Community Behavioral Health Center (CBHC) Provider Technical Assistance Training

September 24, 2019

Ohio | Department of Medicaid

Ohio | Department of Mental Health and Addiction Services

Meeting Agenda

#	TOPIC
3	PROVIDER ENROLLMENT
9	INDIVIDUAL ELIGIBILITY
16	PRIOR AUTHORIZATION
20	CLAIM SUBMISSION AND DENIALS

Provider Enrollment

CBHC Enrollment and Affiliation in MITS

- MITS is the primary source of provider enrollment and affiliation information.
- ODM sends Provider Master File (PMF) to the MCOs on a daily basis.
- All staff must be enrolled as a Medicaid provider in MITS.
- It is imperative that CBHCs update MITS with current information – licensure, education, etc. This will reduce the incidence of denied claims due to rendering provider enrollment issues.
  - If changing provider type, a new application is needed.
  - If upgrading within same specialty, email ODM Provider Enrollment at: MEDICAID_PROVIDER_UPDATE@medicaid.ohio.gov.
- ODM has developed step-by-step instructions for how rendering practitioners can enroll in MITS, become affiliated with their employing agency, and make changes to licenses, provider specialties, and names.
  - July 17th webinar presentation is available on the BH Redesign website at: https://bh.medicaid.ohio.gov/training.

Provider enrollment questions can be sent to the following ODM email box:
MEDICAID_PROVIDER_UPDATE@medicaid.ohio.gov

CBHC Practitioner Enrollment File

- CBHC Practitioner Enrollment File provides an online master listing of all CBHCs enrolled with ODM and their affiliated practitioners, including specialties.
- The CBHC Practitioner Enrollment File is available at https://bh.medicaid.ohio.gov/manuals under "Enrolling Practitioners in Medicaid" section and is refreshed weekly.
- CBHCs should review data specific to their organization and make any corrections/updates in MITS.
- File is separated by Active and Inactive tabs:
  - Active: Shows "active" practitioner enrollments, specialties, and affiliations in MITS, and displays provider types and specialties in MITS that are not available for CBHCs to view in MITS.
  - Inactive: Shows "inactive" practitioners still showing as being "actively" affiliated with the organization. This information is intended to isolate inactive practitioners and give CBHCs an opportunity to end date these affiliations in MITS.

CBHC Practitioner Enrollment File questions can be sent to the following ODM email box:
BHWebinar@medicaid.ohio.gov

More resources are available at https://bh.medicaid.ohio.gov/training and https://bh.medicaid.ohio.gov/manuals (under Enrolling Practitioners in Medicaid)

CBHC Universal Roster

- CBHC Universal Roster (interim step) is a single roster submitted by CBHCs when reporting staff changes, additions, and terminations to Medicaid MCOs.
- The template is available at https://bh.medicaid.ohio.gov/manuals under "Enrolling Practitioners in Medicaid."
- All CBHC Universal Roster submissions should be sent to the MCO-specific email boxes found within the online template.
  - **Do NOT send it to ODM.**
- Latest details are available in the July 1st MITS Bits HERE.

CBHC Universal Roster questions can be sent to the following ODM email box:
BHWebinar@medicaid.ohio.gov

More resources are available at https://bh.medicaid.ohio.gov/training and https://bh.medicaid.ohio.gov/manuals (under Enrolling Practitioners in Medicaid)

QMHS and QMHS +3

Qualified Mental Health Specialist (QMHS) vs. QMHS +3 clarification

- Please note that any service that can be rendered by a qualified mental health specialist (QMHS) with 3 years' experience can also be rendered by and receive the same rate as a QMHS with a bachelor's degree.
- Be sure to use the appropriate modifier of the rendering QMHS practitioner when submitting a claim.

