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

Opportunities
10/14, 10/18, 10/20, 10/27, 11/4, 11/14, 11/15, 11/21
## Agenda

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Implementation and Training Schedule
Implementation Schedule – BH Redesign

- **Go Live for Specialized Recovery Services Program**
- **1/1/2017: OTP coverage updates implemented**
- **7/1/2017: Medicaid requires rendering (NPI) practitioner*, ORP, and/or supervisor on claims**
- **7/1/2017: All providers transition to new code set (CPTs, including E&M, along with HCPCS codes). Medicare and NCCI** edits apply.
- **4/1/2017: Recommended date by which all active practitioners should be enrolled and affiliated**

**Practitioners who must enroll with Ohio Medicaid:**
- Physicians (MD/DO), Psychiatrists
- Advanced Practice Registered Nurses
- Certified Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants
- Licensed Psychologists
- Licensed Independent Social Workers
- Licensed Professional Clinical Counselors
- Licensed Independent Marriage and Family Therapists
- Licensed Independent Chemical Dependency Counselors (LICDC)
- Registered Nurses
- Licensed Practical Nurses

**NCCI prohibits use of nonstandard units (i.e., no more decimals)**
Ohio Medicaid Behavioral Health Redesign Initiative

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

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

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

**Expansion**
Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 400,000 residents with behavioral health needs.

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

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

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

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

**Integration** – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. *Implementation on target for January 1, 2018.*
Ongoing activities related to BH Redesign will continue throughout 2017

State Agency Goals for BH Redesign

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

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

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

Ensure Access
The state will collaborate with boards, providers, and other local entities to ensure ongoing access to services and continuity of care for individuals
START of January 1, 2017 Changes
January 1, 2017 Opioid Treatment Program (OTP) Manual
January 1, 2017 OTP Manual

• The 1/1 OTP Manual addresses for Opioid Treatment Programs (OTPs) changes that are being made in service coverage that will affect them with services provided on and after January 1, 2017.

• All other changes to the behavioral health system will be implemented July 1, 2017.

• All other MH/SUD services remain the same until July 1, 2017.

January 1, 2017 OTP Manual is now available at http://bh.medicaid.ohio.gov/manuals
OhioMHAS Methadone License

Because you are licensed by OhioMHAS, including licensure by The State of Ohio Board of Pharmacy you can provide methadone administration/dispensing (H0020 [daily and/or weekly]). H0020 INCLUDES the cost of the methadone medication administered/dispensed.
OTPs may bill 99211 for the nasal administration of naloxone (J2310). This coding combination is only used when the naloxone is administered nasally on site.

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

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

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

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

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

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

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

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

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

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

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

- OTPs may administer/dispense oral naltrexone (J8499) under their Ohio board of pharmacy license.
A patient receiving a daily Buprenorphine based medication administration or daily methadone administration that has not yet been approved for take home use would attend a daily appointment at the OTP to receive their medication. The OTP would bill each day for the appropriate administration service using the applicable billing code, either H0020 for methadone patients or T1502 for patients receiving Buprenorphine based medications.

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

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

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

(scheduled for implementation January/February 2017)
Respite Services for Medicaid Managed Care Members

What is Respite?

- "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of an individual under the age of twenty-one in order to support and preserve the primary caregiving relationship.

Key Provisions

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

Still under review pending finalization of Ohio Administrative Code
New Respite Eligibility for Children with MH Diagnoses

To be eligible for respite services, the member must meet all of the following criteria:

- Reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services;
- Not be residing in foster care;
- Under the age of 21;
- Enrolled in the managed care plan’s care management program
- Have behavioral health needs as determined by the MCP through the use of a nationally recognized standardized functional assessment tool, and
  (a) Be diagnosed with serious emotional disturbance as described in the appendix to this rule resulting in a functional impairment,
  (b) Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to him or her self or others, and
  (c) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's behavioral health needs, either:
    (i) To prevent an inpatient, institutional or out-of-home stay; or
    (ii) Because the member has a history of inpatient, institutional or out-of-home stays.

Still under review pending finalization of Ohio Administrative Code
Several stakeholders noted that the substance use disorder (SUD) diagnoses originally included in the appendix would not likely rise to the level of requiring respite.

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

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

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

Still under review pending finalization of Ohio Administrative Code
Provider Qualifications: New BH Respite Services

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

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

<table>
<thead>
<tr>
<th><strong>Before</strong> commencing service delivery, the BH provider agency employee <strong>must</strong>:</th>
<th><strong>After</strong> commencing service delivery, the BH provider agency employee <strong>must</strong>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Either be credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board or received training for or education in mental health competencies and have demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency; and</td>
<td>• Receive supervision from an independently licensed behavioral health professional credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board</td>
</tr>
<tr>
<td>• Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.</td>
<td></td>
</tr>
</tbody>
</table>
END of January 1, 2017 Changes
Mental Health Parity and Addiction Equity Act
A formal, methodical process with consultants to address parity with Medicaid services is ongoing.

