‘501’ Behavioral Health Redesign

October 27, October 30, November 1, November 3, November 8, 2017
Agenda

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LUNCH
Welcome and Opening Remarks
Changes Already in Effect
In ADDITION to the outpatient benefit described on slide 21 (through December 31, 2017) and slide 22 (beginning January 1, 2018, and thereafter), the OTP benefit was updated for January 1, 2017 to include Medicaid coverage of:

- Medications – Buprenorphine-based medications (SAMHSA certificate), injectable/nasal naloxone and oral naltrexone (Ohio Board of Pharmacy)
- Medication administration
- Collection of blood samples for external laboratory testing

**OTP Licensure and Certification**

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

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

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

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

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

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

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

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

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

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

**Integration: Implementation on target for July 1, 2018**
Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.
Modernization – Underway, ODM and OhioMHAS are modernizing the community behavioral health benefit package to align with national standards and expand services to those most in need. Implementation on target for January 1, 2018.

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

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

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

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

* BH Benefit remains “carved in” with MyCare Ohio plans
State Readiness Checklist
1. Develop a centralized website dedicated to the education of providers and stakeholders, facilitating two-way communication about the Redesign process.

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

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

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

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


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

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

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

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

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

What is NOT changing?

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

What is changing?

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

Continuity of Certification

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

<table>
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<tr>
<th>If You are Currently Certified for:</th>
<th>Current Rule Number</th>
<th>On January 1, 2018, Your Certification Will Transition to:</th>
<th>New Rule Number</th>
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<td>Residential and Inpatient Substance Use Disorder Services</td>
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</tr>
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Medicaid Mental Health (MH) Benefit
Through December 31, 2017

- Psychiatric Diagnostic Evaluation w/ Medical
  Assessing treatment needs & developing a plan for care

- Mental health Assessment
  Assessing treatment needs & developing a plan for care

- Pharmacological Management
  Services provided by medical staff directly related to MH conditions and symptoms

- Partial Hospitalization
  Teaching skills and providing supports to maintain community based care

- Crisis Intervention
  Services for people in crisis

- Community Psychiatric Supportive Treatment (CPST)
  Care Coordination

- Mental health counseling
  Individual and group counseling may be provided by all credentialed practitioners

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

- Office Administered Medications
  Long Acting Psychotropics

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

- Office Administered Medications
  Long Acting Psychotropics
### Medicaid Substance Use Disorder (SUD) Benefit Through December 31, 2017

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

**Residential**
- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Group Counseling
- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic
Policy Updates and Reminders
Clinical Nurse Specialist (CNS), Certified Nurse Practitioner (CNP), and Physician Assistant

Solution

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

H0004: Behavioral Health Counseling Code for Mental Health

Solution

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

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

Enrollment of Dependently Licensed Practitioners and Paraprofessionals

Solution

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

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

• ODM and OhioMHAS have designed MITS provider types and specialties for the newly enrolling practitioner types (see slides 82 and 83).
Medicaid Coverage of a “Doctor and a Nurse on the Same Day”

Solution

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

SUD Residential Treatment Programs

Solution

- In order to bill Medicaid for SUD residential treatment, your agency needs the appropriate specialty in MITS.

- SUD residential treatment providers must bill the appropriate per diem code for level of care

- If you bill services a la carte, you are misrepresenting the service and level of care

Information on enrolling SUD residential treatment programs in MITS and adding the 954 specialty can be found here:

http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_7-31-2017.pdf
Outpatient SUD Group Counseling

Solution

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

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

• This is a business decision to be made by every SUD provider that offers group counseling to balance productivity and payment.
ODM has revised the reimbursement policy to allow a provider to be paid for SUD IOP group counseling (H0015 no TG modifier) and additional group counseling (H0005) and additional group psychotherapy (90853). One hour for an adult (21 and over) and all medically necessary for a child (under 21).

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

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

**Solution**

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

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

Solution

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

- Payment rate will differ for assistants and trainees as follows:
  1. Assistants/Trainees: under general supervision will receive 85% of their supervisor’s rate
     - Psych assistants: 85% of 100%
     - Social worker trainees, marriage and family therapist trainees, counselor trainees, and chemical dependency counselor assistants: 85% of 85% (72.25%)
  2. Assistants/Trainees under direct supervision will receive their supervisor’s rate if the supervisor’s NPI is on the claim in the supervisor field and the assistant/trainee modifier is also reported
ODM pays for certain behavioral health services when rendered in an emergency room setting (POS 23) or in the community (POS 99). See BH Provider Manual for specific guidance.

- Note: Federal law prohibits Medicaid payment for services rendered when someone is an inmate of a public institution (42 CFR 435.1009)
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
When the MyCare Ohio or managed care plan is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MyCare Ohio plan and managed care plan is directed to accept the CBHC laboratory into their panel.

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

Urine Drug Screening

Solution

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

Outpatient Hospital Clinics

Solution

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

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

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

ODM Rules

• On September 18th, the Joint Legislative Committee on Agency Rule Review (JCARR) hearing included testimony on the ODM rules.

