"Adapting to the Changes of the Ohio BH Redesign and the MCO Carve-In"

Introduction

Presented by:
Behavioral Health Billing Solutions LLC

BHBS

Who is *Behavioral Health Billing Solutions?*

Behavioral Health Billing Solutions, LLC was created after 10+ years experience in the Ohio Behavioral Billing world and seeing the need for training and support of billing departments by an actual billing expert. In addition, we provide assistance with implementation on necessary EHR software, billing consultation to review and identify problem areas within your current billing process, and a full host of additional needed services.

We are now an Affiliate partner with Qualifacts offering associate programs using CareLogic software to agencies to get onto a fully functional, meaningful use certified EHR for a fraction of the cost, in a fraction of the normal time.

DID YOU KNOW??

On January 1st, 2018, Ohio Behavioral Health agencies went through an extensive coding change to the way we have billed for years in an effort to get us into compliance with National standards.

Between January – June, we were also tasked with registering ALL providers (independent, dependent and unlicensed), in addition to contracting with the Managed Care companies to transition our billing under the MCO carve in effective July 1st, 2018.

Many agencies are struggling.

What can we do today to ensure we get to tomorrow?

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How many agencies are currently billing MCO's?

How many are entering claims on the portals?

How many are using an electronic health record to submit?

If you are utilizing an EHR, are you using a clearing house or billing direct using the portals for each MCO?

Let's Talk: Reviewing Explanation of Benefits (EOB's)

Was the claim paid in full?

If the claim was denied, was it a valid denial reason?

Pending claims – How do you track billed, paid, and pending claims? Pended claims (billed with no response) are a high volume issue right now.

If your claim was denied incorrectly or short paid based on the service provided, how are you notifying the MCO? How are you tracking these to ensure all are corrected in a timely fashion?

It’s important to know where to go to get claims assistance

If your claim is denied incorrectly, you must notify the MCO, clarifying the error and ask the claim to be reprocessed.

If your claim paid incorrectly, it’s critical to contact the MCO immediately to find out why. The process to correct an incorrectly paid claim is substantial on both sides so you have to get ahead of it quickly.

It’s your responsibility to understand the rules of the Redesign and how it applies to your claim payments. Attend meetings, ask questions and review the manual. On the next slide is current MCO contact information.

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BH REDESIGN – RAPID RESPONSE TEAMS & TA RESOURCES

MITS FFS Rapid Response Team

- Medicaid Provider Hotline: 1-800-686-1516 — Mon – Fri: 8:00 AM – 5:00PM
- Ohio Medicaid Policy Rapid Response: bh-enroll@medicaid.ohio.gov

AETNA – MYCARE ONLY

- Rapid Response Team: OH_BH_Redesign@AETNA.com
- Prior Authorization Questions: 1-855-364-0974, option 2, then 4
- 24/7 Notification Fax: 1-855-734-9393
- Provider Services: 1-855-364-0974, option 2, then 5
- Escalation/Other Questions: KilincA@aetna.com

Technical Assistance: Aetna Rapid Response Team and TA Resources
Monthly provider webinars scheduled and Provider Relations Liaisons available for onsite visit.

BUCKEYE

- **Rapid Response Team**: BehavioralHealth@centene.com
- Provider Relations: 1-866-246-4356 ext. 24291
- 24/7 Notification Phone Line: 1-866-296-8731
- 24/7 OH Notification Fax: 1-866-535-6974
- Escalation/Other Questions: lpaynter@centene.com

Technical Assistance Resources: Buckeye BH Redesign Webinar Registration
Provider webinars available every Tuesday at 9:00 and Thursday at Noon.

CARESOURCE

- Customer Advocacy Group: 1-800-488-0134 (KATIE system)
- BH e-mails: OhioBHinfo@caresource.com
- 24/7 Notification Fax: 1-937-487-1664
- 24/7 UM Notification e-mail: mm-bh@caresource.com
- Escalation/Other Questions: terry.jones@caresource.com

Technical Assistance: BH Redesign Rapid Response Weekly Webinars Each Wednesday, 3:00 – 4:00 PM. To register, contact at Sherron.Jefferson@CareSource.com or call 614-255-4620 and include organization name and NPI number along with names and e-mail address of individuals planning to participate.

MOLINA

- **Rapid Response Team**: BHProviderServices@MolinaHealthcare.com
- 24/7 Notification Phone Line: 1-855-322-4079
- 24/7 Notification Fax: 1-866-449-6843
- 24/7 Notification e-mail: OHBehavioralHealthReferrals@MolinaHealthcare.com
- Escalation/Other Questions: Emily.Higgins@MolinaHealthcare.com

Technical Assistance Resources: BH Redesign Provider Bulletin
Multiple provider TA webinars scheduled throughout the year. Details and registration in the Provider Bulletin.

UNITED HEALTHCARE/OPTUM

- **Rapid Response Team**: OhioNetworkManagement@optum.com
- 24/7 Notification Phone Line: 1-800-600-9007
- 24/7 Provider Prior Authorization Request: 1-866-261-7692
- 24/7 Online Prior Authorization Request via Provider Portal: www.providerexpress.com and www.UnitedHealthcareOnline.com
- Escalation/Other Questions: tracey.izzard-everett@optum.com

PARAMOUNT – MEDICAID ONLY

- **Rapid Response Team/Testing Assistance:** PHC.BehavioralHealth@ProMedica.org
- 24/7 Notification Phone Line: 1-419-887-2557 or 1-888-891-2564
- 24/7 Notification Fax: 1-567-661-0841
- PHCReferralManagement@ProMedica.org
- Escalation/Other Question: hy.kisin@promedica.org and Linda.NordahlLSWCCM@ProMedica.org

ODM Managed Care Provider Complaint Form: https://providercomplaints.ohiomh.com/

The Ohio Council
Of Behavioral Health & Family Services Providers

BHBS

If you are experiencing issues in any of these areas, please feel free to reach out to BHBS.

It's what we do and we will make time to address your issues.

However, now it's GIVEAWAY time!

BH REDESIGN: POLICY, PROGRESS AND PRACTICE CHANGE

Teresa Lampl, LISW-S, Associate Director

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The Ohio Council
Of Behavioral Health & Family Services Providers

November 7, 2018

The Ohio Council
Of Behavioral Health & Family Services Providers

MISSION: Committed to improving the health of Ohio's communities and the well-being of Ohio's families by promoting effective, efficient, and sufficient behavioral health and family services through member excellence and family advocacy.

We are a statewide trade and advocacy organization representing over 140 private organizations that provide addiction treatment and prevention, mental health, and family services to children, adults, and families in Ohio.

Our members deliver approximately 70% of the Medicaid covered community behavioral health services in our state.

Advocating Today for a Healthy Tomorrow

BH Re-design: THE LONG COMPLEX AND WINDING ROAD…

TODAY'S DISCUSSION ….

- BH Redesign Policy and Service Structure
  - Rules and Documentation Refresher
  - Practitioner Credentialing and Rendering Provider
- Practice Changes
  - Clinical, Administrative, and Operations
- Partnering with Managed Care
  - Contracting, Credentialing, Utilization Management, and Outcomes
  - Billing Tips and Challenges
- Progress with Implementation

BH RE-DESIGN RESOURCE PAGE

- ODM and MHAS have established a one-stop webpage for all things BH Re-design. Use this link to access resources:

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

BH REDESIGN: THE POLICY

1. **ELEVATION (2012)** : Shifted responsibility for Medicaid match to the state to create statewide access to covered behavioral health services.
2. **EXPANSION (2014):** Extended Medicaid coverage to 400,000 low income Ohioans with behavioral health needs that previously relied on local Board levy funds or went untreated.
3. **MODERIZATION (January 1, 2018):** Updated behavioral health billing codes to align with national standards using CPT codes and following National Correct Coding Initiative (NCCI). Expanded the array of services covered by Medicaid.
4. **INTEGRATION (July 1, 2018):** Transitioning payment for behavioral health services to Medicaid Manage Care to better integrate and coordinate physical and behavioral health care.

RE-THINKING BEHAVIORAL HEALTH

NATIONAL ACCREDITATION

- **Recognized as industry standard for quality service delivery, best business practices, and focus on quality improvement and customer satisfaction**

MHAS CERTIFICATION

- Minimum standards to protect health and safety and clinical service delivery
- Recognizes national accreditation through "deemed status" as meeting standards
- Agnostic to payer requirements

PAYER REQUIREMENTS - VARIABLE

ODM COVERAGE & LIMITATIONS

- Requires MHAS Certification to be an eligible provider
- Defines eligible providers
- **Defines coverage for services and payment**
- **Defines documentation requirements.**

FEDERAL/STATE/LOCAL

- Requires MHAS certification and compliance with MHAS regulations
- May establish additional requirement for services based on funding source

COMMERCIAL INSURANCE

- National accreditation recognized
- Contract governs services, payment, and coverage

BH REDESIGN – OAC RULES

MHAS RULES

- 5122-24 & 25: Definition & Certification
- 5122-26: Policies & Procedures
- 5122-27: Documentation
- 5122-28: Quality Improvement
- 5122-29 Service Definitions
  - **CROSSWALK to BH Redesign Rules**
- 5122-30: MH Residential LICENSURE
- 5122-40: OTP

ODM RULES

- 5160-8-05: Behavioral Health Services - Other Licensed Practitioner
  - (F) Documentation Requirements
- 5160-27: Behavioral Health Services
  - -01: Eligible Providers
  - -02: Coverage and Limitations
  - -03: Reimbursement and Appendix A (Fee Schedule)
  - -04 through -12: Services

Providers MUST follow ODM rules for payment purposes

BH Provider Manual Challenges:
1) Not consistent with ODM rules and 2) MITS is designed based on BH Provider Manual
3) MCPs required to following the BH Provider Manual

MEDICAID MH SERVICES

Medical Services	Clinical/Professional Services	Recovery & Rehabilitation Services
• Evaluation & Management • Psychiatric Diagnostic Assessment • Injectable Medications • Nursing (TBS/PSR codes)	• Psychiatric Diagnostic Assessment • Psychological Testing • Individual Psychotherapy • Group Psychotherapy • Family Therapy • Crisis Psychotherapy • ***New*** SBIRT	• CPST • ***New*** TBS • ***New*** PSR • ***New*** ACT • ***New*** IHBT • TBS Group (Day Treatment) (*HCPCS Codes*)

CPT Codes: Medical and Clinical Services. More choice and flexibility in coding services.
Individual rendering practitioner model: Disincentives for team based care.
Pricing: Tiered payment rates based on licensure or education of practitioners.

MH MEDICAID REHAB OPTION: RECOVERY SUPPORTS

Therapeutic Behavioral Service				
ACT	**IHBT**	**TBS Group Svc (aka Day Tx)**	**TBS**	**Nursing**
H0040 + Modifier	H2015	H2012 (Group) H2020 (Per Diem)	H2019 + Modifier	H2019
MD, DO, CNP, CNS, PA, RN, LPN, Ph.D, LISW, LPCC, LIMFT, LSW, LPC, MFT, QMHS HO, QMHS HN, Peer	Ph.D, LISW, LPCC, LIMFT, LSW, LPC, MFT	Ph.D, LISW, LPCC, LIMFT, LSW, LPC, MFT, Psych. Asst., SWT, CT, MFT-T, SWA, QMHS HO, QMHS HN, QMHS(+3)	Psych. Asst., SWT, CT, MFT-T, SWA, QMHS HO, QMHS HN, QMHS(+3)	RN

Psychosocial Rehabilitation			
Code: H2017	Eligible Providers	Psych. Asst., SWT, CT, MFT-T, SWA, QMHS (HM)	Nursing LPN

CPST – No Changes

MEDICAID SUD SERVICES

ASAM Level 1: Outpatient	ASAM Level 2: Intensive	ASAM Level 3: Residential
• Psychiatric Diagnostic Assessment • Assessment • Individual Psychotherapy • Group Therapy • Family Therapy • Crisis Psychotherapy • Medical – E/M codes • Nursing • Medication Assisted Treatment • Opioid Treatment Programs • Urine Drug Screens • SUD Case Management • **NEW** Peer Recovery Supports	**Intensive Outpatient Treatment**: • Combination of outpatient services delivered between 9-19 hours per week. • IOP Group Activities **NEW Partial Hospitalization** • Combination of outpatient services exceeding 20 hours per week • PH Group Activities	**NEW Level of Care**: Per diem payment* for comprehensive services • 3.1 Clinically managed low intensity • 3.2 **WM** Clinically managed (social withdrawal mgmt) • 3.3 Clinically managed– pop specific; hghi intensity • 3.5 Clinically managed– high intensity • 3.7 Medically monitored– high intensity inpatient (residential) adolescent & adult • 3.7 **WM** Medically monitored-high intensity
Withdrawal Management	Withdrawal Management	*Medicaid federally prohibited

DOCUMENTATION REQUIREMENTS

Medicaid Rule 5160-8-05 (F) contains slight variations and more requirement elements that other state or federal regulation.

- All Medicaid services must comply with this rule for documentation.
- (1) Covers **medical record requirements** to support medical necessity
- (2) **Progress note elements** – required in every note
  - type, description, date, time of day, duration, location and, if documenting weekly services, the frequency of treatment, with dates of service
  - *description of the patient's current symptoms and changes in functional impairment*
  - *medication changes, as applicable*
  - *time spent by the provider face-to-face with the patient*
  - *time spent interpreting and reporting for psychological testing, as applicable*
  - assessment of the patient's progress or lack of progress and a brief description of the progress made, if any, significant changes in symptoms, functioning, or events in the life of the patient and recommendation for modifications to the treatment plan, if applicable
  - *evidence of clinical supervision, as required*

PRACTITIONER ENROLLMENT

- Effective July, 1, 2018
  - Each practitioner intending to bill Medicaid must have an NPI
  - Each practitioner must complete a **Medicaid provider enrollment application** AND affiliate with the BH provider organization NPI number(s) (PT 84/95) during enrollment.
  - **QMHS enrollment**: QMHS+3 provider type is ONLY for this subset of staff with 3 yrs. experience and intending to bill TBS services.
    - Include copy of educational achievement or statement of 3 yr. experience AND statement of employment.
- Dual Credentialed Practitioners
  - Register the credential with the HIGHEST scope (not broadest scope) as the primary provider type on the application
  - Include all secondary credentials in the NOTES section of the application if using the secondary license expands the available services for payment purposes.
- 8/23/18 BH MITS Bits: Practitioner Enrollment Reminders

NPI + MODIFIERS – POST JULY 1, 2018

- **NPI + REQUIRED Modifiers – all MCPs:**
  - QMHS staff (MA, BA, HS): continue to use **HM, HN, HO + NPI**
    - QMHS+3: modifier UK is optional TBS Group (Day Tx) – H2012 & H2020; TBS ind/group– H2019
  - ACT services (H0040): **AM, SA, UC, HM, HN, HO + NPI**
  - SUD Group (H0005): **HK and AF required + NPI**
  - SUD IOP (H0015): **HK and TG required + NPI**
- MCP Implementation of Modifiers:
  - United/Optum **REQUIRES** use of all practitioner modifiers.
  - Other MCPs: Other practitioner modifiers are **OPTIONAL**
- SEE Supervisor Rendering Ordering Fields – Post 7/1/18 tabs

NPI + MODIFIER: DUAL CREDENTIALS

- Staff with Dual Credentials will use NPI + Modifiers to access services under secondary license.
  - Primary License (Highest scope) requires only NPI
  - Secondary License offers access to different code set and requires NPI + Modifier

- Example: RN, LSW
  - MH Nursing (H2019) bill with NPI (with ordering NPI)
  - SUD Nursing (T0002) bill with NPI (with ordering NPI)
  - Individual Psychotherapy (90837) bill with **NPI + U4 modifier**

- Dual Licensure Grid
  - **Update:** RN may register as QMHS – see Dual Licensure Grid

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PRACTICE CHANGE: MOVING FORWARD


OLD WAYS
WON'T OPEN
NEW DOORS.

