February SUD 1115 Provider TA Session

Presented by Medicaid Transformation FFS Policy Team
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HEALTH SYSTEMS DIVISION
Medicaid Behavioral Health

Agenda

- Corrections
- Updates
- Submitted Questions
- Q&A
- What topic would you like next?

*Slides & Recording of Session will be posted on SUD 1115 website

Announcement

- We'll be discussing questions related to CCO's and billing today and we are glad to be doing our best to support the conversation. This is a recorded meeting that will be posted on the SUD 1115 Website for others to review. I ask that we try to keep this conversation related to billing and coding questions, and if there are deeper concerns related to Coordinated Care Organizations that we address those offline.

How to escalate CCO concerns:

- First tip: Clarifying with your CCO about which service are and are not covered, or if there's a similar/alternative service that meets the same need.
- Second tip: Always reach out to the CCO's provider services first to resolve the concern at the CCO level if possible. Document your efforts to find resolution with the CCO.
- We'll be discussing this from the point of view of a claim denial:
  - Claim is denied: File appeal with CCO. Make sure you are familiar with your CCO's appeal process, as each CCO has a slightly different process and all have tight timelines.
  - If claim is still denied, make sure you are keeping the final denial of appeal notice you received. Once final denial is received you 30 days to submit an administrative review request. (410-120-150) Admin Review form located HERE (Form HE3085)
  - Contact Provider Services: When you reach out to Provider Services they will want the Final Denial of Appeal, and a timeline of your attempts to resolve this with the CCO. They will then route the concern to our internal team that supports these requests and will begin to work on it.

How to escalate CCO concerns:

- If you have concerns related to the Coordinated Care Organizations, please reach out to Provider Services:
  - Website: https://www.oregon.gov/oha/hsd/ohp/pages/provider-services.aspx
  - E-mail: dmap.providerservices@odhsoha.oregon.gov
  - Provider services will begin the escalation process to support your concern.

Corrections

- H0006
  - CAN NOT be billed prior to assessment, needs a care plan/treatment plan for billing.
- H0010/H0011
  - Incorrect re-imbursement rate referenced in previous TA session. Reimbursement for H0010 & H0011 is $891/day.

Updates

- Max Units on Fee Schedule
  - Heard request to have max units added back to Fee Schedule, updated Fee Schedule coming March 2024 will include max units for codes.

Submitted Questions

- Is MOTS required to bill H0023 (Outreach Services?)
  - Yes, however, to bill H0023 prior to an Assessment and assigned LOC there is an alternative approach:
  - Programs providing services or items that are unencounterable via MOTS, which would be individuals who have not received a full assessment to determine LOC and receive services such as outreach, engagement, prevention, education, and/or recovery support or any items that are unencounterable because there is no specific HCPCS or CPT code such as providing a Bike or Bus Pass or Books, these items and/or services are reported annually. The report is called "Service Element 66 Community Behavioral Services Non-Encounterable Via MOTS". On the report there is a section for an indigent count and Medicaid count of individuals served.
  - Report template can be found here: https://www.oregon.gov/oha/hsd/amh/pages/reporting-requirements.aspx

Submitted Questions cont'd

- What's included in Per Diem Rates?
  - The per-diem rate includes all services routinely used in the residential program. Services provided by medical professional employed by or contracted with the residential program are part of the all-inclusive per diem rate and cannot be billed separately. These routine services are made available to all patients entering the facility.
  - Examples of routine services include all therapies and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dietitians, peer support, etc. Services by a psychologist, psychiatrist, psychiatrist nurse practitioner and psychiatrist physician assistant inherent to the treatment program, such as group therapy, should not be billed separately.
- Can H0038 be billed prior to an assessment?
  - No, peer services must be described in the individualized support plan to be billed for the individual receiving services. However, H0023 is billable prior to an assessment and can be billed by peer service workers.

Q&A

Let’s get to your questions!

Future Topics?

- What future topics would be most helpful to cover? If you think of one outside of this time, please e-mail it to me so I can add it to our list.

Thank you!

Questions?

Contact Heather Uerlings at Heather.N.Uerlings@oha.Oregon.gov