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

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

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

### Behavioral Health Parity FR/QTL Testing

**[Name of Plan]**

- Benefit Package: 1
- Calendar Year: 2018
- [Enter Medicaid Eligibility Group]
- [Enter Applicable Age Group/Gender]
- [Enter additional comments regarding benefit package distinction]

<table>
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<tr>
<th>Classification/Service</th>
<th>Financial Requirements</th>
<th>Quantitative Treatment Limitations [e.g., day/visit/hour limits, age limits, dollar limits]</th>
<th>Annual Dollar Limits or Lifetime Dollars Limits</th>
<th>Comments</th>
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<tr>
<td></td>
<td>Deductible</td>
<td>Copay</td>
<td>Coinsurance</td>
<td>OOP Maximum</td>
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<tr>
<td>Inpatient</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outpatient (PCP and Specialist Office Visit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient (Non-Office Visit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex. Eye exams</td>
<td>N/A</td>
<td>$2 per examination</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Ex. Eyeglasses or contacts</td>
<td>N/A</td>
<td>$1 per fitting</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Ex. Chiropractic</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ex. Physical and occupational therapy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ex. Dental</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<Insert additional rows above as needed>
START of July 1, 2017 Changes
Policy Updates

INCLUDES:

- TBS Years of Experience
- Benefit Administration
Therapeutic Behavioral Services (TBS) Years of Experience
TBS Years of Experience

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

Current policy for practitioners providing TBS is below:

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

Qualified mental health specialists who have a minimum of 3 years of experience on or before July 1, 2017, will be qualified to provide TBS.
Benefit Administration
• Plans will abide by state benefit administration requirements for one year after carve-in and administer it on a calendar year basis (Jan-Dec).

• Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.
Federal law (CFR 42.456.25) requires state Medicaid programs to perform post-payment review of Medicaid claims including recipient and provider profiles to identify and correct any mis-utilization practices.

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

Providers found to have outlier patterns may be contacted for post-payment review and possible recoupment of overpayments. In extreme cases, providers suspected of fraud, waste or abuse may be referred to the Attorney General’s Medicaid Fraud and Control Unit.
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.
ALWAYS Prior Authorized:
**Intensive Home Based Treatment (IHBT)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
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<tbody>
<tr>
<td>Intensive Home Based Treatment (IHBT)</td>
<td>H2015</td>
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</table>

IHBT must be prior authorized per person.
ALWAYS Prior Authorized by 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.*
Services With Prior Authorization
- Billing Provider -
Prior Authorization - Billing Provider: *Psychiatric Diagnostic Evaluations*

**DESCRIPTION**

Psychiatric Diagnostic Evaluation

**CODES**

90791 – with out medical
90792 – with medical

Prior Authorization Requirement

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

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

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>G0396 – 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>G0397 – greater than 30 minutes</td>
</tr>
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</table>

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

*Can not be billed by provider type 95 (SUD treatment programs)*
Prior Authorization - Billing Provider: *Alcohol and/or Drug Assessment*

**DESCRIPTION**

Alcohol and/or Drug Assessment

**CODE**

H0001

2 hours (8 units) per person per calendar year per billing **provider**. Does not count toward ASAM level of care benefit limit. Prior authorization may be requested to exceed the annual limit.
Services With Prior Authorization
- Medicaid Enrollee -
Prior Authorization - Medicaid Enrollee: 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.*
Prior Authorization - Medicaid Enrollee: 

**RN/LPN Nursing Services**

Prior Authorization Requirement

24 hours (96 units) combined per year *per Medicaid enrollee.*

Prior authorization may be requested to exceed the annual limit.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
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</thead>
</table>
| RN/LPN Nursing Services (MH) | H2019 (RN)  
H2017 (LPN) |
| RN/LPN Nursing Services (SUD) | T1002 (RN)  
T1003 (LPN) |
Prior Authorization - Medicaid Enrollee:  
**SUD Residential (Non-Withdrawal Management)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Residential</td>
<td>H2034</td>
</tr>
<tr>
<td></td>
<td>H2036</td>
</tr>
</tbody>
</table>

**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.
Ohio
Department of Medicaid
Department of Mental Health and Addiction Services

Services with No Benefit Limits
No Benefit Limit: **TBS, PSR, and CPST**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Behavioral Services</td>
<td>H2019</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
<td>H2017</td>
</tr>
<tr>
<td>Community Psychiatric Support</td>
<td>H0036</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
</tr>
</tbody>
</table>

