Good Morning:

Welcome to the BH Redesign “401” webinar that is scheduled 10:00 am until 3:00 pm. We will begin promptly at 10:00 and will be recording the webinar.

We will break as close to 12:00 noon as possible for a one hour lunch.

We will be tracking questions using the webinar interface but please keep in mind that due to the volume of registrations/participants, we are unlikely to be able to answer every question.

Audio is available via either your computer or by telephone by calling +1 (415) 930-5321. The telephone audio PIN is shown after you join the webinar.

The slide deck is available via download through the webinar control panel and it will be posted to the bh.medicaid.ohio.gov website along with the recording.
## Agenda

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Ohio Medicaid Behavioral Health Redesign Initiative

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

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

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

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

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

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

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

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

**Integration** – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. *Implementation on target for January 1, 2018.*
Policy Updates
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 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 Updates

2

Staffing Requirements for SUD Residential

Solution

- ODM removed from its rules any language regarding staffing requirements in the Substance Use Disorder (SUD) rules

- Providers will need to document, in accordance with general Medicaid policy, the services provided in the residential setting and adhere to the ASAM criteria for each level of care
Policy Updates

MH Day Treatment, SUD Intensive Outpatient and SUD Partial Hospitalization

Solution

- ODM has revised the reimbursement policy to allow a provider to be paid for day treatment and a group counseling service on the same day – same policy has been implemented for SUD IOP and SUD PH

Refer to slides 30, 31 on MH Day Treatment & slides 57, 62 on SUD IOP & slide 65 on SUD PH
Policy Updates

General Supervision vs. Direct Supervision

Solution

- ODM revised the minimum supervision requirements for psych assistants, social work trainees, marriage and family therapist trainees, counselor trainees, chemical dependency counselor assistants to general supervision (supervisor available by phone)
  - Direct supervision will be optional for these practitioners providing CPT codes
- Note: Payment rate will differ for general versus direct supervision for these practitioners:
  1. Trainees/Assistants 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. Trainees/Assistants billing CPT codes under direct supervision will receive their supervisor’s rate if the supervisor’s NPI is on the claim in the supervisor field and their practitioner modifier is also reported
Policy Updates

5 Documentation Standards

Solution

- Documentation requirements in the rules were aligned to eliminate confusion between the ODM and OhioMHAS rules
Policy Updates

Places Of Service (POS) 23 & 99

Solution

- ODM pays for certain behavioral health services when rendered in an emergency room setting (POS 23) or in the community (POS 99). See July 1, 2017 BH Provider Manual for specific guidance.

- Note: Federal law prohibits Medicaid payment for services rendered when someone is incarcerated (42 CFR 435.1009)
Policy Updates

Transportation

Solution

- 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 Updates

Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) for Assertive Community Treatment (ACT)

**Solution**

- State will allow an SSI or SSDI determination to stand in the place of an Adult Needs and Strength Assessment (ANSA) score, assuming all other eligibility criteria for ACT are met.

Refer to slide 139 – ACT Eligibility & slide 143 – ACT Checklist
Policy Updates

Continuity of Fee-For-Service (FFS) Rates for Managed Care

Solution

- MCPs (including MyCare) will keep the FFS rates as a floor for what they pay through December 31, 2018
- There will be an 18 month period with FFS rates for MyCare as they start in July. MyCare Plans will follow FFS prior authorization policies for a 12 month period.
Policy Updates

Community Behavioral Health Center (CBHC) Laboratories

Solution

- When the MyCare plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare plan is directed to accept the CBHC laboratory into their panel to allow for continuity of care.

- MyCare plans may negotiate with CBHC laboratories.
Policy Updates

Outpatient Hospital Clinics

Solution

• ODM will allow hospital-based agencies to maintain provider types 84 and/or 95 if they choose to until January 1, 2018, but must comply with all other aspects of BH Redesign on July 1, 2017

• Note: If a hospital has received the Joint Commission’s behavioral health accreditation, OhioMHAS will deem them certified
Policy Updates

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Therapeutic Behavioral Services (TBS) / Psychosocial Rehabilitation (PSR)

Solution

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

Collateral Contacts

Solution

• A Medicaid reimbursable collateral contact, as referred to in Ohio Administrative Code rules 5160-27-04 and 5160-27-08, occurs when the practitioner contacts individuals who play a significant role in a Medicaid recipient’s life.

• The information gained from the collateral contact can provide insight into treatment OR basic psychoeducation provided to that collateral contact can assist with the treatment of the Medicaid recipient.
BH Redesign and Managed Care
BH Services are “CARVED OUT” Until January 1, 2018

• Ohio Medicaid recipients enrolled in a Medicaid managed care plan can receive community behavioral health services through any participating Medicaid BH Provider agency.

• Two Exceptions: Respite & all inpatient psychiatric services as of July 1, 2017 (including Institutions for Mental Diseases-IMDs)

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

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

**BH Services are “CARVED IN”**

- Ohio **Medicare and Medicaid** recipients enrolled in a MyCare Ohio plan receive community behavioral health services through their MyCare Plan.

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

*Aetna is a MyCare plan but not a Medicaid Managed Care Plan*
Community Behavioral Health Center (CBHC) Laboratories for MyCare

Guidance

- When the MyCare plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare plan is directed to accept the CBHC Laboratory into their panel to allow for continuity of care.

- CBHC laboratories are *not* included in policy that MyCare plans must maintain 100% of FFS as a floor – just the BH benefit package.
  - MyCare plans will be able to negotiate payments.

- For non-laboratory providers with a CLIA waiver, information on how to add this will come as soon as possible.
MyCare Prior Authorization

Starting in June 2017, MyCare plans will begin processing prior authorization requests for ACT and IHBT. MyCare plans will begin processing prior authorization requests for all other BH services (per state defined limits) in July, 2017.

MyCare plans will follow established procedures for prior authorization of BH services.

However, prior authorization requests must be expedited in 3 days for the following services:

- ACT
- IHBT
- SUD Residential

Reminder: Providers can request expedited prior authorization for any service.
BH Redesign Benefit Package: Mental Health
BH Redesign Changes Support the Treatment of Mental Illness

<table>
<thead>
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<tr>
<td>✓ Expanding MH Benefit package</td>
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<tr>
<td>✓ Adding family psychotherapy both with and without the patient</td>
</tr>
<tr>
<td>✓ Adding primary care services, labs &amp; vaccines</td>
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<tr>
<td>✓ Adding coverage for psychotherapy, psychological testing</td>
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<td>✓ Adding evidence based/state best practices:</td>
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<tr>
<td>▪ Assertive Community Treatment (ACT) - adults with SPMI</td>
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<td>▪ Intensive Home-Based Treatment (IHBT) - youth at risk of out of home placement</td>
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<tr>
<td>✓ Expanding community based rehabilitation: Therapeutic Behavioral Services (TBS) &amp; Psychosocial Rehabilitation (PSR) &amp; maintaining coverage of Community Psychiatric Supportive Treatment (CPST)</td>
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<td>✓ Maintaining prior authorization exemption for second generation antipsychotic medications when dispensed by physicians with a psychiatric specialty and in the standard tablet/capsule formulation</td>
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<td>Medicaid Mental Health Benefit – Pre July 1, 2017</td>
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<td><strong>Psychiatric Diagnostic Evaluation w/ Medical</strong></td>
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<td>Assessing treatment needs &amp; developing a plan for care</td>
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<tr>
<td><strong>Mental health Assessment</strong></td>
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<tr>
<td>Assessing treatment needs &amp; developing a plan for care</td>
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<tr>
<td><strong>Pharmacological Management</strong></td>
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<tr>
<td>Services provided by medical staff, directly related to MH conditions and symptoms</td>
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<td><strong>Partial Hospitalization</strong></td>
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<tr>
<td>Teaching skills and providing supports to maintain community based care</td>
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<td><strong>Crisis Intervention</strong></td>
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<td>Services for people in crisis</td>
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<tr>
<td><strong>Community Psychiatric Supportive Treatment (CPST)</strong></td>
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<td>Care Coordination</td>
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<td><strong>Mental health counseling</strong></td>
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<td>Individual and group counseling may be provided by all credentialed practitioners</td>
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<td><strong>Respite for Children and their Families</strong></td>
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<td>Providing short term relief to caregivers</td>
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<td><strong>Office Administered Medications</strong></td>
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<td>Long Acting Psychotropics</td>
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## Medicaid Mental Health Benefit – July 1, 2017