• That hearing cleared the way for final filing the rules for a January 1, 2018 effective date.

• ODM rules were final filed on September 29th.

OhioMHAS Rules

• The JCARR hearing for the OhioMHAS rules was held on May 30th.

• OhioMHAS rules were final filed on September 29th for a January 1, 2018 effective date.

• The certification crosswalk is complete and will be posted at http://mha.ohio.gov/Default.aspx?tabid=743

The Medicaid OAC rules can be found at the Register of Ohio:
http://www.registerofohio.state.oh.us/jsps/publicdisplayrules/processPublicDisplayRules.jsp?agencyNumberString=5160&actionType=final&doWhat=GETBYFILINGAGENCY&Submit=Search

The OhioMHAS OAC rules can be found at the Register of Ohio:
http://www.registerofohio.state.oh.us/jsps/publicdisplayrules/processPublicDisplayRules.jsp?agencyNumberString=5122&actionType=all&doWhat=GETBYFILINGAGENCY&Submit=Search
UPDATE:

• The final rules, effective January 1, 2018, will be posted on Lawriter: http://codes.ohio.gov/oac/

• Please reference this site in the future.
Per the requirements set forth in House Bill 49, ODM will conduct a beta test to demonstrate provider readiness to go-live with Behavioral Health Redesign on January 1, 2018.

- The beta test will be held between October 25th – November 30th.
- ODM posted scenarios that must be used for beta testing on September 25th to the BH.medicaid.ohio.gov website.
- Any provider who wishes to participate may do so.
- Providers must notify ODM of their intent to participate by sending an email with the subject-line “Intent to Beta Test” to BH-Enroll@medicaid.ohio.gov with the following information:
  - Agency name
  - All agency national provider identifier (NPI) numbers involved in testing;
  - The names of every MyCare Ohio plan with which the agency has or intends to have a contract;
  - If the agency uses a third-party vendor for information technology related to claims payment, the identity of that vendor; and
  - A point of contact, including name and telephone number, for the agency.
- On October 25th, the ODM Rapid Response room will re-open for providers and trading partners to quickly address any questions or concerns.
Per House Bill 49, at least half of the providers participating in the beta test must be able to submit a clean claim for community behavioral health services that is properly adjudicated.

ODM will use the following parameters to calculate the beta test results:

- “Clean claims” will be defined as claims that can be adjudicated properly without seeking additional information from the provider.
- Beta providers must test with both ODM as well as the MyCare Ohio plans with whom they do business.
- Providers must test using scenarios defined at: [http://bh.medicaid.ohio.gov/manuals](http://bh.medicaid.ohio.gov/manuals).
  - Provider type 84s (CMHCs) may test any of 84-related scenarios and
  - Provider type 95s (SUD providers) may test any 95-related scenarios
  - Provider specialty 954s (SUD residential providers) may test any 954-related scenarios.
- Providers must submit test files via EDI.
- Providers must submit files by November 30th to be included in the beta test.
## Beta Test Scenarios

**Beta Test Scenarios Available**

- Providers should review the spreadsheet of beta scenarios at: [http://bh.medicaid.ohio.gov/manuals](http://bh.medicaid.ohio.gov/manuals)

- Providers should test all scenarios applicable to their provider type and array of services rendered.

- While State-defined scenarios must be used for beta testing, *providers are encouraged to submit additional test claims for any scenarios that could be billed in their practice except for services requiring a prior authorization.*

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Recently released MITS Bits detailing this information can be found here: [http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITSBITS/BH-MITS-Bits_09272017.pdf](http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITSBITS/BH-MITS-Bits_09272017.pdf)

Beta Testing: SUD Residential

Provider Specialty 954 (SUD residential)

- The beta scenarios available on the BH Redesign website include 7 scenarios specific to SUD residential.

- In order to test the SUD residential scenarios, providers must have the new MITS provider specialty 954 added to their Ohio Medicaid provider record in MITS*

*Information on enrolling SUD residential treatment programs in MITS and adding the 954 specialty can be found here: http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_7-31-2017.pdf
General 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 during the following times*:
Monday-Friday 7:30 am – 7:00 pm
Saturday 9:00 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 testing issues) OR send email to BH-Enroll@medicaid.ohio.gov.

Rapid Response Team will be available during the following times*:
Monday-Friday 7:30 am – 7:00 pm
Saturday 9:00 am – 1:00 pm

*PLEASE NOTE: In observance of Thanksgiving, the ODM Rapid Response Team and DXC will not be available after 4pm on Wednesday, November 22nd through Thursday, November 23rd. The Rapid Response Team and DXC will be available again starting at 7:30am on Friday, November 24th.
MyCare Ohio
MyCare Ohio Plans Map

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

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

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

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

**IMPORTANT NOTES**

- **MyCare Ohio providers with established contracts should be testing now.**

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

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

- Trading partners are not required to have an agreement with the plans in order to test as long as the MyCare Ohio Plan has accurate billing information from the provider.