*Provider(s) will receive an informational remark in remittance advice at and over 104 hours.*
No Benefit Limit: *Psychotherapy*

- **Individual Psychotherapy**
  - DESCRIPTION
  - CODES
    - 90832, 90834, 90837

- **Group Psychotherapy**
  - DESCRIPTION
  - CODE
    - 90853

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

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

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

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

*Note: Evaluation and Management add-on codes are not subject to any limits.*
No Benefit Limit: *SUD Withdrawal Management*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3-WM Residential Setting</td>
<td>H0010, H0011, H0012 – Per Diem</td>
</tr>
<tr>
<td>Level 2-WM Outpatient Setting</td>
<td>CODE</td>
</tr>
<tr>
<td>(RN/LPN Only)</td>
<td>CODE</td>
</tr>
<tr>
<td></td>
<td>H0014 – Hourly</td>
</tr>
</tbody>
</table>
No Benefit Limit: *MH Day Treatment*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Day Treatment (Adult and Youth)</td>
<td>H2012 – Hourly</td>
</tr>
<tr>
<td></td>
<td>H2020 – Per Diem</td>
</tr>
</tbody>
</table>
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 | |

# 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</td>
<td>H0004 UT</td>
</tr>
<tr>
<td>MH TBS or MH PSR</td>
<td>H2019 UT or H2017 UT</td>
</tr>
</tbody>
</table>
MH Day Treatment
MH Day Treatment Group Activities - Hourly

Rate Development and Methodology

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumes 1 hour of unlicensed BA in an average group size of four</td>
<td>$18.54</td>
</tr>
<tr>
<td>Assumes 1 hour of unlicensed MA in an average group size of four</td>
<td>$21.05</td>
</tr>
<tr>
<td>Assumes 1 hour of licensed practitioner in an average group size of four</td>
<td>$28.10</td>
</tr>
</tbody>
</table>

MH Day Treatment: Additional Details

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

2. All other services must be billed outside of H2012. H2012 can only be billed if the person attends the minimum amount of time (30+ minutes) in a group which doesn’t exceed the practitioner to client ratio.
## MH Day Treatment Group Activities - Per Diem

<table>
<thead>
<tr>
<th>Rate Development and Methodology</th>
<th>$104.55 Per Diem Per Person</th>
<th>$117.05 Per Diem Per Person</th>
<th>$140.51 Per Diem Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2020 Assumes 5 hours of unlicensed BA providing group counseling in an average group size of four</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2020 Assumes 5 hours of unlicensed MA providing group counseling in an average group size of four</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2020 Assumes 5 hours of licensed practitioners providing group counseling in an average group size of four</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MH Day Treatment: Additional Details

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

2. **Only one H2020 per diem, per patient, per day**
3. **Must be nationally accredited**
4. **Must be supervised by a licensed independent practitioner**
SUD Intensive Outpatient and Partial Hospitalization
### SUD Intensive Outpatient Level of Care: Group Counseling - Billing

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

### SUD Intensive Outpatient Group Counseling: Additional Details

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

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

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

SUD Partial Hospitalization: Additional Details

- Maximum group size: 1:12 practitioner to client ratio
- Only used at ASAM Level 2.5
  - For PH, only used if the person attends for the minimum needed to bill the per diem (3+ hours)
  - If person doesn’t meet the minimum 3+ hours, H0005 may be used for unlicensed practitioners and 90853 may be used for licensed practitioners.
    - Service is billed in whole unit only.
- All other services must be billed outside of H0015-TG. H0015-TG can only be billed if the person attends the minimum amount of time (3+ hours) in a group which doesn’t exceed the practitioner to client ratio.
- Must be led by licensed practitioner to bill with HK modifier
- Only one H0015 per diem, per patient, per day.
Crisis Services
## 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>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>MD/DOs and psychologists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other licensed practitioners*</td>
</tr>
<tr>
<td>+90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes</td>
<td>MD/DOs and psychologists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other licensed practitioners*</td>
</tr>
<tr>
<td>90832</td>
<td>Based on Medicare, can be billed with a UT crisis modifier if crisis service does not reach 31 minutes</td>
<td>MD/DOs and psychologists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other licensed practitioners*</td>
</tr>
</tbody>
</table>

* Review supervision requirements for billing guidance
**MH and SUD Crisis Services by Unlicensed Practitioners**

### Guidance for Unlicensed Practitioner Providing Crisis Services

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

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

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

### SUD Crisis Billing for Unlicensed Practitioners

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
<td>UT modifier will be used to differentiate a crisis service vs. a non-crisis service</td>
</tr>
<tr>
<td></td>
<td>BH counseling and therapy, per 15 minutes</td>
</tr>
</tbody>
</table>