Below is a table of all the codes that can be rendered by QMHS +3 and QMHS Bachelor's:

Code	QMHS +3	QMHS Bachelor's	Rate ($)
H2019 office	UK	HN	19.96
H2019 community	UK	HN	25.46
H2019 HQ	UK	HN	6.49
H2012	UK	HN	24.10
H2020	UK	HN	135.92
H0036	UK	HN	19.54
H0036 HQ	UK	HN	8.99

For additional information on QMHS and corresponding modifiers/rates, please review the BH Provider Manual available at: https://bh.medicaid.ohio.gov/manuals.

Questions?

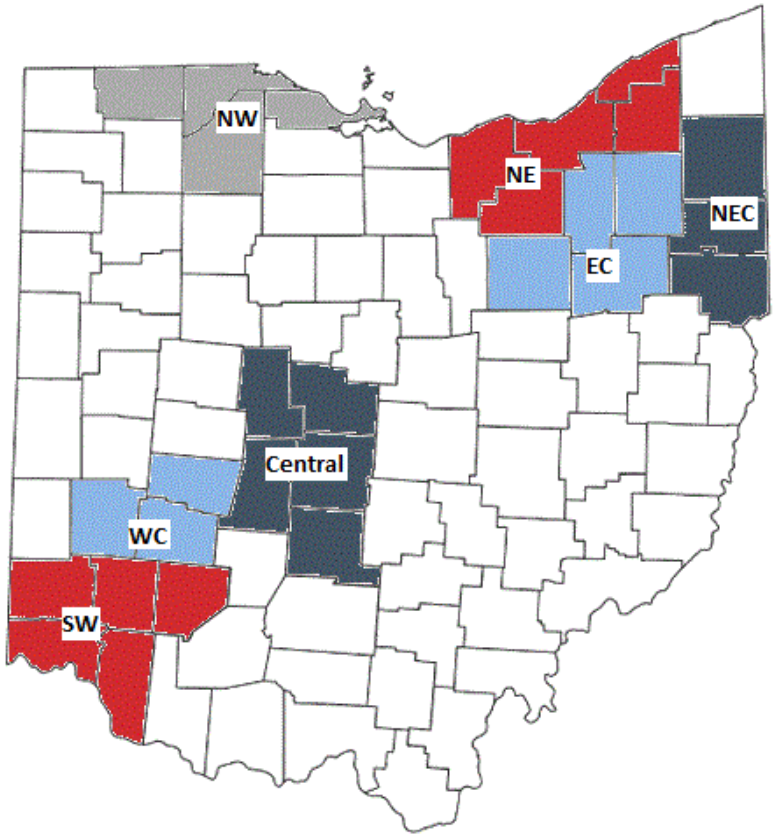
Individual Eligibility

Managed Care Eligibility

- 90% of Medicaid eligible individuals are enrolled in a managed care plan or MyCare Ohio Plan.
  - Adult extension recipients are mandatory managed care.
- Exceptions include:
  - Some of the FFS population includes those with presumptive eligibility and dual eligibility in a non-MyCare Ohio county.

MyCare Ohio Regions

- MyCare Ohio operates in 7 geographic regions serving more than 119,000 members.
- Each region has at least 2 plans (NE region has 3).



Medicaid Eligibility 270/271

Determining Medicaid recipient managed care enrollment:

- The MITS provider portal can be used to check individual eligibility and MCO enrollment and is real time.
- Must check individual eligibility in MITS **at least monthly.**
- Providers can also submit an EDI 270 (Eligibility and Benefit Inquiry) to ODM with a list of Medicaid covered individuals. ODM's 271 response (Eligibility and Benefit Response) will identify in which MCO each Medicaid recipient is enrolled.
  - This same 270/271 process can then be addressed to each MCO with their respective members to get information, including the MCO's member ID.

