Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

EDI/IT Work Group

May 30, 2018

Behavioral Health Redesign

May 30, 2018 Agenda

- Welcome
- Managed Care Advanced Funding
- Testing for July 1
- EDI 270/271 Process
- Dual Licensure - Nurses
- Enrollment of dependently licensed
- MITS Issues
- Form 6614

Testing for July 1

- FFS is not accepting test claims for July 1 configuration changes prior to July 1. Testing can be done after July 1.

- MCPS – Responses will be added to July 1 Specifications grid
  - Are each of the MCOs required to have a “free” option or clearinghouse for EDI claims submission?
  - What steps should providers take if clearinghouses are not willing to participate in EDI testing with the MCOs?
  - Will each MCO be accepting BH test files through 7/1/18 or are there testing cut-off dates?

EDI 270/271

- 270/271 EDI process
  - Must be done through ODM approved trading partner when requesting a 271 from ODM
  - Approval process for ODM - http://medicaid.ohio.gov/Provider/Billing/TradingPartners.
  - OAC 5160-1-20 has the requirements for becoming an approved trading partner

Dual Licensure - Nurses

Fee for Service

- When RN/LPN has a second license and rendering service under second license, ordering practitioner will not be required.

MCP feedback to be added to July 1 Specifications grid

Medicaid Enrollment of Licensed Dependents and Paraprofessionals

As of 5-29-18:

Practitioner	# Enrolled in MITS
LSW	2,046
SW-T	86
SW-A	23
LPC	1,136
C-T	108
Psy Asst	60
LMFT	24
LMFT -T	4

Practitioner	# Enrolled in MITS
LCDC III	235
LCDC II	139
CDC-A	1,058
QMHS *	1,422
QMHS +3 **	528
CMS	360
Peer Recovery	19

Total	7,248

Dependently licensed practitioners – 90 have added the dual license specialty.
Independently licensed/medical staff – 30 have added the dual license specialty.

*Includes those with Master's and Bachelor's degrees

**For those with just high school diploma and 3 years experience

Medicaid Enrollment of Licensed Dependents and Paraprofessionals

Provider Type	Initial Applications "Submit"	Application RTP
Social Work	356	179
Psychology	5	30
Clinical Counseling	193	80
Marriage/Family Therapy	0	3
Chemical Dependency	298	87
Paraprofessionals	541	795

As of 5-29-2018

Provider Enrollment Questions – Responses will be provided at later date

- Will ODM accept electronic verification for HS Diplomas for QMHS enrollment
- What is ODM's policy for enrollment of practitioners that may have a criminal history?
- Is ODM enrolling licensed practitioners that may have had a historical action by a licensing board or that may have a limited practice?
- Provider agencies have attempted to use the MITS portal to complete agency affiliation only to learn that functionality has been suspended. When will providers be able to use the MITS portal to affiliate practitioners with their second agency NPI number?

MITS Issues - Resolved

Issue	Status
Group service on same day as IOP	Resolved
Place of service 23 for H2019	Resolved
Nurse-rendered 96372 on Medicare bypass list	Resolved
Duplicate edit posting but claim paid	Resolved
99211 rate correction	Resolved
H2019 and H2012 paying 85% for UK	Resolved
H2019 tiered pricing applied to nursing service	Resolved
H0014 paying multiple units per day	Resolved
Supervisor for HCPCS codes	Resolved
Crossovers not calculating the correct cost sharing payment	Resolved
H2019 group nursing service incorrect rate	Resolved
Health Home assignment plan blocking PA request for SUD residential	Resolved
Edits across outpatient hospital and 84/95 not working correctly	Resolved
Edit 4140 Billing provider type/provider specialty restriction on procedure coverage rule; Edit 4021 no coverage for procedure code	Resolved
HMO coverage reported as being present when it isn't	Resolved
Claim denying with no error codes	Resolved
POS 57 and POS 53 missing from certain codes	Resolved
96372 denied when non-nursing H2019 provided	Resolved

MITS Issues – In Process

Issue	Status – Release date or workaround
H0014 treated as per diem code in edit 5080	In process - – June 13 tentative
Health Home and MH nursing conflict	In process – June 13 tentative
H2019 tiered pricing when history is POS 99	In process – June 13 tentative
Unable to add 2nd PA when prior requested end date still in future	Work with Kepro
ACT paying more than 2 Bachelor/Peer levels	In process – June 13 tentative
SUD residential denying 30th day	In process – – June 13 tentative
SUD psychotherapy hitting 25 visit annual limit	In process - – June 13 tentative
OPHBH ACT claim denied incorrectly due to other hospital services	In process – June 13 tentative
Add GT modifier to 96101, 96111	In process – June 13 tentative

Form 6614

- Turnaround time for 6614 forms submitted to ODM Coordination of Benefits section is within 7 business day.

- Questions can be directed to Coordination of Benefits Section at 614-752-5768.

Upcoming Meetings

- ✓ **EDI/IT Workgroup**
  - June 13th, 11:00-12:00
  - June 27th, 11:00-12:00

- Agenda topics must be submitted to ODM by noon on the Mondays before the scheduled meetings.

