Behavioral Health Redesign Provider Training: MyCare

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BH1182-122017

Behavioral Health Redesign

- Today: Behavioral Health Redesign: MyCare 1/1/2018
  - New Services & Benefits
  - Prior Authorization & Notification Requirements
  - Billing and Claims Submissions
  - Claim Reconsideration Process
  - Provider Resources
  - How to Contact Us
- Future: Medicaid Carve-In 7/1/2018

Please note the ODM material in this presentation is current as of ODM's Behavioral Health Provider Manual published on 12/4/17.

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Our United Culture

Our mission is to help people live healthier lives
Our role is to make health care work for everyone

Integrity.	Honor commitments Never compromise ethics
Compassion.	Walk in the shoes of people we serve and those with whom we work
Relationships.	Build trust through collaboration
Innovation.	Invent the future, learn from the past
Performance.	Demonstrate excellence in everything we do

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Introduction to Optum

- United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS).

- United Behavioral Health, operating under the brand Optum, is a wholly owned subsidiary of UnitedHealth Group. Optum is a health services business. You will see both UBH and Optum in our communications to you.

- Optum is contracted with UnitedHealthcare Community Plan to administer the behavioral health portion of the Ohio Behavioral Health Redesign Program beginning on January 1, 2018. This includes both mental health and substance use disorders.

Behavioral Health Services

Behavioral and Medical Integration

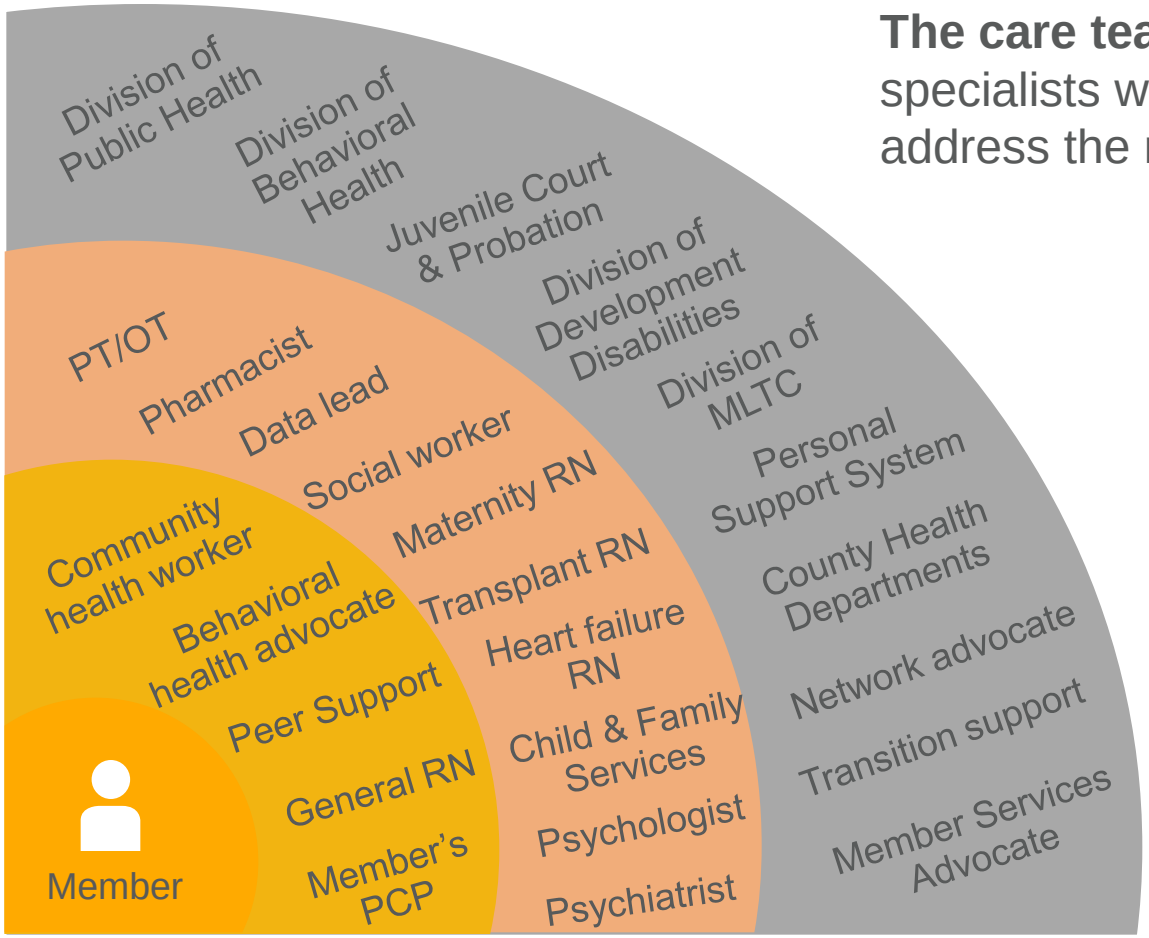
Our Goal: Achieve medical and behavioral health care integration for all members

- Behavioral providers are asked to refer members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment
- Primary Care Physicians are asked to identify and refer members with known or suspected and untreated mental health or substance use disorders for behavioral health examination and treatment

Our Goal: Achieve integration of treatment for mental health and substance use disorder conditions

- Our care management program assists members with complex medical and/or behavioral health needs in the coordination of their care
- All members are expected to be treated from a holistic standpoint; this is especially true for high-risk, high-service utilizers and other members with complex needs