USING CPT CODES: THE ADD ON CODES

- CPT Codes are used for most medical and clinical services delivered by licensed professional for **BOTH MH and SUD Services**.
- These services are authorized under OAC Chapter 5160-04 Physician Services (medical) and under OAC 5160-8-05 (clinical).
- **Prolonged Service** (+99354, +99355) is used to report each additional 30 minutes of service beyond the first hour of service.
  - May be used with E/M codes and Individual Psychotherapy 60 minutes (90837).
  - Less than 30 minutes total duration may NOT be reported.
  - 30-74 minutes for +99354
  - 75-104 minutes would allow adding +99355
- **Interactive Complexity** (+90875) is NOT time based and is used to reflect increased clinical intensity or interaction with client. It may be used with the following codes:
  - E/M codes with psychotherapy add on
  - Psychiatric diagnostic assessment
  - Individual psychotherapy
  - Group psychotherapy for each individual member when applicable

USING CPT CODES: ASSISTANTS & TRAINEES

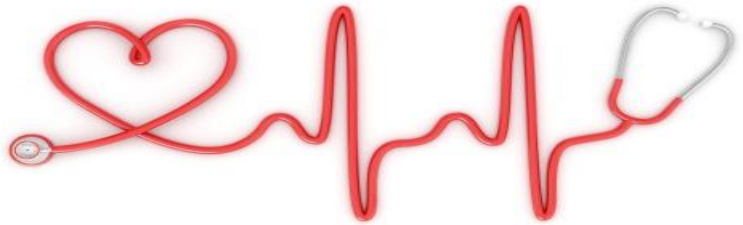
Psychology Assistants, SW Trainees, Counselor Trainees, MFT Trainees and CDCAs

- May use CPT codes for services provided under either General Supervision or Direct Supervision. **OAC 5160-8-05 (D)(2)(b) and (c)**
- **General Supervision** is defined in (D)(2)(b) to require access to a supervising independent licensed practitioner by phone, at a minimum.
  - Service reimbursement reduced to 72.5% of the physician fee
- **Direct Supervision** is defined in (D)(2)(c) to require:
  - Supervising independent practitioner has in person face-to-face contact with patient at initial visit and not less that face-to face contact with patient quarterly.
  - Supervising independent practitioner reviews and updates the patient medical record at least once after each treatment visit.
  - Service reimbursement is at the rate paid to the supervising independent practitioner.
- BH Organization may define organization policy on use of General or Direct Supervision when billing CPT codes.
- Assistants and Trainees may also bill MH and SUD HCPCS Codes for Services

BH NURSING SERVICES

- MHAS Certification: 5122-29-03 General Services
- ODM Rule: 5160-27-11 Behavioral Health Nursing Services
- **MH and SUD Nursing includes**, "those activities that are performed within professional scope of practice….by staff licensed by the Ohio board of nursing and intended to address the behavioral and other physical health needs of individuals receiving treatment for psychiatric symptoms or substance use disorders."
- **RN** may provide assessments and group services. **LPN** may not by ODM rule.
- ODM rule is **SILENT** on whether services must be face-to-face with client or collateral or by phone calls.
- Nursing Board confirmed care coordination with health care provider or other service providers located in a different physical location (phone call) is within the scope of practice of a nurse.

BH NURSING SERVICES



- MH Nursing Services
  - RN Services billed as TBS (H2019) LPN Services billed as PSR (H2017)

- SUD Nursing Services
  - RN Services billed as T1002 LPN Services billed as T1003

- All BH Nursing Services <u>REQUIRE</u> an "Ordering Prescriber" NPI on the claim
  - MD, DO, CNP, CNS, PA
  - Types of "orders" – No other segment of Medicaid requires an "order"
    - Individualized Treatment Plan (ITP) signed by prescriber
    - Standing order signed by prescriber
    - Blanket order signed by Medical Director/prescriber
    - Individual progress note with order in note signed by prescriber

BH NURSING SERVICES & E/M CODES

BH Nursing Services and E/M Codes MAY be billed on the SAME DAY.

- **E/M coding**: Providers must understand how some nursing services, such as vitals, brief review of history/systems are used to arrive at the E/M code or level.
  - **If the information gathered from this nursing "time" is used by the prescriber, the nursing time should NOT be billed separately. This would be considered "duplicate billing".**
- Examples of Allowable SAME DAY services:
  - Pt. has E/M visit post IP discharge with med changes. CPST assists client with obtaining prescriptions. Later in the day, RN see pt. for 30 minute for medication reconciliation, medication education on new med orders, and review of crisis plan for side effects.
  - 3 hours after the E/M appt, the pt. presents in crisis due to paranoid thought about medications changes made earlier in the day. The RN evaluates the pt. symptoms, deescalates the patient, provides additional medication education, and engages Case Manager to provide additional support.
  - LPN spends 20 minutes with patient post E/M visit to assist the pt. in setting up a weekly pill box and reviewing strategies for medication adherence.

RE-THINKING ASSESSMENTS

- National accreditation defines elements of a comprehensive assessment and allows providers to define the organizational process for assessment completion.
- MHAS Rule 5122-29-03: Assessment "should" start prior to other services; defines initial assessment and comprehensive assessment (30 days).
- ODM Rules 5160-04 Physician Services and 5160-8-05 Behavioral Health Services-OLP

Opportunity for RE-THINKING and Improving the Assessment Process!

- Assessment is an ongoing process and providers have choices!
- Improve patient engagement with brief assessment and initiate treatment at 1st visit.
- Accept and update assessment completed within previous 12 months
- **CPT Codes**: 90791 Diagnostic Assessment **or** 90837 Ind. Psychotherapy + Add ons **or** Psychiatric/Medical Assessment using New Patient E/M codes (99201 – 99205) **or** 90792
- Same day open access services (best practice) – understand NCCI edits
- Consider how to use other staff to collect assessment information (i.e. social history)
- What if the client doesn't return for additional appt.?

GROUP COUNSELING SERVICES

- MHAS Certification: 5122-29-03 General Services
- ODM Rule: 5160-8-05 BH Services-OLP and 5160-27-09 SUD Services
- **NOTE:** Difference in Medicaid coverage for MH and SUD Services

Mental Health	SUD Services
• CPT Code 90853	• CPT Code 90853 for service 52 minutes or less in duration • **H0005 for services exceeding 53 minutes (15 minute unit)** • H0005: Rates tiered for physicians, licensed professionals, and CDCA/Trainees

CPST, TBS, PSR, & SUD CASE MANAGEMENT

CPST	TBS	PSR	Targeted CM
MHAS: 5122-29-17 No change	MHAS: 5122-29-18 Individualized supports or care coordination	MHAS: 5122-29-18 Individualized support, restoration, and rehab	MHAS: 5122-29-13 No Change
ODM: 5160-27-02 & 03	ODM: 5160-27-08	ODM 5160-27-08	ODM: 5160-27-10
Eligible Providers: All practitioners except RN/LPN (NEW! Register RN/LPN as QMHS)	Eligible Providers: Unlicensed practitioners with MA, BA or QMHS+3 registered as QMHS	Eligible Providers: Unlicensed practitioners QMHS < 3 yr. experience	Eligible Providers: All practitioners except RN/LPN and Peers
Face-to-face w/client(s) or collaterals, phone calls	Face-to-face w/ client(s) or collaterals	Face-to-face with the individual client	Face-to face w/ client(s) or collaterals, phone calls
One rate; 50% rate reduction after 90 min	Tiered rates for office and home/community; After 90 min, office rate 50% decrease	Tiered rates for office and home/community; After 90 min, office rate 50% decrease	One rate; 50% rate reduction after 90 min

CRISIS SERVICES

- MHAS Certification: 5122-29-10 (MH & SUD)
- ODM Rules: 5160-8-05 and 5160-27-12
- Crisis Psychotherapy: 90839, +90840
  - **MH & SUD Services for NEW and Established patients**
  - NCCI edits limit coverage to 2.5 hours per day per practitioner
  - Crisis psychotherapy codes may be used only once per day
  - **No other psychotherapy or E/M code may be billed on same day**
- Coding Crisis Psychotherapy
  - 90839 is used to report the first 30-74 minutes of crisis psychotherapy on any given day.
  - +90840 is used to report each additional block(s) of time of up to 30 minutes beyond the first 74 minutes.
  - NCCI edits limit use of +90840 to 3 per day

Crisis Services in ED:
There is conflict between OAC 5160-8-05 and the ODM payment policy in the BH Provider Manual.

Medicaid policy is to pay for crisis services in the ED, but by rule, it's not

SUD SERVICES: OUTPATIENT & RESIDENTIAL

OUTPATIENT	RESIDENTIAL
MHAS certification: 5122-29-03 (General); 5122-29-10 (Crisis); 5122-29-13 (CM); 5122-29-15 (Peer); Methadone Treatment (OTP) 5122-40	**MHAS certification**: 5122-29-36 SUD Residential
ODM Rules: 5160-4 (Medical); 5160-8-05 (BH Services-OLP); 5160-27-09 (SUD Services); 5160-27-10 (CM); 5160-27-11 (Nursing)	**ODM Rule**: 5160-27-09 SUD Services
All services based on ASAM Guidelines • Outpatient (LOC 1) • IOP (LOC 2) • PH (LOC 2) – requires prior authorization • Withdrawal Management (WM) as appropriate to LOC	ASAM Guidelines – LOC 3 • 3.1 Clinically managed low intensity • 3.2 WM Clinically managed (social focus) • 3.3 Clinically managed– pop specific; hi int • 3.5 Clinically managed– high intensity • 3.7 Medically monitored– high intensity inpatient (residential) adolescent & adult • 3.7 WM Medically monitored-high intensity

SUD SERVICES: WITHDRAWAL MANAGEMENT

- **The ASAM Criteria: CHAPTER 6 Addressing Withdrawal Management**
- Withdrawal Management protocols can be provided across all LOCs.
  - In many ways, it's similar to an "add on code" approach to service delivery.
- **Level 2 WM**: Ambulatory Withdrawal Management with Extended On-Site Monitoring
  - Staffed by physicians, NPs, and nurses that are "readily available" but do not need to be present at all times.
  - Includes 23-hour observation
  - Level 2WM **may** be provided by an SUD Residential Treatment provider for a client receiving Level 2 outpatient services. **This is still outpatient treatment** – the client is just receiving the WM services not a residential admission.
  - Always provided as an outpatient service.

SUD SERVICES: WITHDRAWAL MANAGEMENT

- What happened to "sub-acute detox"??? Covered by ASAM Level 3
- **Level 3-WM**: Residential/Inpatient Withdrawal Management
  - Two types of Level 3 WM programs
- Level 3.2WM: Clinically Managed Residential Withdrawal Management
  - Social withdrawal management staffed by appropriately credentialed staff that are competent to implement physician approved protocols.
- Level 3.7WM: Medically Monitored Inpatient (Residential) Withdrawal Management
  - Program is staffed by physicians, NPs or PAs and nursing professionals to oversee monitoring of the patients condition, progress, and medication administration on an hourly basis.
  - Physician, NP, or PA is available to assess and provide on-site monitoring of care daily

REVENUE CYCLE MANAGEMENT

- Dedicated and increased resources and skill sets to manage revenue cycle, claims payment, and accounts receivable.
- Clearinghouse and data management
  - 999, 997 reports immediate rejection for "unclean claims"
  - Claims accepted by MCP: 277U reports and 824 Subscriber ID error report
  - 270/271 Batch Eligibility Reports
- Remittance Advice: 835 or paper
  - Full expected payment
  - Denial and reason codes
- Reprocessing Claims with MCPs – 837P or Portal
- Third Party Insurance – contracting, billing, and coordination

HR PRACTICES

- **Practitioner enrollment:** requires hiring and termination process changes to support claims payment.
- **New Hire**
  - Acquire and document individual NPI – prior to hire
  - Enrollment in MITS and/or agency affiliation – on date of hire
  - Notify each MCP (roster)
  - Criminal history – understanding of potential Medicaid enrollment issues
    - CQE application as needed
- **Termination**
  - Notify MITS and terminate agency affiliation
  - Notify each MCP (roster)

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PARTNERING WITH MANAGED CARE

MANAGED CARE RESOURCES

BH Redesign Website: www.bh.Medicaid.ohio.gov

- Medicaid Managed Care Plan Resource Guide
- Medicaid/MyCare Uniform Prior Authorization Form
- Health Care Code Lists: CARC & RARC

GETTING CONTRACTS IN PLACE

- **4 Phases of MCO Contracting**

1. Contracting – General, Addendums
2. Credentialing – Group Practice/Rosters
3. Trading Partner Agreement or Clearinghouse
4. Contracting Loading by MCO

- Claims cannot be properly adjudicated until all 4 steps are complete.

MCO: TRANSITION OF CARE PROVISIONS

- **Transition of Care** – Patient protections to support continuity of care required by ODM contract.

  - MCO must allow payment for all providers for 6 months
  - MCO must 180 days for timely claims filing for 6 months
  - MCO must pay FFS rates for 12 months
  - MCO must follow FFS prior authorization practices for 12 months.
  - MCO must accept FFS prior authorizations approved BEFORE 7/1/18.

