Medicaid Behavioral Health Redesign in Ohio Hospitals

Ohio Department of Medicaid
Revised April 21, 2017
Behavioral Health (BH) Redesign was developed for community behavioral health agencies who employ a variety of practitioners.

After realizing some hospitals were operating community mental health center (CMHC) and substance use disorder (SUD) agencies, ODM explored the applicability of these services in the hospital setting:

» Many services provided in the community behavioral health agencies are already covered in the outpatient hospital setting (i.e. individual and family psychotherapy)

» Medicare Provider-Based Regulations (42 CFR 413.65)

First engagement with hospital providers was in October, 2016.
BH Redesign in Hospitals

To participate in Medicaid, hospitals must meet Medicare Conditions of Participation and be accredited by the appropriate accrediting body

» No separate MHAS licensure/certification is needed for hospitals to provide outpatient BH services to Medicaid-eligible individuals

For dates of service beginning July 1, 2017, hospitals operating CMHC and SUD entities (Ohio Medicaid provider types 84 and 95) will

» Use one Ohio Medicaid provider type (01 or 02)
» Submit BH services that were previously billed under their CMHC or SUD entity on their outpatient hospital claims
» Submit claims for BH services on an institutional claim form
BH Redesign in Hospitals

Letter requesting voluntary termination of 84 and 95 provider types will be sent to identified providers in May 2017

» Allow more transition time for hospitals with administrative issues related to switching to outpatient hospital billing until 9/1/17; all transitions must be complete by 1/1/18

» ODM will terminate CMHC and SUD provider numbers for the hospital-operated entities 12/31/17 if not terminated by then

Hospitals that do not switch to outpatient hospital billing for dates of service between 7/1/17 - 12/31/17 must enroll and affiliate all providers required in community BH redesign by 7/1/17

» Hospitals only need to enroll and affiliate Attending Providers – no changes to existing provider enrollment requirements in a hospital setting
BH Redesign in Hospitals

BH Services provided by outpatient hospitals

» Expanded code set for BH services

» Same rates as BH redesign community benefit; aligned with credentials of the professional performing the service

» All standards required in behavioral health redesign will be required of outpatient hospital providers, including:
  – Benefit limits
  – Prior authorization requirements
  – ASAM criteria
Outpatient Hospital Behavioral Health Benefit Available July 1, 2017

Existing OP BH Services
- Evaluation & Management
- Psych Diagnostic Evaluation
- Individual and Group Psychotherapy
- Psych/Dev/Neuro Testing
- Crisis Intervention

Additional OP BH Services
- Alcohol/substance abuse screening
- SUD IOD, Partial Hospitalization and Residential
- MH Day Treatment/Partial Hospitalization group services
- Case management
- CPST Alcohol/drug testing
- LPN and RN BH services
MH Day Treatment / Partial Hospitalization
MH Day Treatment / Partial Hospitalization

MH Day Treatment consists of group therapies on an hourly or per diem basis.

No bundled package of services for MH Partial Hospitalization at this time.

Other services (psychotherapy, counseling, etc.) comprising a hospital’s partial hospitalization program may be billed in addition to the group services on the days the services were provided.
### MH Day Treatment Group Activities – Hourly Billing Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Practitioner Modifier</th>
<th>Rate Development and Methodology</th>
<th>Hourly per Person Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2012</td>
<td>HE</td>
<td>AH, AJ, U5, U2 or U4</td>
<td>1 hour of licensed practitioner in an average group size of four</td>
<td>$28.10</td>
</tr>
<tr>
<td>H2012</td>
<td>HE</td>
<td>HO</td>
<td>1 hour of unlicensed MA in an average group size of four</td>
<td>$21.05</td>
</tr>
<tr>
<td>H2012</td>
<td>HE</td>
<td>HN</td>
<td>1 hour of unlicensed BA in an average group size of four</td>
<td>$18.54</td>
</tr>
<tr>
<td>H2012</td>
<td>HE</td>
<td>HM</td>
<td>1 hour of QMH Spec 3+ Years in an average group size of four</td>
<td>$15.76</td>
</tr>
</tbody>
</table>

» Maximum group size: 1:12 practitioner to client ratio
  - Only used if the person attends for the minimum needed to bill the unit (30+ minutes) in a group which does not exceed the practitioner to client ratio
  - If the time minimum is not met, 90853 or H2019 may be used
  - All other services are billed outside of H2012

» Maximum of 2 units per person per day
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Practitioner Modifier</th>
<th>Rate Development and Methodology</th>
<th>Hourly per Person Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2020</td>
<td>HE</td>
<td>AH, AJ, U5, U2 or U4</td>
<td>5 hours of licensed practitioner in an average group size of four</td>
<td>$140.51</td>
</tr>
<tr>
<td>H2020</td>
<td>HE</td>
<td>HO</td>
<td>5 hours of unlicensed MA in an average group size of four</td>
<td>$117.05</td>
</tr>
<tr>
<td>H2020</td>
<td>HE</td>
<td>HN</td>
<td>5 hours of unlicensed BA in an average group size of four</td>
<td>$104.55</td>
</tr>
<tr>
<td>H2020</td>
<td>HE</td>
<td>HM</td>
<td>5 hours of QMH Spec 3+ Years in an average group size of four</td>
<td>$88.87</td>
</tr>
</tbody>
</table>