Integrated Care Team



The care team will consist of program specialists who can "flex" to quickly address the needs of the member

Optimal health and well-being

Integrated care is…

a focus on the whole-person: specifically how the physical, behavioral and social needs of a person are inter-connected to maintain good health

Aligned to the delivery system

Care focused on supporting the physician/practitioner to member relationship

Role of the Care Manager

- The care manager helps members with Serious and Persistent Mental Illness (SPMI), complex behavioral health, and co-morbid medical conditions connect with needed services and resources
- Care managers collaborate and partner with individuals in the development of a comprehensive plan of care which coordinates the following:
  - Therapeutic services (therapy, medication management)
  - Community and psychosocial supports (education/support regarding illness, coordination with support system, other supportive services)
  - Coordination of care between physical and behavioral health providers and clinicians
  - Recovery and Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities)
  - Other services as appropriate (legal, shelter, basic needs, etc.)
  - For members with SPMI:
    - Tailored engagement to support whole person treatment/medication follow up
    - Development of a communication strategy for coordination between family, service providers and community service organizations
    - Individualized communication about service gaps

New Covered Mental Health Services

- Respite (Managed Care only)
- Screening, Brief Intervention & Referral (SBIRT)
- Assertive Community Treatment (ACT)
- Intensive Home Based Therapy (IHBT)
- Family Psychotherapy
- TBS Group Treatment (replaces Partial Hosp.)
- Psychological Testing
- Therapeutic Behavioral Service (TBS)
- Psychosocial Rehabilitation (PSR)
- Primary Care Services, Labs, Vaccines

New Covered Substance Use Disorder Services

- Methadone Administration
- Buprenorphine Administration
- Peer Recovery Support
- Intensive Outpatient Group Counseling
- Partial Hospitalization Group Counseling
- SUD Residential
- Primary Care Services, Labs, Vaccines

Substance Use Disorder (SUD) COVERAGE

The Ohio Medicaid program has selected the American Society of Addiction Medicine (ASAM) placement criteria as the standard of measure for guiding treatment for individuals with SUD conditions, including individuals with co-occurring MH conditions.

The ASAM criteria has been selected to bring an objective strengths-based evaluation and placement methodology into practice to address individual patient needs, strengths, and supports.

The Ohio Medicaid program covers community-based SUD services to Medicaid beneficiaries provided by SUD programs within Ohio that are certified by Ohio MHAS and enrolled with ODM as a community SUD service provider.

Specialized Recovery Services (SRS) Program [1915(i)]

The SRS program is available to individuals who meet certain financial criteria and have been diagnosed with a serious and persistent mental illness (SPMI).

In addition to full Medicaid coverage, individuals enrolled in the SRS program have access to Individualized Placement and Support-Supported Employment (IPS-SE) and Peer Recovery Support (PRS).

For further information, please see the SRS Provider Manual.

Psychological Testing

Code **96101** (psychological testing) includes the administration, interpretation, and scoring of the tests mentioned in the CPT descriptions and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Documentation: The medical record must indicate the presence of mental illness or signs of mental illness for:

- Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
- Differential diagnosis between psychogenic and neurogenic syndromes
- Delineation of the neurocognitive effects of central nervous system disorders
- Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
- Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.

Psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved.

Psychological Testing cont.

Code **96118** is defined by the CPT narrative and describes testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain.

The content of neuropsychological testing procedure 96118 differs from that of psychological testing (96101, 96111, 96116) in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.).

Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Vaccines

Ohio Medicaid allows BH providers to administer and receive reimbursement for a limited number of vaccines to their adult clients and to children under the Vaccines for Children program, operated by the Ohio Department of Health (ODH).

Vaccines may be administered at the following place of services: office, inpatient and outpatient residential facilities, and CMHC.

The Vaccines for Children (VFC) program is a federally-funded program overseen by the Centers for Disease Control and Prevention (CDC) and administered by ODH.

The VFC program supplies vaccines at no cost to public and private health care providers who enroll and agree to immunize eligible children in their medical practice or clinic.

Note that vaccines and labs are contracted through UnitedHealthcare.

Vaccines for Children (VFC) Eligibility Criteria

Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccines:

- Medicaid eligible: A child who is eligible for the Medicaid program.
- Uninsured: A child who has no health insurance coverage.
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act.
- Underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC eligible for non-covered vaccines only).

Underinsured children are eligible to receive VFC vaccines only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputation agreement.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

Benefits and Authorizations

Benefits and Prior Authorization

A coverage and limitations workbook has been created to assist providers in understanding the redesigned behavioral health benefit from a coding, payment, practitioner, and coverage perspective.

The workbook may be found at: http://bh.medicaid.ohio.gov/manuals. In the redesigned benefit package, there are services and/or levels of care that are subject to prior authorization.

Authorization Requirements

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
Psychological Testing 96101, 96111, 96116, 96118	Calendar year	Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization once limit is reached
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.

Authorization Requirements cont.

Alcohol or Drug Assessment H0001	Calendar year	2 hours per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached.
SUD Residential H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.

Authorization

Non-emergent situations	Emergent situations
• Prior authorization can be obtained by a member, family member, or a provider. When calling UHC, be prepared to provide demographic information and a brief description of the presenting problem. UHC will explain the services available under their benefit plan.	• A medical professional, a member, or a lay person in an emergency situation can identify the need for behavioral health services. Conditions that warrant an emergency admission are situations in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance abuse. • Contact UHC for prior authorization of continued stay or additional care.