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<td>Provided by paraprofessionals with Master’s, Bachelor’s or 3 years experience</td>
<td>Individual, group, family and crisis</td>
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<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>Assessing treatment needs &amp; developing a plan for care</td>
<td>Assessing treatment needs for MH patients</td>
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<td>Medical (Office/Home, E&amp;M, Nursing)</td>
<td>Medical practitioner services provided to MH patients</td>
<td>Medical practitioner services provided to MH patients</td>
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<td>Assertive Community Treatment (ACT)</td>
<td>Comprehensive team based care for adults with SPMI</td>
<td>Helping SED youth remain in their homes and the community</td>
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<tr>
<td>Intensive Home-Based Treatment (IHBT)</td>
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<tr>
<td>Group Day Treatment</td>
<td>Teaching skills and providing supports to maintain community based care</td>
<td>Teaching skills and providing supports to maintain community based care</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>Covered under crisis psychotherapy and other HCPCS codes</td>
<td>Covered under crisis psychotherapy and other HCPCS codes</td>
</tr>
<tr>
<td>Community Psychiatric Supportive Treatment (CPST)</td>
<td>Care Coordination</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>Screening and brief interventions for substance use disorder(s)</td>
<td>Screening and brief interventions for substance use disorder(s)</td>
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<tr>
<td>Therapeutic Behavioral Service (TBS)</td>
<td>Provided by paraprofessionals with less than Bachelor’s or less than 3 years experience</td>
<td>Provided by paraprofessionals with less than Bachelor’s or less than 3 years experience</td>
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<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
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<tr>
<td>Respite for Children and their Families</td>
<td>Providing short term relief to caregivers</td>
<td>Providing short term relief to caregivers</td>
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<tr>
<td>Office Administered Medications</td>
<td>Long Acting Psychotropics</td>
<td>Long Acting Psychotropics</td>
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<tr>
<td>Psychological Testing</td>
<td>Neurobehavioral, developmental, and psychological</td>
<td>Neurobehavioral, developmental, and psychological</td>
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### Medical Service CPT Codes

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<th>Code Range</th>
<th>Description</th>
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<tr>
<td>99201-99205</td>
<td>Evaluation and Management, Office, New Patients</td>
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<tr>
<td>99211-99215</td>
<td>Evaluation and Management, Office, Established Patients</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Evaluation and Management, Home, New Patients</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Evaluation and Management, Home, Established Patients</td>
</tr>
<tr>
<td>+99354</td>
<td>Prolonged service-first hour</td>
</tr>
<tr>
<td>+99355</td>
<td>Prolonged Service-each add. 30 mins</td>
</tr>
<tr>
<td>+90833</td>
<td>Psychotherapy add on, 30 min</td>
</tr>
<tr>
<td>+90836</td>
<td>Psychotherapy add on, 45 min</td>
</tr>
<tr>
<td>+90838</td>
<td>Psychotherapy add on, 60 mins</td>
</tr>
<tr>
<td>+90785</td>
<td>Interactive Complexity</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic Injection</td>
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All codes are subject to NCCI edits
MH Group Day Treatment - Hourly

Rate Development and Methodology

- H2012: 85% of the bachelor’s rate for QMHS+3 → $15.76 Hourly Per Person
- H2012: Assumes 1 hour of unlicensed BA providing group activities in an average group size of four for rate setting purposes → $18.54 Hourly Per Person
- H2012: Assumes 1 hour of unlicensed MA providing group activities in an average group size of four for rate setting purposes → $21.05 Hourly Per Person
- H2012: Assumes 1 hour of licensed practitioner providing group activities in an average group size of four for rate setting purposes → $28.10 Hourly Per Person

MH Group Day Treatment: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio
   a. For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the unit (30+ minutes). Service is billed in whole units only.
   b. If person doesn’t meet the minimum, 90853 or H2019 (HQ: Modifier for group) may be used.
2. Other services must be billed in addition to H2012. H2012 can only be billed if the person attends the minimum amount of time (30+ minutes) in a group which doesn’t exceed the practitioner to client ratio.
### MH Group Day Treatment - Per Diem

#### Rate Development and Methodology

<table>
<thead>
<tr>
<th>Rate</th>
<th>Description</th>
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<tr>
<td>$88.87</td>
<td>H2020 - 85% of the bachelor’s rate for QMHS+3</td>
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<tr>
<td>$104.55</td>
<td>H2020 - Assumes 5 hours of unlicensed BA providing group activities in an average group size of four for rate setting purposes</td>
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<tr>
<td>$117.05</td>
<td>H2020 - Assumes 5 hours of unlicensed MA providing group activities in an average group size of four for rate setting purposes</td>
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<tr>
<td>$140.51</td>
<td>H2020 - Assumes 5 hours of licensed practitioners providing group activities in an average group size of four for rate setting purposes</td>
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#### MH Group Day Treatment: Additional Details

1. **Maximum group size: 1:12 Practitioner to client ratio**
   - For MH Group Day Treatment, only used if the person attends for the minimum needed to bill the per diem (2.5+ hours).
   - If person doesn’t meet the minimum, 90853, H2019 HQ, or H2012 may be used.
   - Service is billed in whole unit only.
   - Other services must be billed in addition to H2020. H2020 can only be billed if the person attends the minimum amount of time in a group (2.5+ hours) which doesn’t exceed the practitioner to client ratio.

2. **Only one H2020 per diem, per patient, per day**

3. **Must be nationally accredited**

4. **Must be supervised by a licensed independent practitioner**
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/MITSBITS/bh-mits-bits-respite-service-and-policy-change.pdf
Policy Reminder

Children’s BH Services

No diagnosis edits for children services provided by licensed practitioners

Intensive Home-Based Treatment (IHBT)
- OhioMHAS certification
- Fidelity Review by CWRU meeting Medicaid requirements
- Prior Authorization

Additional Services
- Psychological Testing
- Vaccinations via VFC program
H2017 and H2019: Different Uses
Mental Health Services-Therapeutic Behavioral Services (TBS) and Psychosocial Rehabilitation (PSR)

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

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

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

<table>
<thead>
<tr>
<th>Therapeutic Behavioral Services</th>
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<tr>
<td>H2019 HN – TBS, office (Bachelor’s)</td>
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<tr>
<td>H2019 HO – TBS, office (Master’s)</td>
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<tr>
<td>H2019 UK – TBS, office (QMHS: high school and 3 years+ experience)</td>
</tr>
<tr>
<td>H2019 HN HQ – TBS, office, group (Bachelor’s)</td>
</tr>
<tr>
<td>H2019 HO HQ – TBS, office, group (Master’s)</td>
</tr>
<tr>
<td>H2019 UK HQ – TBS, office, group (QMHS: high school and 3 years+ experience)</td>
</tr>
<tr>
<td>H2019 HN – TBS, home or community, (Bachelor’s)</td>
</tr>
<tr>
<td>H2019 HO – TBS, home or community (Master’s)</td>
</tr>
<tr>
<td>H2019 UK – TBS, home or community (QMHS: high school and 3 years+ experience)</td>
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<tr>
<th>Psychosocial Rehabilitation</th>
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</thead>
<tbody>
<tr>
<td>H2017 HM – PSR, office, (less than a Bachelor’s/less than 3 years experience)</td>
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<tr>
<td>H2017 HM – PSR, home or community (less than a Bachelor’s/less than 3 years experience)</td>
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# MH TBS or PSR Services Provided to Patients in Crisis

## Guidance for Providing TBS or PSR to Patients in Crisis

Unlicensed practitioners may only provide and bill Medicaid for TBS or PSR provided to a patient in a crisis only if the recipient of the intervention(s):