» Maximum group size: 1:12 Practitioner to client ratio
  - Only used if the person attends for the minimum time needed to bill the per diem (2.5+ hours), which does not exceed the practitioner to client ratio
  - If person doesn’t meet the minimum, 90853, H2019 and/or H2012 may be used

» One H2020 per diem, per patient, per day

» All other services must be billed outside of H2020, e.g., individual and/or family psychotherapy, may be billed in conjunction with this code if performed on the same day
Expanded Substance Use Disorder (SUD) Benefit
ASAM Levels of Care

The provider manual contains information about each ASAM Level.

- Opioid Treatment Services: Opioid Treatment Programs (OTPs) and Medically Managed Opioid Treatment (MMOT)
- ASAM Level 1 - Outpatient Services
- ASAM Level 2 - WM Ambulatory Withdrawal Management with Extended Onsite Monitoring
- ASAM Level 2.1 - Intensive Outpatient Services
- ASAM Level 2.5 - Partial Hospitalization Services
- ASAM Level 3.1 - Clinically Managed Low-Intensity Residential Treatment (Halfway House)
- ASAM Level 3.2 - WM Clinically Managed Residential Withdrawal Management
- ASAM Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Treatment
- ASAM Level 3.5 - Clinically Managed High Intensity Residential Treatment
- ASAM Level 3.7 - Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent)
- ASAM Level 3.7 - WM Medically Monitored Inpatient Withdrawal Management
### Substance Use Disorder Benefit

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Intensive Outpatient</th>
<th>Partial Hospitalization</th>
<th>Residential</th>
</tr>
</thead>
</table>
| **Adolescents**: Less than 6 hrs/wk  
**Adults**: Less than 9 hrs/wk | **Adolescents**: 6 to 19.9 hrs/wk  
**Adults**: 9 to 19.9 hrs/wk | **Adolescents**: 20 or more hrs/wk  
**Adults**: 20 or more hrs/wk |  |
| - Psychiatric Diagnostic Interview  
- Counseling and Therapy  
  - Psychotherapy – Individual, Group, Family, and Crisis  
- Medical  
- Medications  
- Buprenorphine and Methadone Administration/Dispensing  
- Urine Drug Screening  
- Withdrawal Management Level 2 (Detoxification) | - Psychiatric Diagnostic Interview  
- Counseling and Therapy  
  - Psychotherapy – Individual, Group, Family, and Crisis  
- Medical  
- Medications  
- Buprenorphine and Methadone Administration/Dispensing  
- Urine Drug Screening  
- Additional coding for longer duration group counseling/psychotherapy  
- Withdrawal Management Level 2 (Detoxification) | - Psychiatric Diagnostic Interview  
- Counseling and Therapy  
  - Psychotherapy – Individual, Group, Family, and Crisis  
- Medical  
- Medications  
- Buprenorphine and Methadone Administration/Dispensing  
- Urine Drug Screening  
- Additional coding for longer duration group counseling/psychotherapy  
- Withdrawal Management Level 2 (Detoxification) | - Per Diems ranging from clinical managed to medically monitored  
- Medications  
- Buprenorphine and Methadone Administration/Dispensing |
# SUD Intensive Outpatient Level of Care: Group Counseling – Billing Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Practitioner Modifier</th>
<th>Rate Development and Methodology</th>
<th>Hourly per Person Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>HE</td>
<td>AM, SA, UC, UD, AH, AJ, U5, U2 or U3</td>
<td>Average group size of three for an average duration of 4 hours with licensed practitioner</td>
<td>$149.88</td>
</tr>
<tr>
<td>H0015</td>
<td>HE</td>
<td>U1, U9, UA, U6, or U7</td>
<td>Average group size of three for an average duration of 4 hours with an unlicensed practitioner</td>
<td>$103.04</td>
</tr>
</tbody>
</table>

- Maximum group size: 1:12 practitioner to client ratio
- Used at ASAM Level 2.1
  - Only used if the person attends for the minimum needed to bill the per diem (2+ hours) in a group which does not exceed the practitioner-to-client ratio
  - If person doesn’t meet the minimum 2+ hours, 90853 or H0005 may be used
  - Service is billed in whole unit only
- All other services must be billed outside of H0015
  - *One H0015 per diem, per patient, per day*
ALWAYS Prior Authorized for Medicaid Enrollee: SUD Partial Hospitalization (PH) Level of Care (LoC)