Authorization phone number: 1-866-261-7692

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Prior Authorization Process

Request Via Phone	Request Via Portal (M-F 8 a.m. - 5 p.m. CST only)
• Provider calls **1-866-261-7692** • Provider selects the Mental Health/Substance use option • Provider services representative confirms eligibility/benefit questions • Call is transferred to Behavioral Health Care Advocate to complete the prior authorization	• Provider logs in to **www.unitedhealthcareonline.com** • Provider verifies member eligibility through the portal • Provider enters authorization request on the portal • Authorization request information received by a Behavioral Health Care Advocate • Behavioral Health Care Advocate calls provider back to complete authorization process

Prior Authorization Continued

- Uniform prior authorization form created for community BH services across all MCO's

- http://bh.medicaid.ohio.gov/manuals > Provider > Medicaid Managed Care Plans > MyCare Uniform Prior Authorization Form

Authorization fax number: 1-866-839-6454

Discharge Planning

- Effective discharge planning addresses how a member's needs will be met during transition from one level of care to another or to a different treating clinician
- Planning begins at the onset of care and should be documented and reviewed over the course of care
- Discharge treatment planning focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge. For discharge from an acute inpatient program, the member's follow-up appointment should be scheduled prior to discharge and should occur **within seven days** of the date of discharge
- Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care
- Having a follow-up appointment and prescriptions at the time of discharge helps increase the member's successful transition

Utilization Management Statement

Utilization Management decision-making is based only on the appropriateness of care as defined by

- Medical Necessity Criteria
- Level of Care Guidelines
- Psychological and Neuropsychological Testing Guidelines
- American Society of Addiction Medicine Criteria

United Healthcare does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service.

Outpatient Management

Reduce Administrative Burden	In-Scope Services	Management Strategy
• We have removed precertification requirements for in-scope services	• Individual/Group/Family Outpatient Therapy	Algorithms for Effective Reporting and Treatment (ALERT) Practice Management

ALERT Program

Member Identification	Outreach	Potential Outcome
• Claims data • Service combinations • Frequency and/or duration that is higher than expected	**Licensed care advocate reach out telephonically to treating provider to:** • Review eligibility for the service(s) • Review the treatment plan/plan of care • Review the case against applicable medical necessity guidelines	• Close case (member is eligible, treatment plan/plan of care is appropriate, care is medically necessary) • Modification to plan (e.g., current care is not evidence-based but there is agreement to correct) • Referral to Peer Review (e.g., member appears ineligible for service; treatment does not appear to be evidence-based; duration/frequency of care does not appear to be medically necessary)

Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our Practice Management Program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arise from the claims analysis
- Potential outcomes from discussion
  - No additional action necessary
  - Program audit including record review
  - Corrective Action Plan (CAP)
  - Targeted precertification as part of CAP

Billing and Claims

Claims Submission

- Providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding including, but not limited to ICD-10, CPT, and HCPCS coding
- Please refer to your provider agreement related to timely filing of claims*
- All claim submissions must include:
  - Member name, Medicaid identification number and date of birth
  - Provider's Federal Tax I.D. number
  - National Provider Identifier (NPI) (unique NPI's for rostered clinicians)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov
  - When a provider is contracted as a group or facility, the payment is made to the group/facility and not to the individual clinician

Claims Submission Process

- How to submit:
  - Submit electronically
    - Accepting a wide variety of clearinghouses
  - **www.UnitedHealthcareOnline.com**
    - Secure portal to view eligibility, submit prior authorization request and submit claims for Medicaid members
  - Paper claims may be submitted to the following address:
    United Healthcare Community Plan, PO Box 8207
    Kingston, NY 12402-8207

- What to include:
  - Submit claims with Member's subscriber ID number
  - Use Payer ID number **87726** for all UnitedHealthcare Community Plan claims

Electronic Payment & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at **myservices.optumhealthpaymentservices.com** > How to Enroll. Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.

*Note: For more information, please call **866-842-3278**, option 5, or go to **UnitedHealthcareOnline.com** > Help> Electronic Solutions > Electronic Payments and Statements*

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Third Party Payor (TPP) Coordination of Benefits (COB)

Effective **January 1, 2018**, where Medicare or private insurance coverage exists, payment must be sought from the TPP before Medicaid is billed.

Any payment received from a TPP must be reported on the claim or claims submitted to Ohio Medicaid.

Note: A claim that has been submitted to a TPP using a CPT code cannot be recoded to a HCPCS code to bill Ohio Medicaid.

Claims Tips

To ensure clean claims remember:

- NPI numbers are always required for both rendering/billing provider on all claims *(modifiers will be used until 7/1/18 for non-licensed and non-independently licensed providers).* POST 7/1/18 the same modifiers will continue to be used to differentiate service provider level of training/licensure in addition to the NPI.
- A complete diagnosis is also required on all claims

Claims filing deadline

- Providers should refer to their contract with Optum to identify the timely filing deadline that applies.

Claims Processing

- Clean claims, including adjustments, will be adjudicated within 30 days of receipt.

Balance Billing

- The member cannot be balance billed for behavioral services covered under the contractual agreement.

Rendering Practitioners

These practitioners are licensed by a professional board in the state of operation and are listed below with Medicaid provider type code in parentheses.