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

## MH TBS or PSR Crisis Billing for Unlicensed Practitioners

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<thead>
<tr>
<th>Year</th>
<th>Qualification</th>
<th>Location</th>
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<tr>
<td>H2017</td>
<td>Less than Bachelor’s, Home/Cmty</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td>H2017</td>
<td>Less than Bachelor’s, Office</td>
<td>Office</td>
</tr>
<tr>
<td>H2019</td>
<td>Master’s, Home/Cmty</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td>H2019</td>
<td>Bachelor’s, Home/Cmty</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td>H2019</td>
<td>QMHS+3, Home/Cmty</td>
<td>Home/Cmty</td>
</tr>
<tr>
<td>H2019</td>
<td>Master’s, Office</td>
<td>Office</td>
</tr>
<tr>
<td>H2019</td>
<td>Bachelor’s, Office</td>
<td>Office</td>
</tr>
<tr>
<td>H2019</td>
<td>QMHS+3, Office</td>
<td>Office</td>
</tr>
</tbody>
</table>

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

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

Guidance for Registered Nurses Providing Crisis Services

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

MH Registered Nurse Providing Nursing Services to a Patient in a Crisis Billing Guidance

H2019

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

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

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

HCPCS Codes for Nursing Activities

Registered Nurse

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

Licensed Practical Nurse

H2017 - Home/Community, per 15 minutes
H2017 - Office, per 15 minutes
Nursing Scope of Practice – RNs and LPNs
Ohio Medicaid follows the guidance of the Ohio Board of Nursing regarding the Scopes of Practice for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).

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

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

**What services can a nurse perform?**

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

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

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

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

**CPT/HCPCS Codes for Nursing Activities**

<table>
<thead>
<tr>
<th>SUD</th>
<th>SUD &amp; MH</th>
<th>MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1002</td>
<td>99211</td>
<td>H2019</td>
</tr>
<tr>
<td>T1003</td>
<td>96372</td>
<td>H2017</td>
</tr>
<tr>
<td>H0014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0048</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Takeaways

1. Registered Nurses and Licensed Practical Nurses will need to enroll with Ohio Medicaid because they will be expected to be a rendering provider.

2. When not billing with 99211, please be sure to select the correct code.

All codes are subject to NCCI edits.
Recent Update: TBS/PSR Reimbursement

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

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

All other places of services will be paid at 100% after 90 minutes.

Refer to slide 18 – Policy Update #12
Crisis Services
Psychotherapy for Crisis Situations*

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

90839

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

+90840

All codes are subject to NCCI edits

Psychotherapy for Crisis Services Defined*

Psychotherapy for Crisis Services Definition

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

Psychotherapy for Crisis Services*

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

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

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

Psychotherapy for Crisis Services*

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

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

**MH and SUD Crisis Services by Licensed Practitioners**

Guidance for Licensed Practitioners Providing Crisis Services

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

If a licensed practitioner is providing the intervention, 90839 is billed. +90840 can be billed for each additional 30 minutes.

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

* Review supervision requirements for billing guidance

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

Guidance for Unlicensed Practitioner Providing Crisis Services

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

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

SUD Crisis Billing for Unlicensed Practitioners

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

MH Crisis Billing for Unlicensed Practitioners

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

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

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

Guidance for Registered Nurses Providing Crisis Services

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

Mental Health

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Location</th>
<th>Per 15 minutes:</th>
<th>Per 15 minutes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019 UT</td>
<td>UT modifier will be used to differentiate a crisis service vs. a non-crisis service</td>
<td>Home/Cmty</td>
<td>Home/Cmty</td>
<td>Office</td>
</tr>
</tbody>
</table>

Substance Use Disorder

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Location</th>
<th>Per 15 minutes:</th>
<th>Per 15 minutes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1002 UT</td>
<td>UT modifier will be used to differentiate a crisis service vs. a non-crisis service</td>
<td>Home/Cmty</td>
<td>Home/Cmty</td>
<td>Office</td>
</tr>
</tbody>
</table>

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

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
ASAM Levels of Care

REFLECTING A CONTINUUM OF CARE

Outpatient Services

Early Intervention

Intensive Outpatient/Partial Hospitalization Services

Partial Hospitalization Services

Intensive Outpatient Services

Residential/Inpatient Services

Clinically Managed Low-Intensity Residential Services

Clinically Managed Population-Specific High-Intensity Residential Services

Clinically Managed High-Intensity Residential Services

Medically Managed Intensive Inpatient Services

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

The green arrow represents the scope of Ohio’s Medicaid BH Redesign.
### Medicaid Substance Use Disorder Benefit – July 1, 2017

<table>
<thead>
<tr>
<th>Residential</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Per Diems supporting all six residential levels of care including:</td>
<td>• Level 1 Withdrawal Management (billed as a combination of medical services)</td>
</tr>
<tr>
<td>• clinically managed through medically monitored</td>
<td>• case management</td>
</tr>
<tr>
<td>• two residential levels of care for withdrawal management</td>
<td>• Medicaid is federally prohibited from covering room and board/housing</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Level 2 Withdrawal Management (billed as a combination of medical services)</td>
</tr>
<tr>
<td>• Buprenorphine and Methadone Administration</td>
<td>• Buprenorphine and Methadone Administration</td>
</tr>
<tr>
<td>• Peer Recovery Support</td>
<td>• Peer Recovery Support</td>
</tr>
<tr>
<td>• Case Management</td>
<td>• Case Management</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Intensive Outpatient</th>
<th>Intensive Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents: 6 to 19.9 hrs/wk</td>
<td>Adolescents: 6 to 19.9 hrs/wk</td>
</tr>
<tr>
<td>Adults: 9 to 19.9 hrs/wk</td>
<td>Adults: 9 to 19.9 hrs/wk</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Assessment</td>
</tr>
<tr>
<td>• Psychiatric Diagnostic Evaluation</td>
<td>• Psychiatric Diagnostic Evaluation</td>
</tr>
<tr>
<td>• Counseling and Therapy</td>
<td>• Counseling and Therapy</td>
</tr>
<tr>
<td>• Psychotherapy – Individual, Group, Family, and Crisis</td>
<td>• Psychotherapy – Individual, Group, Family, and Crisis</td>
</tr>
<tr>
<td>• Group and Individual (Non-Licensed)</td>
<td>• Group and Individual (Non-Licensed)</td>
</tr>
<tr>
<td>• Medical</td>
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</tr>
<tr>
<td>• Medications</td>
<td>• Medications</td>
</tr>
<tr>
<td>• Buprenorphine and Methadone Administration</td>
<td>• Buprenorphine and Methadone Administration</td>
</tr>
<tr>
<td>• Urine Drug Screening</td>
<td>• Urine Drug Screening</td>
</tr>
<tr>
<td>• Peer Recovery Support</td>
<td>• Peer Recovery Support</td>
</tr>
<tr>
<td>• Case Management</td>
<td>• Case Management</td>
</tr>
<tr>
<td>• Level 1 Withdrawal Management (billed as a combination of medical services)</td>
<td>• Level 2 Withdrawal Management (billed as a combination of medical services)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents: Less than 6 hrs/wk</td>
<td>Adolescents: Less than 6 hrs/wk</td>
</tr>
<tr>
<td>Adults: Less than 9 hrs/wk</td>
<td>Adults: Less than 9 hrs/wk</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Assessment</td>
</tr>
<tr>
<td>• Psychiatric Diagnostic Evaluation</td>
<td>• Psychiatric Diagnostic Evaluation</td>
</tr>
<tr>
<td>• Counseling and Therapy</td>
<td>• Counseling and Therapy</td>
</tr>
<tr>
<td>• Psychotherapy – Individual, Group, Family, and Crisis</td>
<td>• Psychotherapy – Individual, Group, Family, and Crisis</td>
</tr>
<tr>
<td>• Group and Individual (Non-Licensed)</td>
<td>• Group and Individual (Non-Licensed)</td>
</tr>
<tr>
<td>• Medical</td>
<td>• Medical</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Medications</td>
</tr>
<tr>
<td>• Buprenorphine and Methadone Administration</td>
<td>• Buprenorphine and Methadone Administration</td>
</tr>
<tr>
<td>• Urine Drug Screening</td>
<td>• Urine Drug Screening</td>
</tr>
<tr>
<td>• Peer Recovery Support</td>
<td>• Peer Recovery Support</td>
</tr>
<tr>
<td>• Case Management</td>
<td>• Case Management</td>
</tr>
<tr>
<td>• Level 1 Withdrawal Management (billed as a combination of medical services)</td>
<td>• Level 2 Withdrawal Management (billed as a combination of medical services)</td>
</tr>
</tbody>
</table>
# SUD Outpatient: Medical Services

