“Decoding your 835’s and Remittance Advice Payments”

Presented by:

Behavioral Health Billing Solutions, LLC

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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.

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On July 1st, 2018, Ohio Behavioral Health agencies underwent another substantial change called “The Managed Care Carve in”. This meant rather than billing Medicaid directly, if a client has managed care Medicaid, we have to bill them directly. At the same time, ALL behavioral health providers, licensed and unlicensed, were required to be registered with Medicaid in order to provide and bill for services.

In the last 6 months there have been substantial delays in payment, incorrect denials for covered services, and short payments for a variety of services.

In addition, there have been substantial problems around provider enrollment, rules surrounding tiered offenses for providers, and very impactful issues related to provider enrollment coordination between the MCO’s and the Ohio Department of Medicaid.

After many months of meetings and task force gatherings and overall instability in the Ohio Behavioral Health field, on January 1st, 2019, a MITS BITS was released with the heading “Behavioral Health Redesign and Integration – Ongoing Assistance for Behavioral Health Providers”.

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MITS BITS **PROVIDER INFORMATION RELEASE**

BH Redesign and Integration – Ongoing Assistance for BH Providers

January 4, 2019

Behavioral Health Redesign and Integration – Ongoing Assistance for Behavioral Health Providers

As we work to complete the transition to managed care billing through Behavioral Health Integration, the Department of Medicaid (ODM) has facilitated a series of regional meetings around the state to gather feedback, hear concerns and brainstorm ideas with the provider community and county boards. Based upon those conversations, ODM has worked with the managed care plans to maintain robust technical assistance programs, rapid response teams, and has also developed additional strategies and guidelines to help resolve any outstanding billing issues.

ODM continues to closely monitor the implementation of Behavioral Health Redesign and assess any impacts on member access to critical behavioral health services. We are confident that through a partnership with members, providers, and those valued stakeholders who have engaged with us on this journey, that we will continue with forward progress in improving services to Ohio Medicaid members.

Several strategies have been identified to help providers and managed care plans resolve challenges that may have resulted in outstanding accounts receivable. These strategies include:

Delay Repayment of Contingency Payments

Repayment for contingency plan advances may be delayed beyond January 2019 as a result of one-on-one discussions between managed care plans and providers. Please refer to the managed care plan contact information referenced below to schedule a one-on-one call or in-person meeting.

Extend behavioral health redesign 'transition of care patient protection' requirements that managed care plans must follow to sustain access to care, continuity of services, and treatment capacity.

- Extend the requirement to maintain current Fee-for-Service payment rates, covered benefits and prior authorization requirements from June 30, 2019, to December 31, 2019.
- Extend timely claims submission period from 180 days to 365 days through December 31, 2019, for Medicaid managed care.
- Extend requirement for payment to out-of-network providers. Members who are currently receiving services from a provider who is not in network with a managed care plan, may continue to receive services from that provider until June 30, 2019. The managed care plan may prior authorize these services, where appropriate, or assist the member to access services through a network provider when any of the following occur:
    - the member's condition stabilizes, and the managed care plan can ensure no interruption to services;
    - the member chooses to change to a network provider;
    - the member's needs change to warrant a change in service;
    - or quality concerns are identified with the provider.

This will also allow for additional time for MCPs and providers to collaboratively complete contracting, provider credentialing, contracting loading, and final contract execution.

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Ensuring Access and Capacity to Critical Services

- Psychological Testing: Maintain rates so there is no loss of access and there is no reduction in the service as delivered currently. Recent changes in federal HCPCS codes required ODM to set new rates; however, as announced in the MITS Bits issued December 26, 2018, the rates have been revised with the intent of no reduction in payment due to the new coding structure.

- ACT: Revise the financial structure; eliminate the face-to-face requirement for the prescribing team member; continue to require the four contacts per month; and keep the provider and service requirements, fidelity expectations, and prior authorizations as is. ODM is working to determine an implementation date given there will be rule amendments as well as possible system configuration changes.

Additional opportunities for one-on-one technical assistance for providers experiencing complications with claims processing and payment is available.

For claims submitted between July 1, 2018, and December 31, 2018, the managed care plans will have until February 1, 2019, to:

- develop a collaborative plan with providers through one-on-one technical assistance to fix claims that have been submitted with errors in order to reprocess those claims; and/or
- pay providers for claims that are being held due to managed care plan system issues.

