OhioRISE | Resilience through Integrated Systems and Excellence

OhioRISE Provider Enrollment and Billing Guidance

Version 1.6

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The most recent version of this guidance may be found at the [OhioRISE Resources for Community Partners and Providers Website]

OhioRISE Provider Enrollment and Billing Guidance Version Log			
Version	Description of Changes	Last Editor	Release Date
Version 1.0	• Initial Release	State OhioRISE Team & Aetna Better Health of Ohio	5/19/2022
Version 1.1	• Corrected MRSS Stabilization Service billing information to reflect "stabilization" (previously said "follow-up"). • Clarified requirements for entering information into the CANS IT System. • Updated links in the document. • Added Aetna practitioner modifier table, clarified practitioner modifier requirements, updated LSW practitioner modifiers for consistency. • Added temporary billing options for practitioner modifiers.	State OhioRISE Team & Aetna Better Health of Ohio	6/15/22
Version 1.2	• Updated Aetna's practitioner modifier requirements to align with ODM fee-for-service. • Added POS clarification.	State OhioRISE Team & Aetna Better Health of Ohio	6/21/22
Version 1.3	• Updated links to rules throughout the document. • Updated Provider Enrollment instructions to reflect updated, Provider Network Management (PNM) information (p.3). • Added clarification re MRSS billing of the initial mobile response code when an external entity is involved during an MRSS provider's first year of initial certification (p.19). • Added prior authorization information about inpatient behavioral health stays for hospitals (p.34).	State OhioRISE Team & Aetna Better Health of Ohio	9/30/22
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Legal Disclaimer: Ohio Department of Medicaid (ODM) strives to make the information in this guidance document as accurate, complete, reliable, and timely as possible. However, ODM makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of this information. This is the most current version of the OhioRISE Provider Guidance document, which is being released as an informational and educational tool; however, this document is subject to change and future revisions as the implementation and operations of the OhioRISE program changes. ODM, its employees, agents, or others who provide the answers will not be liable or responsible to you for any claim, loss, injury, liability, or damages related to your use of or reliance upon this information. This guidance is intended solely as an informational and educational resource for providers intending to participate in the OhioRISE program and for the public. The information contained in this document is not intended to set new standards and requirements beyond the scope of those standards and requirements found in the Ohio Administrative Code or Ohio Revised Code. In the case of any conflict between the information contained in this document and Ohio Administrative Code or Ohio Revised Code, the Ohio Administrative Code or Ohio Revised Code, as applicable, prevails. This information is not intended to be a substitute for professional legal, financial, or business advice. This document does not create, nor is it intended to create, an attorney-client relationship between you and Ohio. You are urged to consult with your attorney, accountant, or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

Introduction

The Ohio Department of Medicaid (ODM) supported by the Governor's Family and Children First Cabinet Council, and in partnership with state sister agencies, stakeholders, and providers, developed Ohio's first-ever integrated program to help children who have complex and serious behavioral health needs. OhioRISE (Resilience through Integrated Systems and Excellence) aims to improve care and outcomes for these children and their families or caregivers by:

- Creating a seamless delivery system for children and youth, families/caregivers, and system partners.
- Providing a "locus of accountability" by offering community-driven comprehensive care coordination through local Care Management Entities (CMEs).
- Expanding access to critical behavioral health treatment services and supports needed for this population such as Intensive and Moderate Care Coordination, Mobile Response and Stabilization, Behavioral Health Respite, Intensive Home-Based Treatment, and Flexible Funds.
- Assisting youth, families, state, and local child serving agencies, and other health providers to locate and use these services.

The OhioRISE program covers a range of behavioral health (BH) services for youth that are comprised of existing, enhanced, and new behavioral health and care coordination services. This guide is intended to share policies related to billing for the new and enhanced OhioRISE services when they are billed to the OhioRISE Plan, Aetna Better Health of Ohio.

For youth enrolled in OhioRISE, existing behavioral health services will be covered by Aetna OhioRISE in accordance with the OhioRISE Mixed Services Protocol. While the existing behavioral health services are not described in detail in this guidance document, general billing requirements described in this guidance document are applicable to claims submitted to Aetna OhioRISE. All other services not described in this guidance document should be billed to the appropriate payer consistent with the billing policies outlined in the appropriate provider type billing guidelines, including those issued by managed care entities.