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

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

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

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

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

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

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

Group leader = Doug, LICDC

9 am
Group topic 1

10 am
Group topic 2

11 am
Group topic 3

12 pm

Patient

H0005 HK 12 units

A + B = H0005 HK 8 units

90853 1 encounter/unit
(45 minutes)
Example: ASAM 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  OR  H0005  12 units

H0005 HK  12 units  OR  H0005  12 units

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

H0005 HK  8 units  OR  H0005  8 units

90853  1 unit (encounter)
(45 minutes)
ASAM Outpatient Level of Care 2
Intensive Outpatient and Partial Hospitalization
SUD IOP Level of Care Example – 16 Hours

Scenario (patient-specific weekly IOP schedule)

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

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

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate Per Diem Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>$103.04</td>
</tr>
<tr>
<td>H0015 HK</td>
<td>$149.88</td>
</tr>
</tbody>
</table>

SUD Intensive Outpatient Group Counseling: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio.
2. Used at ASAM Level 2.1
   a. For IOP, only used if the person attends for the minimum needed to bill the per diem (2+ hours)
   b. If person doesn’t meet the minimum 2+ hours, H0005 or 90853 may be used.
   c. Service is billed in whole unit only.
3. Other services must be billed in addition to H0015. H0015 can only be billed if the person attends the minimum amount of time (2+ hours) in a group which doesn’t exceed the practitioner to client ratio.
4. Must be led by licensed practitioner to bill with HK modifier
5. **Only one H0015 per diem, per patient, per day.**
Example: ASAM Outpatient Level of Care 2.1 IOP
SUD Group Counseling

Group leader

* = Doug, LICDC

Patients

9 am 10 am 11 am 12 pm

Group topic 1

Group topic 2

Group topic 3

H0015 HK 1 unit

H0015 HK 1 unit

A + B = H0015 HK 1 unit

A

B

H0015 HK 1 unit

H0015 HK 1 unit

H0015 HK 1 unit

90853 1 unit (encounter)

(45 minutes)
Example: ASAM Outpatient Level of Care 2.1 IOP SUD Group Counseling CO-FACILITATION

**Group leaders**

- Doug, LICDC
- Sysilie, CDCA

**Patients**

- [Image of patient icons]

**Schedule**

- 9 am: Group topic 1
- 10 am: Group topic 2
- 11 am: Group topic 3

**Codes**

- 90853: 1 unit (encounter) (45 minutes)
- H0015: 1 unit (encounter)

A + B = H0015 HK 1 unit or H0015 1 unit
SUD Partial Hospitalization Level of Care: Group Counseling - Billing

SUD Partial Hospitalization: Additional Details

1. Maximum group size: 1:12 practitioner to client ratio
2. Only used at ASAM Level 2.5
   a. For PH, only used if the person attends for the minimum needed to bill the per diem (3+ hours)
   b. If person doesn’t meet the minimum 3+ hours, H0015 (without TG, 2+ hours), H0005 or 90853 may be used.
   c. Service is billed in whole unit only.
3. Other services must be billed in addition to H0015 TG. H0015 TG can only be billed if the person attends the minimum amount of time (3+ hours) in a group which doesn’t exceed the practitioner to client ratio.
4. Must be led by licensed practitioner to bill with HK modifier
5. Only one H0015 per diem, per patient, per day.
Example: ASAM Outpatient Level of Care 2.5 PH SUD Group Counseling

Group leader

Doug, LICDC

Patients

Group topic 1

9 am

Group topic 2

10 am

Group topic 3

11 am

12 pm

H0015 HK TG  1 unit

H0015 HK TG  1 unit

A + B = H0015 HK  1 unit

A

B

H0015 HK  1 unit

H0015 HK  1 unit

H0015 HK  1 unit

90853  1 unit (encounter)

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

Group leaders

| Group leaders | Doug, LICDC | Sysilie, CDCA |

Patients

- H0015 HK TG 1 unit OR H0015 TG 1 unit
- A + B = H0015 HK 1 unit
- A + B = H0015 1 unit
- H0015 HK 1 unit OR H0015 1 unit
- H0015 HK 1 unit OR H0015 1 unit

90853 1 unit (encounter) (45 minutes)
Staffing for ASAM Residential Levels of Care
Staffing for American Society of Addiction Medicine (ASAM) Residential Levels of Care

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

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

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

Administration of medications by site based staff is covered within the SUD per diem residential rate, but the cost of the medication itself may be billed in addition to the per diem. If medication is administered by an agency other than the residential treatment agency, both administration and medication rates may be billed to Ohio Medicaid.
Benefit Administration Timeline, Policies, and Program Integrity
Updated Timeline: 2017 – 2019

- Plans will follow state benefit administration policies for one year.
- MCP year is administered on a calendar year basis (Jan-Dec). Note: 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.

Refer to slide 15 – Policy Update #9
Surveillance, Utilization and Review (SUR)  
A Mandated Responsibility of Administering Medicaid

Federal law (CFR 42.456.25) requires state Medicaid programs to perform post-payment review of Medicaid claims - including recipient and provider profiles - to identify and fix any incorrect practices.

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

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

Additional resources at bh.medicaid.ohio.gov
Services Which are
- ALWAYS Prior Authorized -
ALWAYS Prior Authorized:
Assertive Community Treatment (ACT)

**DESCRIPTION**
Assertive Community Treatment (ACT)

**CODE**
H0040

**Prior Authorization Requirement**
ACT must be prior authorized per person and all SUD services (except for medications) must be prior authorized for ACT enrollees.

All codes are subject to NCCI edits.
ALWAYS Prior Authorized: 
**Intensive Home-Based Treatment (IHBT)**

**DESCRIPTION**
Intensive Home-Based Treatment (IHBT)

**CODE**
H2015

Prior Authorization Requirement

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

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

**DESCRIPTION**

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

**CODES**

Combination of CPT and HCPCS codes

Prior Authorization Requirement

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

All codes are subject to NCCI edits
Services With Prior Authorization
- Per Billing Provider -
**Prior Authorization:**

*Psychiatric Diagnostic Evaluation*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>90791 – with out medical 90792 – with medical</td>
</tr>
</tbody>
</table>

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

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

**DESCRIPTION**

Screening Brief Intervention and Referral to Treatment (SBIRT)

**CODES**

- G0396 – 15 to 30 minutes
- G0397 – greater than 30 minutes

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

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

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

**Prior Authorization Requirement**

- Alcohol and/or Drug Assessment by an unlicensed practitioner

**DESCRIPTION**

- Alcoholic and/or Drug Assessment by an unlicensed practitioner

**CODE**

- H0001

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

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

**DESCRIPTION**

Psychological Testing

**CODES**

- 96101 – psychological testing by a psychologist/physician
- 96111 – developmental testing, extended
- 96116 – neurobehavioral status exam
- 96118 – neuropsychological testing by psychologist/physician

**Prior Authorization Requirement**

Up to 12 hours/encounters per calendar year *per Medicaid enrollee* for 96101, 96111, and 96116.

Up to 8 hours per calendar year *per Medicaid enrollee* for 96118.

Prior authorization may be requested to exceed the annual limits.