MCP CASH ADVANCE CONTINGENCY PLAN

- **INTENT**: To support sustained access to services during the transition to managed care and minimize risk of cash flow disruption.
- Each MCP offered an opportunity to sign-up for 4 months cash advance equal to 54.6% of CY 2016 claims.
  - CareSource and Molina offered an Enhanced 80% Cash Advance Option
- Repayment was to begin November 1, 2018
- Currently, MCPs and providers are individually negotiating extended repayment plans due to slow progress in stabilizing claims payment.
- SEE: Extended Repayment Information | Plan-by-Plan Extended Repayment Approach

MCP OUTCOMES: MOVING TO VALUE

- ODM MCP Provider Agreement: Updated every 90-180 days
- Appendix K – Quality Care
- Appendix M – Quality Measure and Standards
- Appendix O – Pay for Performance (P4P) and Quality Withholding
  - FY 2018 - P4P Measures
  - FY 2019 – Quality Withholding (2% capitation payment)
    - Four areas: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children
    - Defined in Appendix M

MCP OUTCOMES: MOVING TO VALUE

- **Quality Withholding Measures: FY 2019 based on FY 2018 data**
- **Behavioral Health**
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - 7 day Follow-Up After Hospitalization for Mental Illness
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Total
- **Chronic Disease: Diabetes**
  - Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)
  - Comprehensive Diabetes Care – HbA1c Testing
  - Comprehensive Diabetes Care - Eye Exam (Retinal) Performed
  - Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
  - Controlling High Blood Pressure
  - Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy, Total

48

BILLING TIPS & CHALLENGES

BILLING TIPS AND CHALLENGES

- **Rendering Provider**: NPI issues (and "U" modifiers) remain the most common error.
  - Every claims must have either an NPI and/or "U" modifier
  - Missing NPIs common – ***confirm submission on originating claim***
- **Rendering NPIs: Header vs. claim line detail.**
  - If a claim has multiple claims lines with different rendering practitioners, leave rendering NPI blank in the header.
  - Put rendering NPI in the detail line.
  - *Paramount can only process a single, unique rendering NPI per claim.*

BILLING TIPS AND CHALLENGES

- **Duplicate billing issues:**
  - CPT codes – same day service – NCCI modifiers
    - Medicaid NCCI Edit tables: PTP column 1 and column 2.
    - XE, XP, XS, XU or 59 when permitted same day services
    - The NCCI modifier goes on the code in column 2
    - **Example**: 90853 and 90837 XE to bill same day, same clinician.
  - HCPCS Codes: Rolling up (limited)
    - "Rolling" requires same: client, DOS, HCPCS code, individual rendering practitioner NPI, supervisor NPI (as applicable), and POS.

BILLING TIPS AND CHALLENGES

- **Third Party Liability (TPL) – Medicare COB**
  - MCPs did not initially configure Medicare and TPL Bypass
  - MCPs follow OAC 5160-26-09.1 for TPL
  - MCPs are required to provide TPL information and provider must check with the third party carrier and/or client.
  - If TPL data is incorrect, Provider must notify the MCP and manually add "other payer information" via MITS to request review.
  - See Submitting Other Payer Information Instructions

BILLING TIPS AND CHALLENGES

- **Nursing**: each claims requires an "ordering prescriber".
  - DK qualifier required and reported in Loop 2420E Segment NM1 Element 1
- **Other common claims denials:**
  - Service billed under the wrong agency NPI (PT)
    - *Confirm accuracy on provider originating claim file*
  - Service not covered under contract/wrong fee schedule
  - Provider specialty/wrong taxonomy
  - Add on codes – missing base code
  - Diagnosis codes – Use 2019 ICD-10 DX Code Groups BH Redesign
  - POS codes as defined by service in BH Provider Manual

BILLING TIPS AND CHALLENGES

- **Prior Authorization**
  - Services requiring PA include:
    - ACT, IHBT, SUD Partial Hospitalization before service delivery
    - SUD Residential after 30 days or 3rd admission within a year.
    - Assessment, psychological testing and SBIRT can be prior authorized beyond benefit limit.
  - Uniform Prior Authorization Form
  - Each MCP has processes for requesting authorizations, requesting peer-to-peer reviews, appeals, and grievances.
  - **PA requests must be individualized to the client specific treatment needs.**
  - **MCPs** are expected to individually authorize services based on medical necessity and individual needs of each member.
  - Providers have raised issues with certain MCPs authorization practices; however ODM has indicated they will not intervene.

BH REDESIGN – RAPID RESPONSE TEAMS & TA RESOURCES

MITS FFS Rapid Response Team

- Medicaid Provider Hotline: 1-800-686-1516 — Mon – Fri: 8:00 AM – 5:00PM
- Ohio Medicaid Policy Rapid Response: bh-enroll@medicaid.ohio.gov

AETNA – MYCARE ONLY

- Rapid Response Team: OH_BH_Redesign@AETNA.com
- Prior Authorization Questions: 1-855-364-0974, option 2, then 4
- 24/7 Notification Fax: 1-855-734-9393
- Provider Services: 1-855-364-0974, option 2, then 5
- Escalation/Other Questions: KilincA@aetna.com

Technical Assistance: Aetna Rapid Response Team and TA Resources
Monthly provider webinars scheduled and Provider Relations Liaisons available for onsite visit.

BUCKEYE

- **Rapid Response Team:** BehavioralHealth@centene.com
- Provider Relations: 1-866-246-4356 ext. 24291
- 24/7 Notification Phone Line: 1-866-296-8731
- 24/7 OH Notification Fax: 1-866-535-6974
- Escalation/Other Questions: lpaynter@centene.com

Technical Assistance Resources: Buckeye BH Redesign Webinar Registration
Provider webinars available every Tuesday at 9:00 and Thursday at Noon.

CARESOURCE

- Customer Advocacy Group: 1-800-488-0134 (KATIE system)
- BH e-mails: OhioBHinfo@caresource.com
- 24/7 Notification Fax: 1-937-487-1664
- 24/7 UM Notification e-mail: mm-bh@caresource.com
- Escalation/Other Questions: terry.jones@caresource.com

Technical Assistance: BH Redesign Rapid Response Weekly Webinars
Each Wednesday, 3:00 – 4:00 PM. To register, contact at Sherron.Jefferson@CareSource.com or call 614-255-4620 and include organization name and NPI number along with names and e-mail address of individuals planning to participate.

MOLINA

- **Rapid Response Team:** BHProviderServices@MolinaHealthcare.com
- 24/7 Notification Phone Line: 1-855-322-4079
- 24/7 Notification Fax: 1-866-449-6843
- 24/7 Notification e-mail: OHBehavioralHealthReferrals@MolinaHealthcare.com
- Escalation/Other Questions: Emily.Higgins@MolinaHealthcare.com

Technical Assistance Resources: BH Redesign Provider Bulletin
Multiple provider TA webinars scheduled throughout the year. Details and registration in the Provider Bulletin.

UNITED HEALTHCARE/OPTUM

- **Rapid Response Team:** OhioNetworkManagement@optum.com
- 24/7 Notification Phone Line: 1-800-600-9007
- 24/7 Provider Prior Authorization Request: 1-866-261-7692
- 24/7 Online Prior Authorization Request via Provider Portal: www.providerexpress.com and www.UnitedHealthcareOnline.com
- Escalation/Other Questions: tracey.izzard-everett@optum.com

PARAMOUNT – MEDICAID ONLY

- **Rapid Response Team/Testing Assistance:** PHC.BehavioralHealth@ProMedica.org
- 24/7 Notification Phone Line: 1-419-887-2557 or 1-888-891-2564
- 24/7 Notification Fax: 1-567-661-0841
- PHCReferralManagement@ProMedica.org
- Escalation/Other Question: hy.kisin@promedica.org and Linda.NordahlLSWCCM@ProMedica.org

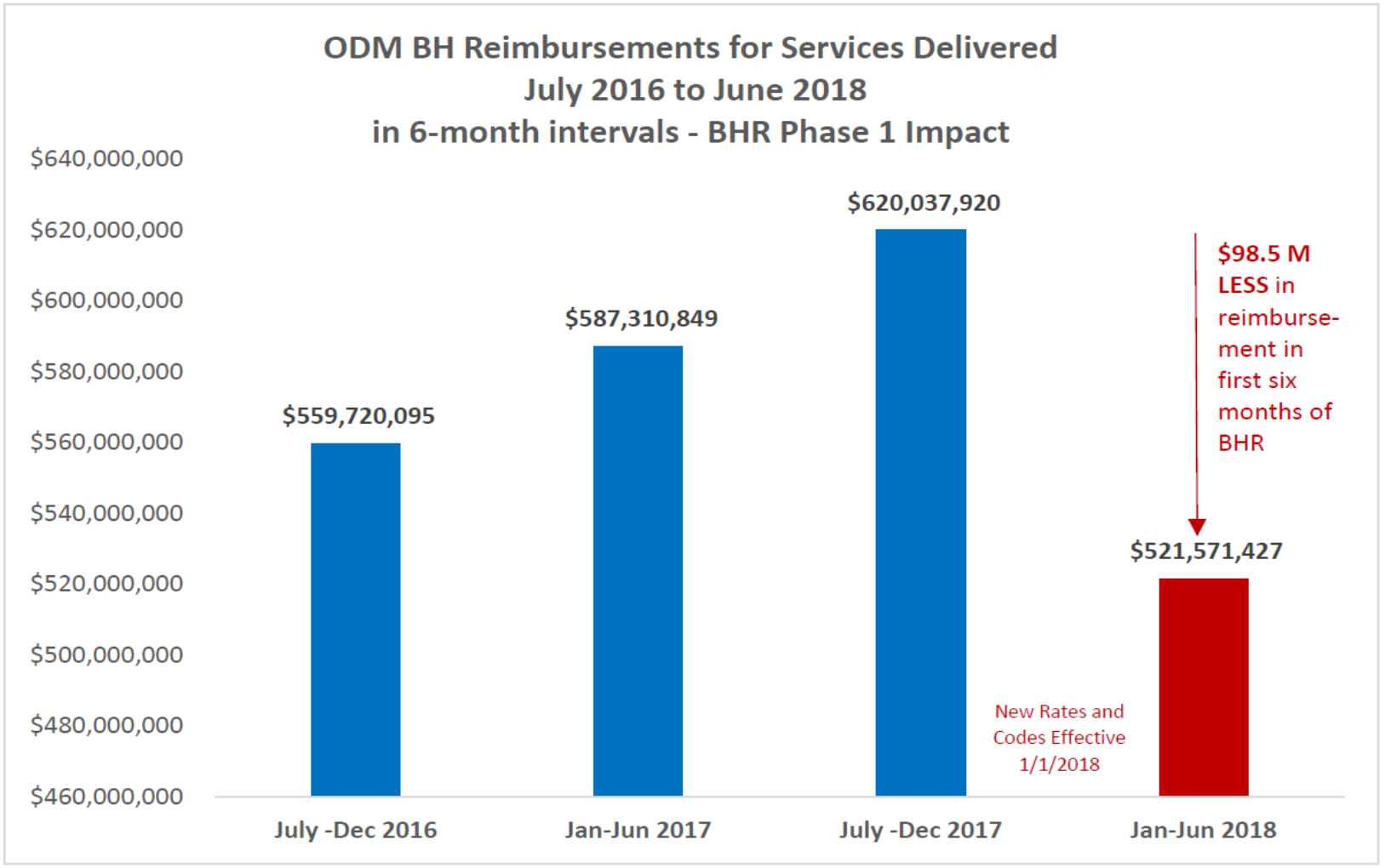
ODM Managed Care Provider Complaint Form: https://providercomplaints.ohiomh.com/

IMPLEMENTATION: HOW IS IT GOING?

BH REDESIGN - SHARED GOALS

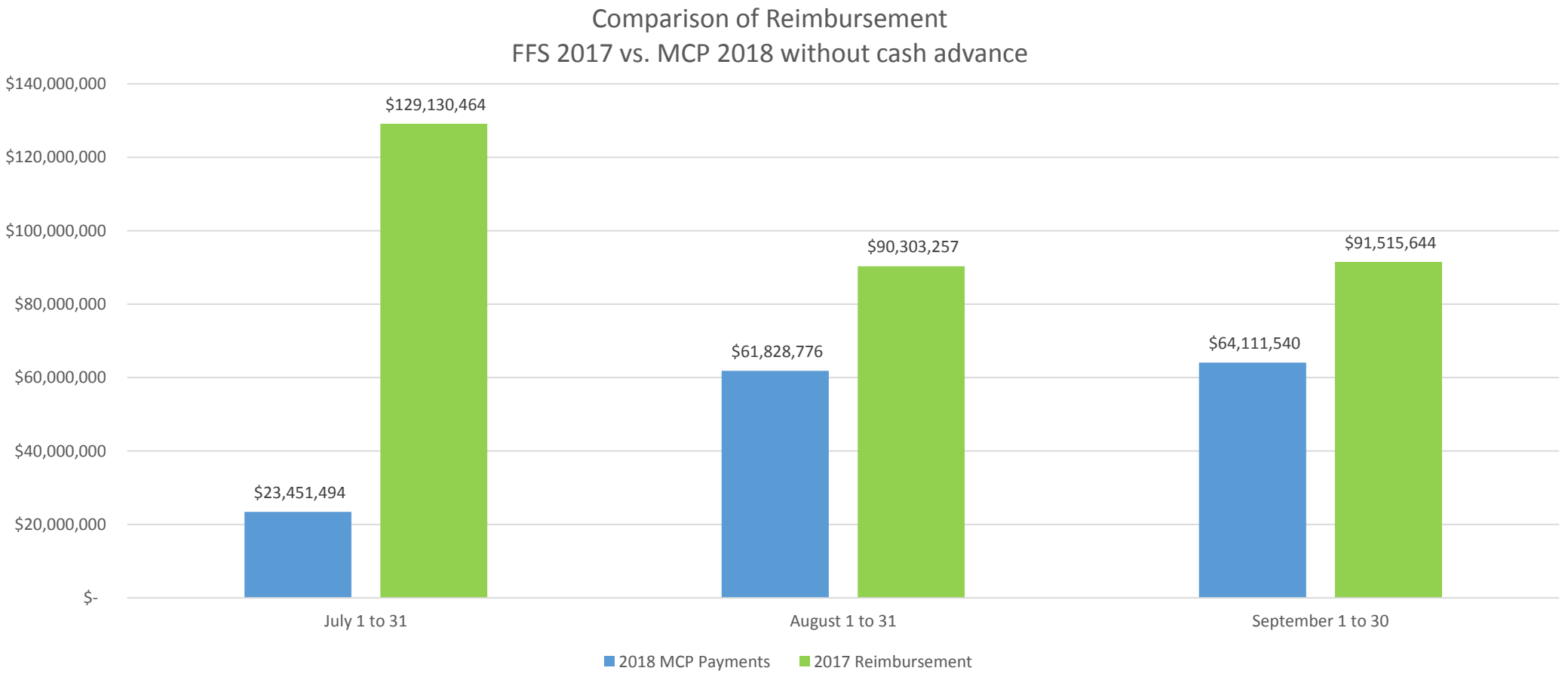
- Successful integration of behavioral health services in managed care.
- Improved claims payment and stabilization of the provider system finances
- Sustained service access and capacity
- Maintain the behavioral health workforce

MEDICAID BH CLAIMS: JAN – JUNE 2018



Data source: JMOC as pulled from the ODM flash report ascertained through the state accounting system.