In order for this to be successful, providers who are experiencing hardships or challenges with billing or claims payment must reach out directly to the identified contacts for each managed care plan for one-on-one assistance. The Plans will examine various provider specific strategies to help mitigate these challenges.

In limited circumstances, additional dollars may be available through the MCPS to providers who qualify. This determination will be made on a case-by- case basis. Factors to be considered may include, but are not limited to:

- Whether or not the provider is billing.
- Whether or not the provider is contracted with the managed care plan.
- Whether or not the provider has been paid less through claims than they received in advance payments between July – October.

Please refer to the contact information referenced below to schedule a one-on-one call or in-person meeting. This information is in follow up to, and replaces, the information communicated in the November 15, 2018 MITS Bits Provider Information Release.

Third Party Liability (TPL)

ODM has established a TPL taskforce and is working with managed care plans and providers to improve the process to update TPL information so that both ODM and managed care plan systems reflect more accurate information. The taskforce will also develop best practices and resources to assist providers in navigating TPL requirements and coordination of benefits. ODM is committed to working collaboratively with the managed care plans and providers to identify areas to operationalize efficiencies within the boundaries of federal regulation by January 31, 2019, and implement those strategies by April 1, 2019.

Provider Enrollment and Affiliation

All claims must include both the agency/billing and rendering National Provider Identifier (NPI). The managed care plan shall adjudicate the claim for payment consistent with timely payment requirements. Managed care plans shall not deny claims when an agency/billing or rendering NPI on the claim is not known in MITS. Additionally, plans are not required to ensure the individual rendering practitioner is affiliated to their agency at this time. Plans shall not deny a

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claim when the practitioner is not affiliated to the agency/billing provider. The claim should continue to be denied when no agency/billing or rendering NPI is submitted on the claim. This approach shall be taken until ODM and the managed care plans complete the work to implement the universal roster and/or ODM generated provider enrollment report.

For more information on Behavioral Health Redesign and Integration, visit http://bh.medicaid.ohio.gov. We value your feedback and questions; submit inquiries at http://bh.medicaid.ohio.gov/Contact-Us

Providers having persistent issues with a Managed Care Plan may follow the link below to register a complaint for Ohio Medicaid to investigate.

https://medicaid.ohio.gov/Provider/ManagedCare/ProviderComplaint

Managed Care Plan Technical Assistance Contacts

Aetna: Provider Assistance Resources: 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 3 Escalation/Other Questions: Afet Kilinc, 959-299-7278, 614-254-3229, KilincA@AETNA.com
Buckeye: Provider Assistance Resources: Rapid Response Team: BehavioralHealth@centene.com Provider Relations: 1-866-246-4356, ext 24291 24/7 Prior Authorization Line: 1-800-224-1991 24/7 OH Notification Fax: 1-866-535-6974 Escalation/Other Questions: Natalie A. Lukaszewicz, Natalie.A.Lukaszewicz@CENTENE.COM, 866-246-4356, ext 24783
CareSource: Provider Assistance Resources: Rapid Response Team: 1-800-488-0134 24/7 Notification Fax: 1-937-487-1664 24/7 Notification Email: OhioBHInfo@caresource.com Escalation/Other Questions: Terry Jones, 614-225-4613, Terry.Jones@caresource.com
Molina: Provider Assistance Resources: Rapid Response Team: BHProviderServices@MolinaHealthcare.com Provider Services/Prior Authorization Questions: 1-855-322-4079 24/7 Notification Fax: 1-866-449-6843 Care Management Referrals: OHBehavioralHealthReferrals@MolinaHealthcare.com Escalation/Other Questions: Deanna Putman, 888-562-5442, ext 212340, Deanna.Putman@MolinaHealthCare.Com
Paramount: Provider Assistance Resources: Rapid Response Team: 1-419-887-2564 Rapid Response Email: PHCBehavioralHealth@ProMedica.org 24/7 Notification Fax: 1-844-282-4901 Provider Relations Email: Paramount.ProviderRelations@promedica.org Behavioral Health Fax: 1-567-661-0841 Escalation/Other Questions: Linda Nordahl, 419-887-2279, Linda.Nordahl@promedica.org
United: Provider Assistance Resources: Rapid Response Team: OhioNetworkManagement@optum.com 24/7 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, 614 698-3837, Tracey.izzard-everett@optum.com

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What does all this mean?