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

**DESCRIPTION**

SUD Residential

**CODES**

H2034  
H2036

---

**Prior Authorization Requirement**

*Up to 30 consecutive days without prior authorization *per Medicaid enrollee.*

*Prior authorization then must support the medical necessity of continued stay; if not, only the initial 30 consecutive days are reimbursed.*

*Applies to first two stays; any stays after that would be subject to prior authorization.*

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

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN/LPN Nursing Services (MH)</td>
<td>H2019 (RN)</td>
</tr>
<tr>
<td></td>
<td>H2017 (LPN)</td>
</tr>
<tr>
<td>RN/LPN Nursing Services (SUD)</td>
<td>T1002 (RN)</td>
</tr>
<tr>
<td></td>
<td>T1003 (LPN)</td>
</tr>
</tbody>
</table>

*All codes are subject to NCCI edits*

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

Therapeutic Behavioral Services

H2019

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

DESCRIPTION

Psychosocial Rehabilitation

CODE

H2017

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

**DESCRIPTION**
Community Psychiatric Support Treatment

**CODE**
H0036

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

### Individual Psychotherapy
- **DESCRIPTION**: Services will accrue to ASAM outpatient, IOP, and PH levels of care.
- **CODES**: 90832, 90834, 90837

### Group Psychotherapy
- **DESCRIPTION**: 
- **CODE**: 90853

### Family Psychotherapy
- **DESCRIPTION**: 
- **CODES**: 90846, 90847, 90849

*All codes are subject to NCCI edits*
**No Benefit Limit: *E&M (Medical) Visits***

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

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

*All codes are subject to NCCI edits*
### Residential SUD Treatment Programs

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

### Outpatient SUD Treatment Programs

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

*Note: Per diems cover all services provided by medical and clinical staff. When RN/LPN hourly or 15 minute services are provided, services provided by other medical staff are billed using evaluation and management coding. Services provided by clinical staff are billed accordingly. Level 1 RN/LPN services will be subject to prior authorization after 24 hours.*

All codes are subject to NCCI edits.
No Benefit Limit: **Group MH Day Treatment**

**DESCRIPTION**

Group MH Day Treatment (Adult and Youth)

**CODES**

H2012/HQ – Hourly  
H2020 – Per Diem

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

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

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

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

All codes are subject to NCCI edits.
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></td>
</tr>
<tr>
<td>Licensed School Psychologists</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></td>
</tr>
<tr>
<td>Licensed School Psychologists</td>
<td></td>
</tr>
<tr>
<td>A CBHC employing or contracting with any of these rendering providers <strong>may</strong> submit the claim directly to Medicaid.</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).

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.

Dates of Service
July 1, 2017
Third Party Liability

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, [www.bh.Medicaid.ohio.gov/manuals](http://www.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.
Supervision Requirements
## Supervision Types

<table>
<thead>
<tr>
<th>Types of Supervision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General supervision:</strong> Supervising practitioner must be available by telephone to provide assistance and direction if needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Direct supervision:</strong> Supervising practitioner must be “immediately available” and “interruptible” to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.</td>
<td></td>
</tr>
</tbody>
</table>
## Minimum Supervision Requirements for CPT

<table>
<thead>
<tr>
<th>Practitioner Providing the Service:</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed professional counselor</td>
<td>General</td>
</tr>
<tr>
<td>Licensed chemical dependency counselor II or III</td>
<td>General</td>
</tr>
<tr>
<td>Licensed social worker</td>
<td>General</td>
</tr>
<tr>
<td>Licensed marriage and family therapist</td>
<td>General</td>
</tr>
<tr>
<td>Psychology assistant, intern, trainee</td>
<td>General</td>
</tr>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>General</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>General</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>General</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>General</td>
</tr>
</tbody>
</table>
## Optional Direct Supervision

### Guidance

- Trainees or assistants registered/credentialed with a professional board in the state of Ohio are authorized to practice under Direct or General clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions.

- This includes:
  - Psychology assistants, interns, trainees;
  - Chemical dependency counselor assistants;
  - Counselor trainees;
  - Social worker trainees;
  - Marriage and family therapist trainees.
## Example: CPT Codes

### General Supervision:
A social worker trainee (SW-T) conducts a psychotherapy session with a patient with their supervising practitioner (LISW) available by phone. The claim would be submitted with the U9 modifier (representing the SW-T credential). **The rendering field MUST BE blank and the billing field will contain the agency NPI.** MITS will adjudicate the claim using the SW-T rate (85% of their supervisor’s rate).

### Direct Supervision:
A SW-T conducts a psychotherapy session with a patient, and their supervisor (LISW) is immediately available and interruptible if the social worker trainee needs direction while providing this session. The claim would be submitted with the U9 modifier (representing the SW-T credential) with the supervisor’s NPI in the supervisor field. **The rendering field MUST BE blank and the billing field will contain the agency NPI.** The supervisor takes the responsibility for the service. MITS will adjudicate the claim using the LISW rate.
## Minimum Supervision Requirements for HCPCS

<table>
<thead>
<tr>
<th>Practitioner Providing the Service:</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology assistant, intern, trainee</td>
<td>General</td>
</tr>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>General</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>General</td>
</tr>
<tr>
<td>Social worker assistant</td>
<td>General</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>General</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>General</td>
</tr>
<tr>
<td>Qualified Mental Health Specialist</td>
<td>General</td>
</tr>
<tr>
<td>Care Management Specialist</td>
<td>General</td>
</tr>
<tr>
<td>Peer Recovery Supporters</td>
<td>General</td>
</tr>
</tbody>
</table>
Example: HCPCS Codes

**General Supervision:** A SW-T provides Psychosocial Rehabilitation to a patient in their home with their supervising practitioner available by phone. The claim would be submitted with the U9 modifier (representing the SW-T credential). *The rendering field MUST BE blank and the billing field will contain the agency NPI.* MITS will adjudicate the claim using the SW-T rate.
Reporting Supervisor
General Supervision

Listing Supervisor on Claims

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

### Practitioners for CPT/HCPCS:

- Licensed professional counselor
- Licensed chemical dependency counselor II or III
- Licensed social worker
- Licensed marriage and family therapist
- Psychology assistant, intern, trainee
- Chemical dependency counselor assistant
- Counselor trainee
- Social worker assistant
- Social worker trainee
- Marriage and family therapist trainee
- Qualified mental health specialist
- Care management specialist
- Peer recovery supporters

**Note:** Appropriate supervision must be provided and documented in the medical record.
Guidance on How to Report Supervisor NPI

ODM Guidance at this Point in Time:

• Report supervising practitioner at the header level only: Loop 2310D
• Do not report supervisor at the detail level: Loop 2420D
• Report only one supervisor per claim at the header. Any detail lines under this header must have been directly supervised by this supervisor.
• On this claim only report services that are directly supervised by this supervisor.
Billing Example: Correct Reporting of Supervisor

- Supervisor reported at header applies to all detail lines
- Claim will pay based on the supervisor’s rate

### Header Level

<table>
<thead>
<tr>
<th>Supervisor</th>
<th>Rendering</th>
<th>Billing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor NPI</td>
<td>-</td>
<td>Agency NPI</td>
</tr>
</tbody>
</table>

### Detail Level

<table>
<thead>
<tr>
<th>Line #:</th>
<th>DOS</th>
<th>Code</th>
<th>Units</th>
<th>Modifiers</th>
<th>Rendering</th>
<th>Supv</th>
<th>Ordering</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-2-17</td>
<td>90839</td>
<td>1</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>7-2-17</td>
<td>90840</td>
<td>2</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>3</td>
<td>7-10-17</td>
<td>90839</td>
<td>1</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Billing Example: Incorrect Reporting of Supervisor

- Supervisor reported at the header applies to all detail lines
- Services that are not performed under supervision should not be reported on the same claim – the claim may adjudicate incorrectly

<table>
<thead>
<tr>
<th>Line #</th>
<th>DOS</th>
<th>Code</th>
<th>Units</th>
<th>Modifiers</th>
<th>Rendering</th>
<th>Supv</th>
<th>Ordering</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-2-17</td>
<td>90839</td>
<td>1</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>7-2-17</td>
<td>90840</td>
<td>2</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>7-10-17</td>
<td>90839</td>
<td>1</td>
<td>U9</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>7-11-17</td>
<td>90839</td>
<td>1</td>
<td>-</td>
<td>LISW NPI</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>7-12-17</td>
<td>90839</td>
<td>1</td>
<td>-</td>
<td>RN NPI</td>
<td>-</td>
<td>Ordering NPI</td>
</tr>
</tbody>
</table>
Practitioner Enrollment and Affiliation
### Medicaid Covered Behavioral Health Practitioners *