### MH Crisis Billing for Unlicensed Practitioners

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>UT modifier will be used to differentiate a crisis service vs. a non-crisis service</td>
</tr>
<tr>
<td></td>
<td>TBS, per 15 minutes: <strong>Master's, Home/Cmty</strong></td>
</tr>
<tr>
<td></td>
<td>TBS, per 15 minutes: <strong>Bachelor's, Home/Cmty</strong></td>
</tr>
<tr>
<td></td>
<td>TBS, per 15 minutes: <strong>Master's, Office</strong></td>
</tr>
<tr>
<td></td>
<td>TBS, per 15 minutes: <strong>Bachelor's, Office</strong></td>
</tr>
<tr>
<td>H2017</td>
<td>UT modifier will be used to differentiate a crisis service vs. a non-crisis service</td>
</tr>
<tr>
<td></td>
<td>Psychosocial rehabilitation service: <strong>Home/Cmty</strong>, per 15 mins</td>
</tr>
<tr>
<td></td>
<td>Psychosocial rehabilitation service: <strong>Office Setting</strong>, 15 minute units</td>
</tr>
</tbody>
</table>
Substance Use Disorder (SUD) Benefit – ASAM Criteria
ASAM Levels of Care

REFLECTING A CONTINUUM OF CARE

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

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

The provider manual contains information about each ASAM Level.

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

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

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

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

**Residential**
- Per Diems ranging from clinical managed to medically monitored
- Medications
- Buprenorphine and Methadone Administration/Dispensing
- Urine Drug Screening
ASAM Levels 1 & 2: Outpatient Services

**Level 1**
- Only Exclusions:
  - Crisis psychotherapy codes
  - Psychiatric diagnostic interview w/ & w/o medical
- Excludes individual counseling with crisis modifier
  - H0015 not available
- All others count towards weekly hours

**Level 2 (IOP)**
- Only Exclusions:
  - Crisis psychotherapy codes
  - Psychiatric diagnostic interview w/ & w/o medical
- Excludes individual counseling with crisis modifier
  - H0015 (no TG modifier available)
- All others count towards weekly hours

**Level 2.5 (PH)**
- Only Exclusions:
  - Crisis psychotherapy codes
  - Psychiatric diagnostic interview w/ & w/o medical
- Excludes individual counseling with crisis modifier
  - H0015 (w/ & w/o TG modifier available)
- All others count towards weekly hours

**Prior Authorized**
- 20+ hours per week

**Hours of service per week**
- <9 Adults
- <6 Adolescents
- 9-19.9 Adults
- 6-19.9 Adolescents
- 20+ hours per week
ASAM Level 1 & 2: Withdrawal Management
Medical Services

NOTE: Withdrawal Management is not subject to prior authorization
ASAM Level 3: Withdrawal Management

Level 3

H0010
(clinically managed)

OR

H0011
(medically monitored)

Residential (per diem codes)

NOTE: Withdrawal Management is not subject to prior authorization
ASAM Level 3: Residential Treatment (Non-Withdrawal Management)

- Level 3.1: H2034
- Level 3.3: H2036 HI
- Level 3.5: H2036
- Level 3.7: H2036 TG

Outside of per diem: H0020; T1502; J-Codes
Outside of per diem: Psychiatrist treating MH diagnosis as billing diagnosis; ACT & IHBT; J-Codes
Prior Authorization - Medicaid Enrollee:  
*SUD Residential (Non-Withdrawal Management)*

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

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

Applies to first two stays; any stays after that would be subject to prior authorization.
Specialized Recovery Services (SRS) Program
SRS Program- Ohio Home Care Case Management

Cincinnati Region – Available Recovery Management:
Council on Aging
(855) 372-6176
CareStar
(800) 616-3718

Columbus Region – Available Recovery Management:
CareSource
(844) 832-0159
CareStar
(800) 616-3718

Cleveland Region – Available Recovery Management:
CareSource
(877) 209-3154
CareStar
(800) 616-3718

Marietta Region – Available Recovery Management:
CareSource
(855) 288-0003
CareStar
(800) 616-3718
Recovery Manager and Independent Entity Interaction

Ongoing Behavioral and Physical Health Care Coordination

1. **Potentially Eligible Individual Identified**
2. **Independent Entity Selects Recovery Manager to work with individual**
3. Recovery Manager performs ANSA, develops the Person-Centered Plan of Care, collects documentation and makes recommendation to the Independent Entity on eligibility.
4. Independent Entity performs final review of documentation received from Recovery Manager and makes eligibility recommendation to send to CDJFS for final determination.
5. Recovery Manager begins care coordination and recovery management services.
6. Recovery Manager works with the individual to ensure adequate services, supports and other needs are met.
Specialized Recovery Services Program

