 3060
Farmington, MO 63640-3822
MyCare Ohio Opt-Out Sample Card

Buckeye Community Health Plan - MyCare Ohio

Member Name: <Cardholder Name>
Health Plan: <Card Issuer Identifier>
MMIS Number: <Medicaid Recipient ID#2>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

RxBin: 600428
RxPCN: 0624000
RxID: <RxID#3>

* Buckeye Medicaid Member Only *

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service: <866-549-8289>
TTY: 800-750-0750

Behavioral Health Crisis: <866-549-8289>

Care Management: <866-549-8289>

24-Hour Nurse Advice: <866-246-4358>
TTY: 800-750-0750

Eligibility Verification: <866-246-4358>
Pharmacy Help Desk: <877-935-8021>
Claim Inquiry: <866-246-4358>

Website: http://mmp.bchpohio.com

Send Medicaid claims to: Buckeye Community Health Plan
PO Box 6200
Farmington, MO 63640

*Note: Member is eligible for Medicare through original Medicare or another health plan. You must submit Medicare claims to the member’s primary care insurance.
Managed Care and MyCare Ohio Breakdown

**MCPs providing “Traditional” Medicaid Managed Care**
- Buckeye (Centene)
- CareSource
- Molina
- United HealthCare
- Paramount

**MCPs participating in MyCare Ohio**
- Buckeye (Centene)
- CareSource
- Molina
- United HealthCare
- Aetna
MyCare Ohio Region Breakdown

Northwest
- Aetna
- Buckeye
- Fulton
- Lucas
- Ottawa
- Wood

Southwest
- Aetna
- Molina
- Butler
- Warren
- Clinton
- Hamilton
- Clermont

West Central
- Buckeye
- Molina
- Clark
- Green
- Montgomery

Central
- Aetna
- Molina
- Union
- Delaware
- Franklin
- Pickaway
- Madison

East Central
- Caresource
- United
- Summit
- Portage
- Stark
- Wayne

Northeast Central
- Caresource
- United
- Trumbull
- Mahoning
- Columbiana

Northeast
- Caresource
- Buckeye
- United
- Lorain
- Cuyahoga
- Lake
- Geauga
- Medina
Provider Complaint Form

http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx

**Ohio Medicaid Managed Care Provider Complaint Form**

**Instructions**

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1616.

**Complaint Details**

- **MCP Name:**
  - *

- **Complaint Reason:**
  - *

- * Are you contracted with this Health Plan?  ○ Yes  ○ No

- * Is this complaint related to the MyCare Program?  ○ Yes  ○ No

- * Have you already contacted the MCP about this issue?  ○ Yes  ○ No

- * Is this complaint related to any previously submitted complaints?  ○ Yes  ○ No

- * Is this complaint related to children with special health care needs?  ○ Yes  ○ No

- * Is the patient receiving or seeking mental health or substance abuse services?  ○ Yes  ○ No
Medicaid Consumer Liability 5160-1-13.1

A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider’s charge, as well as for the following:

- Medicaid claim denial
- Unacceptable claim submission
- Failure to request a prior auth
- Retroactive Peer Review stating lack of medical necessity
When Can you Bill an Individual?

- Notified in writing prior to the service that Medicaid will not be billed.
- Agrees to be liable for payment and signs statement.
- Explain the service could be free by another provider.
Billing Assistance

http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#161541-provider-billing-instructions
Modifiers Recognized by Medicaid

Scroll to the bottom of the page

PHARMACY CLAIMS:
- ODM Pharmacy Benefits

PROFESSIONAL CLAIMS:
- Telemedicine Billing Guidance
- Web Portal Billing Guide for Professional Claims
- EDI Companion Guide for Professional Claims

INSTITUTIONAL OR FACILITY-BASED CLAIMS:
- Web Portal Billing Guide for Institutional Claims
- EDI Companion Guide for Institutional Claims
- ODM Hospital Billing Guidelines
  - For Dates of Discharge and Dates of Service On or Before 7/31/2017
  - For Dates of Discharge and Dates of Service On or After 8/1/2017

DENTAL CLAIMS:
- Web Portal Billing Guide for Dental Claims
- EDI Companion Guide for Dental Claims

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQs
How do I log into MITS

*Go to http://Medicaid.ohio.gov
*Select the “Provider Tab” at the top
*Click on the “MITS Portal” icon

Once directed to this page, click the link to “Login”

You will then be directed to another page where you will need to enter your “User ID” and “Password”
MITS Navigation

“COPY”, “PASTE”, and “PRINT” features all work in the MITS Portal

**DO NOT** use the previous page function (back arrow) in your browser

**DO NOT** use the “enter” key on the keyboard, use the “tab” key or mouse to move between fields

MITS access will time-out after 15 minutes of system inactivity
How do You Search Medicaid Eligibility?