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD PH LoC</td>
<td>Combination of CPT and HCPCS codes</td>
</tr>
<tr>
<td>20 or more hours of SUD services per week per adult or adolescent</td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Requirement
SUD PH LoC must be prior authorized for an adult or adolescent to exceed 20 hours of SUD services per week.
SUD Partial Hospitalization Level of Care: Group Counseling – Billing Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Practitioner Modifier</th>
<th>Modifier 3</th>
<th>Rate Development and Methodology</th>
<th>Hourly per Person Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>HE</td>
<td>AM, SA, UC, UD, AH, AJ, U5, U2 or U3</td>
<td>TG</td>
<td>Average group size of three for an average duration of 6 hours with licensed practitioner</td>
<td>$224.82</td>
</tr>
<tr>
<td>H0015</td>
<td>HE</td>
<td>U1, U9, UA, U6, or U7</td>
<td>TG</td>
<td>Average group size of three for an average duration of 6 hours with an unlicensed practitioner</td>
<td>$154.56</td>
</tr>
</tbody>
</table>

» Maximum group size: 1:12 practitioner to client ratio

» Only used at ASAM Level 2.5
  – Only used if the person attends for the minimum needed to bill the per diem (3+ hours) in a group that does not exceed the practitioner to client ratio
  – If person doesn’t meet the minimum 3+ hours, 90853 or H0005 may be used
  – Service is billed in whole unit only

» All other services must be billed outside of H0015

» **One H0015 per diem, per patient, per day**
Outpatient Hospital Claim Submission Guidelines for BH Services
Hospital Billing for BH Services

BH services must be submitted FFS until 1/1/18 (when they will be carved into managed care)

» Submit BH and SUD services to MyCare plans for dual-eligible individuals (Medicare and Medicaid) enrolled in MyCare plans beginning 7/1/17

Outpatient hospitals must follow prior authorization standards for BH redesign

Bill one facility claim for entire service; no separate professional and facility claims

Identify the relevant BH services on the institutional claim form with all of the following on each detail line:

» Use of specific Revenue Center Codes
» The ‘HE’ modifier (Mental Health Program)
» A modifier signifying the highest level of practitioner who performed the service (where applicable)
» A mental health/substance abuse diagnosis code
Ohio Medicaid Revenue Center Codes for Outpatient BH Services

<table>
<thead>
<tr>
<th>RCC</th>
<th>Description</th>
<th>Currently Covered OPH</th>
<th>Covered in Outpatient Hospital for BH redesign services (with HE modifier) effective 7/1/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>BH Treatment/Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0904</td>
<td>Activity Therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0905</td>
<td>IOP - Psychiatric</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0906</td>
<td>IOP - Chemical Dependency</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0907</td>
<td>Day Treatment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0911</td>
<td>Rehabilitation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0912</td>
<td>Partial Hospitalization - Less Intensive (Half Day)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0913</td>
<td>Partial Hospitalization - Intensive (Full Day)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0914</td>
<td>Individual Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0915</td>
<td>Group Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0916</td>
<td>Family Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0918</td>
<td>Testing</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0919</td>
<td>Other Psych Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0671</td>
<td>Outpatient Special Residence Charges - All Home or Community Based Services</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# Hospital Claim Submission for BH Services

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Type of Medicaid Enrollment</th>
<th>Claims for Appendix F* Services</th>
<th>Claims for BH Services with modifier ‘HE’</th>
<th>Claims for Medical Services</th>
<th>Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient Age Under 21 or Over 65</td>
</tr>
<tr>
<td>4/1/2017</td>
<td>FFS</td>
<td>FFS</td>
<td>Not Available</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>Not Available</td>
<td>MCP</td>
<td>MCP</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>Not Available</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>FFS</td>
<td>MCP</td>
<td>MCP</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
<tr>
<td>1/1/2018</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
</tbody>
</table>

*Appendix F services relate to services described in Appendix F of Ohio Administrative Code rule 5160-2-21, which will continue to be available via EAPG beginning 7/1/17.

| FFS = Fee-for-Service Medicaid |
| MCP = Medicaid Managed Care   |
| MyCare = MyCare Ohio (dual-eligible) Plan |
Stakeholder Resources for BH Redesign
(all available at BH.Medicaid.Ohio.gov under provider tab)

Medicaid Behavioral Health Provider Manual - describes every community-based MH and SUD service and outlines its policy re: coverage, admission criteria, coding, rendering practitioner, rates, etc., most of which apply to the services added to the outpatient hospital benefit.

Coverage and limitations workbook – Massive Excel workbook listing every community BH service, CPT/HCPCS procedure code, modifiers, unit definition, eligible rendering practitioners, payment rates; Separate Hospital Code Chart will be added soon.

Learn how to use the provider manual, coding chart, and the coverage and limitations work book to effectively bill services. The Hospital Billing Guidelines will be updated to include specific instructions for billing in the hospital setting.
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Sign up online for the BH Redesign Newsletter.
Questions?