Physicians (MD/DO), Psychiatrists (20)	Licensed Independent Social Workers (37)
Certified Nurse Practitioners (72)	Licensed Professional Clinical Counselors (47)
Clinical Nurse Specialists (65)	Licensed Independent Marriage and Family Therapists (52)
Physician Assistants (24)	Licensed Independent Chemical Dependency Counselors (54)
Registered Nurses (38-384)	Licensed Practical Nurses (38-385)
Licensed Psychologists (42)	

These providers will be required to have a National Provider Identifier (NPI) to render services to Medicaid enrollees AND they will be required to enroll in the Ohio Medicaid program.

- The rendering practitioner for behavioral health services must be listed on claims submitted to Ohio Medicaid for payment.
- Practitioners required to enroll in Medicaid must include their personal NPI in the rendering field on the claim for each service they provide.
- Those practitioners who are not required to enroll in Medicaid must leave the rendering field blank.

Overview of Supervision

Ohio Medicaid covers services provided by practitioners who, under state licensing, require supervision. The types of practitioners who may supervise is determined according to the appropriate licensing board.

Types of Supervision

General supervision: The supervising practitioner must be available by telephone to provide assistance and direction if needed.

Direct supervision: The supervising practitioner must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

- In order to be paid for services at the supervisor rate when performed by an unlicensed practitioner under direct supervision, the supervisor's NPI must be included on the claim. Failure to report the direct supervisor's NPI will result in a claim being adjudicated at the lower rate.

Practitioners Requiring Supervision per Ohio Medicaid

Table 1-1: Supervision for CPT Codes

Practitioner Providing the Service:	Type of Supervision
Licensed professional counselor	General
Licensed chemical dependency counselor II or III	General
Licensed social worker	General
Licensed marriage and family therapist	General
Psychology assistant, intern, trainee	Direct/General
Chemical dependency counselor assistant	Direct/General
Counselor trainee	Direct/General
Social worker trainee	Direct/General
Marriage and family therapist trainee	Direct/General

Table 1-2: Supervision for HCPCS Codes

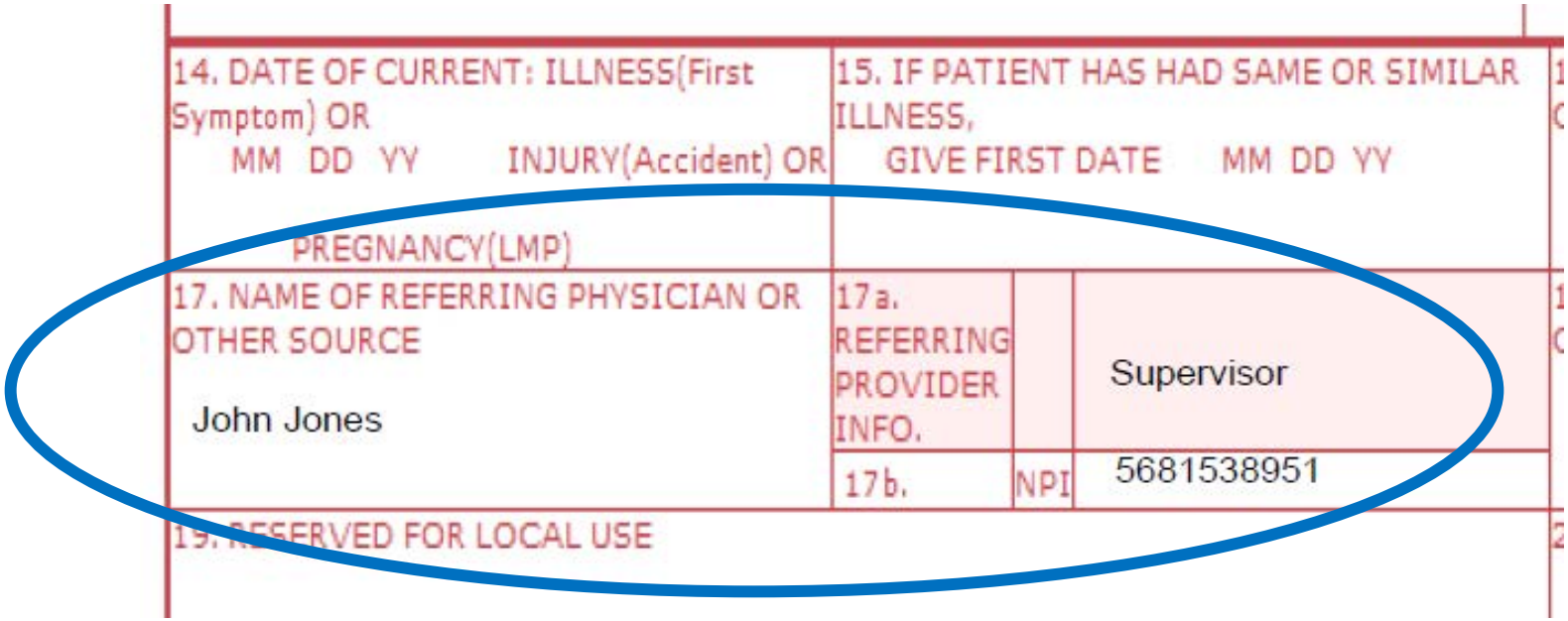
Practitioner Providing the Service:	Type of Supervision
Psychology assistant, intern, trainee	General
Chemical dependency counselor assistant	General
Counselor trainee	General
Social worker assistant	General
Social worker trainee	General
Marriage and family therapist trainee	General
Qualified Mental Health Specialist	General
Care Management Specialist	General
Peer Recovery Supporters	General

Supervision: additional comments

- Reporting supervising NPI on the claim will be optional beginning January 1, 2018 for MyCare claims and July 1, 2018 for Medicaid Claims and.
- Practitioners requiring supervision must be supervised at all times, including supervisor sick days, trainings, vacations, etc.
- Each licensing board regulates supervision requirements for their provider types and may have specific requirements pertaining to supervisor coverage during absences. In the absence of board guidance on supervisor coverage, Ohio Medicaid does not require practitioners to be assigned to a specific supervisor, therefore, any qualified supervising practitioner permitted by the practitioner's respective licensing board's OAC may provide coverage during absences but must assume all supervision responsibilities, including signing off on services provided.