BH MEDICAID PAYMENTS: FFS VS. MCP



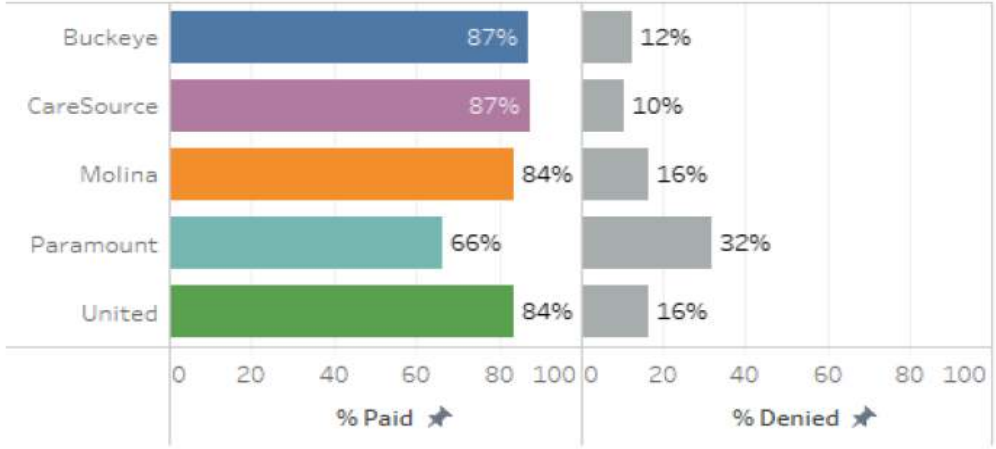
Behavioral Health August Glide Path - Plan Category Breakdown

	Unique Providers That Have Submitted Claims	Total Clean Claims Paid	Total Clean Claims Denied	Pended Claims	Total Claims	Total Paid Amount ($)	Unclean Claims
Buckeye	353	72,808	10,327	256	83,391	6,665,924	2,633
CareSource	473	371,622	43,907	9,553	425,082	35,852,122	8,611
Molina	358	74,609	14,659	19	89,287	7,231,240	6,755
Paramount	213	55,702	26,787	1,280	83,769	5,039,125	1,013
United	284	70,703	13,653		84,356	7,040,366	9,862
Grand Total		645,444	109,333	11,108	765,885	61,828,776	28,874

Data timeframe is 8-1-18 thru 8-31-18 as reported on 10-5-18

On average, plans denied 17% of claims received in August

% Paid or Denied - August



% Paid or Denied is for the entire month of August. Total may not add up to 100% due to pended claims.

Contingency Payments - September

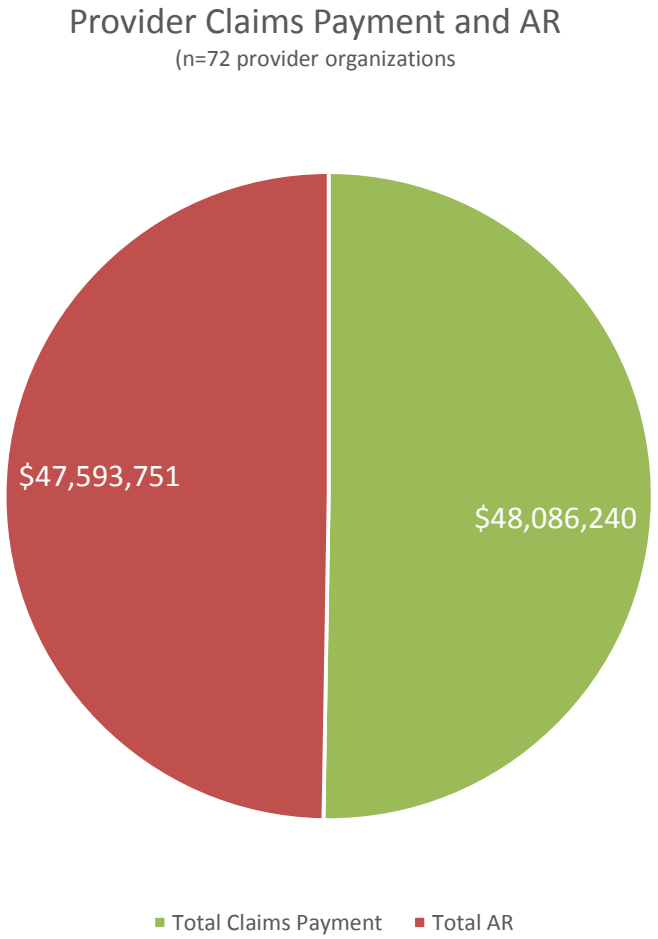
Plan	Sum of Number of Unduplicated Providers Sent a Contingency Payment	Sum of Total Amount of Contingency Payments
Buckeye	144	$3,716,779.96
CareSource	241	$22,675,208.37
Molina	147	$4,143,491.94
Paramount	140	$3,170,432.07
United	152	$3,449,923.80

OHIO COUNCIL SURVEY: FIRST 90 DAYS

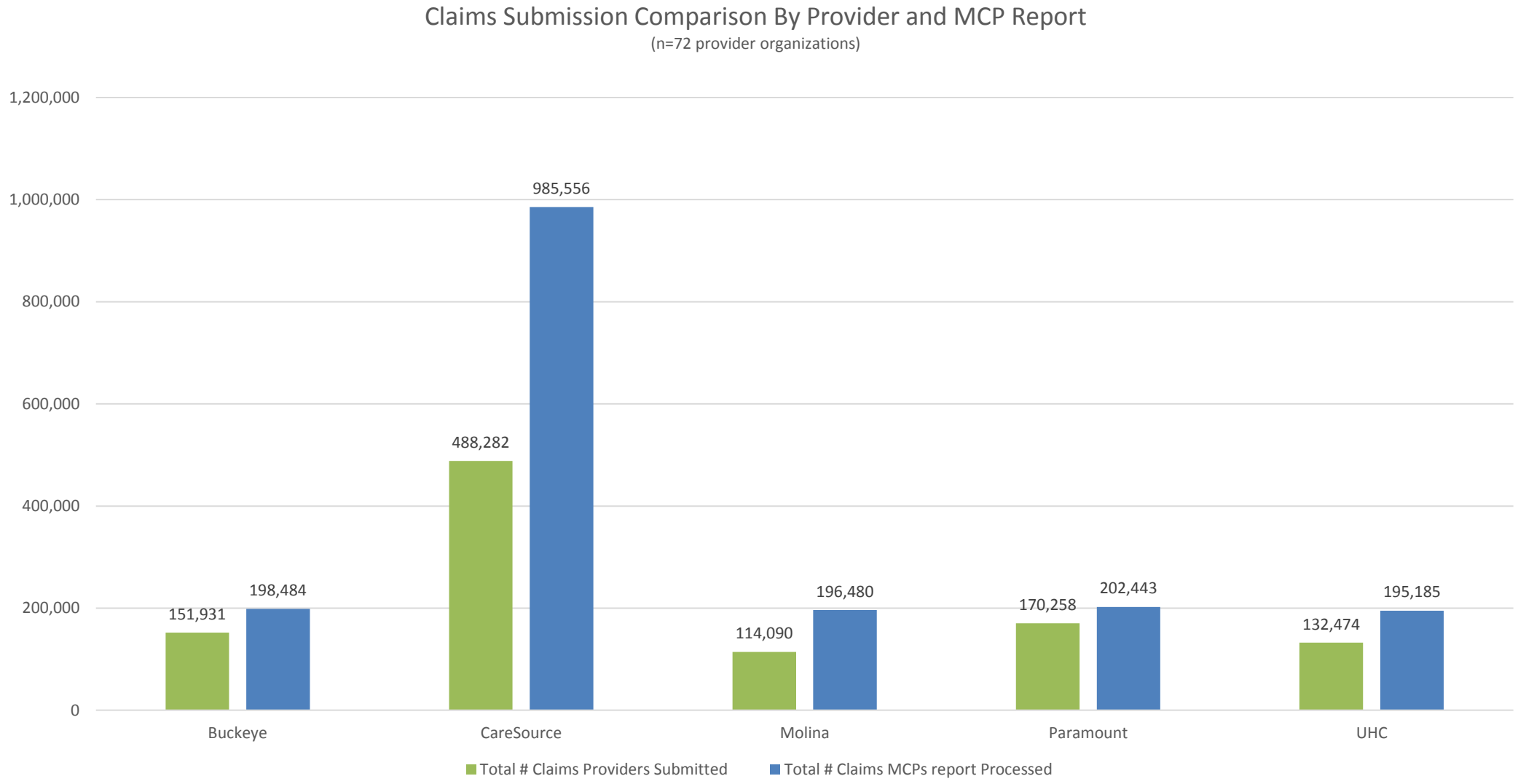
	Total # Claims Submitted	Total Contract Adjusted Claims Value	Total Claims Payment	% of Claims Paid by MCP	Total AR
Buckeye	151,931	$19,121,352.24	$9,774,170.39	51.12%	$7,146,581.42
CareSource	488,282	$38,035,335.32	$23,765,094.93	62.48%	$22,221,692.53
Molina	114,090	$9,024,123.09	$4,099,884.60	45.43%	$6,111,056.37
Paramount	170,258	$11,773,560.67	$5,310,712.89	45.11%	$7,031,173.05
UHC	132,474	$8,826,648.52	$5,136,377.49	58.19%	$5,083,247.55
SYSTEM TOTAL	1,057,035	$86,781,019.84	$48,086,240.30	55.41%	$47,593,750.92

Ohio Council First 90 Days – BH Payment Integration Survey Results
Sample: 72 Ohio Council member organizations. Survey conducted 9/28 – 10/2 reporting on services billed between 7/1/18 and 9/28/18.

OHIO COUNCIL SURVEY: FIRST 90 DAYS



OHIO COUNCIL SURVEY: FIRST 90 DAYS



RECOMMENDATIONS & NEXT STEPS…

- **Improve claims payment** and restore service access and capacity to pre-2018 levels
- **Extend Transition of Care** Requirements
- **Re-visit payment policies** negatively impacting service delivery
  - Crisis services
  - Group counseling
  - Nursing
  - ACT
  - Psychological Testing
- **Streamline and standardize processes**
  - Practitioner credentialing in MITS
  - TPL data
- SUD Residential – Proposed 1115 Waiver
- Behavioral Health Care Coordination (BHCC) – Pending Rule 5160-1-73

PROVIDER ADVOCACY: WHAT YOU CAN DO!

- **Contact Your Elected Officials**
- **New Administration, Senator(s) and House Members**
  - Tell them how BH Redesign has effected your business
    - Describe change in service access and capacity and changes in your workforce
    - Describe the financial impact and your current AR
    - Suggest Recommendations to achieve success
- **To find your Legislator, use this link:**
  - https://www.legislature.ohio.gov/legislators/find-my-legislators
  - Type in your zip code to identify your House Representative and State Senator!

OTHER DISCUSSION….

Teresa Lampl, LISW-S

E-mail: lampl@theohiocouncil.org

Phone: 614-228-0747

Break & Networking

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How are you going to get Value out of Value Based Care?

Thriving, Not Just Surviving

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TODAY'S SPEAKER

TODD CHAREST

Chief Product Officer, Qualifacts

Todd Charest is the Chief Product Officer at Qualifacts and has over 24 years of experience and a proven track record leading healthcare technology firms and provider-based healthcare organizations. His experiences cross product management and innovation, IT strategy and operations, and business process redesign efforts but has always been focused on the intersection of enabling technology and healthcare delivery in ways that provide tangible value to providers and the consumers they serve.

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qualifacts | AGENDA

- Drivers for all this Change
- Value Based Care
- Shifts to:
  - New Delivery Models
  - Consumerism
  - Community Care

- *OH Is Making Changes*
- Preparedness: Ready, Set, Go

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MACRO TRENDS IMPACTING BEHAVIORAL HEALTH AGENCIES

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IMPROVE PRODUCTIVITY AND QUALITY

Current Payments **NOT** Sustainable

Consumer Engagement and Activation

VALUE BASED CARE: Payments shifting away from "billable encounters"

MERGERS AND ACQUISITIONS

NEW COMPETITION AND PARTNER ALLIANCES

BUSINESS INSIGHTS THROUGH DATA

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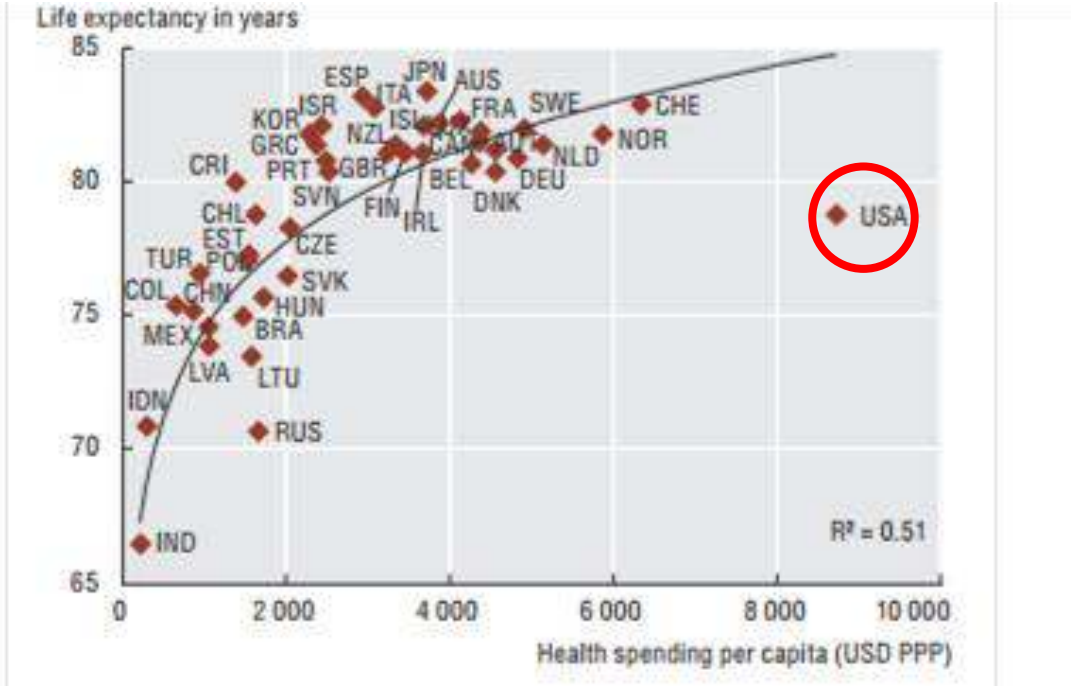
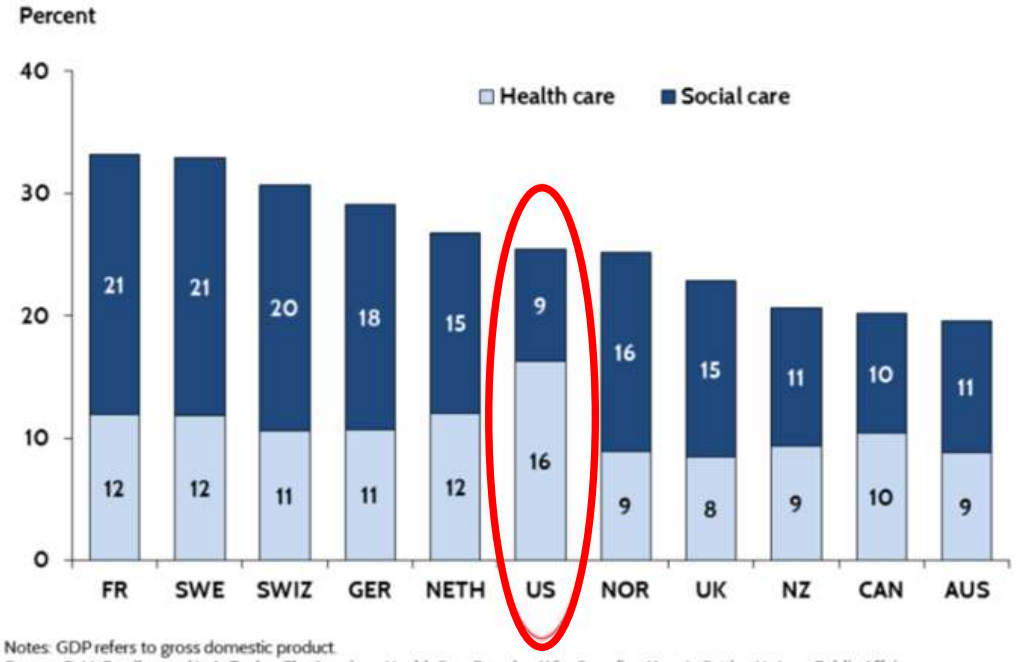
WHAT IS DRIVING THE TRENDS WE FEEL?