Link to MITS Bits for MyCare Ohio Plan Testing Information:

http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf
### MyCare Ohio Policy Reminders

<table>
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<tr>
<th><strong>Timely Filing</strong></th>
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<tr>
<td>• Until December 31, 2018, the MyCare Ohio Plan must accept provider claims for community BH services described in OAC Chapter 5160-27 for no less than 180 days and not to exceed 365 days after the service is provided. A plan may negotiate timely filing requirements within these limitations through their contract with the community BH provider.</td>
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<table>
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<tr>
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<tr>
<td>• MyCare Ohio Plans will prior authorize the new behavioral health benefit package beginning January 1, 2018, using ODM established criteria until December 31, 2018. As of January 1, 2019, plans may establish their own prior authorization criteria.</td>
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<table>
<thead>
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<th><strong>Rates</strong></th>
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<tbody>
<tr>
<td>• MyCare Ohio Plans must maintain FFS rates as a floor for community BH providers through December 31, 2018, when the MyCare Ohio Plan and provider contract pays on a FFS basis.</td>
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<table>
<thead>
<tr>
<th><strong>Continuity of Care</strong></th>
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<tbody>
<tr>
<td>• The continuity of care period is from January 1, 2018, until March 30, 2018. Therefore, contracts with MyCare Ohio Plans should be in place before January 1, 2018. If a provider/MyCare Ohio Plan contract has not been executed by March 30, 2018, then the provider and the MyCare Ohio Plan may enter into a single case agreement or may transition the member to an in-network provider to assure continuity of care for the Medicaid enrollee.</td>
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Practitioner Enrollment and Affiliation
Practitioners must be enrolled in MITS and affiliated with their employing/contracted agency or agencies effective for dates of service on or after those listed above.
Practitioners Required to Enroll in Ohio Medicaid, Effective For Dates of Service On and After January 1, 2018

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<th>Medical and Licensed Independent Practitioners</th>
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<tr>
<td>Physicians</td>
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<tr>
<td>Certified Nurse Practitioners</td>
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<tr>
<td>Clinical Nurse Specialists</td>
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<td>Licensed Practical Nurses</td>
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Exception: Prescribers already registered with ODM as Ordering, Referring or Prescribing providers need not re-enroll.

ORP is no longer a valid provider status so no new enrollments.

**ADDITIONAL GUIDANCE**

- Practitioners must be affiliated with their employing/contracted agency or agencies; either the agency or practitioner may perform the affiliation in MITS.
- Practitioner or agency/agencies may “un-affiliate” rendering practitioners listed above when necessary.
- BH Provider Affiliation Report MITS Bits was released on April 11th and can be found at: [HTTP://MHA.OHIO.GOV/PORTALS/0/ASSETS/FUNDING/MACSIS/MITS-BITS/BH-MITS-BITS-BH-REDESIGN-UPDATE_4-11-17.PDF](HTTP://MHA.OHIO.GOV/PORTALS/0/ASSETS/FUNDING/MACSIS/MITS-BITS/BH-MITS-BITS-BH-REDESIGN-UPDATE_4-11-17.PDF)
- See section below on Enrolling Dependently Licensed and Paraprofessionals (page 80)
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>
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<tr>
<td>Licensed Professional Clinical Counselor</td>
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<tr>
<td>Licensed Independent Marriage and Family Therapist</td>
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<td>Licensed Independent Chemical Dependency Counselor</td>
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</tr>
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<td></td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td></td>
</tr>
<tr>
<td>Licensed School Psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
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<th></th>
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</tbody>
</table>

*Now – 12/31/17*
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).

**Dates of Service**

- January 1, 2018

**In Ohio, the MAC is CGS Administrators LLC.**
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.
MyCare Ohio Members

**NOTE**

1. **Submit claims to the MyCare Ohio plan**

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

3. **When the Medicaid rate is higher than Medicare, there are is no additional payment from Medicaid**
Non-MyCare Medicare/Medicaid Members

**NOTE**

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

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

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

CGS Medicare Part B contact information: [https://www.cgsmedicare.com/partb/cs/contactinfo.html](https://www.cgsmedicare.com/partb/cs/contactinfo.html)
National Correct Coding Initiative (NCCI)
Remember that Medicaid NCCI edits will be effective January 1, 2018

Two types of edits:
- Procedure to Procedures (PTP) and Medically Unlikely Edits (MUEs)

Providers should check NCCI quarterly updates (Jan, Apr, Jul, Oct)

NCCI edits are active in the MITS testing environment

Due to NCCI edits and timing of enrollment of dependently licensed practitioners, the State will allow H0004 to be used until July 1, 2018, for mental health individual and group counseling services. This will allow payment when the service is rendered by two dependently licensed practitioners, on the same day, to the same client, at the same agency. *(reference back to slide 22)*

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

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

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

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

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

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

SOLUTION:
The State has obtained a list from the Ohio Board of Nursing and will update it regularly.
Prior Authorization Calendar
Prior Authorization Calendar