For claims submitted between July 1, 2018 and December 31, 2018, the managed care plans will have until February 1, 2019 to:

- Develop a collaborative plan with providers through one-on-one technical assistance to fix claims that have been submitted with errors in order to reprocess those claims; and/or
- Pay providers for claims that are being held due to managed care plan system issues.

However, the responsibility for identifying issues and reaching out to the MCO's lies with each of the agencies experiencing issues.

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So we are going to walk through some of the key issues we are seeing at Behavioral Health Billing Solutions with our clients and hopefully provide some insight on how to take this information and apply it to your agency's procedures.

Before we begin, I would like to touch on the latest issue to arise in BH and it has to do with this quarter's CMS updates to the NCCI edit rules that all BH agencies in Ohio must now comply with.

The Ohio Department of Medicaid's rule for billing SUD group counseling is if the service is between 16-52 minutes, it should be billed as a CPT code of 90853 as an encounter code with 1 unit. 53 minutes or more should be billed with the HCPC code H0005 in 15 minute increments of 1 unit. If you bill H0005 for less than 4 units, it would deny.

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SUD Group Counseling and SUD Case Management:

The recent 1/1/2019 NCCI edit table update included two new Medically Unlikely Edits (MUEs) that limit the number of units of SUD Group Counseling (H0005) and SUD Case Management (H0006) to 1 unit per day.

A further review of the HCPCS code definition reveals that the unit definition was also updated to be variable, meaning H0005 and H0006 are no longer nationally defined as 15 minute units. This means that any H0005 SUD Group Counseling and H0006 SUD Case Management service billed from more than 1 unit after 1/1/2019 will deny due to an NCCI edit. In addition, several MCO's are applying these new edits to services prior to 01/01/2019.

BHBS originally heard about the edit issue from a peer who works for a board assisting with various issues, including updating their system to comply with National and State guidelines.

The Board immediately identified these obviously problematic issues and decided not to apply them in their system and immediately contacted ODM.

Unfortunately not all payers reacted that way. Most systems were automatically updated with the new rules and some backdated the edit to dates of services prior to the implementation of the edit in 2018. Many groups including Ohio Council and legislators are attempting to work with ODM to convey how devastating this rule would be to the SUD agencies across Ohio.

There is no current timeline for resolution.

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It's my understanding that some of the MCO's are meeting with ODM next Friday in an effort to resolve.

In the meantime it's up to each agency, whether you hold billing these services or bill as normal, in hopes that the MCO's will reprocess these claims once the issue is resolved.

Our recommendation is for agencies to continue to bill for SUD groups that are 52 minutes or under as a 90853 (remember this must go to insurance first if the client has insurance). As for any SUD group over 53 minutes, I would hold billing until a resolution is released. And unfortunately the same recommendation would apply to SUD case management. Bill 1 unit services and hold all others. We realize this could cause serious cash flow issues for agencies, so the decision resides with each agency that provides these services.

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In the interim, I would recommend reaching out to your House and Senate representatives and make sure they understand your current situation.

Ohio House of Representatives by District

Ohio Senate Directory

Most agencies are still struggling with provider enrollment, adapting to TPL requirements, the MCO carve in, and a variety of issues related to problems surrounding all 3 that are causing devastating cash flow issues.

Adding these edits, on top of an already unstable environment is unacceptable and they should be immediately removed.

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Now onto the fun stuff.

How do you review, identify and report problematic denials post July 1st from the MCO's? How do you identify what you as an agency need to correct, from a workflow standpoint?

The issues we are seeing at BHBS are widespread but we have developed a method that we use that I realize may not be available to all agencies currently.

We will give you information on how to purchase and utilize the tools we use at the end of this presentation, but my hope is that by showing you what to look for, regardless of whether you are reviewing electronically or on paper EOB's, you will leave this session with a better understanding of how to move forward.

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So how can you review your denials and payments and identify these issues??

In order to efficiently review your payments for issues, you must have access to exactly what was billed and then your remittance advice or preferably an 835 from the payer.

IF you bill manually through the portals, you must keep logs of what you are billing, noting supervised services, licensures, the Billing NPI the claim was processed under, the rendering provider and any modifiers included. Without a tracking of the services being billed, you will have to go to the portal it was entered in and review it manually, which is not realistic or efficient.

IF you bill using an EHR and send 837 EDI billing files, my recommendation is to get a reader or print out of the same items included above so you can easily compare to the remittance advice and check for errors.