Must have the billing number or SSN plus the DOB

You can search up to 3 years at a time!!
## Medicaid Eligibility in MITS

### Recipient Information
- **Medicaid Billing Number**: [Image]
- **SSN**: [Image]
- **County of Residence**: CRAWFORD
- **County of Eligibility**: [Image]
- **County Office**: http://jfs.ohio.gov/County/County_Directory.pdf
- **Number Bed Hold Days Used Paid CY**: 20160101: 4

### Benefit / Assignment Plan

<table>
<thead>
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### Case/Cat/Seq Spenddown

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<td>PHYSICIAN/OUTPATIENT COVERAGE</td>
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<td>02/28/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IND</td>
<td>INPATIENT COVERAGE</td>
<td>02/01/2015</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>

### Managed Care

<table>
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<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>06/01/2014</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>
Medicaid Eligibility in MITS

Search for children who are on the same case as their mother
Search for an Ordering Practitioner in MITS
Internal Control Number (ICN)

All claims are assigned an ICN

2017170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>17</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
Claim Submission OAC 5160-1-19

Providers have 365 days to submit FFS claims

During that 365 days providers can attempt to submit the claim for payment (if receiving a denial) or adjust it as many times as they need to

An additional 180 days from the date of a claim denial are given, even when the date is beyond 365 days from the original DOS

Claims over 2 years old will be denied

There are exceptions to the 365 day rule if claim submission by the provider was delayed due to eligibility issues for the individual and a hearing was done
Submitting a Claim Over 365 Days Old

- Use this panel on the claim for billing over 365 days, when timely filing criteria has been met.
- Enter the previously denied ICN for audit trail and tracking purposes.
- When done correctly, MITS will bypass timely filing edits.

**Supporting Data for Delayed Submission / Resubmission**

*DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.*

Previously Denied ICN or TCN | Reason
--- | ---
Special Timely Filing Bill Instructions

Hearing Decision: **APPEALS###CCYYMMDD**
### is the hearing number and the CCYYMMDD is the date on the hearing decision

Eligibility Determination: **DECISIONCCYYMMDD**
CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown

Notes

**DECISION 20171225**
For claims submitted through electronic data interchange (EDI), ANSI ASC X12 HIPPA 5010:

Loop 2300-NTE Claim Note
NTE01-ADD
NTE02-

(1) For appeals/hearings, report the appeals/hearing number and date (The XXXXXXXX is the hearing number) in this format:
APPEALS XXXXXXXX CCYYMMDD
Example: NTE*ADD*APPEALS 123456A 20130613

(2) For a delayed eligibility determination, enter the eligibility determination decision date in this format:
DECISION CCYYMMDD
Example: NTE*ADD*DECISION 20130821
Enforcement of Third Party Liability (TPL)

All claims for mental health or substance use disorder services will now be edited for third party liability.

- Medicare is the most common TPL payer.
  - Enrollment with Medicare allows for claims to “cross-over” to Ohio Medicaid for co-payment adjudication.
- Providers will need to pursue Medicare enrollment if their agency and/or individual practitioners are not already enrolled.
  - Payment from commercial insurance plans and Medicare is required prior to billing Ohio Medicaid.
COB Claim Submission Facts

Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.

HIPAA compliant adjustment reason codes and amounts are required to be on the claim.

MITS will automatically calculate the allowed amount.
Header vs Detail

Header level

- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim.

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Detail Payment COB Claim Submission
Detail Payment COB Claim Submission
Detail Payment COB Claim Submission

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10/15/2015</td>
<td>1.00</td>
<td>$120.00</td>
<td>$20.65</td>
<td>PAID</td>
<td>21</td>
<td>99233</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.