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

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

<table>
<thead>
<tr>
<th>Rendering Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Certified Nurse Practitioners</td>
</tr>
<tr>
<td>Clinical Nurse Specialists</td>
</tr>
<tr>
<td>Physician Assistants</td>
</tr>
<tr>
<td>Registered Nurses</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
</tr>
</tbody>
</table>

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

ADDITIONAL GUIDANCE

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

<table>
<thead>
<tr>
<th>Practitioner Providing the Service</th>
<th>Professional Abbreviation</th>
<th>Practitioner Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed professional counselor</td>
<td>LPC</td>
<td>U2</td>
</tr>
<tr>
<td>Licensed chemical dependency counselor III</td>
<td>LCDC III</td>
<td>U3</td>
</tr>
<tr>
<td>Licensed chemical dependency counselor II</td>
<td>LCDC II</td>
<td>U3</td>
</tr>
<tr>
<td>Licensed social worker</td>
<td>LSW</td>
<td>U4</td>
</tr>
<tr>
<td>Licensed marriage and family therapist</td>
<td>LMFT</td>
<td>U5</td>
</tr>
<tr>
<td>Psychology assistant, intern, trainee</td>
<td>PSY assistant</td>
<td>U1</td>
</tr>
<tr>
<td>Chemical dependency counselor assistant</td>
<td>CDC-A</td>
<td>U6</td>
</tr>
<tr>
<td>Counselor trainee</td>
<td>C-T</td>
<td>U7</td>
</tr>
<tr>
<td>Social worker assistant</td>
<td>SW-A</td>
<td>U8</td>
</tr>
<tr>
<td>Social worker trainee</td>
<td>SW-T</td>
<td>U9</td>
</tr>
<tr>
<td>Marriage and family therapist trainee</td>
<td>MFT-T</td>
<td>UA</td>
</tr>
<tr>
<td>QMHS – high school</td>
<td>QMHS</td>
<td>HM</td>
</tr>
<tr>
<td>QMHS – Associate’s</td>
<td>QMHS</td>
<td>HM</td>
</tr>
<tr>
<td>QMHS – Bachelor’s</td>
<td>QMHS</td>
<td>HN</td>
</tr>
<tr>
<td>QMHS – Master’s</td>
<td>QMHS</td>
<td>HO</td>
</tr>
<tr>
<td>QMHS – 3 years’ experience</td>
<td>QMHS</td>
<td>UK</td>
</tr>
<tr>
<td>Care management specialist – high school</td>
<td>CMS</td>
<td>HM</td>
</tr>
<tr>
<td>Care management specialist – Associate’s</td>
<td>CMS</td>
<td>HM</td>
</tr>
<tr>
<td>Care management specialist – Bachelor’s</td>
<td>CMS</td>
<td>HN</td>
</tr>
<tr>
<td>Care management specialist – Master’s</td>
<td>CMS</td>
<td>HO</td>
</tr>
<tr>
<td>Peer recovery supporter</td>
<td>PRS</td>
<td>HM</td>
</tr>
</tbody>
</table>
Provider Enrollment Applications and Revalidations

Status

- ODM staff has been working through any remaining backlog to prepare for July 1st

- As of May 15th: 175 agencies had no affiliated practitioners

- Remittance advice includes a message for all 84s and 95s

- 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

- Report of Affiliated Practitioners by agency is posted on the BH Redesign site at: http://bh.medicaid.ohio.gov/manuals

Medicaid Provider Enrollment Webinar can be found http://bh.medicaid.ohio.gov/training
## Provider Enrollment Applications and Revalidations

### Statistics

Enrollment status as of May 10th:

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>Enrollments</th>
<th>Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total enrolled as of 04/10/17</td>
<td>Total enrolled as of 4/26/2017</td>
</tr>
<tr>
<td>LISW (Type 37)</td>
<td>1,887</td>
<td>1,982</td>
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<tr>
<td>LPCC (Type 47)</td>
<td>1,973</td>
<td>2,108</td>
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<tr>
<td>LIMFT (Type 52)</td>
<td>44</td>
<td>51</td>
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<tr>
<td>LICDC (Type 54)</td>
<td>296</td>
<td>336</td>
</tr>
<tr>
<td>Nurses (Type 38)</td>
<td>897</td>
<td>915</td>
</tr>
<tr>
<td></td>
<td>5,097</td>
<td>5,392</td>
</tr>
</tbody>
</table>

* Provider enrollment concentrating efforts on getting RTP and Nurse applications processed
Resources on How to Enter a Prior Authorization
Resources on How to Enter a Prior Authorization

- To view the PA webinar, please go to http://medicaid.ohio.gov/PROVIDERS/Training/BasicBilling.aspx


Submit a Prior Authorization Request

Overview
In this topic, you learn how to submit a prior authorization (PA) request. You can submit three PA request types:

- Prior Auth
- Prior Auth—Hospital
- Pre-Cert—Hospital

Who
Providers and their designated agents can submit a prior authorization request.

When
Based on the type of prior authorization a patient needs, the answer from ODJFS could arrive the same day or take several days—depending on how complex the case is. Thus, it is important to submit the prior authorization request in time to receive an answer when needed for the patient’s condition.

Relevance
Submitting a prior authorization request directly in Ohio MITS can save time for you and the patient.

Guidelines
When you submit a prior authorization request, these guidelines can help:

- The choice you make in the Assignment Type field determines what is available in the Authorization Type drop-down list. Prior Auth, Prior Auth—Hospital, or Pre-Cert—Hospital.
- The amount you request to be paid for the procedure may or may not be granted by ODJFS.
- If a message displays stating you might not need a prior authorization, and you want to proceed, you must select the Ignore checkbox and then click Continue to go to the next panel.
May 23rd – Behavioral Health Prior Authorization Webinar

Information

- ODM is hosting a training webinar on May 23rd from 1-3 p.m. that will provide 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.

- Click on this link to register: https://register.gotowebinar.com/register/8342927488327893763

- After registering, you will receive a confirmation email containing information about joining the webinar.

Note: The webinar will be recorded. The recording and slide presentation will be posted to the BH.Medicaid.Ohio.Gov website.
National Correct Coding Initiative (NCCI)
# National Correct Coding Initiative

## Overview

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

## What Does This Mean For You?

- **NCCI policies are applied as edits (claims denials) to Medicaid health care claims**
- **Two types of edits:**
  - Procedure to procedure edits: Pairs of codes that may not be reported together when delivered by the same provider for the same recipient on the same date of service. Applied to current and historic claims.
  - Medically unlikely edits: These edits define the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same recipient on the same date of service.
Defines HCPCS and CPT codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Medicaid PTP (including those that can be overridden by specific modifiers), MUE edits and other relevant information can be found at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers.

Where services are “separate and distinct,” it may be necessary to override the procedure-to-procedure edit using a specific modifier. Documentation must support “separate and distinct” services.

Example 1: The same physician performs a psychotherapy service and E&M service on the same day to the same client (significant and separately identifiable services). NCCI will not allow the psychotherapy code 90834 to be billed with an E&M office visit code 99212, as there are separate add-on codes (+90833, +90836, and +90838) for psychotherapy services provided in conjunction with E&M services. This cannot be overridden with the modifier.
NCCI Medically Unlikely Edits (MUEs)

MUEs define, for each HCPCS / CPT code, the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

Medically Unlikely Edits will review anything that, from a medical standpoint, is unlikely to happen. MUEs cannot be overridden with the 59, XE, XS, XP, XU modifiers.