Supervising Provider's NPI on Claims

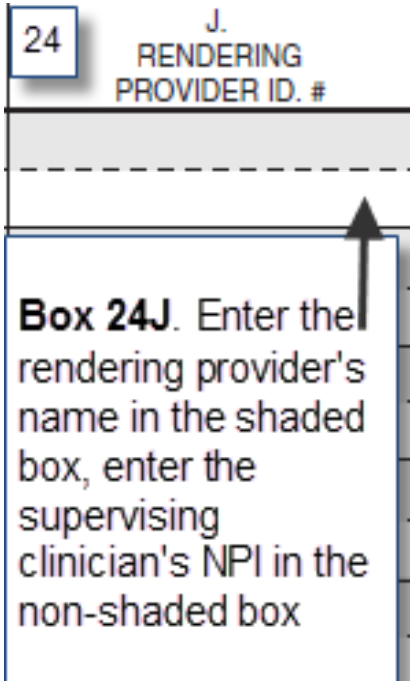
- **Box 17**: Enter the supervising provider's name in box 17. Insert the word "supervisor" in box 17a. Enter the supervising provider's NPI in box 17b.



14. DATE OF CURRENT: ILLNESS(First Symptom) OR MM DD YY INJURY(Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE John Jones	17a. REFERRING PROVIDER INFO.		Supervisor
	17b.	NPI	5681538951
19. RESERVED FOR LOCAL USE			

Supervising Provider's NPI on Claims

- **Box 24J**: Enter the **rendering** provider's name (may be non-licensed) in the **shaded** portion, and the **NPI number of the independently licensed** supervising clinician in the **non-shaded** portion



Practitioner Modifiers

- It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims appropriately.

- Modifiers are always two characters in length. They may consist of two numbers from 21 to 99, two letters, or a mix (alphanumeric).

- Ohio Medicaid will accept modifiers in any order, however, modifier fields must be populated in order from one to four (the first modifier field must be populated before the second modifier field, etc.).

Required Modifiers

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

Procedure Modifiers

Service Circumstance	Modifier
Group service	HQ
Physician, team member (ACT)	AM
CNP team member (ACT)	UC
PA or CNS, team member (ACT)	SA
Master's level, RN, LPN, team member (ACT)	HO
Bachelor's level, team member (ACT)	HN
Peer recovery supporter, team member (ACT)	HM
Pregnant/parenting women's program	HD
Complex/high tech level of care	TG
Cognitive Impairment	HI
Licensed practitioners providing TBS Group Hourly/Per Diem (day treatment) or SUD group counseling	HK
OTP Daily Administration	HF
OTP One Week Administration (2 – 7 Days)	TV
OTP Two Week Administration (8 – 14 Days)	TU
OTP Three Week Administration (15 – 21 Days)	TS
OTP Four Week Administration (22 – 28 Days)	HG
Significant, separately identifiable Evaluation & Management (E/M) service by physician or other qualified health professional on the same day of the procedure or other service	25
NCCI modifiers (See NCCI Section)	59, XS, XE, XU and XP
CLIA waived test- certificate of waiver – CMS certificate type code 2 or higher required	QW
Crisis modifier used on T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004 and 90832	KX
Physician delivering SUD group counseling	AF
Secured video-conferencing (See code charts for allowable services)	GT

Interactive Complexity

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur ***during*** the delivery of the service.

Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients.

This add-on code may be reported in conjunction with:

- Psychiatric Diagnostic Evaluation (90791, 90792),
- Psychotherapy (90832, 90834, and 90837),
- Psychotherapy add-ons (90833, 90836, and 90838), and
- Group Psychotherapy (90853).

Interactive Complexity cont.

Include **90785** in addition to the primary procedure, when at least one of the following communication factors is present during the visit:

- The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Interactive Complexity cont.

Interactive complexity is often present with patients who:

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

The following examples are NOT interactive complexity:

- Multiple participants in the visit with straightforward communication.
- Patient attends visit individually with no sentinel event or language barriers.
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors.

Place of Service Codes

Providers must accurately identify and report on each claim detail line where a service took place using the most appropriate CMS place of service code.

Services Delivered in an Inpatient or Outpatient Hospital Setting
If a provider wishes to provide services in an inpatient or outpatient hospital setting, they must contract with the hospital to receive reimbursement for those services, as the payment of these services is included in the payment to the facility.

“Other Place of Service” Setting
Place of service “99-Other Place of Service” has been redefined for Ohio Medicaid as Community.

- POS Code 99 may only be used when a more specific place of service is not available.
- POS Code 99 shall not be used to provide services to a recipient of any age if the recipient is in custody and held involuntarily through the operation of law enforcement authorities in a public institution.