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

Transition to new BH code set
- Jan 2018
  • MyCare Ohio plans process new PAs in accordance with state policy for their members
  • KEPRO processes all other new PAs

Managed Care Carve-In
- Apr 2018
  • Managed Care Carve-In
  • 6 months remain of MyCare Ohio plans honoring state policy
  • MCPs process new PAs in accordance with state policy & honor existing PAs until they expire
- Jul 2018
  • Managed Care Carve-In
  • 6 months remain of MCPs honoring state PA policy
- Oct 2018
  • Managed Care Carve-In
  • MyCare Ohio plans set their own policies for new PAs and honor existing PAs until they expire
- Jan 2019
  • Managed Care Carve-In
  • MCPs set their own policies for new PAs and honor existing PAs until they expire

2018
2019
2020
## Prior Authorization under BH Redesign

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<th>Description and Code</th>
<th>Benefit Period</th>
<th>Authorization Requirement</th>
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Any service or ASAM level of care not listed in this table is not subject to prior authorization.
Behavioral Health Redesign Website
Behavioral Health Redesign Website

Preparing for BH Redesign

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

• Manuals, Rates & Resources
• Training Opportunities
• MITS Bits Provider Information Releases

Go To: bh.medicaid.ohio.gov
Implementation of the New BH Benefit Package: 1/1/18 – 6/30/18
Providers must consult OAC rules, the BH Provider Manual and BH Workbook Code Chart for complete policy guidance on Medicaid behavioral health service definitions, client eligibility requirements, standards for medical record documentation and when prior authorization is required. However, neither these resources nor ODM staff can provide coding and billing guidance specific to individual provider business models or clinical circumstances. Providers should seek qualified billing guidance from certified coders, CPT/HCPCS code books, and professional associations to determine the most appropriate coding and billing logic for each individual situation.

NOTES ON CODING & BILLING GUIDANCE:

Final Version is now available at http://bh.medicaid.ohio.gov/manuals

Final Version is now available at http://bh.medicaid.ohio.gov/manuals
Are You Using the BH Benefit Package for Your Clients?
How is your agency utilizing the new community BH benefit package to meet each of the client’s needs?

**Introspective Questions For Your Agency:**

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

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

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

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

**MHAS Resources:**

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

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

<table>
<thead>
<tr>
<th></th>
<th>Things you should be monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>837P/835: HIPAA standardized inbound and outbound claim EDI transactions</td>
</tr>
<tr>
<td>2</td>
<td>MITS portal-entered claims/remittance advice - DON’T show up in the 835</td>
</tr>
<tr>
<td>3</td>
<td>Pay attention to denial reasons</td>
</tr>
<tr>
<td>4</td>
<td>See <a href="http://www.bh.medicaid.ohio.gov">www.bh.medicaid.ohio.gov</a> under the IT Resources section for ‘MITS to HIPAA Explanation of Benefits (EOB) Crosswalk’</td>
</tr>
<tr>
<td>5</td>
<td>Modifying claims as needed in MITS <em>(stay for ombuds training for more information)</em></td>
</tr>
<tr>
<td>6</td>
<td>Call MITS provider hotline at 1-800-686-1516 or contact the appropriate MyCare Ohio plan</td>
</tr>
</tbody>
</table>
Timely Filing for FFS: Claim Submission

OAC 5160-1-19

Providers have 365 days to submit FFS claims.

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

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

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

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

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

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

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

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

How to Contact ODM

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

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

**GOAL:**

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

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

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

- ODM continually monitors the MyCare Ohio plans for program compliance.
- In addition, ODM is performing a readiness review process with the plans during October and November.
Enrolling Dependentlly Licensed and Paraprofessionals
Begin Enrolling Behavioral Health Practitioners During this Time Period *

<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>

For BHPs listed in light blue boxes:
- Practitioners must be enrolled and affiliated by July 1, 2018, and any new practitioners must be enrolled and/or affiliated thereafter.
- Practitioners will be able to enroll in MITS by early 2018.
- Once enrolled, practitioners can be affiliated.

* When employed by or contracted with an OhioMHAS certified agency/program
### Dependently Licensed Practitioners

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

### Additional Information

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

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

**Additional Information**

- Paraprofessional practitioners can begin the process by obtaining an NPI now if they do not currently have one by using [https://nppes.cms.hhs.gov/#/](https://nppes.cms.hhs.gov/#/).


- Information on timeline for enrolling in MITS is forthcoming.
# How to Obtain a National Provider Identifier

**STEPS**


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

3. Complete enrollment

4. If enrollment status fails to update within 2-4 days, follow the steps below to update:
   - Go to NPPES and log in as the provider
   - On the home screen, select “Manage Provider Information” to show application status
   - If it shows “Change in Progress”, click the pencil option
   - make sure all steps of the application process are completed
   - Click through each screen to verify the information
   - Click next at the bottom of each screen
   - On the final page, click submit
   - Enrollment status then should change
How to Enroll a Paraprofessional in Medicaid Without an NPI

1. The NPI field in the Medicaid application is not required for Care Management Specialist, Qualified Mental Health Specialists, Peer Recovery Supporters, and IPS-SE Practitioners who are not another type of practitioner. Leave that field blank and continue on with the rest of the application.