Life Expectancy At Birth And Health Spending Per Capita



Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.
StatLink http://dx.doi.org/10.1787/888933280727

Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

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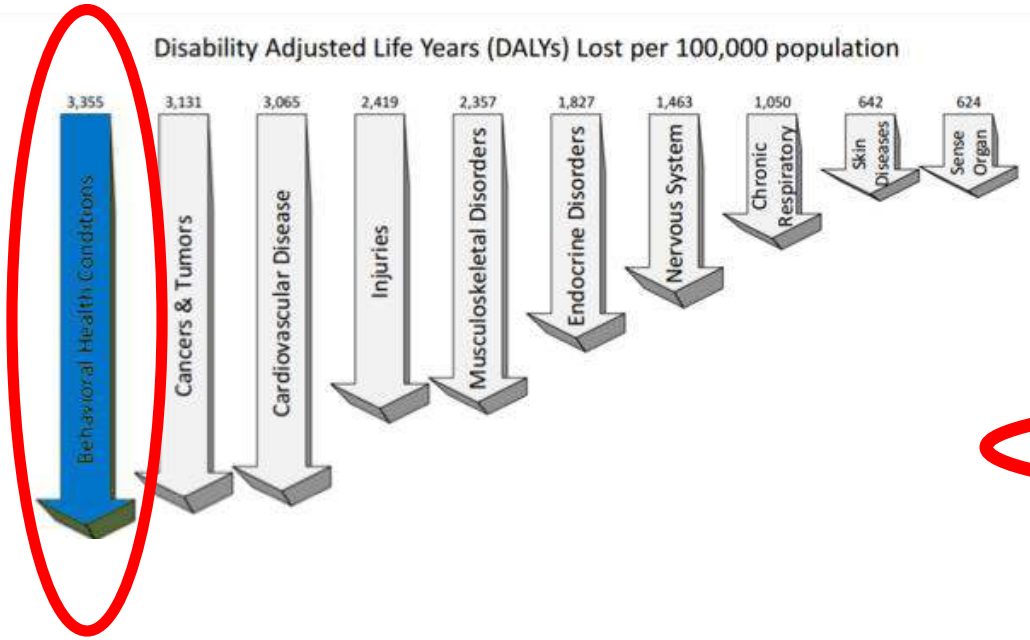
qualifacts | BEHAVIORAL HEALTHCARE COSTS

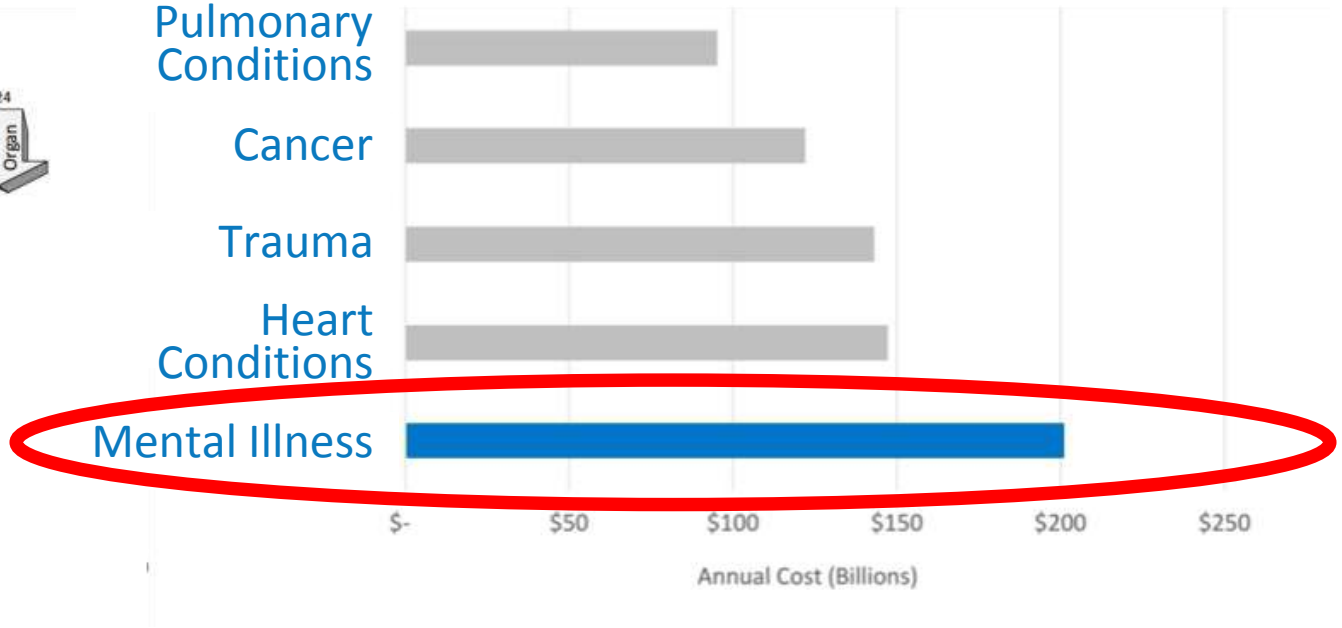
Behavioral Health Disorders Were The Largest Cause of Disease Burden In U.S.



Behavioral Health Conditions

Source: Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415.

Mental Illnesses Are Some Of The Most Costly Conditions



Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.

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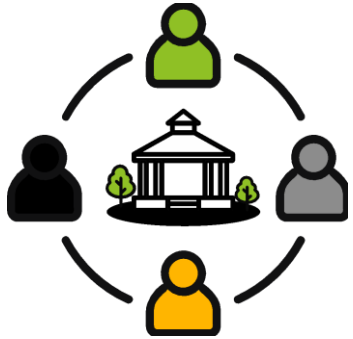
FOUR INDUSTRY TRENDS

Value Based Care

New Competition

Consumerism



Community Care

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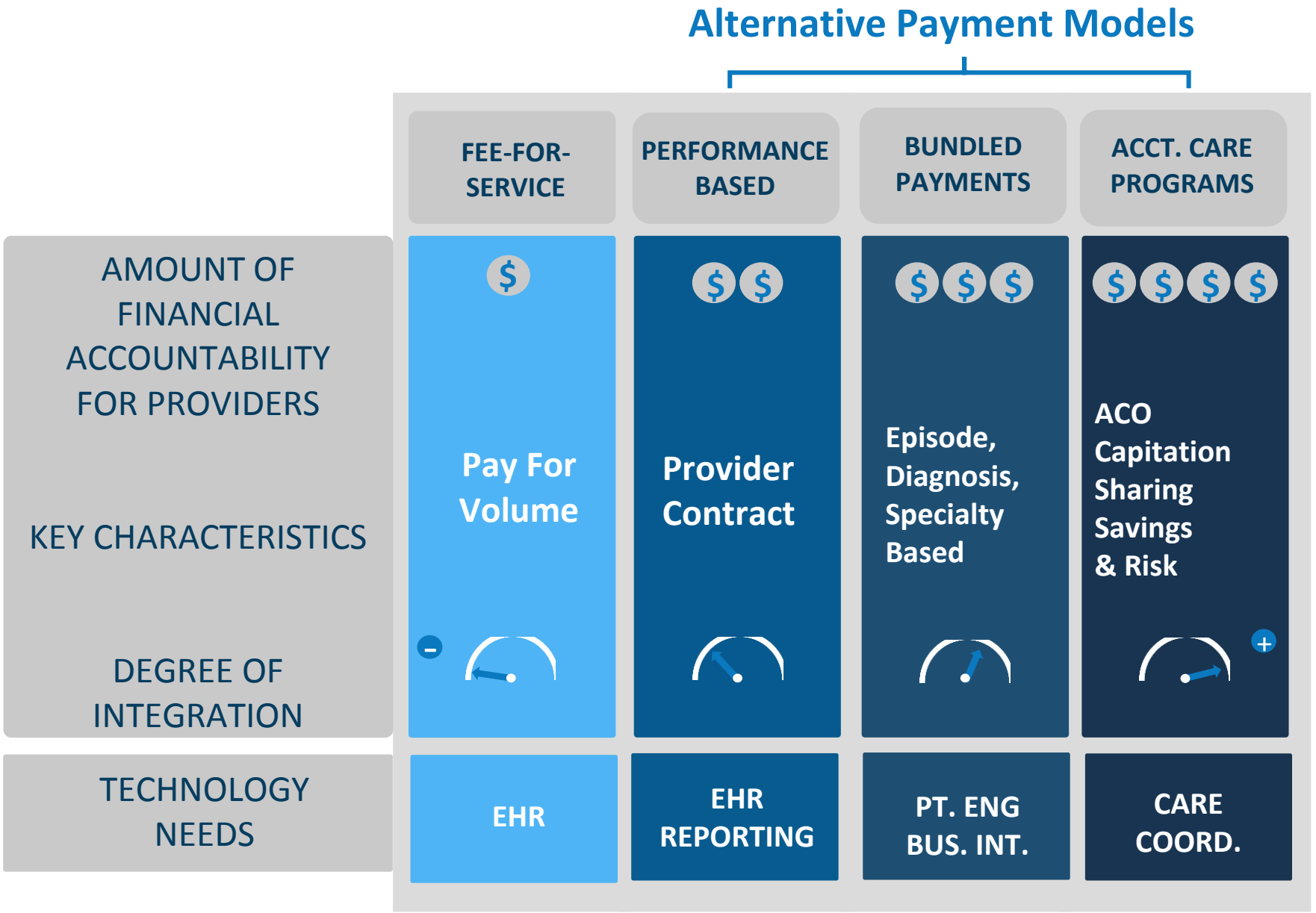
qualifacts | # ALTERNATIVE PAYMENT MODEL CONTINUUM



VBC

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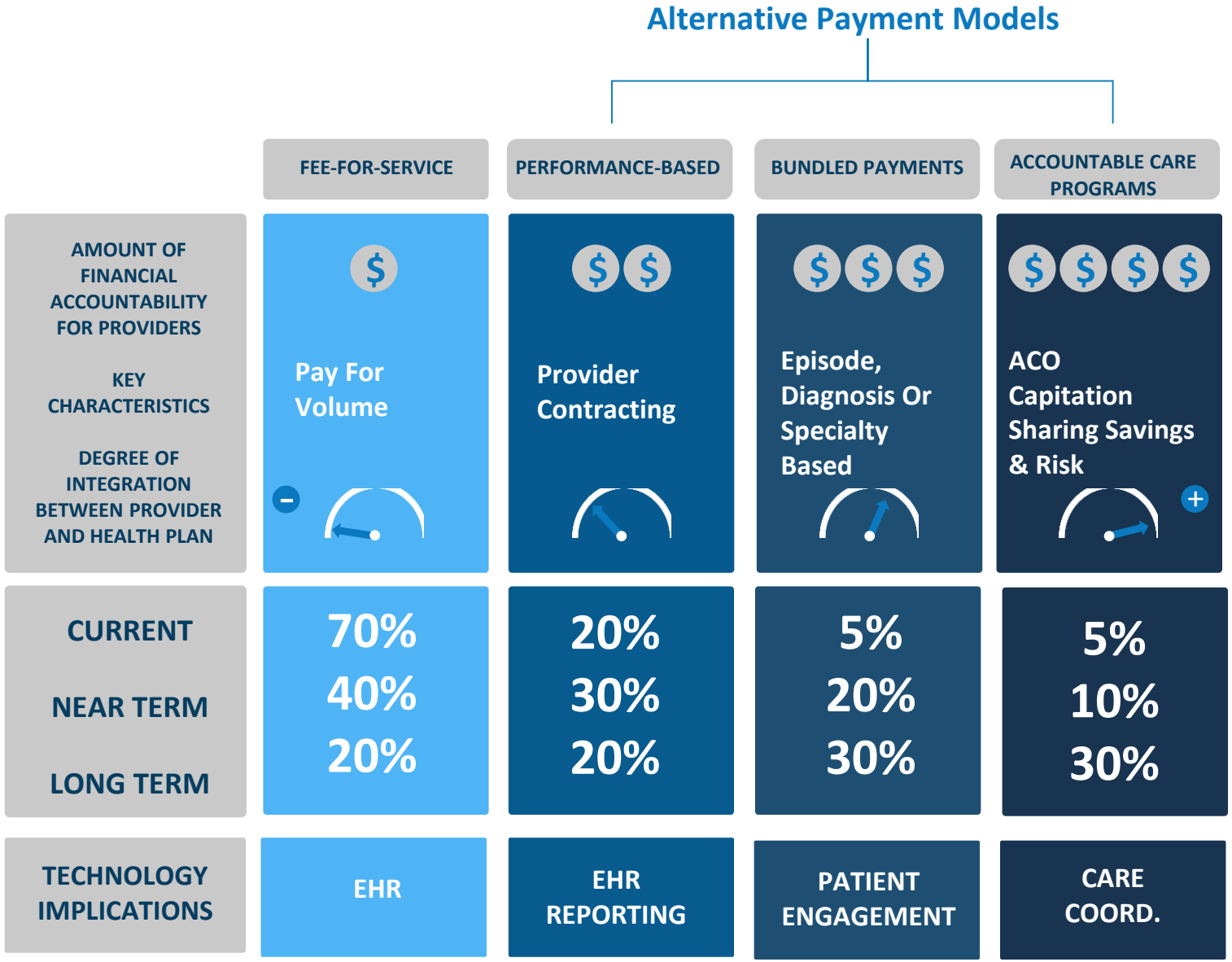
LOOKING AHEAD



Payment % Shifting

VBC is Reducing Cost

Technology Eco Systems Changing

VBC

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THE COMPETITIVE LANDSCAPE IS CHANGING

New Competitor Is NOT Down The Street

$ LEVERAGE TECHNOLOGY FOR NEW COST POINT + IT LIVES IN YOUR CONSUMER'S POCKET = WILL DETERMINE YOUR MARKET SHARE

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NEW COST POINTS AND BETTER CARE ?