Claims Detail Rollup for Same Day Services

When the same service(s) are provided to the same patient on the same day, claims need to be “rolled up” and submitted as one detail line even if the services are not provided continuously on the same day.

The implementation of rendering practitioner NPI, supervisor NPI, and practitioner modifier (U modifier) requirements change the claims rolling process effective January 1, 2018.

Services that need to be rolled must be rolled by the same date of service, same client, same HCPCS code, same modifier(s), same individual rendering practitioner NPI, same supervisor NPI, and same place of service.

- When more than one practitioner is facilitating an IOP and/or PH group counseling service, claims are billed under the highest level practitioner.

Claims Detail Rollup: Example 1

Amy Smith, RN (NPI 9876543210) and John Jones, RN (NPI 9876543211) each provide two 15-minute nursing services (H2019) to Betty Brown. The correct way to bill these services is by submitting two detail lines on a single claim.

1. **Claim detail one would be: Amy Smith, RN, NPI in rendering provider field: 9876543210, with two units of H2019.**
2. **Second claim detail would be: John Jones, RN, NPI in rendering provider field: 9876543211, with two units of H2019.**

- It would be inappropriate to roll these services under either just Amy or John and bill 4 units of H2019 since Amy and John are separately enrolled in MITS with their own unique NPIs.
- Claims with practitioners who are not required to individually enroll in Medicaid are rolled at the same date of service, same supervisor NPI, same place of service, same practitioner and other modifier(s).
- For practitioner(s) not required to enroll in Medicaid, the rendering provider field must be left blank. (After 7/1/18 all providers will have an NPI)

Claims Detail Rollup: Example 2

Two different LSWs provide individual CPST to the same client on the same day under the same supervisor and at the same place of service (office).

These services must be rolled as they use the same practitioner modifier (U4) and the rendering provider field is blank.

However, if a LSW and a LPC provide individual CPST to the same client on the same day, those services may not be rolled because the practitioner modifiers are different (U4 and U2, respectively).

National Drug Code (NDC)

- With the exception of hospital claims, federal law requires that any code for a drug covered by Medicaid must be submitted with the **11-digit NDC** assigned to each drug package.
- The NDC specifically identifies the manufacturer, product and package size.
- Each NDC is an 11-digit number, sometimes including dashes in the format 55555-4444-22.
- When submitting claims to Medicaid, providers should submit each NDC using the 11-digit NDC without dashes or spaces.
- The NDC included on the claim must be the exact NDC that is on the package used by the provider.
- The NDC will be required at the detail level when a claim is submitted with a code that represents a drug (e.g., J-codes and S-codes).

National Drug Code (NDC) cont.

Some drug packages include a **10-digit NDC**. In this case, the provider should convert the 10 digits to 11 digits when reporting this on the claim.

When converting a 10-digit NDC to an 11-digit NDC, a leading zero should be added to only one segment:

- If the first segment contains only four digits, add a leading zero to the segment;
- If the second segment contains only three digits, add a leading zero to the segment;
- If the third segment contains only one digit, add a leading zero to the segment.

Missed Appointments

There are no procedure codes for missed appointments (i.e., cancellations and/or “no shows”).

A missed appointment is a “non-service” and is not reimbursable by Ohio Medicaid.

Per state and federal guidelines, Medicaid clients **cannot** be charged a “missed appointment fee.”

Per the CMS Medicare Program Integrity Manual, missed appointments should be documented in the clinical record.

Laboratory Codes

CLIA Certification Overview

To bill laboratory codes, a provider must obtain the appropriate CLIA certification and enroll as a laboratory provider with Ohio Medicaid.

- These laboratory services under CLIA are carved into Managed Care and payment must be coordinated with the individual plans.
- The Laboratory Certification Program works to ensure Ohioans receive accurate, cost-effective clinical laboratory testing as a part of their health care.

New Applications

- Generally, each separate location or address is required to have a separate CLIA number.
- There are exceptions for not-for-profit/government-owned laboratories or hospitals. Call the Ohio Department of Health if you think your organization qualifies for one of these exceptions.

Claims Contact Information

Prior Authorization	UnitedHealthcare at 1-866-261-7692
Paper Claim Submission	Mail paper claims to: United Healthcare Community Plan PO Box 8207 Kingston, NY 12402-8207
Electronic Claim Submission	Through Link or via EDI clearing house Payor ID 87726
Claims Status	Web portal at Link on **UnitedHealthcareOnline.com**
Claims Appeals	United Healthcare Community Plan Appeals and Grievances PO Box 31364 Salt Lake City, UT 84131-0364
Eligibility Verification	View eligibility online at Link on **UnitedHealthcareOnline.com**
Provider Service Center	800-600-9007 for Community Plan Customer Service
Update Practice Information	**providerexpress.com** or via 877-614-0484

Appeals and Grievances

Appeals

Non-Urgent (Standard)	Urgent (Expedited)
• Must be requested within 90 days from receipt of the Notice of Action letter • When an appeal is requested, Optum will make an appeal determination and notify the provider, facility, Member or authorized Member representative in writing within 45 calendar days of receipt of request	• Must be requested as soon as possible after the Adverse Determination • Optum will make a reasonable effort to contact you prior to making a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time • Notification will occur as expeditiously as the member's health condition requires, within two (2) business days, unless the appeal is pertaining to an appeal relating to an ongoing emergency or denial of continued hospitalization, which we will complete investigation and resolution of no later than one (1) business day after receiving the request

Appeal requests can be made verbally or in writing.
Verbal requests must be followed with a written and signed appeal.