Place Of Service: 21
Procedure Code: 99233
Emergency: [ ]

Referred EPSDT Service/Family Planning: [ ]
Diagnosis Code Pointer: 01, 02, 03, 04
Modifiers: [ ]
Final EAPG: [ ]
Pay Action: [ ]

---

**Detail - Other Payer**

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>Electronic Payer ID</th>
<th>Paid Date</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15202</td>
<td>11/05/2015</td>
<td>$80.95</td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.

Pay Date: 11/05/2015
Paid Amount: $80.95
Allowed Amount: $101.60
Detail Payment COB Claim Submission

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/15202</td>
<td>CO-Contractual Obligations 253</td>
<td>$1.65</td>
<td></td>
</tr>
<tr>
<td>1/15202</td>
<td>CO-Contractual Obligations 45</td>
<td>$16.75</td>
<td></td>
</tr>
<tr>
<td>1/15202</td>
<td>PR-Patient Responsibility 2</td>
<td>$20.65</td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update - or - click add an item button below.

Payer Line Level Adjustment Reason Codes (ARC) and Amounts

Select row above to update - or - click add an item button below.

Attachments

Supporting Data for Delayed Submission / Resubmission

Claim Status Information

Claim Status: PAID
Claim ICN
Paid Date: 11/11/2015
Paid Amount: $20.65

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

Reason:

Claim Status Information

Claim Status: PAID
Claim ICN
Paid Date: 11/11/2015
Paid Amount: $20.65
### Header Payment COB Claim Submission

#### Billing Information
- **ICN**
- **Claim Received Date**: 12/29/2015
- **Claim Type**: M - PROFESSIONAL
- **Medicaid Billing Number**
- **Provider ID**
- **Date of Birth**
- **Last Name**
- **First Name, MI**
- **Patient Account #**
- **Medical Record #**
- **Referring Provider #**
- **Supervising Provider #**
- **Rendering ID**
- **Medicare Assignment**: NOT ASSIGNED
- **Patient Amount Paid**: $0.00
- **ICD Version**: 09

#### Service Information
- **Release of Information**: NOT ALLOWED TO RELEASE DATA
- **From Date**: 08/07/2015
- **To Date**: 08/07/2015
- **Signature Source**: SIGNED AUTHORIZATION ON FILE
- **Accident Related To**
- **Accident State**
- **Accident Country**
- **Accident Date**
- **EPSDT Referral**
- **Prior Authorization #**
- **Hospital Discharge Date**
- **Last Menstrual Period**

#### TOTAL CHARGES
- **Total Charges**: $120.00
- **Medicaid Allowed Amount**: $61.24
- **TPL Paid Amount**: $0.00
- **Total Medicaid Paid Amount**: $61.24
- **Medicaid CoPay Amount**: $0.00
- **Note Reference Code**
Header Payment COB Claim Submission

Diagnosis

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>02</td>
<td>78720</td>
<td>DYSPHAGIA NOS</td>
</tr>
<tr>
<td>01</td>
<td>78900</td>
<td>ABDMNAL PAIN UNSPCF SITE</td>
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</table>

Header - Other Payer

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF</td>
<td></td>
<td></td>
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<td></td>
<td>SELF</td>
<td>$0.00</td>
<td>08/18/2015</td>
<td>39065</td>
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</tbody>
</table>

Claim Filing Indicator: COMMERCIAL INSURANCE

Policy Holder Relationship to Insured: SELF

Policy Holder Last Name

Policy Holder First Name, MI

Policy Holder Date of Birth: 06/25/1987

Gender: FEMALE

Paid Amount: $0.00

Paid Date: 08/18/2015

Allowed Amount: $92.40

Insurance Carrier Name: ASSURANT HEALTH

Electronic Payer ID: 39065

Insured’s Policy ID

Payer Sequence: PRIMARY

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes
Header Payment COB Claim Submission
### Header Payment COB Claim Submission

#### Detailed Information

**No rows found**

- **Delete**
- **Add an Item**

**Attachments**

**No rows found**

- **Delete**
- **Add an Item**

### Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

- **Previously Denied ICN or TCN**
- **Reason**

### Claim Status Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>PAID</th>
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<tbody>
<tr>
<td>Claim ICN</td>
<td></td>
</tr>
<tr>
<td>Paid Date</td>
<td>01/06/2016</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$61.24</td>
</tr>
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</table>
Tertiary Claim Submission
Tertiary Claim Submission

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>78906</td>
<td>ABDMNAL PAIN EPIGASTRIC</td>
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</tbody>
</table>

Select row above to update -or- click add an item button below.