- **Individualized Placement and Support-Supported Employment (IPS-SE)**
  - Available to all individuals enrolled in SRS program

- **Recovery Management (RM)**
  - Required for all individuals enrolled in SRS program

- **Peer Recovery Support (PRS)**
  - Available to all individuals enrolled in SRS program
To be eligible for enrollment an individual must:

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

To be eligible for enrollment an individual must:

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

To be eligible for enrollment an individual must:

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

To be eligible for enrollment an individual must:

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

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

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

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

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

Ongoing Identification and Outreach
Supporting Individuals to Enroll

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

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

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

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

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

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

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

To help determine an individual’s eligibility and for other helpful information, visit [https://benefits.ohio.gov/ddr.html](https://benefits.ohio.gov/ddr.html).

**More information on the SRS referral process can be found in the May 23rd issue of MITS Bits.**
Supporting Individuals to Enroll

Educational Resources

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

- **Educational video** explaining the program and its benefits: [https://www.youtube.com/watch?v=fZW4p1fOmWM](https://www.youtube.com/watch?v=fZW4p1fOmWM)


- **Sample letter** sent to individuals who may be eligible for the SRS program: [http://www.medicaid.ohio.gov/Portals/0/Initiatives/DDR/Letter-SRS-2016-04.pdf](http://www.medicaid.ohio.gov/Portals/0/Initiatives/DDR/Letter-SRS-2016-04.pdf)
The 9/9 release of the Specialized Recovery Services (SRS) Program Manual is to help providers understand how to provide and be reimbursed for SRS by Ohio Medicaid.

The manual includes information on services offered through the SRS program, eligibility requirements, the provider enrollment process, billing codes and rates, guidance on enrolling individuals and more.

The SRS Program Manual is now available at: http://bh.medicaid.ohio.gov/Providers1#42721-specialized-recovery-services
Evidence-Based or State-Best Practices for Mental Health
Assertive Community Treatment (ACT)
ACT – Fidelity Measurement

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Fidelity Review</td>
<td>ACT Prior Authorization and Eligibility</td>
<td>ACT is a “Lock In” BH Benefit</td>
<td>ACT Billable Events</td>
<td>ACT Services to Hospitalized Enrollees</td>
</tr>
</tbody>
</table>
ACT Medium Team Monthly Billing Example

**DACTS (w/ 2 BAs): Code - H0040**

- MD/DO: $615.64
- Licensed/Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Bachelor’s: $199.70

**Total: $1,266.95**

**Unit Rates**
- MD/DO: $251.91
- Licensed/Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Peer Recovery Supporter: $159.24

**DACTS (w/ 1 BA, 1 PRS): Code - H0040**

- MD/DO: $615.64
- Licensed/Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Peer Recovery Supporter: $159.24

**Total: $1,226.49**

**DACTS (w/ 2 PRSs): Code - H0040**

- MD/DO: $615.64
- Licensed/Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Peer Recovery Supporter: $159.24
- Peer Recovery Supporter: $159.24

**Total: $1,186.03**

**Unit Rates**
- MD/DO: $251.91
- Licensed/Master’s/RN/LPN: $251.91
- Bachelor’s: $199.70
- Peer Recovery Supporter: $159.24
- Peer Recovery Supporter: $159.24

**ACT is a fully prior authorized service**
ACT Team Patient Scenario

Scenario Example

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

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

Scenario is for **illustrative purposes only**
## 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>
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<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
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<tr>
<td>Unlicensed BA Visit</td>
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<tr>
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<td>RN Visit</td>
<td>Psychiatrist Visit</td>
<td></td>
<td>LPN Visit</td>
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<tr>
<td>Unlicensed BA Visit</td>
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<td>26</td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Unlicensed BA Visit</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Supporter Visit</td>
<td>RN Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlicensed BA Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Intensive Home-Based Treatment (IHBT)
IHBT – Fidelity Measurement

Fidelity Measures to qualify for the IHBT billing methodology were built on premises similar to ACT.

### IHBT Fidelity Document

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Intensity of service</td>
<td>Average one or less service hours per week and less than 1 contact per week for each IHBT consumer.</td>
<td>Average 6 service hours per week and 1 face-to-face contact per week for each IHBT consumer.</td>
<td>Average 6 service hours per week and a minimum of 2 face-to-face contacts with the youth and family each week during the intensive phase of treatment, of which has to be with the youth and family.</td>
<td>Averages 6 or more service hours per week and 1 or more face-to-face contacts with the youth and family, and 2 or more face-to-face contacts per week during the intensive phase of treatment.</td>
</tr>
<tr>
<td>2) Location of service</td>
<td>40% or less of total services delivered in home &amp; community.</td>
<td>50% to 75% of total services delivered in home &amp; community.</td>
<td>75% to 99% of total services delivered in home &amp; community.</td>
<td>100% of total services delivered in home &amp; community.</td>
</tr>
<tr>
<td>3) Caseload</td>
<td>For single provider: Averages 15 or greater. For teams of two: Averages 20 or greater.</td>
<td>For single provider: Averages 8 to 11. For teams of two: Averages 12 to 19.</td>
<td>For single provider: Averages 8 to 11. For teams of two: Averages 12 to 19.</td>
<td>For single provider: Averages 7 cases. For teams of two: Averages 10 to 16.</td>
</tr>
</tbody>
</table>