Without access in some way to the claims that were billed, you will never be able to accurately diagnosis incorrect problems with denials or payments.

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EMS Healthcare Informatics

At BHBS, we utilize tools available from EMS Healthcare Informatics. The tools they offer are below and they provide a discount to Ohio BH agencies and they are one of the best companies I've had the pleasure of working with. They are on the call today and I will provide contact information at the end of the presentation.

EDI Power Reader

Open healthcare EDI files as easily as spreadsheets. HIPAA EDI files are translated and presented in an interactive user-friendly grid. Read 835, 837, 277, 271, 834 files and more.

EDI Power Generator

Create outbound HIPAA transaction set EDI Files, such as 270 Eligibility Requests or 837 Claims files from source data files. Convert data from text, XML, or database files into X12 EDI files.

EDI Power Toolbox

A comprehensive collection of tools to manage and edit EDI files within one program. No in-depth knowledge of EDI loops, segments or elements needed. Ideal for business and technical teams.

EDI Export Engine

Generate custom exports and choose exact elements to be extracted from 837 claims and 835 remittances. Import data into warehouses, billing systems and denial management systems.

EDI Power Converter

Convert ANSI X12 HIPAA transaction files from the 4010 standard to the 5010 standard, and from 5010 to 4010. Provides a solution for bi-directional legacy system compatibility.

EDI Claim Reconciler

Reconcile claim acknowledgements & status files against source billed claims, file by file, claim by claim. ANSI compatible for APCD post-adjudicated reporting for 837 and 277 code readers.

EDI 270 Power Generator

Create outbound 270 eligibility requests and read incoming 271 responses. Features a 271 File Reader. Convert data from text files into X12 270 EDI files. Generate 270 eligibility benefit inquiries and read 271 response files.

837 Claim File Generators

Coming soon from EMS: Our 837 Professional Claim File Generator and 837 Institutional Claim File Generator to help you get paid faster, and to gather more detail on potentially rejected files.

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Etactics
Passion. Excellence. Innovation.

In addition to tools to read your files, second on the list is a good clearing house to check eligibility (whether you manual bill or electronically), and to send claims and receive 835's back from payers. Traditionally, I recommend Claim Remedi or Etactics because I've worked with both and they provide the access I need to do my job efficiently.

I do have a representative from Etactics on the call today and his information will be provided at the end of the presentation as well.

They do allow for agencies to contract with them for eligibility alone and process 270 batch eligibility, as well as allow you to check individually.

I also recently found out that when using their batch eligibility processing, it returns if a client has third party liability. An incredible perk from my perspective.

As all of you know it's now our responsibility to bill third party as well as determine a client's MCO prior to billing, so the importance of eligibility checking has increased dramatically.

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I also want to add Behavioral Health Billing Solutions does not specialize in everything you need. We aren't clinical, we aren't CPT code experts, we know nothing about contracting and credentialing and we leave the strategic planning a lot of agencies need right now to the people that specialize in these areas.

I believe in my ability to recognize peers I think are the best in their field and are valuable to build and maintain a relationship with. Peers that do the things that we either don't specialize in or, at this time, do not have the capacity to offer the service.

So at the end of the presentation I'm going to give you contact info for my guru's in these areas. People I trust and depend on to answer questions correctly and timely.

As always, I believe every agency in Ohio should belong to the Ohio Council for Behavioral and Family Services. They fight the battle for us every day, whether you are a member or not. But if you're not a member, you don't get the essential training and updates they frequently provide to members.

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Now moving on to what to look for
Most commonly found incorrect denials and short payments for services

Comments
Incorrect Denial for add on
Incorrect Denial for Diagnosis
Incorrect Denial for Format?
Incorrect Denial for HCPC for Insurance Client
Incorrect Denial for Incomplete Payer Address?
Incorrect Denial for Location- 55 is Residential
Incorrect Denial for misrouted claim
Incorrect Denial for Missing information
Incorrect Denial for Modifier-Modifier Correct
Incorrect Denial for nursing service
Incorrect Denial for Procedure not Followed
Incorrect Denial for Provider Type
Incorrect Denial for Supervised Service
Incorrect Denial-No Reason
Incorrect Short Pay for Licensure
Incorrect Short Pay for Supervised Service
Incorrect Short Pay-Licensed Provider
Incorrect Short Pay-Partial Paid as IOP
Incorrectly Denied for Prior Auth
Incorrectly Denied-No Valid Reason
Itemized Statement-Reported never Repaid
Partial Paid as IOP-Reported in Oct
Prior Auth Not Required for Service
Prior Auth Not Required-1st 30

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Most commonly found correct denials that agencies need to identify and fix

Comments
Check Provider Credential
Client has Insurance Primary
Client has MCO
Copy of Medicare Card
DX Not Allowed
Exceeded Benefits
Incorrect Location
Entity not Found
Missing Prior Auth
Need to Rebill as 90853
No Ordering
Residential
Same Day Service
Unbillable DX

So how do we go about identifying issues and reconciling to our billing files or claims sent?