2. The system will assign you a Medicaid ID – this is the number you should use on all Medicaid claims in the NPI field.
Preparing for Managed Care Carve-In
Preparing for Managed Care Carve-In

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

**IMPORTANT NOTES**

- Behavioral Health providers should begin contracting with the Managed Care Plans to prepare for carve-in if they have not already done so.
- Testing can begin as soon as providers have contacted the plans and verified billing information to obtain testing access if necessary.
- Providers do not have to be fully credentialed to begin testing with the plans.
- Trading partners are not required to have an agreement with the plans in order to test as long as the Managed Care Plan has accurate billing information from the provider.

Note: Managed Care Plans will have to close their testing sometime before July 1, 2018
State Monitoring of Managed Care Plan Readiness

Monitoring

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

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

b. 75% of test claims submitted correctly by contracted BH providers must adjudicate correctly through the system by May 31, 2018.
The plans have developed a managed care information grid with important information related to carve-in. This document addresses point of contacts, operations, billing, prior authorization, and pharmacy. This document is available at http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans.
Prior Authorization
Prior Authorization Calendar

Transition to new BH code set

Jan

2018

Managed Care Carve-In

Apr

Jul

Oct

2019

2020

- MyCare Ohio plans process new PAs in accordance with state policy for their members
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- Medicaid benefit year is the calendar year (Jan-Dec).
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Any service or ASAM level of care not listed in this table is not subject to prior authorization.
Resources on How to Enter a FFS Prior Authorization
Resources on How to Enter a FFS Prior Authorization in MITS

- 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 the 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.
Submitting FFS Prior Authorization Requests in MITS

- ODM hosted a training webinar on May 23rd that provided step-by-step instructions on how community behavioral health agencies can submit requests for prior authorization for services such as ACT, IHBT, SUD Partial Hospitalization, SUD Residential, etc.

- The webinar recording and slide presentation was posted to the BH Redesign website at: [http://bh.medicaid.ohio.gov/training](http://bh.medicaid.ohio.gov/training)
  - View the webinar: [https://register.gotowebinar.com/register/8342927488327893763](https://register.gotowebinar.com/register/8342927488327893763)
## Managed Care Prior Authorization for BH Redesign

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

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

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

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

### Both MyCare Ohio Plans and Managed Care

- Both MyCare Ohio and Managed Care Plans will be required to follow behavioral health coverage policies as established through redesign for 12 months (including prior authorization and rates).
  - MyCare Ohio until December 31, 2018
  - Managed Care until June 30, 2019
Community BH Benefit Fully Integrated with Medicaid MCPs: 7/1/18 – Thereafter
Integration – The community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. **Implementation on target for July 1, 2018.**

**July 1, 2018: Behavioral health benefit incorporated into managed care:**

**AKA “Carve-In”**

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

### Things you should be monitoring

1. **837P/835:** HIPAA standardized inbound and outbound claim EDI transactions
2. **MCP portal-entered claims**
3. Pay attention to denial reasons
4. Talk to your MCP about explanation of benefit coding and modifying and adjusting claims
Plan Requirements
Post-Integration
Plans are Required to Follow ODM Policy
Post-Integration

Timely Filing

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

Prior Authorization

- Managed care plans are required to accept and continue ODM prior authorizations until they expire.
- Plans are required to use ODM’s prior authorization criteria for one year after integration through June 30, 2019.

Rates

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

Continuity of Care

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

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

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

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

**CareSource**
- 24/7 Notification Fax Line: 1-937-487-1664
- 24/7 Notification Email: mm-bh@caresource.com
- Escalation/Other Questions: brandon.carr@caresource.com

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

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

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

How to Contact ODM

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

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

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

2. Providers submit claims as they do today.

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

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

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

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

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

   Compare to predetermined “commendable” and “acceptable” levels.
Ohio’s episode timeline by wave

<table>
<thead>
<tr>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Wave 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>• Acute PCI, Asthma, COPD, Non-acute PCI, Perinatal, Total joint replacement</td>
<td>• Appendectomy, Cholecystectomy, Colonoscopy, EGD, GI bleed, URI, UTI</td>
</tr>
<tr>
<td></td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
<tr>
<td>2015</td>
<td>Performance Y1</td>
<td>Performance Y1</td>
</tr>
<tr>
<td>2016</td>
<td>Performance Y2</td>
<td>Performance Y2</td>
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<tr>
<td>2017</td>
<td>Performance Y3</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td>Reporting only¹</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