Intensive Home-Based Treatment Fidelity Rating Tool Last Updated 0-23-2016
IHBT Billing Structure

Code - H2015

Unit Rate (15 minute)

Licensed clinician (modifier or NPI)

$33.26

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

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

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

Go Live for Specialized Recovery Services Program

1/1/2017: OTP coverage updates implemented

7/1/2017: Medicaid requires rendering (NPI) practitioner*, ORP, and/or supervisor on claims

7/1/2017: All providers transition to new code set (CPTs, including E&M, along with HCPCS codes). Medicare and NCCI** edits apply.

4/1/2017: Recommended date by which all active practitioners should be enrolled and affiliated

*Practitioners who must enroll with Ohio Medicaid:

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

**NCCI prohibits use of nonstandard units (i.e., no more decimals)
Rendering Practitioners Required to Enroll in Ohio Medicaid, Effective For Dates of Service On and After July 1, 2017

<table>
<thead>
<tr>
<th>Rendering Practitioners</th>
<th>Enrollment Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (MD/DO), Psychiatrists</td>
<td>Licensed Independent Social Workers</td>
</tr>
<tr>
<td>Advanced Practice Registered Nurses</td>
<td>Licensed Professional Clinical Counselors</td>
</tr>
<tr>
<td>Certified Nurse Practitioners</td>
<td>Licensed Independent Marriage and Family Therapists</td>
</tr>
<tr>
<td>Clinical Nurse Specialists</td>
<td>Licensed Independent Chemical Dependency Counselors (LICDC)</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Registered Nurses</td>
</tr>
<tr>
<td>Licensed Psychologists</td>
<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 agency or agencies; either the agency or practitioner may perform the affiliation in MITS.
- Practitioner or agency/agencies may “un-affiliate” rendering practitioners listed above when necessary.
April 1, 2017 Checklist

**PROVIDER CHECKLIST**

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

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

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

- **IT Systems:** Trading Partner testing of new coding.
  - Estimated date trading partners can begin testing new coding: April 1, 2017
  - Complete testing prior to July 1, 2017, to ensure claim processing is not disrupted
BH Agency (PT 84 AND PT 95) Provider Enrollment and Practitioner Enrollment and Affiliation

ABC BH AGENCY

- MH (PT 84)
- AND
- SUD (PT 95)

- Employee
  - LISW
  - LICDC
  - Psychologist

Enroll and affiliate
- WITH BOTH PT 84 and PT 95
- WITH PT 95 only
- WITH BOTH PT 84 and PT 95
MH Agency (PT 84) or SUD Agency (PT 95) Provider Enrollment and Practitioner Enrollment and Affiliation

MH AGENCY
MH (PT 84)

SUD AGENCY
SUD (PT 95)

Employee LISW
Enroll and affiliate with PT 84

Employee LSW
No need to enroll and affiliate

Employee LICDC
Enroll and affiliate WITH PT 95

Employee LISW
Enroll and affiliate WITH PT 95

CDCA
No need to enroll and affiliate
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></td>
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<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>A CBHC employing any of these rendering providers <strong>must bill the</strong></td>
</tr>
<tr>
<td>Licensed Professional Clinical Counselor</td>
<td><strong>Medicare program prior to billing Medicaid if the service is covered by</strong></td>
</tr>
<tr>
<td>Independent Marriage and Family Therapist</td>
<td><strong>Medicare.</strong></td>
</tr>
<tr>
<td>Licensed Independent Chemical Dependency Counselor</td>
<td></td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td></td>
</tr>
<tr>
<td>Marriage and Family Therapist</td>
<td></td>
</tr>
<tr>
<td>Licensed Chemical Dependency Counselor</td>
<td></td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td>A CBHC employing any of these rendering providers <strong>may submit the</strong></td>
</tr>
<tr>
<td>School Psychologists</td>
<td><strong>claim directly to Medicaid.</strong></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurse</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
Coverage and Limitations
Work Book
C&L Work Book Clarification – Registered Nurses and Licensed Practical Nurses

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

CPT/HCPCS Codes for Nursing Activities

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

Key Takeaways

1. Registered Nurses and Licensed Practical Nurses will need to enroll with Ohio Medicaid because they will be expected to be a rendering provider.
2. When not billing with 99211, please be sure to select the correct code.
What has changed with the C&L Work Book?