For the next half hour or so, I'm going to show you how my team at BHBS does this.

We take all 835's files received each week from the client's we work with. We run it through the EMS Power Reader and using excel and a billing database we keep for each client, we pull into the 835 several critical fields needed to determine whether the denial is correct or not.
Fields you need from your billing file or tracking are:

- Billing NPI
- Rendering
- Provider Credential – From your system or obtained from HR
- Supervising
- Ordering
- Location
- Diagnosis

We import those fields into our excel version of our 835 and then begin our review.

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Below are some of the error codes and adjustment code combinations that agencies will see that are correctible at the agency level:

- M77 - Missing/incomplete/invalid/inappropriate place of service. 5 - The procedure code/bill type is inconsistent with the place of service.
- MA92 - Missing plan information for other insurance. 22 - This care may be covered by another payer per coordination of benefits.
- M62 - Missing/incomplete/invalid treatment authorization code.; 197 - Precertification/authorization/notification absent.
- 22- This care may be covered by another payer.
- 23-The impact of prior payers adjudication including payments or adjustments.
- 24 - Charges are covered under a capitation agreement/managed care plan.
- 26- Expenses incurred prior to coverage.
- 27 Expenses incurrent after coverage terminated.
- 31 – Patient cannot be identified as our insured.
- 177 –Patient has not met the eligibility requirements.
- 29 - The time limit for filing has expired.
- 18 - Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO).
- 1- Deducible Amount;2- Co-insurance Amount; 3-Co-pay Amount.
- 4, 6, 8, 146, 204, A1 when present on a denial indicates the client has QMB, SLMB, some other non-Medicaid coverage.
- B7- Client is enrolled in Health Home and be billed for CPST.
- N479 - Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. 109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

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Below are some of the error codes and adjustment code combinations that agencies will see that may need reported to the MCO's:

- N95 - This provider type/provider specialty may not bill this service. 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- N34 - Incorrect claim form/format for this service. 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Report to MCO if claim was billed correctly.
- M16 - Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service. Verify provider was eligible and correct Billing NPI was used, if correct report to MCO.
- N55 - Procedures for billing with group/referring/performing providers were not followed. 96 - Non-covered charge(s). If Provider is credentialed and it was billed under the correct Billing NPI, report to MCO.
- N524 - Based on policy this payment constitutes payment in full. If short paid or denied, report to MCO.
- N10 - Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review. - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. If denied or short paid, report to MCO.
- N381 - Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. If short paid or denied, report to MCO.
- M76 - Missing/incomplete/invalid diagnosis or condition. 146 - Diagnosis was invalid for the date(s) of service reported. Verify diagnosis was correct, if it was, report to MCO.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. If received with a denied claim or short payment with no other error code, this could be incorrect.
- N640 - Exceeds number/frequency approved/allowed within time period. 150 - Payer deems the information submitted does not support this level of service. New NCCI edit for H0005 and H0006. If applied to dates of service prior to 01/01/2019, report to MCO.
- N519 - Invalid combination of HCPCS modifiers. - 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. If claim was billed correctly, report to MCO.

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Summary of next steps for agencies

- 1. Begin reviewing your 835 files or Remittance advice in comparison to what was billed.
- 2. Compare what you should be paid for each service vs what you are being paid.
- 3. Note each denial or short payment you feel may be incorrect, stating why and what is wrong.
- 4. Reach out to each MCO (their information is listed on the next page) and establish a relationship.
- 5. Partner with a clearing house and develop a full understanding on the new eligibility guidelines.
- 6. Keep in mind CareSource and Paramount use unique ID's. You cannot not submit with the client's Medicaid number.
- 7. If you are billing via 837 and receiving 835's, consider getting a reader to turn your files into excel which will give you more capability to understand and isolate problems.
- 8. If you are working with an MCO and find them untimely in responding to or resolving issues, file a complaint. Ohio Medicaid only knows of issues that are reported to them.
- 9. In my professional opinion, all Behavioral Health agencies in Ohio should consider becoming a member of Ohio Council. Yes, there's an expense but the benefit is worth it.
- 10. Make sure the legislators in your area are aware of your challenges. They were elected to support you.