- The opportunity for cost savings in behavioral health is not as well-established as it is for other medical conditions
- Examples of over-diagnosis and over-treatment are cited in many areas of health care but it is just the opposite for behavioral healthcare
- Under-identification, under-treatment, gaps in care transitions, and poor coordination across the healthcare system seem to be more serious issues for behavioral healthcare

For example, patients referred for psychotherapy to treat depression often don't make their first appointment, and among those that do initiate treatment, early dropout is common. One study showed that the average number of therapy sessions completed is only two.

https://www.3mhisinsideangle.com/blog-post/behavioral-health-value-based-care-time/

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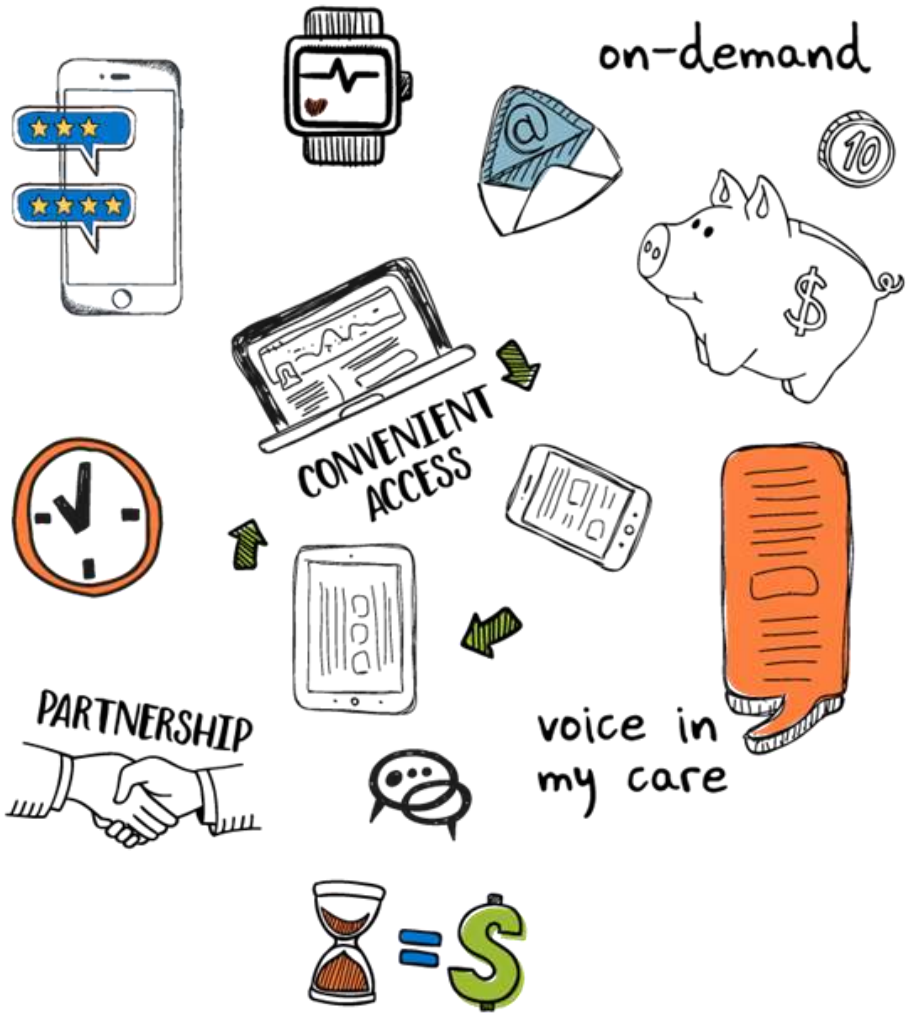
CONSUMERS WANT CONVENIENCE



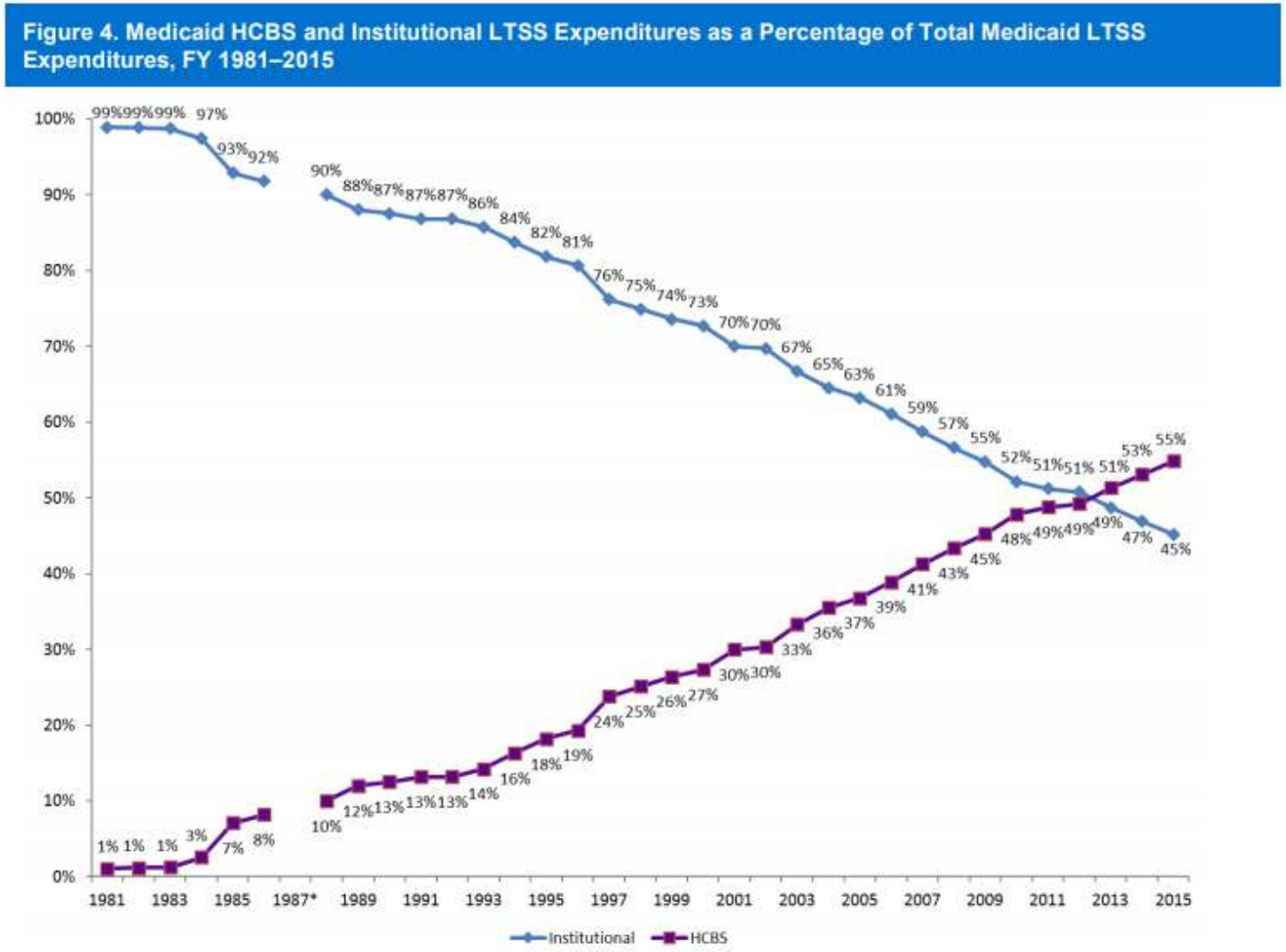
82%

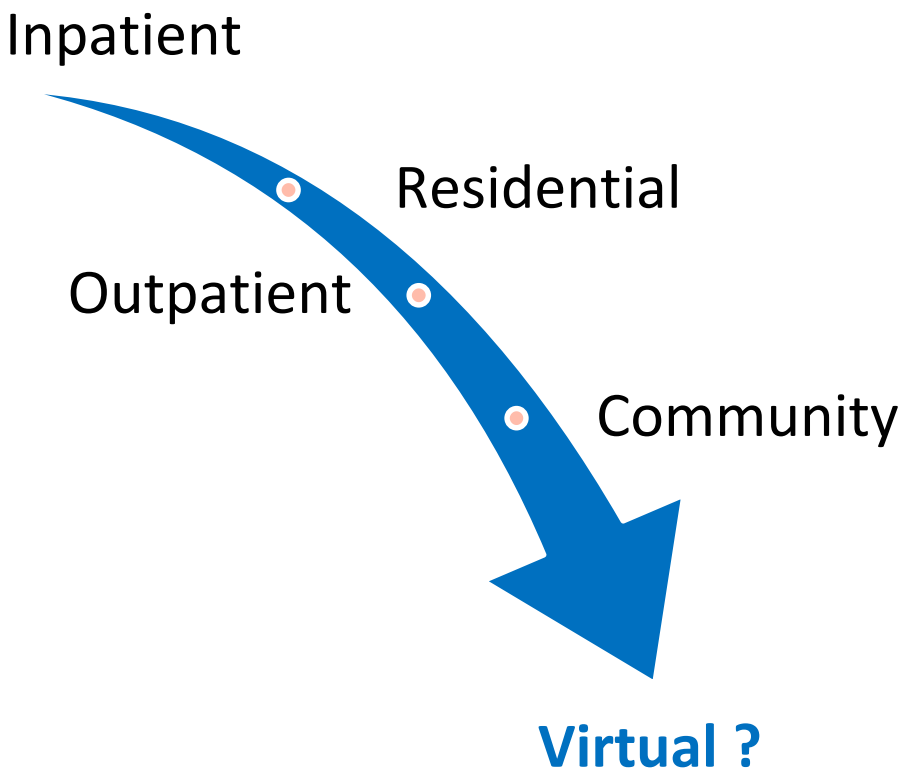
of health care consumers use online reviews

New Healthcare Consumer

- Easy Consumer Facing Technology
- Simple Path To Coordinated Care
- Improved Treatment Compliance

THE SHIFT TO COMMUNITY BASED CARE





https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

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IT'S NOT IF BUT WHEN…

"Movement to value based contracting is slow – by Payers, by Health Plans, and by Provider organizations. But I think of it as glacial. Glaciers move slowly, but they are massive forces that inexorably sculpt the face of every landscape they touch."

Open Minds 10/2/2018 'Preparing for the Very Glacial VBR Rollout in Some Markets' Monica E. Oss, interviewing Kent Dunlap CEO Stars Behavioral Health Group

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4 TRENDS SHAPING HOW WE THINK OF CARE

Value Based Care

New Competition

Consumerism

Community Care

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Ohio Is Making Changes…

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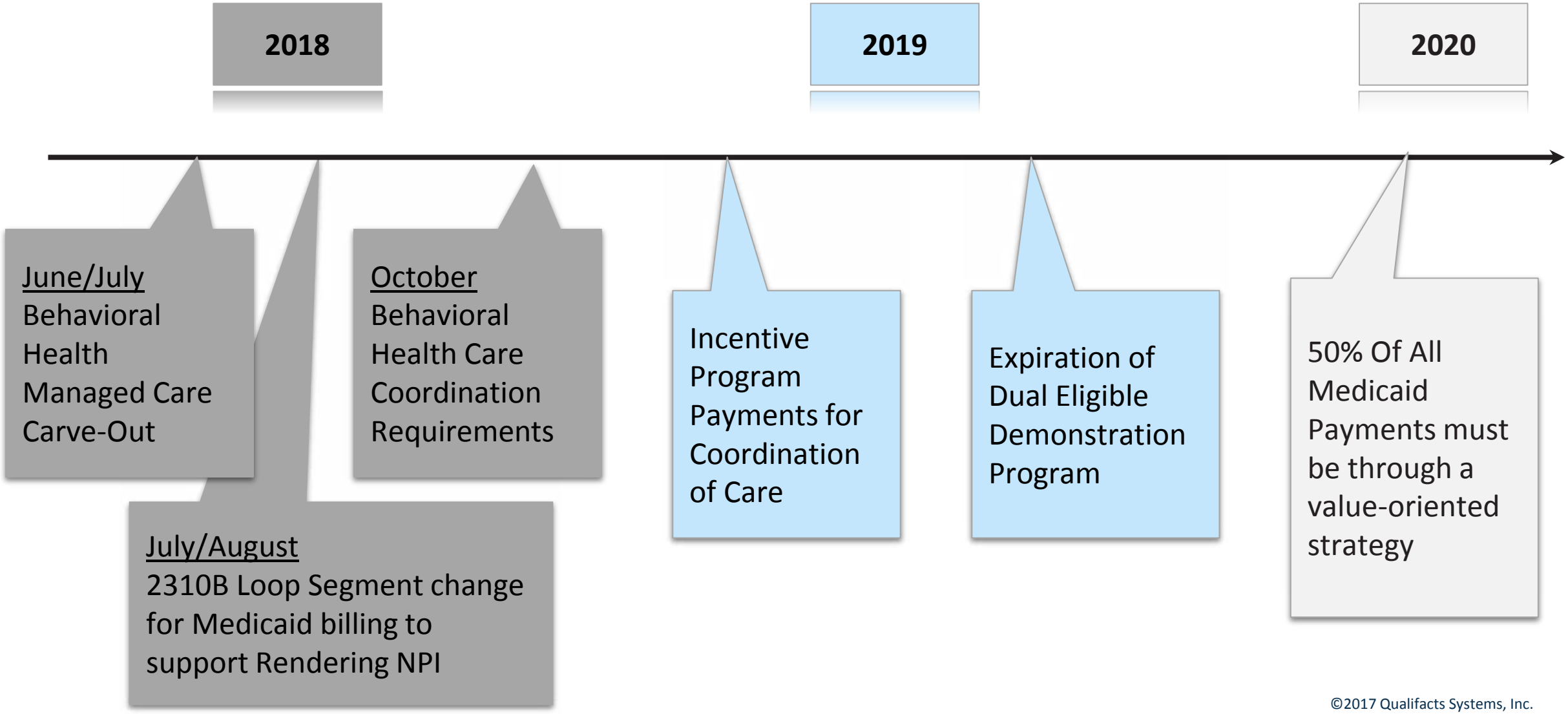
OHIO TAKING ACTION



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PREPERATION AND READINESS ARE KEY

What can you do to fully take advantage of the shifts to VBC

- Evaluate, measure, collection and analysis against measures expected by payers/State
- Review current workflows against managed care requirements (e.g., authorization rules, *credentialing of providers*, treatment caps or bundles, reporting)
- Understand the segmentation of the consumer populations you serve
- Understand your variations in care delivery by Dx and also Clinician
- Understand unit costs and improvement opportunities
- Fully leverage your EHR Capabilities to drive our variations in care
- Go Beyond the EHR: Patient Engagement Platforms and Care Coordination Platforms
- Establish a Network of Providers who treat populations together
- Work to develop positive payer relationships with your key payers

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READINESS ASSESSMENT

- Evaluates and identifies areas in the following key organizational domains:
  - Provider Network Management
  - Clinical Management & Clinical Performance Optimization
  - Consumer Access, Service Engagement
  - Financial Management
  - Technology & Reporting Infrastructure
  - Leadership & Governance

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THE FUTURE

There is no crystal ball, though most of us would surely appreciate it.