Services While in Appeal

- You may continue to provide service following an adverse determination if the following are met:
  - The Member is informed of the adverse determination
  - The Member is informed that the care will become the financial responsibility of the Member from the date of the adverse determination forward
  - The Member agrees in writing to these continued terms of care and acceptance of financial responsibility
  - You charge no more than the United contracted fee for such services, although a lower fee may be charged

- If, subsequent to the adverse benefit determination and in advance of receiving continued services, the Member does not consent in writing to continue to receive such care and we uphold the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member pursuant to the terms of your Agreement

Appeals and Grievances

- Claims reconsideration through

www.UnitedHealthcareOnline.com > Claims & Payments > Claim Reconsideration.

- Corrected claims or any paper attachments to be submitted via Optum Cloud.

- Appeals & Grievances mailing address

UnitedHealthcare Community Plan
UnitedHealthcare Community Plan of Ohio
P.O. Box 31364
Salt Lake City, UT 84131-0364

- Call 800-600-9007 for Community Plan Customer Service

Member Information

Member Verification

All relevant contact information will be on the back of the card for both medical and behavioral customer service.

Please note this image is for illustrative purposes only.

Member Rights and Responsibilities

Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system.

Members have the right to disability related access per the Americans with Disabilities Act.

You will find a complete copy of Member Rights and Responsibilities in the Network Manual.

These can also be found on the website: **providerexpress.com**

These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting.

We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the members.

Provider Resources

Access to Care – Standards

Life-threatening Emergency: Behavioral Health	**Immediate**	**Immediate appointment for individuals with a life threatening emergency** (life threatening emergency means a situation requiring appointment availability in which immediate assessment or care is needed to stabilize a condition or situation where there is risk of harm or death to self or others)
Non-Life-threatening Emergency: Behavioral Health	**6 hours**	**Soonest available appointment for individuals with a non-life threatening emergency** (non-life threatening emergency means a situation requiring appointment availability in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others)
Urgent Care: Behavioral Health	**48 hours**	**Soonest available appointment for individuals with urgent needs** (urgent means a situation in which immediate care is not needed for stabilization, but if not addressed in a timely manner could escalate to an emergency situation)

Access to Care – Standards cont.

Initial Visit for Routine Care: Behavioral Health	**Within 10 business days**	**Soonest available routine initial appointment** (an assessment of care is required, with no urgency or potential risk of harm to self or others)
Follow-Up Routine Care: Behavioral Health Prescribers	**≤ 60 calendar days**	**Soonest available routine follow-up appointment** (an assessment of care is required, with no urgency or potential risk of harm to self or others)

Link

- Link is the new gateway to our online tools

- Use Link applications to help simplify daily administrative tasks:
  - Check Member eligibility and benefits
  - Submit and manage claims
  - Review coordination of benefits information
  - Use the integrated applications to complete multiple transactions
  - View care opportunity information for UnitedHealthcare Members

- To register for Link, sign in to **www.unitedhealthcareonline.com** using your Optum ID or click “New User” if you do not have an Optum ID. If you have questions, please call the Optum Support Center at 855-819-5909.

UnitedHealthcare Provider Website

For important UnitedHealthcare Community Plan-specific information visit **UHCCommunityPlan.com** > For Health Care Professionals > Ohio to see:

- Provider Directory
- Claims and Member information
- Clinical Practice Guidelines
- Provider Forms
- Reimbursement Policies
- Provider News, Alerts and Trainings
- Pharmacy and Drug information

Other Online Tools

Liveandworkwell.com

- Member and family education and support
- Also available in Spanish

providerexpress.com

- Level of Care, Best Practice and Coverage Determination Guidelines
- Provider demographic changes / Roster management
- Welcome to our network – MyCare Ohio and Medicaid specific news, trainings, notifications

http://bh.medicaid.ohio.gov/manuals*

Network Participation

M-BHPs and I-BHPs

- Licensed by a professional board in the state of Ohio
- Have specialty experience and/or training related to persons with behavioral health conditions.

Medical Behavioral Health Providers	Licensed Independent Behavioral Professionals
Authorized to practice some level of general medicine	Authorized to practice independently
• Physicians • Clinical nurse specialists • Clinical nurse practitioners • Registered nurses • Licensed practical nurses. • Physician assistants	• Psychologists • School psychologists • Licensed professional clinical counselors • Licensed independent social workers • Licensed independent marriage and family therapists • Licensed independent chemical dependency counselors

BHPs Behavioral Health Professionals

- Licensed by a professional board in the state of Ohio
- Have specialty experience and/or training related to persons with behavioral health conditions.
- Authorized to practice under direct or general clinical supervision

Licensed	Trainees/Assistants
• Board licensed school psychologists • A licensed professional • A licensed social worker • A licensed marriage and family therapist • A licensed chemical dependency counselor III • A licensed chemical dependency counselor II	• A psychology assistant/intern/trainee • A school psychology assistant/intern/trainee • A counselor trainee • A social work trainee • A social work assistant • A marriage and family therapist trainee • A chemical dependency counselor assistant

These providers are not yet enrolled in MITS and are identified by a modifier when billing.

BHP-Ps Behavioral Health Paraprofessionals

- NOT licensed by a professional board in the state of Ohio
- Specially trained to provide a specialty service or services to persons with or in recovery from substance use disorders (SUD) and/or mental health (MH) conditions

  - Peer Recovery Supporter (PRS)
  - Care Management Specialist (CMS)
  - Qualified Mental Health Specialist (QMHS)

These providers are not yet enrolled in MITS and are identified by a modifier when billing.