Please consider the following for newly eligible recipients:

- Managed Care Day One is the enrollment of an individual into managed care on the first day of the month that the individual becomes eligible for Medicaid. (Retro-enrollment and presumptive eligibility would be FFS)

Third-Party Liability

- ODM and OhioMHAS have developed two TPL resource documents to provide CBHCs with helpful information.
  - Available on the BH Redesign website at https://bh.medicaid.ohio.gov/manuals, under the Billing and IT Resources section:
    1. Frequently Asked Questions: Medicaid Coordination of Benefits & Third-Party Liability for Community Behavioral Health Centers
    2. Third-Party Liability Provider Information Grid by Fee-For-Service & Medicaid Managed Care Plan
- For more information on TPL, including background information, the TPL bypass list, tips for TPL claims processing, and the 270/271 transaction in FFS, please review the February 21st MITS Bits.
- **Always check the payer's TPL information.** TPL information may differ across MCOs and FFS. Rely on the information that the payer has since they will be the ones processing the claim(s).
- *Coming Soon: TPL SPA is approved, and ODM is working on rule change to specify that providers make one billing attempt (instead of three) before submitting to ODM for payment.*

Third-Party Liability

270/271 Transaction in FFS

1. Authorized Trading Partners may submit the EDI 270 Eligibility Inquiry transaction to ODM in either a batch or in real-time.
2. ODM will then provide the 271 Eligibility Response transaction.
3. If the Medicaid recipient has third party coverage known to MITS, the information will be returned on the 271 Eligibility Response in the 2115C Subscriber Eligibility or Benefit Additional Information and 2120C Subscriber Benefit Related Entity Name loops.
   - At a minimum, the payer name and payer identification number will be provided.

- Providers can use the Authorized Trading Partner list found at: https://medicaid.ohio.gov/Provider/Billing/TradingPartners/AuthorizedTradingPartners as a resource.

- MCOs may offer similar processes for batch inquiries and providers should contact each MCO to ask about options for TPL inquiries.

Questions?

Prior Authorization

Prior Authorized Services

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
Psychological Testing 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Calendar year	Up to 20 hours/encounters per patient per calendar year for all psychological testing codes. Prior authorization once limit is reached.
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.
Alcohol or Drug Assessment H0001	Calendar year	2 assessments per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached.
SUD Residential H2034, H2036	Calendar year	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.
SUD Peer Recovery H0038	Calendar year	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

More information on these services is available in the BH Provider Manual at: https://bh.medicaid.ohio.gov/manuals

Prior Authorization References

- *Medicaid/MyCare Uniform Prior Authorization Form*
  The Ohio MCOs/MCOPs have developed a uniform prior authorization form for community BH services.
  Uniform PA Form

- *Ohio Urine Drug Testing Prior Authorization Request Form*
  ODM and OhioMHAS, in collaboration with the Medicaid MCOs, have released a standard UDT PA form available for use by behavioral health community providers to request PA for UDT that exceeds the guidelines that became effective July 1, 2019.
  Standard UDT PA Form
  - Both PA forms are available at: https://bh.medicaid.ohio.gov/manuals and https://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans

Questions?

Claim Submission and Denials

Claim Submission Reminders

- Ensure agency NPI and all rendering NPIs are accurate and on claim:
  - Note differences between MCOs (header vs. detail).
    - Refer to Medicaid MCP Resource Guide, Billing Guide tab (available at: https://bh.medicaid.ohio.gov/manuals and https://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans).
  - Recognize 84 NPI and services vs. 95 NPI and services to avoid mix-ups.

- Ensure services are rendered by appropriate practitioner types.

- Add-on codes need to be on the same claim as the primary procedure – not a separate claim.

- Dual specialties:
  - Ensure enrolled correctly;
  - Ensure claim has necessary modifier to reflect second specialty;
  - Ensure appropriate effective date.

BH claim submission questions can be sent to the following ODM email box: BH-Enroll@medicaid.ohio.gov or call ODM Provider Assistance at: 1-800-686-1516, option 5.

Claim Reconciliation

Considerations:

- Your trading partner can help you to reconcile claims issues.