<table>
<thead>
<tr>
<th>Header - Other Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>CHILD</td>
</tr>
<tr>
<td>CHILD</td>
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</table>

Select row above to update -or- click add an item button below.

Claim Filing Indicator: COMMERCIAL INSURANCE

<table>
<thead>
<tr>
<th>Insurance Carrier Name</th>
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<th>Insured’s Policy ID</th>
<th>Payer Sequence</th>
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<tbody>
<tr>
<td>MEDICAL MUTUAL OF OHIO</td>
<td>SX057</td>
<td></td>
<td>SECONDARY</td>
</tr>
</tbody>
</table>

Paid Amount: $161.06
Paid Date: 05/01/2015
Allowed Amount: $209.11

*** No rows found ***

Select row above to update -or- click add an item button below.
# Tertiary Claim Submission

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place Of Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>03/01/2015</td>
<td>1.00</td>
<td>$249.00</td>
<td>$59.35</td>
<td>PAID</td>
<td>23</td>
<td>99284</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.

- **From DOS**: 03/01/2015
- **To DOS**: 03/01/2015
- **Units**: 1.00
- **Charges**: $249.00
- **Medicaid Allowed Amount**: $59.35
- **Rendering Provider**:
- **Submitted EAPG**:
- **Initial EAPG**:
- **Status**: PAID

### Referral Information
- **Place Of Service**: 23
- **Procedure Code**: 99284
- **Emergency**: 
- **Referred EPSDT Service/Family Planning**: 
- **Diagnosis Code Pointer**: 01
- **Modifiers**: 
- **Final EAPG**:
- **Pay Action**:

### Other Payer Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Electronic Payer ID</th>
<th>Paid Date</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SX057</td>
<td>05/01/2015</td>
<td>$161.06</td>
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<tr>
<td>1</td>
<td>60054</td>
<td>04/09/2015</td>
<td>$24.53</td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.

- **Detail Item**: 1
- **Electronic Payer ID**: 60054
- **Paid Date**: 04/09/2015
- **Paid Amount**: $24.53
- **Allowed Amount**: $209.11
# Tertiary Claim Submission

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
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<tbody>
<tr>
<td>1/60054</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
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<td>1/60054</td>
<td>PR-Patient Responsibility</td>
<td>2</td>
<td>$6.13</td>
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<tr>
<td>1/60054</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$39.89</td>
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<tr>
<td>1/SX057</td>
<td>CO-Contractual Obligations</td>
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<td>$39.89</td>
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<td>1/SX057</td>
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<td>PR-Patient Responsibility</td>
<td>2</td>
<td>$23.52</td>
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</tbody>
</table>

Select row above to update -or- click add an item button below.

## Attachments

***No rows found***

Select row above to update -or- click add an item button below.

## Supporting Data for Delayed Submission / Resubmission

**DISCLAIMER:** Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

<table>
<thead>
<tr>
<th>Reason</th>
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</table>

## Claim Status Information

<table>
<thead>
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<th>Claim ICN</th>
<th>Paid Date</th>
<th>Paid Amount</th>
</tr>
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<tbody>
<tr>
<td>PAID</td>
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<td>05/27/2015</td>
<td>$0.00</td>
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</table>
Crossover Claim Submission
Crossover Claim Submission

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>496</td>
<td>CHR AIRWAY OBSTRUCT NEC</td>
</tr>
<tr>
<td>01</td>
<td>4011</td>
<td>BENIGN HYPERTENSION</td>
</tr>
</tbody>
</table>

Select row above to update - or - click add an item button below.

**Header - Other Payer**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
<th>Insurance Carrier Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SELF</td>
<td></td>
<td></td>
<td>$21.72</td>
<td>04/29/2015</td>
<td></td>
<td>CENTENE BUCKEYE MCR</td>
</tr>
</tbody>
</table>

Select row above to update - or - click add an item button below.

**Claim Filing Indicator**

- HMO, MEDICARE RISK

**Policy Holder Relationship to Insured**

- SELF

**Policy Holder Last Name**

- 

**Policy Holder First Name, MI**

- 

**Policy Holder Date of Birth**

- 

**Gender**

- 

**Paid Amount**

- $21.72

**Paid Date**

- 04/29/2015

**Allowed Amount**

- $81.86

**Header - Other Payer Amounts and Adjustment Reason Codes**

No rows found
Crossover Claim Submission

Select row above to update -or- click add an item button below.