<table>
<thead>
<tr>
<th>Unit of Measure</th>
<th>CPT/HCPCS</th>
<th>Pricing Modifier(s)</th>
<th>Description</th>
<th>Medical Behavioral Health (BH) Practitioners</th>
<th>Independent BH Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASAM</td>
<td>Procedure Code</td>
<td></td>
<td>Pre-Claim Rate</td>
<td>MD</td>
</tr>
<tr>
<td>Encounters</td>
<td>15715</td>
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<td>NA</td>
<td>$32.81</td>
</tr>
<tr>
<td>Encounters</td>
<td>15716</td>
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<td>NA</td>
<td>$64.44</td>
</tr>
<tr>
<td>Encounters</td>
<td>15717</td>
<td></td>
<td></td>
<td>NA</td>
<td>$32.81</td>
</tr>
<tr>
<td>Encounters</td>
<td>15718</td>
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<td></td>
<td>NA</td>
<td>$64.44</td>
</tr>
<tr>
<td>Encounters</td>
<td>15719</td>
<td></td>
<td></td>
<td>NA</td>
<td>$64.44</td>
</tr>
<tr>
<td>Encounters</td>
<td>15720</td>
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<td>NA</td>
<td>$64.44</td>
</tr>
<tr>
<td>Encounters</td>
<td>15721</td>
<td></td>
<td></td>
<td>NA</td>
<td>$64.44</td>
</tr>
</tbody>
</table>

Changes Made to the Coding Chart Since June 15, 2016

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

Version updates are noted on a separate tab sheet.

New Version releases will be uploaded onto the Ohio Behavioral Health Redesign website.

Version 5.0 of the Coverage and Limitations Work Book is now available at http://bh.medicaid.ohio.gov/manuals
National Correct Coding Initiative (NCCI)
National Correct Coding Initiative

Overview
- Required by Affordable Care Act
- Goals: Assure practitioners work within scope, control improper coding, prevent inappropriate payment by Medicare and Medicaid.
- Implemented, governed and regularly updated by Centers for Medicare & Medicaid Services (CMS)
- Implemented October 1st, 2010, in rest of Ohio’s Medicaid program – not in BH
- To be implemented July 1st, 2017, for Ohio Medicaid BH providers

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

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

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

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

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

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

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

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

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

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

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

**General Supervision:** An LSW conducts a psychotherapy session with a patient with their supervising practitioner available by phone. The claim would be submitted with the U4 modifier (representing the LSW credential) with the supervisor’s NPI in the supervisor field. **The rendering field MUST BE blank and the billing field will contain the agency NPI.** MITS will adjudicate the claim using the LSW rate.

**Direct Supervision:** A social worker trainee conducts a psychotherapy session with a patient, and their supervisor (LISW) is immediately available and interruptible if the social worker trainee needs direction while providing this session. The claim would be submitted with the U9 modifier (representing the social worker trainee credential) with the supervisor’s NPI in the supervisor field and the rendering field is blank. The billing field will contain the agency NPI. The supervisor takes the responsibility for the service. MITS will adjudicate the claim using the LISW rate.
Minimum Supervision Requirements for HCPCS

<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

<table>
<thead>
<tr>
<th><strong>General Supervision:</strong> A SWT provides Psychosocial Rehabilitation to a patient in their home with their supervising practitioner available by phone. The claim would be submitted with the U9 modifier (representing the SWT credential) with the supervisor’s NPI in the supervisor field. <strong>The rendering field MUST BE blank and the billing field will contain the agency NPI.</strong> MITS will adjudicate the claim using the SWT rate.</th>
</tr>
</thead>
</table>

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

Interactive complexity is an add-on code which may be reported in conjunction with Psychiatric Diagnostic Evaluation (90791, 90792), Psychotherapy (90832, 90834, and 90837), Psychotherapy add-ons (90833, 90836, and 90838) and Group Psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur during the delivery of the service. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients.