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

- 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

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

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 weeks</td>
<td>Align on care delivery model and sources of value</td>
</tr>
<tr>
<td>3 weeks</td>
<td>Determine target population and scope of activities</td>
</tr>
<tr>
<td>3 weeks</td>
<td>Align on accountability and provider eligibility</td>
</tr>
<tr>
<td>2 weeks</td>
<td>Determine framework for incentive structure and considerations for implementation</td>
</tr>
<tr>
<td>3-6 months</td>
<td>Detailed design and launch</td>
</tr>
<tr>
<td></td>
<td>Prioritize design decisions</td>
</tr>
<tr>
<td></td>
<td>Share case studies from other states</td>
</tr>
<tr>
<td></td>
<td>Review member-journeys to align on sources of value</td>
</tr>
<tr>
<td></td>
<td>Create definition for high-needs BH population</td>
</tr>
<tr>
<td></td>
<td>Test activities required to support care coordination and address sources of value</td>
</tr>
<tr>
<td></td>
<td>Develop hypotheses for which providers are well positioned to fulfil care coordination</td>
</tr>
<tr>
<td></td>
<td>Determine split of accountability between CPC and BH providers</td>
</tr>
<tr>
<td></td>
<td>Outline activities to be driven by BH provider</td>
</tr>
<tr>
<td></td>
<td>Build member journeys to test “edge cases” and points of potential entry / exit to BH care coordination</td>
</tr>
<tr>
<td></td>
<td>Align on high-level care team requirements (to support care coordination requirements)</td>
</tr>
<tr>
<td></td>
<td>Outline potential incentive streams</td>
</tr>
<tr>
<td></td>
<td>Outline considerations for detailed design and implementation</td>
</tr>
<tr>
<td></td>
<td>Determine provider assessment and enrollment process</td>
</tr>
<tr>
<td></td>
<td>Finalize member eligibility and attribution logic</td>
</tr>
<tr>
<td></td>
<td>Finalize payment model</td>
</tr>
<tr>
<td></td>
<td>Determine reporting, infrastructure &amp; regulatory requirements</td>
</tr>
</tbody>
</table>
Questions?
Medicaid Basic Billing Training for BH Provider Agencies
External Business Relations Team

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

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

Is the fundamental concept underlying the Medicaid Program

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

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

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

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

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

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

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

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

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

Medicaid **ONLY** pays their Medicare Part B premium
This is **NOT** Medicaid eligibility
There is **NO** cost-sharing eligibility
Conditions of Eligibility and Verifications
OAC 5160:1-2-10

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

How do you know someone is enrolled?

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

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

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAGI-GROUP VIII: Alternative Benefit Plan Medicaid Expansion</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
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<tr>
<td>MAGI-GROUP VIII: MRDD Targeted Case Mgmt</td>
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<tr>
<td>MAGI-GROUP VIII: Alcohol and Drug Addiction Services</td>
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<td>02/28/2017</td>
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<td>MAGI-GROUP VIII: Ohio Mental health</td>
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<td>02/28/2017</td>
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<td>MAGI-GROUP VIII: Medicaid</td>
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<td>02/28/2017</td>
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**Case/Cat/Seq Spenddown**

***No rows found***

**TPL**

***No rows found***

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<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>
Managed Care Sample Card

Name:  
MMIS#:  
PCP Name:  
Effective Date:  
DOB:  
PCP Phone #:  

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

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

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

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
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<tr>
<td>MRDD Targeted Case Mgmt</td>
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<td>Alcohol and Drug Addiction Services</td>
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<td>Ohio Mental Health</td>
<td>01/01/2017</td>
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**Case/Cat/Seq Spenddown**

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**TPL**

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**Managed Care**

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<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, MyCare Ohio</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td>Dual Benefits</td>
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</table>

**Lock-In**

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**Medicare**

<table>
<thead>
<tr>
<th>Coverage</th>
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<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>HIC</th>
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<tbody>
<tr>
<td>PART A</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
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<tr>
<td>PART B</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
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<tr>
<td>PART C</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td>CARESOURCE MYCARE OHIO</td>
<td>H8452</td>
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<td>PART D</td>
<td>01/01/2017</td>
<td>01/31/2017</td>
<td>&quot;H8452/001&quot;</td>
<td>001</td>
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</tr>
</tbody>
</table>

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

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

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

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

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

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

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

Buckeye Community Health Plan - MyCare Ohio

Member Name: <Cardholder Name>
<Health Plan: <Card Issuer Identifier>>

MMIS Number: <Medicaid Recipient ID#2>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

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

* Buckeye Medicaid Member Only *

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

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

Behavioral Health Crisis: <866-549-8289>
Care Management: <866-549-8289>
24-Hour Nurse Advice: <866-246-4358>
TTY: 800-750-0750