However, there are two key points we can and should concentrate on:

1. Accelerated understanding and use of your organizations Data

2. Holistic approach to our clients

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DATA UNDERSTANDING AND USAGE

- Delivery of services is changing to support improved outcomes and lower costs – understanding your performance is key.
- Financial forecasting will be more important than ever. Understanding true cost of care will be vital for contract negotiation and grant requests in the future.
- Federal and State program reporting requirements will continue to evolve and expand from reputational to direct payment.

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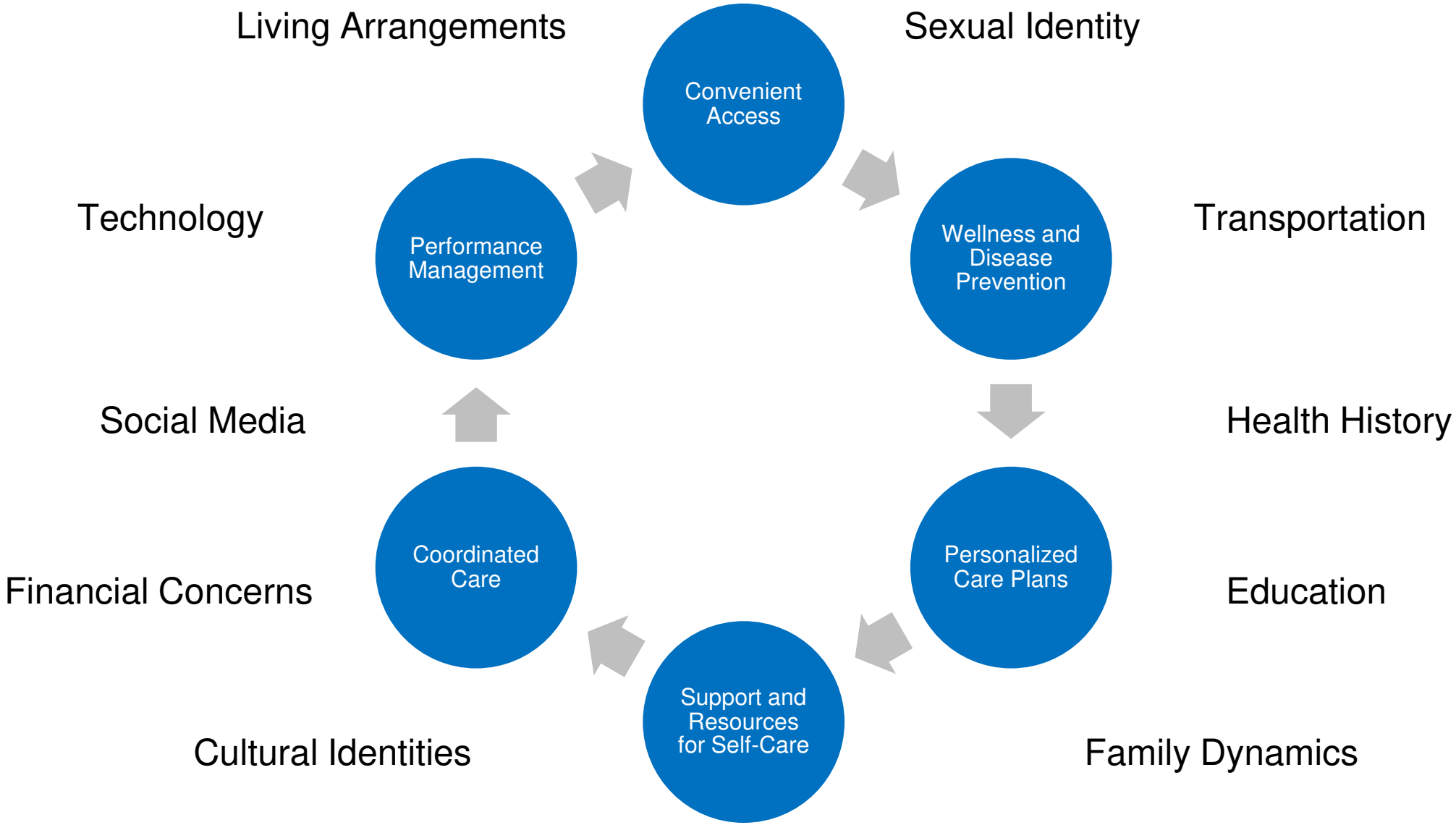
HOLISTIC APPROACH IS IN OUR FUTURE



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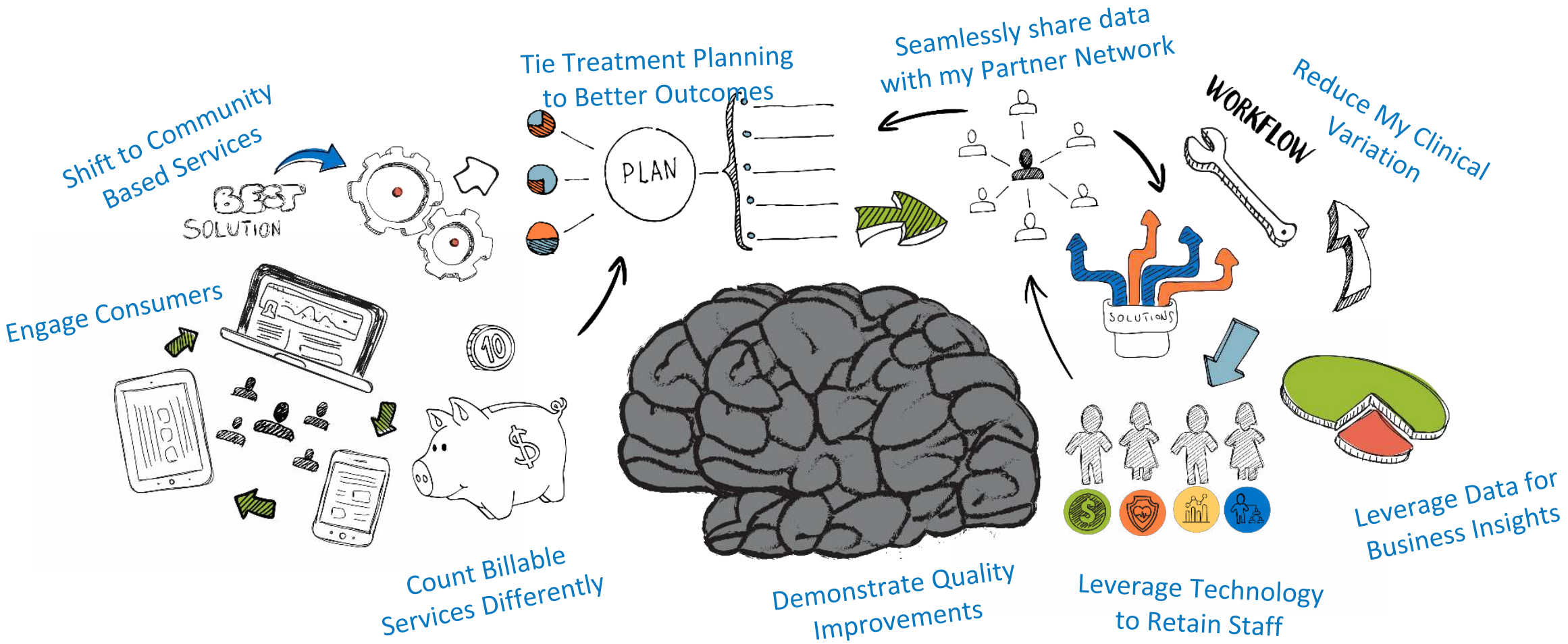
CREATE A STRATEGIC PLAN TO ADDRESS VBC



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qualifacts | Q&A

Questions?

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DID YOU KNOW?

Presented by:

Teresa Heim, CEO

Behavioral Health Billing Solutions LLC

BHBS

DID YOU KNOW?

With the changes effective July 1st, it is critical to check client eligibility and verify not only active Medicaid, but also which MCO they are signed up with.

How many agencies are doing this process manually?

How many are sending an electronic 270 eligibility batch to MITs or your clearing house?

Since CareSource and Paramount utilize unique IDs instead of the client's Medicaid number for claim submission, capturing these unique IDs needs to be factored into the equation.

Solution: Find a mechanism to check eligibility in bulk through MITS and your clearing house.

If your software doesn't offer this functionality, we have vendors here that can offer alternatives.

In your folder, you will find a free 3-month trial of the Power Generator from EMS. This includes demonstrating its use and training on the best practice for Ohio Agencies.

BHBS

If you want to talk in more detail about the options available, stop by the vendor area.

However, now it's GIVEAWAY time!

BHBS

Feel free to reach out with questions or ask for assistance!

Teresa Heim, *CEO of Behavioral Health Billing Solutions LLC*
Email: teresaheim@bhbillingsolutions.com
Phone: (614) 395-0136

Lunch

"Adapting to the Changes of the Ohio BH Redesign and the MCO Carve-In"

Panel Discussion

Presented by:
Behavioral Health Billing Solutions LLC

BHBS

BHBS

What is Menti?

Mentimeter AKA “Menti” is an application used to ask questions in real time during an event or seminar.

Simply download the app on your Android or Apple device, or visit https://www.menti.com and enter the code:

69 73 84

Our team will be monitoring the application for questions that submitted and convey them to our panel members, vendors, and presenters.

Mentimeter

Panel Members

- *Teresa Lampl, LISW-S, Associate Director of The Ohio Council of Behavioral Health & Family Services Providers*
- *Todd Charest, Chief Product Officer of Qualifacts*
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- *Chris Wolf, CEO of TIL Consulting & Executive at Connect-A-Voice*
- *Gary Humble, Executive Director of Pinnacle Partners*
- *Teresa Heim, CEO of Behavioral Health Billing Solutions*

BHBS

Thank you to all of our attendees and panel members for your participation!

However, now it's GIVEAWAY time!

Understanding Difficult Coding Concepts

Tips for accurate documentation and coding under BH Redesign

Presented by:

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CODING ADVANTAGE
Education for the Business Side of Medicine

"Adapting to the Changes from the Ohio BH Redesign and Managed Care Carve in"

November 7th, 2018

BHBS

Session Discussion

- Review NCCI edits
- Overview E&M documentation
- Learn what's on the horizon for E&M (CMS Final Rule)
- Discuss appropriate use of add-on codes

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Claims Edits
PTP
NCCI
Other

NCCI EDIT REMINDERS:

Two main edits:

- **Code Pair Edits:** Performed on the same day or during the same encounter by the same provider (*aka* PTP or procedure to procedure)
- **Medically Unlikely Edits (MUE):** Unlikely to be performed due to maximum number of units listed in the coding rules

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Claims Edits
PTP
NCCI
Other

NCCI policies and edits are used by most all carriers.

- Specific to BH
  - In 2015, the APA was successful in providing clinical support to billing individual psychotherapy and family therapy on the same day.
- You can over-ride the NCCI edit with a modifier
  - Must be done with consideration to the rules adding to every situation will cause an agency to be flagged for an audit.

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Claims Edits
PTP
NCCI
Other

NCCI manual that is available publicly for free

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code ***solely to bypass an NCCI PTP edit*** *if the clinical circumstances do not justify its use.*

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NCCI Manual

Procedure to Procedure (*PTP edits or code pair edits*)

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

1	Payable code
2	Not payable when submitted with column 1 code unless modifier allowed
3	If edit in existence since 1996
4	Effective date of edit
5	Deleted date of edit if appl.
6	If modifier permitted
7	Where rationale comes from

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Colum1/Column2 Edits

1	2	3	4	5	6	7
Column 1	Column 2	*=in existence	Effective	Deletion	Modifier	PTP Edit Rationale
		prior to 1996	Date	Date	**0=not allowed**	
				*=no data	1=allowed	
					9=not applicable	
90791	90837		20141001	*	0	CPT Manual or CMS manual coding instructions
90791	99201		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99202		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99203		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99204		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99205		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99211		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99212		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99213		20130101	*	0	CPT Manual or CMS manual coding instructions
90791	99214		20130101	*	0	CPT Manual or CMS manual coding instructions

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Claims Edits
PTP
NCCI
Other

NCCI Manual – Psychiatry Specific

Psychotherapy Ind/Fam:

- 90832-90838 include psychotherapy provided to a patient which can be with family members, if present as informants
- 90846/90847 is provided addressing interactions between the patient and family members may be reported separately.
- Must be separately documented and be clear provided at separate time interval.
- The modifier must be on the correct code not just any code…..90837 (see next slide)

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90847 is a **Column 1** code (reimbursable) in the following pairs:

Column 1	Column 2							
90847	0359T[0]	0360T[0]	0361T[0]	0362T[0]	0363T[0]	0364T[0]	0365T[0]	0366T[0]
	0367T[0]	0368T[0]	0369T[0]	0370T[0]	0371T[0]	0372T[0]	0373T[0]	0374T[0]
	36591[0]	36592[0]	36640[1]	90832[1]	90833[1]	90834[1]	90836[1]	90837[1]
	90838[1]	90865[1]	90870[1]	96116[1]	96127[0]	96150[0]	96151[0]	96152[0]
	96153[0]	96154[0]	96155[0]	97802[0]	97803[0]	97804[0]	99201[1]	99202[1]
	99203[1]	99204[1]	99205[1]	99211[1]	99212[1]	99213[1]	99214[1]	99215[1]

Snapshot of 90847 and 90837 NCCI edit screen

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Claims Edits
PTP
NCCI
Other

NCCI Manual – Medicaid Specific Codes

Can be found at the following link:

https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Quarter Begin Date	Category	Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator	PTP Edit Rationale
10/1/2018	Practitioner Services	H0011	99408	10/1/2017		1	More extensive procedure
10/1/2018	Practitioner Services	H0011	99409	10/1/2017		1	More extensive procedure
10/1/2018	Practitioner Services	H0011	G0396	10/1/2017		1	More extensive procedure
10/1/2018	Practitioner Services	H0011	G0397	10/1/2017		1	More extensive procedure
10/1/2018	Practitioner Services	H0011	H0010	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0012	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0013	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0014	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0015	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0018	7/1/2017		0	Mutually exclusive procedures
10/1/2018	Practitioner Services	H0011	H0019	7/1/2017		0	Mutually exclusive procedures

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Types of E/M Services

New patient visits ***99201-99205***

- ***99201 – level 1***
- ***99202 – level 2***
- ***99203 – level 3***
- ***99204 – level 4***
- ***99205 – level 5***

Established patient visits ***99211-99215***

- ***99211 – level 1***
- ***99212 – level 2***
- ***99213 – level 3***
- ***99214 – level 4***
- ***99215 – level 5***

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Elements of Documentation

Elements required for documentation:

- History - ***Subjective***
- Exam – ***Objective (MSE)***
- Medical Decision Making – ***Assessment and plan***

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History Elements

CPT	HPI	ROS	PFSH
New Pt.			
99201	Brief 1-3	None	None
99202	Brief 1-3	Pertinent 1	None
99203	4 or more	Extended 2-9 systems	Pertinent 1
99204	4 or more	10+ systems	Complete 2-3
99205	4 or more	10+ systems	Complete 2-3
Established Pt.			
99212	Brief 1-3	None	None
99213	Brief 1-3	Pertinent 1	None
99214	4 or more	Extended 2-9 systems	Pertinent 1
99215	4 or more	10+ systems	Complete 2-3