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

<table>
<thead>
<tr>
<th>Relevant Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791 – Psychiatric Diagnostic Evaluation</td>
</tr>
<tr>
<td>90792 – Psychiatric Diagnostic Evaluation – Includes Medical</td>
</tr>
<tr>
<td>90832 – Psychotherapy, 30 minutes (16-37)</td>
</tr>
<tr>
<td>90834 – Psychotherapy, 45 minutes (38-52)</td>
</tr>
<tr>
<td>90837 – Psychotherapy, 60 minutes (53+)</td>
</tr>
<tr>
<td>+90833 – Psychotherapy, 30 minutes, with E&amp;M (16-37)</td>
</tr>
<tr>
<td>+90836 – Psychotherapy, 45 minutes, with E&amp;M (38-52)</td>
</tr>
<tr>
<td>+90838 – Psychotherapy, 60 minutes, with E&amp;M (53+)</td>
</tr>
<tr>
<td>90853 – Group Psychotherapy</td>
</tr>
</tbody>
</table>

Note: Report 90785 in addition to the primary procedure, when certain communication factors are present during the visit. Please see the Provider Manual for further details.
Interactive Complexity can be added on to the following codes per practitioner:

<table>
<thead>
<tr>
<th>MD/DO</th>
<th>CNS</th>
<th>CNP</th>
<th>PA</th>
<th>PSY</th>
<th>LISW</th>
<th>LIMFT</th>
<th>LPCC</th>
<th>LICDC</th>
<th>LI School PSY</th>
<th>LSW</th>
<th>LMFT</th>
<th>LPC</th>
<th>LCDC II/III</th>
<th>Train/Assist*</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>90791</td>
<td>90791</td>
<td>90791</td>
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* under direct supervision
Interactive Complexity Professional Guidance Example


For additional AACAP CPT & Reimbursement language, click here.
Interactive Complexity Professional Guidance Example

Typical Patients

Interactive complexity is often present with patients who:

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

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

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

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.

3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), “90785 generally should not be billed solely for the purpose of translation or interpretation services” as that may be a violation of federal statute.
Trading Partner Information
Trading Partner Information & File Testing

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

The following can be accessed here:

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

New Trading Partner Resources

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

http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners/HPVendorInformation.aspx
837P Companion Guide
**IT Workgroup Changes for July 1, 2017**

---

**Electronic Data Interchange:**

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

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

---

Initial meeting May 31, 2016

Met October 3, 2016
- [Link to presentation](#)
  Future dates: November 9 and December 6, 2016

Reviewing companion guides to identify updates needed to support upcoming changes
837P Companion Guide – Overview

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

**837P GUIDANCE**

**Ongoing Activities**

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

### INPUT

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

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<td>2010AA</td>
<td>NM109</td>
<td>Billing Provider identifier</td>
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<td>Provider NPI. For provider types 84 and 95, this would be the agency NPI</td>
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<td></td>
<td>Provider NPI. For provider types 84 and 95 if the practitioner is enrolled in Medicaid, use practitioner’s NPI. Otherwise leave field blank.</td>
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<tr>
<td>456</td>
<td>2420E</td>
<td>NM109</td>
<td>Ordering Provider Identifier</td>
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<td></td>
<td>Provider NPI For provider types 84 and 95, when an RN or LPN provides the service, this field must have NPI of ordering practitioner</td>
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This next loop, Rendering Provider, would only be used IF there were multiple detail lines on the claim and the individual rendering this particular service line was different than what was sent in the 2310B:

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<td></td>
<td>For provider types 84 and 95 if the practitioner is enrolled in Medicaid, use practitioner’s NPI. Otherwise leave field blank.</td>
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</table>

Subject to UAT results, may need to add language to Supervisor field
END of July 1, 2017 Changes
Provider Enrollment Updates
The Ohio Department of Medicaid has established a Medicaid mailbox to collect and respond to questions from behavioral health providers.

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

The mailbox address is bh-enroll@medicaid.ohio.gov
Provider Enrollment for Type 84 and Type 95 Providers

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

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

- An agency National Provider Identifier number (NPI) from the National Plan and Provider Enumeration System (NPPES)
  - If applying as both provider types, the agency must have two NPIs
- A signed copy of the IRS W-9 form for the applicant MH or SUD agency
- And verification of an application fee payment
  - If the provider is a Medicare provider, they may use the Medicare payment confirmation
    BUT the NPI number and address must much match the Medicaid application

Information on OhioMHAS mental health services or SUD treatment program certification can be obtained from the OhioMHAS Bureau of Licensure & Certification by calling 614-752-8880 or by visiting the OhioMHAS licensure and certification webpage here: [http://mha.ohio.gov/Default.aspx?tabid=123](http://mha.ohio.gov/Default.aspx?tabid=123).
Next Steps and Schedule
Key Topics: Next Steps

**Mobile Crisis and BH Urgent Care**

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

**High Fidelity Wraparound**

Work Group will reconvene in the fall of 2016

**Payment Innovation**

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

- Focusing on ADHD and ODD

**Managed Care Transition**

Working with stakeholders to prepare for January 2018
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.
Click on the PROVIDERS tab.

Go To: bh.medicaid.ohio.gov

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

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<td>SRS Program Manual</td>
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