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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

Contacts for Services not provided by Behavioral Health Billing Solutions, LLC

Teresa Lampl, MSW, LISW-S

Associate Director of **The Ohio Council of Behavioral Health & Family Services Providers**

Membership information for agencies:

https://www.theohiocouncil.org/membership-applications

Teresa Lampl is currently an Associate Director with The Ohio Council of Behavioral Health & Family Services Providers, a statewide trade and advocacy organization located in Columbus, Ohio. In this role she advocates for public policies that support 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. Ms. Lampl has more than 20 years of experience in community behavioral health. She has held both clinical and administrative positions in community behavioral health organizations prior to joining the Ohio Council in 2005. She has a Bachelor of Science degree in Psychology and Business from Muskingum College and a Master of Social Work degree from The Ohio State University. She is a Licensed Independent Social Worker with supervision designation in Ohio

Sonda J. Kunzi, CPC COC CRC CPB CPCO CPMA CPPM CPC-I

Coding Advantage, LLC

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With more than 30 years of experience in healthcare, Sonda's expertise includes comprehensive knowledge of ICD10 and CPT coding concepts, documentation and training, compliance and healthcare reimbursement methodology. Her experience comes from working in a variety of positions both as an outside consultant and as a professional within hospital-owned and private medical practices. She has experience with review and application of the Ohio Administrative Code (OAC) relating to her work with community behavioral health agencies in Ohio. Sonda holds many certifications including coding, billing, compliance, practice management, risk-based coding, and is a licensed coding instructor through AAPC. Sonda also teaches ICD-10 and Advanced Coding at Lakeland Community College in Kirtland, Ohio.

Contacts for Services not provided by Behavioral Health Billing Solutions, LLC

SMALLEY & ASSOCIATES

Christine Smalley, M.A., LPCC-S

Smalley & Associates

christinedsmalley@gmail.com

I have worked in the Behavioral Health space for over 25 years, with 16 of those years in Mental Health Management and oversight. I have an extensive skill set related to analyzing systems at both the macro and micro levels. I have worked directly with clients, serving clients with mental health and addiction disorders. I have worked in non-profit and for -profit administration, developing compliance departments, establishing policies and procedures, attaining certifications and accreditations for agencies of all sizes. I have also worked at the county government level, auditing clinical work, analyzing service systems and collaborating across systems to establish streamlined services, increase client access to care and drastically reducing wait times for county services. I received my Master's degree in Clinical and Pastoral Counseling, Clinical Counseling from Ashland Theological Seminary and am currently an Ohio licensed professional clinical counselor.

pinnacle PARTNERS

Gary Humble, BA

Executive Director, **Pinnacle Partners**

http://pinnacle-partners.org/

ghumble@pinnacle-partners.org

Gary Humble is the Executive Director of Pinnacle Partners and has over thirty-six (36) years in the managed care industry and specifically, over twenty-six years in the behavioral health industry.

After graduating from John Carroll University in 1982 with a BA in Economics, Gary began working for several Health Maintenance Organizations (HMOs) as an account representative, marketing various managed care products to large employer groups in Northeast Ohio.
In April 2014, he joined Pinnacle Partners, a Shared Services Organization (SSO) that is committed to provide more effective care to patients by creating efficiencies within member operations; sharing resources; and networking to assure comprehensive treatment and prevention solutions for patients. Pinnacle Partners' mission is to assist the behavioral health community to not only survive but thrive in a managed care environment.

Contacts for Services not provided by Behavioral Health Billing Solutions, LLC

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EMS Healthcare informatics offers a variety of tools for the healthcare industry that simply make our jobs easier.

Ray Dalessandro

Etactics

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Etactics is a clearing house but much more. They offer 270/271 eligibility, 837 file processing, 835 retrieval and much more.

BHBS

Thank you for your time and attention today. Hopefully, the information presented was helpful and will assist you in addressing current issues.

As always, Behavioral Health Billing Solutions, LLC is here to help. Our website is https://bhbillingsolutions.com

My direct email is teresaheim@bhbillingsolutions.com and my cell phone is 614-395-0136.