For more information:
August 2010 (Questions and Answers Section 6507 of the ACA, NCCI Methodologies)
September 1, 2010 (State Medicaid Director Letter [SMD] 10-017)
September 29, 2010 (CMS letter to The National Medicaid EDI Healthcare Workgroup)
April 22, 2011 (SMD 11-003)

Example 1: The same licensed independent social worker (LISW) performs two diagnostic evaluations (2 units of 90791) with the same client on the same day. NCCI will deny the second evaluation, as it is medically unlikely that one client would need two complete diagnostic evaluations in the same day.
Peer Recovery Support
Peer Recovery Support Service

### Mental Health Benefit

**Program**

- **Specialized Recovery Services**
- **ACT**

**Authorization**

- Authorized by Person Centered Care Plan
- Act service is prior authorized by Medicaid
- No more than 4 hours per day

**Billing**

- Only for individuals eligible for SRS
- H0038 - Individual
- H0038/HQ - Group

**Peer recovery supporter is a full member of the ACT team, a face to face contact can be used for a monthly “billing event”**

### Substance Use Disorder Benefit

**Program**

- SUD Outpatient
- SUD Residential

**Authorization**

- Discrete service as medically necessary
  - SUD residential service is prior authorized by Medicaid

**Billing**

- Peer recovery supporter is part of clinical team
  - H0038 - Individual
  - H0038/HQ - Group
  - Covered as part of the per diem

**Available to all residents when peer recovery supporter is part of clinical team**
Medicaid-Funded Assertive Community Treatment (ACT)
Behavioral Health Timeline: Assertive Community Treatment

- As of January 1, 2017, agencies employing ACT team(s) may begin requesting CWRU Fidelity Reviews for Medicaid enrollment.
- Once an agency ACT team has met minimum fidelity, they may be enrolled in Ohio Medicaid and begin submitting prior authorization requests for consumers in their ACT caseload.
- Agency begins using the Medicaid ACT billing model July 1, 2017.
### Why Initiate Medicaid Payment for ACT?

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

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

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

1. ACT team fidelity measurement will be based on DACTS until carve in to managed care.
   • Team Fidelity must be measured by CWRU Center for Evidence Based Practice under contract with ODM.
   • TMACT fidelity measurement encouraged post carve in.

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

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

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

3 Requirements for ACT Team Leaders:
   • Must be dedicated to only one team.
   • Must be licensed (preferably licensed independent with a supervisory endorsement)
   • Be enrolled in MITS as an active Medicaid provider

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

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

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

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0
## ACT Team Monthly Billing Example – Physician Prescriber

<table>
<thead>
<tr>
<th>DACTS (w/ 2 BAs): Code - H0040</th>
<th>Unit Rates</th>
<th>DACTS (w/ 1 BA, 1 PRS): Code - H0040</th>
<th>Unit Rates</th>
<th>DACTS (w/ 2 PRSs): Code - H0040</th>
<th>Unit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO</td>
<td>$615.64</td>
<td>MD/DO</td>
<td>$615.64</td>
<td>MD/DO</td>
<td>$615.64</td>
</tr>
<tr>
<td>Master’s/ RN/LPN</td>
<td>$251.91</td>
<td>Master’s/ RN/LPN</td>
<td>$251.91</td>
<td>Master’s/ RN/LPN</td>
<td>$251.91</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>$199.70</td>
<td>Bachelor’s</td>
<td>$199.70</td>
<td>Bachelor’s</td>
<td>$199.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Recovery Supporter</td>
<td></td>
<td>Peer Recovery Supporter</td>
<td></td>
</tr>
<tr>
<td>Total: $1,266.95</td>
<td></td>
<td>Total: $1,226.49</td>
<td></td>
<td>Total: $1,186.03</td>
<td></td>
</tr>
</tbody>
</table>

**ACT is a fully prior authorized service – ACT billable events must occur in person face-to-face for minimum of 15 minutes**
ACT Team Monthly Billing Example – APRN/PA Prescriber

<table>
<thead>
<tr>
<th>DACTS (w/ 2 BAs): Code - H0040</th>
<th>Unit Rates</th>
<th>Total: $1,004.06</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRN/PA</td>
<td>$352.75</td>
<td></td>
</tr>
<tr>
<td>Master’s/RN/LPN</td>
<td>$251.91</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>$199.70</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>$199.70</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DACTS (w/ 1 BA, 1 PRS): Code - H0040</th>
<th>Unit Rates</th>
<th>Total: $963.60</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRN/PA</td>
<td>$352.75</td>
<td></td>
</tr>
<tr>
<td>Master’s/RN/LPN</td>
<td>$251.91</td>
<td></td>
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<tr>
<td>Bachelor’s</td>
<td>$199.70</td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Supporter</td>
<td>$159.24</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DACTS (w/ 2 PRSs): Code - H0040</th>
<th>Unit Rates</th>
<th>Total: $923.14</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRN/PA</td>
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<tr>
<td>Master’s/RN/LPN</td>
<td>$251.91</td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Supporter</td>
<td>$159.24</td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Supporter</td>
<td>$159.24</td>
<td></td>
</tr>
</tbody>
</table>

ACT is a fully prior authorized service – ACT billable events must occur in person face-to-face for minimum of 15 minutes
A 57-year-old client, Mary, is receiving services from an ACT team. She has Schizophrenia with a long history of multiple inpatient hospitalizations due to chronic paranoia, hallucinations, disorganized and delusional thinking. She has been able to maintain community living since initiating services with the ACT team 2 months ago. However, she continues to have poor medication compliance with her recently prescribed Clozapine, poor hygiene skills and overall poor ADLs and IADLs. She receives multiple services throughout the month to help her maintain in independent living and to reduce periods of decompensation.

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

Scenario is for illustrative purposes only
# ACT Services/Billing Events: November 2016

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
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<tbody>
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<td>1</td>
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</tbody>
</table>

**Service Event**
- Peer Recovery Supporter Visit
- RN Visit
- Unlicensed BA Visit

**Billable Event**
- LPN Visit
- Psychiatrist Visit

ACT Services/Billing Events: November 2016

- Peer Recovery Supporter Visit
- RN Visit
- Unlicensed BA Visit
- LPN Visit
- Psychiatrist Visit
- Unlicensed BA Visit
ACT and Coordination of Benefits

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

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

- The Ohio Department of Medicaid has contracted with Case Western Reserve University to perform fidelity reviews for Medicaid.
- ACT Teams must achieve a minimum average score of 3 on the DACTS fidelity scale. Once an ACT Team has met minimum fidelity, they will be authorized to begin using the ACT billing model (see slides 132-133).
- Teams who fail to achieve a minimum fidelity score of 3 are not penalized.
  - These teams may seek technical assistance from Case Western under the OhioMHAS funded component of CWRU CEBP*
- ACT teams must renew and pass fidelity review every 12 months

*see next slide for further detail
ACT Technical Assistance

Technical Assistance Guidance

- Free technical assistance is available for provider agencies interested in or providing ACT (but not yet ready for Medicaid fidelity review) from CWRU via OhioMHAS financing
ACT Prior Authorization and Eligibility

- Medicaid recipients may only be enrolled with ACT teams after they have been prior authorized by the ODM designated PA entity.
- Prior Authorization requests must be submitted via MITS
- **Webinar tomorrow, May 23rd on submitting BH Prior Authorization Requests** –
  - Link: [https://attendee.gotowebinar.com/register/8342927488327893763](https://attendee.gotowebinar.com/register/8342927488327893763)

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

- Age 18 or over
- Diagnosis of schizophrenia spectrum, bipolar spectrum, or major depressive disorder with psychosis
- Functional limitation(s) measured by:
  - Adult Needs and Strengths Assessment (ANSA), or
  - SSI/SSDI determination
- One of the following risk factors:
  - At risk of psych inpatient psych hospitalization
  - One or more previous inpatient psych admissions
When a person is enrolled on an ACT team, no other Medicaid BH services will be paid

**Exceptions:**
- BH medications including physician administered medications and methadone/buprenorphine administration by OTPs
- recovery management through the SRS program
- SUD services that are prior authorized

**ACT enrollees may receive other non-BH Medicaid services like:**
- Inpatient and emergency room visits
- Physician services (e.g. OBGYN, cardiac, and other specialties)
- Prescription and over the counter (OTC) medications
ACT teams are expected to maintain contact with their enrollees if they are hospitalized

- ACT teams should assist with admission and discharge planning, However, these are not billable events while a hospital is being paid for Medicaid inpatient stay
- Depending on length of stay, the ACT team may want to consider the clinical appropriateness of maintaining the individual on case load until they are discharged

Note: Crisis services will be covered when provided by another agency for an ACT enrollee
Disenrollment from ACT

**Planned Disenrollment**

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

**Unplanned Disenrollment**

- ACT enrollees may lose touch with the team for some period of time
- It is recommended ACT teams disenroll the consumer after a month of no communication
- This will allow the consumer to receive BH services outside the ACT team
- The ACT team may pursue expedited re-enrollment once the consumer is found
TO DO

- All independently licensed members of ACT team (Prescriber, LISW, LPCC, LIMFT, LICDC, Psychologist, RN/LPN, Team Leader) must be enrolled in Ohio Medicaid and affiliated with the billing agency.