EXAM Components Psychiatry

1997– Psychiatry Specialty Exam

Level of Exam	Measurement	E&M code
Problem Focused	1-5 bullets	99212
Expanded Problem Focused	6 bullets	99213
Detailed	9 bullets	99214
Comprehensive	All elements – Document every element in shaded borders and one element in unshaded border	99215

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Exam Elements

LEVEL OF EXAM

PF	**1-5** elements identified by a bullet
EPF	**6** elements identified by a bullet
DET.	**9** elements identified by a bullet
COMP.	**every** element in a **shaded** box ***and*** **at least one** element in every **unshaded** box

SYSTEM/BODY AREA	ELEMENTS OF EXAMINATION
Constitutional	• **Any 3 of the following** vital signs: 1) sitting or standing blood pressure 2) supine blood pressure 3) pulse rate/ regularity 4) respiration 5) temperature 6) height 7) weight • General appearance of patient
Musculoskeletal	• Assessment of muscle strength and tone w/notation of any atrophy and abnormal movements • Exam of gait and station
Psychiatric	• Description of speech including: rate, volume, articulation coherence and spontaneity w/notation of abnormalities • Description of thought processes • Description of associations • Description of abnormal or psychotic thoughts • Description of patient's judgment and insight Complete mental status exam including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge • Mood and affect

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Medical Decision Making Elements View

Elements of Key Component	Definitions of Elements
1. Number of diagnoses or management options	Number and types of problems addressed Complexity of establishing a diagnosis Management Decisions made by physician
2. Amount and/or complexity of data to be reviewed	Types of diagnostic testing ordered or reviewed Need to obtain previous records Need to obtain history from other source(s)
3. Risk of complications and/or morbidity or mortality	**Presenting problem** and the risk related to the disease process **Diagnostic procedures** and the risk during and immediately following the procedure **Possible management options** and the risk during and immediately following the treatment

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LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	1 self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	2 or more self-limited or minor problems; or 1 stable chronic illness (e.g., well-controlled depressions); or Acute uncomplicated ill-ness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)

MDM - Psychiatry

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LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or Undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological testing	Prescription drug management Open-door seclusion ECT, inpatient, outpatient, routine; no comorbid medical conditions
High	1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia); or Acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation ECT; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint (e.g., droperidol)

MDM - Psychiatry

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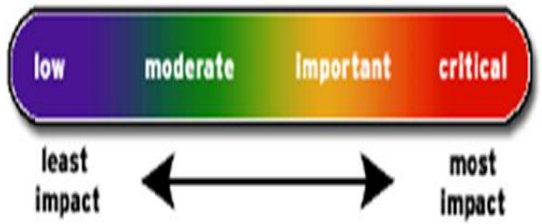
Medical Decision Making Element: Diagnosis

Tips for documenting severity

- Severe significant symptoms of…
- New onset of…
- Not sleeping (significant change from normal pattern)
- Suicidal ideation
- Threatening or combative behaviors
- Sudden exacerbation of…



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E&M Code selection based on time

Time Component

Record should reflect the following statement:

- 50% or more of the visit spent in counseling and/or coordination of care. Total time spent _____ .
- The record should also reflect details about the discussion, treatment options, and if present any family members or caregivers present.

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Counseling and Coordination of Care

Counseling and Coordination of care CPT definition:

- Discussion with a patient and/or family concerning one or more of the following areas:
  - Diagnostic results and/or recommended diagnostic studies
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reduction

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Psychotherapy defined

Psychotherapy <u>CPT definition</u>:

- Treatment of mental illness and behavioral disturbances through definitive therapeutic communication to:
  - alleviate emotional disturbances
  - reverse or change maladaptive patterns of behavior; and
  - encourage personality growth and development.

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Future of E&M Coding and Reimbursement

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Reduce Redundancy in Documentation

What's the latest:

- CMS modified its proposals and will maintain a separate level of payment for the most complex patient care, or level 5 visit *(was previously on chopping block)*
- Delaying implementation of E&M coding reforms *(payment changes)* until 2021
- Physicians will see some immediate changes in 2019 that reduce burden

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Reduce Redundancy in Documentation

Effective January 1, 2019

- E/M office/outpatient visits, practitioners need not re-enter information on the patient's chief complaint and history already entered by ancillary staff
- The practitioner may simply indicate he or she reviewed and verified this information

Stay tuned for updates……

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Add-on Codes

Approach with care!!!

E/M with Psychotherapy

- The E/M service must be **separate and identifiable**
- It does NOT have to have a different diagnosis
- You need to meet the elements of the E/M without indication to time. Psychotherapy needs to be clearly documented separately.
- The psychotherapy must have time documented.

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Prolonged Services

99354

99355

May be added to E&M or Psychotherapy

Misunderstood add-on codes…..

- Count only the duration of **direct face-to-face contact with the patient beyond** the typical time of the visit code billed
- You cannot bill prolonged services for time spent by office staff or time the patient remains unaccompanied in office.
- Service must be sufficiently documented to support that providing prolonged services was medically necessary and that services were personally furnished as direct face-to-face.
- Time MUST be documented

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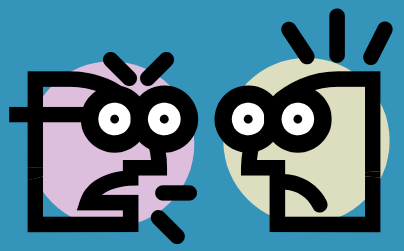
Interactive complexity

+ 90785



Coding Tips:

- Remember to be careful using code for simple language barrier
- Document in medical record to reflect the difficulties and related increased work to support billing for code
- When performed with psychotherapy, interactive complexity relates ONLY to the increased work intensity It is not about time

Helpful Hints: *(IC might be used when…)*

- Difficult communication involving emotional family members
- Patients maladaptive communication issues (anger, anxiety, reaction) with verbal impairment or underdeveloped in communication skills
- Third party active involvement in the care process – parents, guardians, other significant others, agencies, court involved persons, schools
- Therapy that was court ordered and patient refuses to participate in the session.

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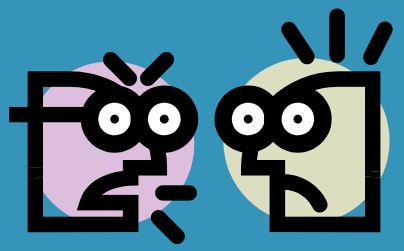
Interactive complexity

+ 90785



Quote from American Academy of Child and Adolescent Psychiatry:

"It would not be appropriate to advise clinicians to use the interactive complexity code anytime they provide psychotherapy to children, and in fact, I suspect that such use of the code would put clinicians at increased risk of audit."

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Break & Networking

QUALITY ASSURANCE PLANS & CLINICAL DOCUMENTATION

SMALLEY
& ASSOCIATES

QUALITY ASSURANCE PLANNING FOR CLINICAL DOCUMENTATION

What Is It??? & How Does It Help??

The formalized plan for systematic monitoring of clinical documentation

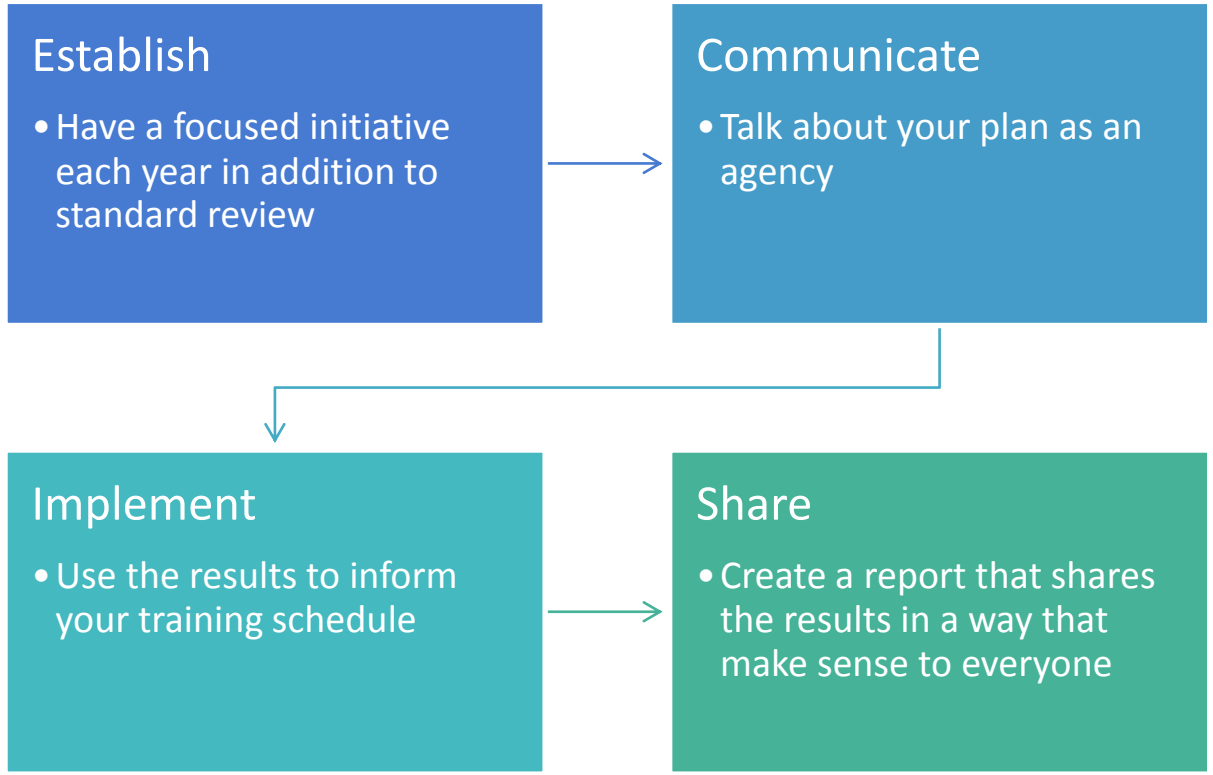
The plan is used to determine if agency documentation meets specified requirements

The plan establishes measurable goals for the agency's clinical documentation

The plan helps identify agency trends and inform training agendas

A strong QA plan not only improves services delivered to clients, it increases reimbursement and reduces agency risk during audits from outside entities

MAKING YOUR QA PLAN MEANINGFUL



THE PLAN SET-UP

- Determine which specifications your agency is going to review – state, county, insurance or other
- What is your compliance goal
- How frequently will your agency review
- Who will be responsible for the reviews
- How will reviews be completed
- What will you do with the results
- How will you manage follow-ups/follow-thru

IMPLEMENTING THE PLAN
IT SHOULD BE MORE THAN A CHART REVIEW

- Everyone does chart review – we are missing the point
  - This is how we change the conversation from "paperwork is an annoying add-on" to "reintegrating clinical documentation into our clinical practice"
  - This is how we can make our practice even more client-focused
  - This is where we get everyone on staff involved
  - This is where we prove that our services change lives

PLAN REVIEW

Review your plan regularly

Keep quality initiatives for at least a year

If your plan isn't helpful, you need a new plan

TIDBITS FROM THE MCO WORLD

Essential Elements

- What's happening right now with your client
- Why should your client continue the service
- What supports are still needed
- Provide an update on what has happened in the last 30 days
- What is the discharge/transition plan

MORE TIDBITS FROM THE MCO WORLD

Individualize notes and treatment plans

If your client is seeing an outside psychiatrist or other provider demonstrate what is happening. This will provide support on dimension 2 or 3

If your client is receiving MAT services - give description - on site or off site and how it is happening

Discuss psychosocial issues within the family so a reviewer can see what is going on in the client's system

SMALLEY
& ASSOCIATES

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Strategy: The Path Forward

Chris Wolf, MS
TIL Consulting, LLC

Initial Trends: Know Your Data

- ✓Know Your Cost of Care
- ✓Data Management (Treatment Outcomes)
- ✓Remove Barriers to Access
- ✓Key Performance Measurement (Operational Performance)

New Trends: Efficiency and/or Growth

- ✓Acquisitions
- ✓Collaboratives: The Child and Family Health Collaborative of Ohio
- ✓Outsourcing w/Service Level Agreements
- ✓Affiliations or Diversification of Services

Know Your Payor?

- ✓NCQA Accreditation
  - **The National Committee for Quality Assurance (NCQA®)** over 94 metrics -7 domains of care measuring health outcomes related to physical and behavioral health.
- ✓Quality Withhold and Sanction Model
  - 7 day post hospitalization follow up
  - 30 day post hospitalization follow up
  - Expedient Access to Substance Abuse Treatment post diagnosis
  - Children and Psychotropics
  - Use of anti-depressants

Strategy

Strategic Planning involves addressing what you are not doing currently

- ✓Market (Who and Where)
- ✓Services (What and How)
- ✓Fiscal (Sustainability)
- ✓Quality (Sustain or Improve)

SWOT: Internal and External Assessment

Project Management: Change Will Require It

- ✓Plan
- ✓Implement & Communicate
- ✓Measure & Correction

"Adapting to the Changes of the Ohio BH Redesign and the MCO Carve-In"

Closing Remarks

Presented by:

Behavioral Health Billing Solutions LLC

Special Thanks to our Presenters and Panel Members

- *Teresa Lampl, LISW-S, Associate Director of The Ohio Council of Behavioral Health & Family Services Providers*
- *Todd Charest, Chief Product Officer of Qualifacts*
- *Sonda Kunzi, CPC, COC, CPB, CPCO, CPMA, CPPM, CPC-I, President of Coding Advantage*
- *Christine Smalley, M.A., LPCC-S, President of Smalley & Associates*
- *Chris Wolf, CEO of TIL Consulting & Executive at Connect-A-Voice*
- *Gary Humble, Executive Director of Pinnacle Partners*
- *Teresa Heim, CEO of Behavioral Health Billing Solutions*

BHBS

Thank you to our Vendors and Sponsors

- *David Pontrello and Erich Cominsky, EMS Healthcare Informatics*
- *Todd Charest and Dana Matlak, Qualifacts*
- *Teresa Lampl and Lori Criss, The Ohio Council of Behavioral Health & Family Services Providers*
- *Ray Delessandro, Etactics*
- *Ken Wiederman, AltaServe Coffee Service*
- *Representatives from CareSource, Buckeye (Centpatico), United Healthcare Community Plan, Paramount and Molina*

Thank you to our team at BHBS. We appreciate all you do!

- *Michelene Steinmetz, COO of BHBS*
- *Josh Penning, CareLogic Certified System Admin*
- *Katie Bentley, Project Manager*
- *Chelsea Kohler, Project Manager*
- *Sherry Kearns, Project Manager*
- *Judy Bentley, Project Manager*
- *Brittany Adkins, Project Manager*

Thank you for attending Behavioral Health Billing Solutions' first full-day seminar!

All attendees will receive an attendee list, a copy of all presentations AND a full video of the event.

The video will be sent once editing is completed.

Thank you for your time and attention!!

Safe travels!