To register for these meetings, use the link below:
https://attendee.gotowebinar.com/register/7614727541154396930

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

Appendix

Dually Licensed Practitioners

- Highest scope of practice or license is the enrollment's primary specialty
  - Medicare eligible practitioners will have the Medicare billable specialty as their primary
- Licensed independent is primary enrollment over dependents, trainees/assistants
- Can only have 1 specialty within a scope of practice
  - Cannot have both LISW and LSW specialties
- If RN/LPN and also dependently licensed, should already be enrolled as RN/LPN
- QMHS/CMS/Peer can enroll with multiple paraprofessional specialties within PT 96
- QMHS/CMS - any other license should be primary enrollment

Clarification on Medicaid payment cycle

- EDI claims submitted by NOON on 4/11/18, will be paid on April 26th
- Portal claims submitted by 5:00 p.m. 4/13/18, will be paid on April 26th.
- EDI claims submitted by NOON on 4/18/18, will be paid on May 3rd
- Portal claims submitted by 5:00 p.m. 4/20/18, will be paid on May 3rd.

- 2018 EDI Processing calendar can be found here: http://medicaid.ohio.gov/Portals/0/Providers/Billing/TradingPartners/Production/EDI-Processing-Calendar-2018.pdf?ver=2017-10-20-084808-100

July 1 Specifications - FFS and MCPs

What is covered in this grid
Practitioner "U" modifiers
Rendering practitioner reported in header or detail
Limits allowable trading partners
Paper claims possible
Provider portal for claims
Supervisor reported for HCPCS code (H codes)
Dually licensed instructions
Rapid Response contact information
SUD residential services on admission/discharge date

Refer to July 1 specifications spreadsheet:
http://bh.medicaid.ohio.gov/manuals under “Medicaid Managed Care Plan Resource Guide”

Questions regarding coordination of benefits

With the new requirement for BH providers to bill third party payers as of 1/1/2018, ODM receives many questions about coordination of benefits including the requirement for denials for unlicensed, dependent and students/trainees.

- These claims aren't billable to commercial insurance and some commercial insurance will not send denials. Requiring denials creates a lot of work for ODM and providers when the outcome is known and predetermined.

Coordination of Benefits rule 5160-1-08

- Paragraph (D) states: "…*ODJFS [ODM] reimburses for covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODJFS [ODM]. Providers who have gone through reasonable measures to obtain all third party payments, but who have not received payment from a TPP…may use an appropriate code on the claim to obtain payment and submit a claim to ODJFS requesting reimbursement for the rendered service(s).*

- Examples of "Reasonable measures" are provided in paragraph (D)(1) of the rule:

  (1) Providers are considered by ODJFS to have taken reasonable measures to obtain all third party payments if they comply with one of the following requirements

Coordination of Benefits rule 5160-1-08, continued

(D)(1)(d) states*: "The provider did not send a claim to the TPP, but has received and retained at* ***least one of the following types of documentation*** *that indicates a valid reason for non-payment for the service(s) as set forth in paragraph (D)(2) of this rule:*

(i) Written documentation from the TPP;
(ii) Written documentation from the TPPs automated eligibility and claim verification system;
(iii) Written documentation from the TPPs member benefits reference guide/manual; or
(iv) Any other reliable method for obtaining information and/or documentation from the TPP that there is no third party benefit coverage for the rendered service(s)."

- If one of the above conditions are met, providers are not required to submit a claim to the TPP. Since TPPs vary widely, all providers should check with the TPP if they are unsure whether the particular BH practitioner or service may be covered by the TPP

Coordination of Benefits rule 5160-1-08, continued

- Once the provider type 84 or 95 verifies that the particular BH practitioner or service is not covered by the TPP, information can be provided on the claim to bypass TPP edits.
  - Instructions can be found here: Submitting Other Payer Information
    - These instructions apply only to non-Medicare TPPs

Coordination of Benefits with Medicare rule 5160-1-05

When the individual has Medicare coverage **and** the service rendered is covered by Medicare (not on the Medicare TPL by-pass list or the rendering can enroll with Medicare):

- Medicare or the Medicare Advantage Plan must be billed first
- Refer to rule 5160-1-05: Medicaid coordination of benefits with the Medicare program (Title XVIII) 5160-1-05
- Claims paid by traditional Medicare will automatically "crossover" to Medicaid for cost-sharing determination
- Claim paid by Medicare Advantage Plans (Part C) do not automatically crossover – providers must submit claim for cost-sharing determination

Coordination of Benefits with Medicare rule 5160-1-05, continued

- For claims denied by Medicare, the 6653 process can be used for Medicaid payment consideration. Instructions can be found here:
  - http://medicaid.ohio.gov/Portals/0/Providers/MITS/Information%20Releases/October%202011/Claims_Denied_by_Medicare_rev_2011-10-25.pdf

New MITS Resource section on ODM website

- http://medicaid.ohio.gov/ → Hover over “Providers” → Select “MITS Resources”