Practitioner Abbreviations Key

Practitioner Abbreviations Key			
MD/DO	Physician	**PSY assistant**	Psychology assistant
CNS	Clinical nurse specialist	**LSW**	Licensed social worker
CNP	Certified Nurse practitioner	**LMFT**	Licensed marriage and family therapist
PA	Physician assistant	**LPC**	Licensed professional counselor
RN	Registered nurse	**LCDC II or LCDC III**	Licensed chemical dependency counselor II or III
LPN	Licensed practical nurse	**SW-A**	Social worker assistant
PSY	Psychologist	**SW-T**	Social worker trainee
LISW	Licensed independent social worker	**MFT-T**	Marriage and family therapist trainee
LIMFT	Licensed independent marriage and family therapist	**C-T**	Counselor trainee
LPCC	Licensed professional clinical counselor	**CDC-A**	Chemical dependency counselor assistant
LICDC	Licensed independent chemical dependency counselor	**CMS**	Care management specialist
Lic school PSY	Board licensed school psychologist	**QMHS**	Qualified mental health specialist
		PRS	Peer recovery supporter

Joining Our Network

Clinicians:

- Complete the Network Participation Request Form (NPRF) online via **providerexpress.com**
- Also complete the CAQH universal application online at **www.caqh.org**
- Additional required application materials will be distributed once the NPRF has been received:
  - Signed Optum Provider Agreement
  - Medicaid Addendum
- For more information regarding the contracting process, visit **www.providerexpress.com** > Join Our Network

Joining Our Network *(continued)*

CMHCs, FQHCs, RHCs and other agencies:

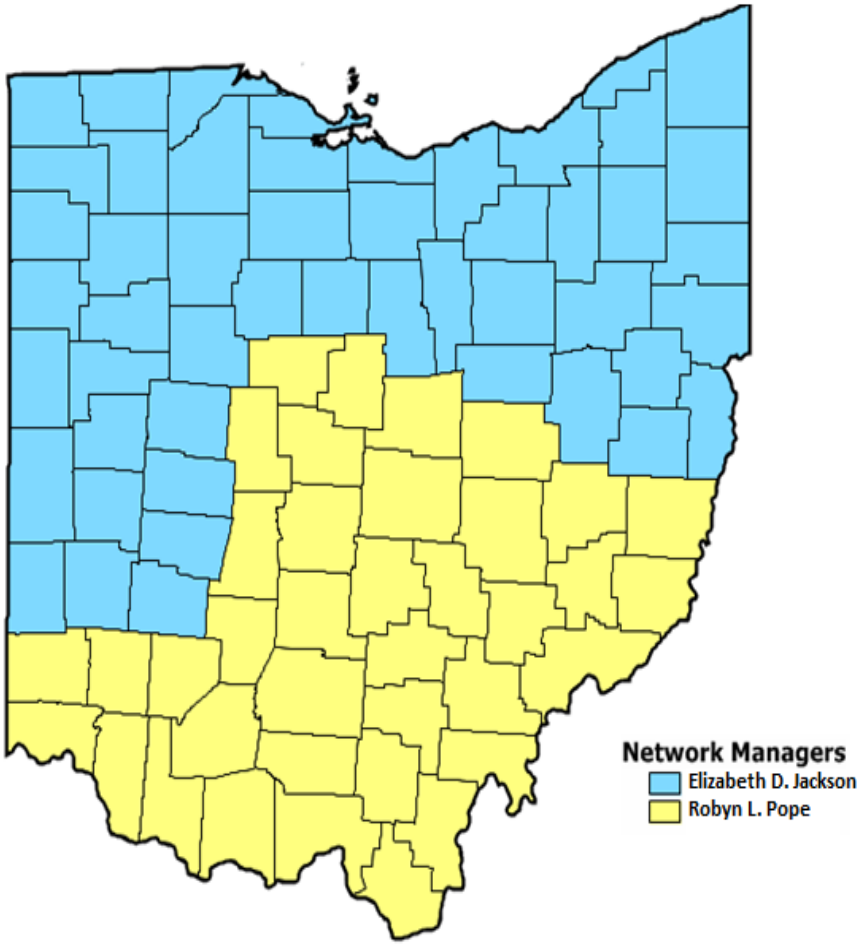
- For agencies that employ licensed professional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity
- Agencies must submit the Optum agency application, indicating the services being provided and the licensed clinical professionals on the staff roster
- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under an Optum group contract
- Please contact your Optum Network Manager via OhioNetworkManagement@Optum.com to obtain the agency application and group contract as appropriate

Joining Our Network *(continued)*

Facility Contracting:

- Facility level contracting applies to levels of care such as Acute Inpatient, Residential Services or Partial Hospitalization Programs
- Please contact your Optum Network Manager to discuss new facility contracting or to update your current facility contract
- Facility applications can be found via **providerexpress.com**. Click on "Join Our Network" on the main page, follow the prompts for the state of Ohio to be routed to the Facility Network Request Form.

Optum Network Management



Elizabeth D. Jackson, Network Manager

- Phone: 804-267-5236
- Email: Elizabeth.Jackson@Optum.com

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- Phone: 713-599-5502
- Email: Robyn.Pope@Optum.com

Urgent Post Go Live Issues:
OhioNetworkManagement@Optum.com

Thank you