Redesign & Carve-in FAQ

buckeye health plan

1. Who requires an NPI?

Effective for dates of service on and after January 1, 2018, those practitioners independently licensed by a professional board are required to be reported using their personal NPI as the rendering practitioner. ODM requires that the rendering practitioner for behavioral health services be listed on claims submitted to Ohio Medicaid for payment. When practitioners are required to enroll in Medicaid, their personal NPI must be reported in the rendering field on the claim for each service they provide.

2. Who requires an Ohio Medicaid Number?

All providers eligible for Medicaid that render services to Ohio members must have a Medicaid number by 7/1/2018. Not having this number by the corresponding date will cause claims for services rendered to deny.

3. What requires a prior authorization for Buckeye Health Plan?

- All out-of-network (non-par) services and providers require prior authorization, excluding emergency care and out-of-area urgent care
- All inpatient stays
- ACT-Assertive Community Treatment
- IHBC-Intensive Home Based treatment
- SUD Residential
- Partial Hospitalization

4. Who requires a modifier?

Effective for dates of service January 1, 2018 through June 30, 2018, practitioner modifiers are required when submitting claims to Ohio Medicaid and are rendered by the provider types listed below. **Please note after 7/1/2018 modifier usage is subject to change dependent upon the practitioner type.**

Practitioner Type	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2
Licensed chemical dependency counselor III	LCDC III	U3
Licensed chemical dependency counselor II	LCDC II	U3
Licensed social worker	LSW	U4
Licensed marriage and family therapist	LMFT	U5
Psychology assistant, intern, trainee	PSY assistant	U1
Chemical dependency counselor assistant	CDC-A	U6
Counselor trainee	C-T	U7
Social worker assistant	SW-A	U8
Social worker trainee	SW-T	U9
Marriage and family therapist trainee	MFT-T	UA
QMHS – high school	QMHS	HM
QMHS – Associate's	QMHS	HM
QMHS – Bachelor's	QMHS	HN
QMHS – Master's	QMHS	HO
QMHS – 3 years' experience	QMHS	UK
Care management specialist – high school	CMS	HM
Care management specialist – Associate's	CMS	HM
Care management specialist – Bachelor's	CMS	HN
Care management specialist – Master's	CMS	HO
Peer recovery supporter – high school	PRS	HM
Peer recovery supporter – Associate's	PRS	HM
Peer recovery supporter – Bachelor's	PRS	HN

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All information given can be validated at:
http://www.bh.medicaid.ohio.gov/manuals

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5.Do we need to contract with each MCP?

Effective July 1, 2018 all mental health benefits for Medicaid members will be managed by the managed care plans. If a provider is rendering services to a member with Buckeye Health insurance, a contract will be needed. If you are not contracted, a prior authorization is required prior to rendering any services to a Buckeye Health member. Please visit our website: **buckeyehealthplan.com/providers/behavioral-health.html** or call our Medical Management Team **1-800-224-1991.**

6. How do you join the BHP network? How long does credentialing take?

- Go To **BuckeyeHealthPlan.com/Provider** and click on "Join our Network" Please call Buckeye Provider Relations **1-866-246-4356 - ext. 24291**
- The process can take up to 90 days

7. How would I submit a claim with dual licensure?

The Ohio Department of Medicaid (ODM) recognizes that some individuals may hold more than one license or an assistant/trainee credential with differing scopes of practice. In order to allow these practitioners to operate under the scope of multiple professional credentials, please ensure you are using the correct modifiers when billing.

For instructions on to add these additional independent medical licenses to a practitioner's Medicaid enrollment. Please refer to:
http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_1-26-2018.pdf

For different scenarios, and what providers should do for services rendered between January 1, 2018 and June 30, 2018, please refer to:
http://www.bh.medicaid.ohio.gov/Portals/0/Providers/Final%20BH%20Manual%20V1.5_01302018.pdf?ver=2018-01-30-132135-363

Claim: Common reasons for claims not being adjudicated (Common Claim boo-boo's)

1. **Incorrect modifiers being used for provider service type.** For further guidance please refer to **www.bh.medicaid.ohio.gov/manuals**