- Use the 276/277 EDI transaction
  - Your trading partner can submit a HIPAA compliant 276 EDI transaction to MCO and/or MCO's clearinghouse. The MCO/clearinghouse will respond with a complete HIPAA compliant 277 EDI transaction within the required CAQH CORE timeframes with the HIPAA compliant claim status category code(s) and claim status code(s) that will provide the status of all denied, paid, or pended claims to the submitter.
  - Providers can request information on up to 4,000 claims per transaction in a batch or 1 claim at a time in a real-time environment. The Claim Status Inquiry and Response timeliness falls within the CAQH CORE Operating Rule Phases I and II. If a batch 276 Inquiry is submitted by 9:00 pm ET, the 277 must be returned by 7:00 am ET the next business day. For real-time inquiries, the response time is 20 seconds or less to be compliant with the CAQH CORE rules.

Common Denial Errors

It is important to determine the reason for denial. Common denial errors include:

- No indication of who rendered the service
  - No practitioner modifier or rendering NPI
- Rendering NPI not enrolled in Medicaid and/or affiliated with agency
- Rendering provider is not enrolled correctly and cannot provide the service billed
- Primary diagnosis not valid for service being rendered. For example, a mental health diagnosis for an SUD service.
- Incorrect use of modifiers
- Allowable places of service
  - Make certain the places of service on claims are included in the rate chart from the BH Provider Manual
  - POS 11 vs. 57 or 53

Working with MCOs

Work with the MCOs if you believe claim(s) inappropriately denied or underpaid:

1. Work with MCO representative;
2. Provide claims examples for reference;
3. Explain reasoning;
4. Request re-processing of claims;
5. File managed care complaint form with ODM if necessary
   - Form can be found at: http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx.

MCO BH Escalation Points of Contact

Aetna: • Rapid Response Team: OH_BH_Redesign@AETNA.com • Escalation/Other Questions: ▪ Linda Ihnat, 419-309-9394, Ihnatl@aetna.com ▪ Chris Toland, 614-359-3609, TolandC@aetna.com	Buckeye: • Rapid Response Team: BehavioralHealth@centene.com • Escalation/Other Questions: ▪ Laura Paynter, 866-246-4356, ext. 24446, lpaynter@centene.com
CareSource: • Provider Services: 1-800-488-0134 • Jordan Stanley, Team Lead, Behavioral Health ▪ 937-344-9577 or earlene.stanley@caresource.com • John Nisky, Manager, Behavioral Health ▪ 216-816-5426 or john.nisky@caresource.com • Terry Jones, Director, Behavioral Health ▪ 614-255-4613 or terry.jones@caresource.com	Molina: • Rapid Response Team: BHProviderServices@MolinaHealthcare.com • Escalation/Other Questions: ▪ Deanna Putman, Provider Services Director, deanna.putman@molinahealthcare.com, 614-212-2340
Paramount: • Deborah Tesch – Provider Relations Representative, Behavioral Health-Ohio ▪ 419-887-2807 or 855-312-5372, Deborah.Tesch@ProMedica.org ▪ Fax: 567-585-9403 • Escalation/Other Questions: ▪ Linda Nordahl, 419-887-2279, Linda.nordahl@promedica.org	United: • Karen Argabrite, Karen.Argabrite@Optum.com, 763-361-8265 • Donna Bunning, Donna.Bunning@Optum.com, 763-797-5098 • Nanna Horton, Nanna.Horton@Optum.com, 763-361-8092 • Kim Dokes, Kim.Dokes@Optum.com, 612-632-5117 ▪ Refer to: https://www.providerexpress.com/content/ope-provexpr/us/en/contact-us/nmContacts/oh.html If no resolution, escalate to: • Lori Moncherry, Lori.Moncherry@Optum.com, 763-283-2862 • Amanda Gloeckner, Amanda.Gloeckner@Optum.com, 612-428-6652

Additional contact information is available in the BH MCP Integration Document found at https://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans.

Questions?

Thank you

Today's presentation will be made available at:

https://bh.medicaid.ohio.gov/training

Have a question about BH Redesign?
Submit a question at:

BH-Enroll@medicaid.ohio.gov