"Ohio Behavioral Health Agencies – Where are we today and how do we ensure we get to tomorrow?"

Presented by:

Behavioral Health Billing Solutions, LLC

BHBS

Who is *Behavioral Health Billing Solutions?*

Behavioral Health Billing Solutions, LLC was created after 11+ 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 built by experts in Ohio Behavioral Health.

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The time period between January 1st, 2018 and today, into 2020, has been extremely challenging for Ohio Behavioral Health agencies. First, the substantial coding change occurred in January and then just as some were starting to recover, we moved into the Managed Care carve in and the additional requirement to register "ALL" providers.

The changes that went into place July 1st, 2018 made an already unstable environment go into a downslide. The multitude of issues experienced range from the MCO's systems not being ready to work properly with the Redesign coding to a massive backlog for provider enrollment and payment errors and delays across the board. Task forces have been put in place to review the critical areas, however, it doesn't seem to be happening fast enough.

January 1st, 2019, a new administration moved into place. They are aggressively trying to provide assistance on various levels. Friday, they released an additional correspondence on steps they are taking and providing agencies experiencing a hard ship direct lines of contact to get immediate assistance. See below for who to reach out to. And on the next slide is the contact information for the MCO's.

One positive step has been ODM posting the affiliated provider lists on the bh.Medicaid.ohio.gov website. In addition, they have stated the following:

We know there is a need for immediate help, so both departments are committing specific resources to providing direct technical assistance to providers through BH-enroll@medicaid.ohio.gov. If you are a provider agency that has, or is considering, releasing staff or eliminating programming or otherwise struggling financially as a result of behavioral health redesign, please contact either Director Corcoran at Maureen.corcoran@medicaid.ohio.gov or Director Criss at Lori.criss@mha.ohio.gov .

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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: ivy.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

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So I am 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.

First, let's talk about the challenge of determining your client's eligibility for Medicaid and what MCO, if any, they are contracted with. Best case scenario, you are on a clearing house that accepts 270 Eligibility files and can process these checks regularly in bulk. Worst case, you are going to each MCO portal to verify eligibility and look for third party liability, that now is required to be billed first.

If you are working directly with the portals, I highly recommend you consider partnering with a clearing house, like Etactics, that will enable you to check eligibility individually or in bulk through a variety of methods. It is worth the investment.

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It's critical to keep in mind as you are verifying eligibility that CareSource and Paramount do not accept traditional Medicaid numbers, they require you to bill with a unique id. CareSource id's end with oo and Paramount starts with an A.

A client's eligibility can change frequently. An inability to check eligibility monthly is one of the biggest issues we see with agencies. It's critical to get it right. Also, it's important to note that if your client has an MCO, ODM recommends you go by their third party information and not what is on the MITS portal as this information will frequently be different. They are working on coordinating this process but currently, it is a daily challenge.

Due to the fact that I believe this process is currently broken and I believe the TPL adjudication should be removed, I recently posted in detail some of the challenges and a recommendation to agencies on what to do to impact change. https://bhbillingsolutions.com/2019/04/10/ohio-bh-tpl/

Take time to read through this and provide feedback to your representatives.

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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. However, it's pretty easy to point you in the right direction of what to look for.

The top 3 incorrect denials or short payments we are seeing are:

1. Denials for Provider type
2. Denials for Prior Authorization for services that don't require one.
3. Short payments for direct supervision and licensed services.

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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.

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.

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EMS
Healthcare Informatics

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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

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. Keep in mind, even though QMB and SLMB do not cover BH, we cannot charge the client, by law.
- 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.

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.

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 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.

I also want to add Behavioral Health Billing Solutions does not specialize in everything you need. We aren't clinical, we aren't CPT coding experts, we know minimal 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.

Some of these areas are becoming critical as letters are being sent out that high utilization providers of specific new codes may be subject to audit. BHBS has contacts to point you to that we trust in these areas and I am more than happy to share that with all of you. They are listed in the next few slides.

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

https://www.codingadvantage.com/

skunzi@codingadvantage.com

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

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.

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

David Pontrello and Erich Comminsky

EMS Healthcare Informatics

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dpontrello@emscorp.biz

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

Ray Dalessandro

Etactics

www.etactics.com

rdalessandro@etacticsinc.com

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

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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.