- Item: 1
- From DOS: 03/27/2015
- To DOS: 03/27/2015
- Units: 1.00
- Charges: $126.00
- Medicaid Allowed Amount: $22.92
- Place Of Service: 12
- Procedure Code: 99348
- Emergency: No
- Referred EPSDT Service/Family Planning: Other
- *Diagnosis Code Pointer: 
  - 01: 
  - 02: 
  - : 
  - : 
  - : 
- Modifiers: 
- Final EAPG: 
- Pay Action: 
- Submitted EAPG: 
- Initial EAPG: 
- Status: PAID

**Detail - Other Payer**

Select row above to update -or- click add an item button below.

- Electronic Payer ID: 68069
- Paid Date: 04/29/2015
- Paid Amount: $21.72

**LINE LEVEL ADJUSTMENT REASON CODES AND AMOUNTS**

- Detail Item: 1
- Electronic Payer ID: 
- Paid Date: 04/29/2015
- Paid Amount: $21.72
- Allowed Amount: $81.86
Crossover Claim Submission
The Washington Publishing website provides adjustment reason codes (ARCs) that must be noted on claims that involve “other payers.”

- **1** • Deductible
- **2** • Coinsurance
- **3** • Co-payment
- **45** • Contractual Obligation/Write off
- **96** • Non-covered services

[Link to the list of ARCs](http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/)
Health Insurance Fact Request (Form 6614)

The 06614 is not meant to be used for Managed Care plan or County demographic information. Any information other than Commercial Insurance or Medicare cannot be processed by the TPL & Buy-in units.

Questions regarding Managed Care - contact the plan involved. Questions regarding updating the Date of Birth, Gender or other demographics – contact the County involved.

Please select which health insurance information to update: [ ] Private Health Insurance [ ] Medicare

Provider Information

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
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<tr>
<th>Contact Person</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Fax Number</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</table>

Recipient Information

<table>
<thead>
<tr>
<th>Patient(s) Name</th>
<th>Medicaid Billing Number</th>
<th>Patient’s Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Insurance

Address

City

State

Zip Code

Insurance Carrier Phone Number

Policy Holder Name

Policy Number or Medicare Number

Policy Group Number

Policy Holder Social Security Number (SSN)

Policy Holder Phone Number

If payment has been received from health insurance other than Medicaid or Medicare, please note first payment date:

Date

Date health insurance terminated per attached documents

Additional Comments

Return original to:

Ohio Department of Medicaid
Cost Avoidance Unit
Coordination of Benefits Section
P.O. Box 182410
Columbus, Ohio 43218-2410

If you have questions contact the Coordination of Benefits Section at (614) 752-5768. The FAX number is (614) 728-0757.
Questions?
Appendix
Inpatient Psychiatric Services
Inpatient Psychiatric Benefit

- State is moving forward with January 1, 2018, full carve-in of the inpatient psychiatric benefit.

- Remember, MCPs should be contacted for triage and level of care (LOC) determination.

- The IMD FAQs have been finalized, shared with the plans, and are now uploaded to the BH website under the Trainings tab at: [http://bh.medicaid.ohio.gov/training](http://bh.medicaid.ohio.gov/training)
When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan MUST* be contacted for triage, level of care determination, and setting options. This includes MyCare Ohio plans when an enrollee has exhausted their lifetime Medicare inpatient psychiatric benefit.

*If a plan is not able to be reached prior to admission, the MCP has deferred its triage, level of care determination, and placement authority to the clinical judgment of the practitioner recommending inpatient psychiatric care. Admissions must meet medical necessity criteria. If medical necessity for admission is not met, the MCPs would be responsible for the medically necessary professional services only.

** MCPs may review LOC, assessments and other pertinent information to authorize the length of stay, setting, etc. based on medical necessity

For a person needing medically appropriate inpatient psychiatric care, they must be offered #1 or #2 to then be offered #3 or #4.