Practitioner Type	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2
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Social worker assistant	SW-A	U8
Social worker trainee	SW-T	U9
Marriage and family therapist trainee	MFT-T	UA
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Claim: Common reasons for claims not being adjudicated (Common Claim boo-boo's)

2. Incorrect modifiers being used for procedure service type. For further guidance please refer to **www.bh.medicaid.ohio.gov/manuals**

Service Circumstance	Modifier
Group service	HQ
Physician, team member (ACT)	AM
CNP team member (ACT)	UC
PA or CNS, team member (ACT)	SA
Master's level, RN, LPN, team member (ACT)	HO
Bachelor's level, team member (ACT)	HN
Peer recovery supporter, team member (ACT)	HM
Pregnant/parenting women's program	HD
Complex/high tech level of care	TG
Cognitive Impairment	HI
Licensed practitioners providing TBS Group Hourly/Per Diem (day treatment) or SUD group counseling	HK
OTP Daily Administration	HF
OTP One Week Administration (2 – 7 Days)	TV
OTP Two Week Administration (8 – 14 Days)	TU
OTP Three Week Administration (15 – 21 Days)	TS
OTP Four Week Administration (22 – 28 Days)	HG
Significant, separately identifiable Evaluation & Management (E/M) service by physician or other qualified health professional on the same day of the procedure or other service	25
NCCI modifiers (See NCCI Section)	59, XS, XE, XU and XP
CLIA waived test- certificate of waiver – CMS certificate type code 2 or higher required	QW
Crisis modifier used on T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004 and 90832	KX
Physician delivering SUD group counseling	AF
Secured video-conferencing (See code charts for allowable services)	GT

3. Incorrect place of service codes: Providers must accurately identify and report on each claim detail line where a service took place using the most appropriate CMS place of service code. Each billing chart in the ODM manual will list the place of service codes.

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Claim: Common reasons for claims not being adjudicated (Common Claim boo-boo's)

4. Code H2019 cannot be billed in location 51

Unit Value	15 minutes
Permitted POS	**Individual TBS** – 03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99 If more than six (6) units are delivered on the same date of service by the same agency in places of service 11 and/or 53, subsequent units will be paid at 50% of the above rates. **Group TBS** –11, 53 If more than six (6) units are delivered on the same date of servce by the same agency in places of service 11 and/or 53, subsequent units will be adjudicated at 50% of the above rates.
TBS to address a crisis	Add KX modifier to inticate TBS provided when a patient is experiencing a crisis, as allowable within the practioner's scope of practive.

5. Incorrect HCPC codes (H0004 & H0005 only billable for CMHC's)
H0004 will be available for licensed dependent practitioners until June 30, 2018. For individual counseling services provided on and after July 1, 2018, these practitioners will use individual psychotherapy CPT codes.

Permitted POS	**Individual TBS** – 03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99 If more than six (6) units are delivered on the same date of service by the same agency in places of service 11 and/or 53, subsequent units will be paid at 50% of the rates. **Group TBS** – 11, 53 If more than six (6) units are delivered on the same date of service by the same agency in places of service 11 and/or 53, subsequent units will be adjudicated at 50% of the rates.

6. Denials pertaining to primary insurance: Please ensure you verify the members primary insurance via our website, submit the claims to the members primary insurance and then submit to Buckeye Health Plan. This can be done using the link listed below https://provider.cenpatico.com/sso/login

7. H0015: does not require a prior authorization (IOP). Prior Authorization is required when claim is submitted with a TG modifier.

8. H0040: requires prior authorization (ACT)

Description and Code	**Benefit Period**	**Authorization Requirement**
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees

9. HE, HF, and HN are no longer valid modifiers. Currently there are no services linked to each these modifiers.

10. Validate location and services: Make sure locations being used are matching the service being rendered
For a complete list of place of service codes, please go to:
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

11. Correct modifier usage: Modifiers must be used from 1/1/18- 6/30/18 for any provider that requires general or direct supervision. After 6/30/18 if NPI is attainable you must bill with your NPI. If NPI is unattainable you must continue to use the correct modifiers.

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