- Contact CWRU to schedule fidelity review.

- Team should have a member competent in conducting the ANSA.

- Team should be able to verify SSI/SSDI status.

- Agency must have an IT system that supports medical documentation plus clinical and billing nuances.

- Attend training on use of the MITS PA functionality and prepare to submit PA requests for potential ACT enrollees, including documentation of their eligibility for ACT.
Intensive Home-Based Treatment (IHBT)
IHBT Provider Requirements

1. Team must meet or exceed fidelity scores *(see slide 147 for IHBT Fidelity Rating Tool)*

2. Employing/contracting agency must be certified by OhioMHAS for the IHBT service

3. Team members must be licensed by either Psychology or Counselor, Social Worker & Marriage and family therapy board

IHBT Prior Authorization Requirements

1. IHBT is fully prior authorized from Day 1

2. Maximum amount authorized for a PA is 72 hours within a 6 month date span. More than 72 hours within the 6 month span will require additional PA request
IHBT Consumer Eligibility

1. Younger than 18 unless SED onset occurs before age 18; then 18-21 year olds may receive IHBT
   - At risk of out of home placement or
   - Returned within last 30 days from out of home or
   - Requiring highly intense MH intervention to remain safely at home

2. SED diagnosis

3. CANS functional scale

4. A family member or other responsible adult who authorizes and participates in IHBT

Note: Crisis services will be covered when provided by another agency for an IHBT enrollee
Fidelity Measures to qualify for the IHBT billing methodology were built on premises similar to ACT.
IHBT Billing Structure

Code - H2015  

Unit Rate (15 minute)  

Licensed clinician  
(modifier or NPI)  

$33.26  

Although services delivered via telephone or video conference are not prohibited, only face to face, in person services are billable
Care Coordination
These high-needs patients may benefit from intensive coordination led by BH provider with strong primary care capabilities.

These individuals have significant medical needs – coordination may be best driven by primary care provider.

These individuals could benefit from specialty BH care that partners closely with a primary care practice.
Accountability for Care Coordination

• Require health plans to delegate components of care coordination to qualified behavioral health centers ("Model 2" commitment)
• 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

Medicaid Managed Care Plan

Qualified Behavioral Health Center

Comprehensive Primary Care (CPC)

• 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
ODM and OhioMHAS Rules Update
ODM and OhioMHAS Rules Timeline

**2017**

**February**
- Updates shared with Benefit & Service Development Workgroup, February 15

**March**
- CSIO public comment, March 17 – March 31

**April**
- Original file submitted, April 14
- Updates shared with Benefit & Service Development Workgroup, April 19
  - Rule updates following stakeholder feedback, including review of 300+ comments

**May**
- Public hearings on Rules: ODM, May 15; OhioMHAS, May 17
  - JCARR hearing, May 30

**June**
- Final file date, June 21

**July**
- Rules take effect, July 1
Stakeholder Resources
Available Resources

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:
- Client Rights and Advocacy Resources (http://mha.ohio.gov/Default.aspx?tabid=270)

Local Resources:
- National Alliance on Mental Illness helpline: 1-800-686-2646
- Ohio Association of County Behavioral Health Authorities, Board Directory (http://www.oacbha.org/mappage.php)

MCP Resources:
- Medicaid Consumer hotline: 1-800-324-8680

SRS Resources:
For questions related to the Specialized Recovery Services program, please contact your RM agency:
- CareSource SRS Program Manager: Dawn Rist-Opal (Phone: 216-618-8124; Email: Dawn.RistOpal@CareSource.com)
- Council on Aging SRS Program Manager: Christy Nichols (Phone: 513-592-2779; Email: Cnichols@help4seniors.com)
- CareStar SRS Program Manager: Mary Farrell (Phone: 614-729-6319; Email: Mfarrel@CareStar.com)
Behavioral Health Redesign Work
Book Updates
What has changed with the BH Redesign Work Book?

<table>
<thead>
<tr>
<th>Description</th>
<th>Medical Behavioral Health (BH) Practitioners</th>
<th>Independent BH Professionals</th>
</tr>
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<tbody>
<tr>
<td>Procedure Code</td>
<td>Pros Dom Rate</td>
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<tr>
<td>Aligned Direct Supervision for CPT codes</td>
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<tr>
<td>Aligned General Supervision for CPT/HCPCS codes</td>
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<tr>
<td>Aligned H0012 to allow medical staff only as rendering</td>
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<tr>
<td>Removed SBIRT from CDCA tab</td>
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</table>

Version 9.0 of the BH Redesign Work Book is now available on the at [www.bh.medicaid.ohio.gov](http://www.bh.medicaid.ohio.gov)
Urine Drug Screening Recent Update
Urine Drug Screening Recent Update

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

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

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

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

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

ODM Will Define Place of Service 99 as “Community”

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

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

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

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

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

- **Services Billable to Medicare (Final Version)** - Identifies those codes that require third party billing as well as those that do not
- **Supervisor Rendering Ordering Fields** - Identifies what information is in these fields for all CPT and HCPCS codes
- **Services Crosswalk** - Details what codes can be billed on same date of service
- **ACT-IHBT** - What is allowed to be billed with these two new services, what is not allowed and what requires prior authorization
- **Dx Code Groups** - Allowable diagnoses for behavioral health services
- **Limits, Audits and Edits** - Includes benefit limits as well as audits to limit some combination of services on same day
- **EDI/IT Q-and-A** - Contains responses to questions received from EDI/IT work group
EDI File Testing

*Week of May 10th:*
Medicaid trading partners submitting electronic claim files on behalf of non-hospital BH providers (MITS PTs 84/95) began sending test files.

*May 12th:*
MyCare plan testing timeline announced.

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

**GO-LIVE: JULY 1**

Please refer to the two Trading Partner Testing MITS Bits for more details:

1. [http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits%205-1-17_Medicaid-Trading-Partner-Testing.pdf](http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits%205-1-17_Medicaid-Trading-Partner-Testing.pdf)
2. [http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf](http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf)
Ensuring Success: BH Redesign Rapid Response Team

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

“Rapid Response” **Team A**
May – June
- Respond to trading partner-identified issues
- Communicate ODM-identified issues

“Rapid Response” **Team B**
July – end date determined based on need
- Respond to provider-identified issues regarding claims processing

Information on how to contact the Rapid Response team can be found in the May 1st issue of MITS BITS
EDI File Testing

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 the following times:
Monday-Friday 7:30am-7:00 pm
Saturday 8 am – 1:00 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 claims issues) OR send email to BH-Enroll@medicaid.ohio.gov.
Rapid Response Team will be available the following times:
Monday-Friday 7:30am-7:00 pm
Saturday 8am-1pm
Checklist for July 1, 2017

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

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

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

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

☑ Train all levels of staff on BH Redesign changes
  • Attend trainings
  • Watch webinars
  • Study documents at BH.Medicaid.Ohio.gov
Behavioral Health Monitoring
BH Monitoring Mission – **Short Term Objectives**

**GOAL:**

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

*Example metrics to begin monitoring*

*July 1, 2017 –*

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

**GOAL:**

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

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

- Members Served
- System & Service-Level Spending
Behavioral Health Redesign Website
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Sign up online for the BH Redesign Newsletter.

Go to the following OhioMHAS webpage: http://mha.ohio.gov/Default.aspx?tabid=154 and use the “BH Providers Sign Up” in the bottom right corner to subscribe to the BH Providers List serve.
Questions?