Website: http://mmp.bchpohio.com

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

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

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

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>Aetna Buckeye, Fulton, Lucas, Ottawa, Wood</td>
</tr>
<tr>
<td>Southwest</td>
<td>Aetna Molina, Butler, Warren, Clinton, Hamilton, Clermont</td>
</tr>
<tr>
<td>West Central</td>
<td>Buckeye Molina, Clark, Green, Montgomery</td>
</tr>
<tr>
<td>Central</td>
<td>Aetna Molina, Union, Delaware, Franklin, Pickaway, Madison</td>
</tr>
<tr>
<td>East Central</td>
<td>Caresource United, Summit, Portage, Stark, Wayne</td>
</tr>
<tr>
<td>Northeast Central</td>
<td>Caresource United, Trumbull, Mahoning, Columbiana</td>
</tr>
<tr>
<td>Northeast</td>
<td>Caresource Buckeye United, Lorain, Cuyahoga, Lake, Geauga, Medina</td>
</tr>
</tbody>
</table>
Provider Complaint Form

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

OH Medicaid Managed Care Provider Complaint Form

Instructions

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

Complaint Details

MCP Name: *

Complaint Reason: *

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

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

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

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

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

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

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

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

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

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

Scroll to the bottom of the page

PHARMACY CLAIMS:
- ODM Pharmacy Benefits

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

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

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

MODIFIERS:
- Modifiers recognized by ODM

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

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

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

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

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

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

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

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

Must have the billing number or SSN plus the DOB

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

### Recipient Information

- **Medicaid Billing Number**
- **Last Name**
- **First Name**
- **Gender**
- **Date of Birth**
- **Date of Death**
- **SSN**
- **County of Residence**
- **County of Eligibility**
- **Number Bed Hold Days Used Paid CY**

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Medicaid</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
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<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<td>Ohio Mental health</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII: Alternative Benefit Plan Medicaid Expansion</td>
<td>03/01/2014</td>
<td>04/30/2014</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<td>MAGI-GROUP VIII: MRDD Targeted Case Mgmt</td>
<td>03/01/2014</td>
<td>04/30/2014</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

---

### TPL

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Carrier Number</th>
<th>NATIC</th>
<th>Policy Number</th>
<th>Policy Holder</th>
<th>Coverage Type</th>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IND</td>
<td>PHYSICIAN/OUTPATIENT COVERAGE</td>
<td>02/01/2015</td>
<td>02/28/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IND</td>
<td>INPATIENT COVERAGE</td>
<td>02/01/2015</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>

### Managed Care

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

Search for children who are on the same case as their mother
Search for an Ordering Practitioner in MITS

![Screen capture of MITS interface with search results](image)

<table>
<thead>
<tr>
<th>Ordering Provider NPI</th>
<th>Ordering Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH, JOHN D</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN A</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN M</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN R</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN S</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN B</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN F</td>
<td></td>
</tr>
<tr>
<td>SMITH, JOHN P</td>
<td></td>
</tr>
</tbody>
</table>
## Internal Control Number (ICN)

All claims are assigned an ICN

### Example ICN: 2017170357321

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

Providers have 365 days to submit FFS claims

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

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

Claims over 2 years old will be denied

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

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

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN  Reason  

Special Timely Filing Bill Instructions

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

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

Must use the spacing shown

```
Notes
DECISION20171225
```
Special Filing Bill Instructions for EDI

For claims submitted through electronic data interchange (EDI), ANSI ASC X12 HIPPA 5010:
Loop 2300-NTE Claim Note
NTE01-ADD
NTE02-

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

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

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

Medicare is the most common TPL payer

Providers will need to pursue Medicare enrollment if their agency and/or individual practitioners are not already enrolled

Enrollment with Medicare allows for claims to “cross-over” to Ohio Medicaid for co-payment adjudication

Payment from commercial insurance plans and Medicare is required prior to billing Ohio Medicaid
COB Claim Submission Facts

- Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.
- HIPAA compliant adjustment reason codes and amounts are required to be on the claim.
- MITS will automatically calculate the allowed amount.
Header vs Detail

Header level

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

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items
Medicare Part B only Claim Submission
Medicare Part B only Claim Submission

### Diagnosis

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>N390</td>
<td>URINARY TRACT INFECTION, SITE NOT SPECIFIC</td>
</tr>
<tr>
<td>02</td>
<td>R0902</td>
<td>HYPOXEMIA</td>
</tr>
<tr>
<td>03</td>
<td>R4182</td>
<td>ALTERED MENTAL STATUS, UNSPECIFIED</td>
</tr>
<tr>
<td>04</td>
<td>N179</td>
<td>ACUTE KIDNEY FAILURE, UNSPECIFIED</td>
</tr>
</tbody>
</table>

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

### Header - Other Payer

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SELF</td>
<td></td>
<td>11/05/2015</td>
<td></td>
</tr>
</tbody>
</table>

Insurance Carrier Name: CGS ADMINISTRATORS, LLC OH
Electronic Payer ID: 
Insured’s Policy ID: 
Payer Sequence: PRIMARY
Medicare ICN:

Allowed Amount: $101.60

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

*** No rows found ***

Select row above to update - or - click add an item button below.
Medicare Part B only Claim Submission
Medicare Part B only Claim Submission
Tertiary Claim Submission
Tertiary Claim Submission
Tertiary Claim Submission

| Item | FDOS       | Units | Charges | Medicaid Allowed Amount | Status | Place of Service | Procedure Code | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 | Final EAPG |
|------|------------|-------|---------|-------------------------|--------|------------------|----------------|-------------|------------|------------|------------|------------|------------|
| 1    | 03/01/2015 | 1.00  | $249.00 | $59.35                  | PAID 23| 23               | 99284          |             |            |            |            |            |

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

- Place Of Service: 23
- Procedure Code: 99284

- Referred EPSDT Service/ Family Planning
  - Diagnosis Code Pointer: 01

- Final EAPG: 23
- Pay Action: 23

**Detail - Other Payer**

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

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

**Line Level Adjustment Reason Codes and Amounts**

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>Electronic Payer ID</th>
<th>Paid Date</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/01/2015</td>
<td></td>
<td>$161.06</td>
</tr>
</tbody>
</table>

Detail - Other Payer Amounts and Adjustment Reason Codes
Tertiary Claim Submission
Crossover Claim Submission
Crossover Claim Submission
Crossover Claim Submission
Crossover Claim Submission

### Crossover Claim Submission Form

#### Detail - Other Payer Amounts and Adjustment Reason Codes

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$43.70</td>
</tr>
<tr>
<td>1/</td>
<td>PR-Patient Responsibility</td>
<td>2</td>
<td>$5.54</td>
</tr>
<tr>
<td>1/</td>
<td>CO-Contractual Obligations</td>
<td>44</td>
<td>$0.44</td>
</tr>
<tr>
<td>1/</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$54.60</td>
</tr>
</tbody>
</table>

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

#### Payer Line Level Adjustment Reason Codes (ARC) and Amounts

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$54.60</td>
</tr>
</tbody>
</table>

#### Attachments

***No rows found***

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

#### Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Reason

#### Claim Status Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Claim ICN</th>
<th>Paid Date</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAID</td>
<td></td>
<td>09/30/2015</td>
<td>$22.92</td>
</tr>
</tbody>
</table>
The Washington Publishing website provides adjustment reason codes (ARCs) that must be noted on claims that involve “other payers”.

**COMMON ARCs:**

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

Health Insurance Fact Request (Form 6614)

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

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

Please select which health insurance information to update  □ Private health insurance  □ Medicare

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number</td>
<td>Provider Name</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Email Address</td>
<td>Fax Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recipient Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient(s) Name</td>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Name of Insurance</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Policy Holder Name</td>
<td>Policy Number or Medicare Number</td>
</tr>
<tr>
<td>Policy Holder Social Security Number (SSN)</td>
<td>Policy Holder Phone Number</td>
</tr>
</tbody>
</table>

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

Date health insurance terminated per attached documents

Additional Comments

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

If you have questions contact the Coordination of Benefits Section at (614) 752-5768. The FAX number is (614) 728-0757.

Complete for Medicare and TPL file updates ONLY

For faster service fax the form, do not mail!
Questions?
Appendix
Inpatient Psychiatric Services
Inpatient Psychiatric Benefit

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

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

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

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

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

* For a person needing medically appropriate inpatient psychiatric care, they must be offered #1 or #2 to then be offered #3 or #4.
  * This ensures inpatient psychiatric services are provided “in lieu of services” covered under the state plan (#1 and #2)
## Inpatient Psychiatric Admissions – Managed Care

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

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Group topic 1</th>
<th>Group topic 2</th>
<th>Group topic 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 am</td>
<td>Group leader</td>
<td>Group leader</td>
<td>Group leader</td>
</tr>
<tr>
<td>10 am</td>
<td>#Doug, LICDC</td>
<td>#Sysilie, CDCA</td>
<td></td>
</tr>
</tbody>
</table>

Patients

H0005 HK 12 units

A + B = H0005 HK 1 unit

OR

A + B = H0005 U6 1 unit

H0005 HK 8 units OR H0005 U6 8 units

H0005 HK 8 units OR H0005 U6 8 units

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

Group leaders
- Doug, LICDC
- Sysilie, CDCA

Patients

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 U6 1 unit

H0005 HK 8 units OR H0005 U6 8 units

H0005 HK 8 units OR H0005 U6 8 units

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

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

Group leaders

Doug, LICDC
Sysilie, CDCA

Patients

9 am
Group topic 1

10 am
Group topic 2

11 am
Group topic 3

12 pm

H0015 HK TG 1 unit

H0015 HK TG 1 unit

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

H0005 HK TG 8 units
OR
H0005 U6 TG 8 units

H0005 HK TG 8 units
OR
H0005 U6 TG 8 units

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

(45 minutes)
Examples of Medicaid Cards
Example of MyCare Ohio Managed Care Cards
(as of the date of this presentation)

CareSource:

CareSource MyCare Ohio Medicare-Medicaid Member ID Card:

CareSource MyCare Ohio Medicaid Only Member ID Card:

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

Back of CareSource MyCare Ohio Medicaid Only Member ID Card:

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

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

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