- This ensures inpatient psychiatric services are provided “in lieu of services” covered under the state plan (#1 and #2)
# Inpatient Psychiatric Admissions – Managed Care

<table>
<thead>
<tr>
<th>Ages</th>
<th>Benefit Coverage</th>
<th>IMDs: Pre-July 1</th>
<th>IMDs: July 1 – Dec. 31, 2017</th>
<th>IMDs: Jan. 1, 2018, &amp; Forward</th>
<th>General Hospital Psych Units</th>
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</thead>
<tbody>
<tr>
<td>21-64</td>
<td>N/A</td>
<td>N/A</td>
<td>Managed Care Plans</td>
<td>Managed Care Plans</td>
<td>Managed Care Plans</td>
</tr>
<tr>
<td>Payment</td>
<td>N/A</td>
<td>Professional Services: MCPs Facility Charges*: MCPs *If admission meets medical necessity criteria</td>
<td>Professional Services: MCPs Facility Charges*: MCPs *If admission meets medical necessity criteria</td>
<td>Managed Care Plans</td>
<td>Managed Care Plans</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Under Age 21</th>
<th>Benefit Coverage</th>
<th>IMDs: Pre-July 1</th>
<th>IMDs: July 1 – Dec. 31, 2017</th>
<th>IMDs: Jan. 1, 2018, &amp; Forward</th>
<th>General Hospital Psych Units</th>
</tr>
</thead>
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<td>Permedion</td>
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<td>Managed Care Plans</td>
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<tr>
<th>Over Age 64</th>
<th>Benefit Coverage</th>
<th>IMDs: Pre-July 1</th>
<th>IMDs: July 1 – Dec. 31, 2017</th>
<th>IMDs: Jan. 1, 2018, &amp; Forward</th>
<th>General Hospital Psych Units</th>
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<td>Professional Services: Medicaid</td>
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<td>Managed Care Plans</td>
<td>Managed Care Plans</td>
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*Facility Charges*: Managed Care Plans

*If admission meets medical necessity criteria*
Outpatient SUD Group Counseling
Example: Outpatient Level of Care 1
SUD Group Counseling CO-FACILITATION

Group leaders

Doug, LICDC
Sysilie, CDCA

 Patients

Group topic 1
9 am

Group topic 2
10 am

Group topic 3
11 am

12 pm

H0005 HK  12 units

H0005 HK  12 units

A + B = H0005 HK 1 unit  B
OR
A + B = H0005 U6 1 unit

H0005 HK 8 units  OR  H0005 U6 8 units

H0005 HK 8 units  OR  H0005 U6 8 units

90853 1 unit (encounter)  OR  90853 U6 1 unit (encounter)
(45 minutes)
Example: Outpatient Level of Care 2.1 IOP
SUD Group Counseling CO-FACILITATION

<table>
<thead>
<tr>
<th>Group leaders</th>
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<tr>
<td>= Doug, LICDC</td>
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<tr>
<td>= Sysilie, CDCA</td>
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<th>Patients</th>
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</table>

H0015 HK 1 unit

H0015 HK 1 unit

A + B = H0015 HK 1 unit

A + B = H0015 U6 1 unit

H0005 HK 8 units OR H0005 U6 8 units

H0005 HK 8 units OR H0005 U6 8 units

90853 1 unit (encounter) OR 90853 U6 1 unit (encounter)

(45 minutes)
Example: Outpatient Level of Care 2.5 PH
SUD Group Counseling CO-FACILITATION

Group leaders

Doug, LICDC
Sysilie, CDCA

Patients

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

H0015 HK TG 1 unit
H0015 HK TG 1 unit
A + B = H0015 HK TG 1 unit
A + B = H0015 U6 TG 1 unit

OR

OR

H0005 HK TG 8 units
H0005 HK TG 8 units
OR
OR
90853 1 unit (encounter)
90853 U6 1 unit (encounter)
(45 minutes)
Examples of Medicaid Cards
Example of MyCare Ohio Managed Care Cards
(as of the date of this presentation)

CareSource:

CareSource MyCare Ohio Medicare-Medicaid Member ID Card:

CareSource MyCare Ohio Medicaid Only Member ID Card:

Back of CareSource MyCare Ohio Medicare-Medicaid Member ID Card:

Back of CareSource MyCare Ohio Medicaid Only Member ID Card:

https://www.caresource.com/providers/ohio/caresource-mycare-ohio/patient-care/
Examples of Medicaid Managed Care Cards
(as of the date of this presentation)

http://medicaid.ohio.gov/FOROHIOANS/Programs/ManagedCareforOhioans.aspx
Example of Fee For Service Card
(as of the date of this presentation)

Additional information can be found on the back of the FFS card