Table 1-1: OhioRISE Program Services

	Description	Applicable Ohio Administrative Code (OAC) Rule(s)	Billing Instructions
Existing	Community Behavioral Health (BH) Services	Chapter 5160-27	BH Provider Manual
	Psychiatrist, Physician Assistant (PA) and Advanced Practice Registered Nurses (APRN) Services	5160-04-03 5160-4-04	Schedules and Rates
	Other Licensed Behavioral Health Practitioner Services	5160-8-05	Schedules and Rates
	Inpatient Hospital Services	5160-2-65	Schedules and Rates
	Outpatient Hospital Services	5160-2-75	Schedules and Rates
	Provider Administered Drugs	5160-4-12	BH Provider Manual
	Pharmacist Services	5160-8-52	Schedules and Rates
	Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services	5160-28-03	OhioRISE Provider Guidance
New	Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) Assessment	5160-59-01	OhioRISE Provider Guidance
	Mobile Response and Stabilization Service (MRSS)	5160-27-13	OhioRISE Provider Guidance
	Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC)	5160-59-03.2	CME Manual on OhioRISE Website
	Supplemental In-Home Assessment	5160-59-03.2	CME Manual on OhioRISE Website
	Behavioral Health Respite	5160-59-03	OhioRISE Provider Guidance
	Flex Funds	5160-59-03.5	OhioRISE Provider Guidance
	OhioRISE Waiver Transitional Services & Supports	5160-59-05.2	OhioRISE Provider Guidance
	OhioRISE Waiver Secondary Flex Funds	5160-59-05.3	OhioRISE Provider Guidance
	OhioRISE Waiver Out-of-Home Respite	5160-59-05.1	OhioRISE Provider Guidance
	In-State Psychiatric Residential Treatment Facility (PRTF)	5160-59-03.6	OhioRISE Provider Guidance
Enhanced	Intensive Home Based Treatment (IHBT), Multi Systemic Therapy (MST) & Functional Family Therapy (FFT)	5160-59-03.3	OhioRISE Provider Guidance

The Ohio Administrative Code contains specific regulatory information that is the basis for the information contained in this guidance document. Chapter 5160-1 contains regulatory information on the Medicaid program in general and OhioRISE services are covered in Chapter 5160-59. Additional information is available in the following Ohio Administrative Code (OAC) Chapters:

- Chapter 5101:2-1 Children Services Definition of Terms
- Chapter 5122-29 Requirements and Procedures for Behavioral Health Services
- Chapter 5123-9 Vocational Activities; Administration of Individuals' Funds; Behavior Modification
- Chapter 5160-2 Hospital Services
- Chapter 5160-26 Managed Care Programs
- Chapter 5160-27 Community Mental Health Agency Services
- Chapter 5160-28 Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services
- Chapter 5160-4 Medical and Surgical Services
- Chapter 5160-43 Specialized Recovery Services Program
- Chapter 5160-44 Home and Community-Based Care
- Chapter 5160-45 ODM Administered Waiver Services
- Chapter 5160-8 Therapeutic and Diagnostic Services

It is the state's expectation that a practitioner will work within their scope of practice and consult their respective licensing board for practice considerations.

Organization

This guidance document is organized into two sections.

- Section 1 includes information regarding provider enrollment, provider specialties and rendering providers.
- Section 2 provides specific service requirements and claims billing information for services covered under the OhioRISE program.

Section 1: Provider Enrollment

OhioRISE services may be provided by a range of provider types, including individual practitioners, groups, facilities, and organizational providers. All providers are required to enroll as an Ohio Medicaid provider and contract with the OhioRISE plan. Billing providers are the entities eligible to submit claims for services in accordance with state regulations. Rendering providers are those who provide (render) a service to an individual. When a rendering provider is required to be listed on a claim, both the billing provider and the rendering practitioner need to obtain a National Provider Identifier (NPI) and enroll with Ohio Medicaid.

Enrollment as a Medicaid provider includes completion of an online application and uploading supporting documentation (i.e., W9's, licensure/certification information and other information specific to the type of provider). Some organizational providers are required to pay an application fee. Certain providers of OhioRISE waiver services may also be required to complete Ohio Department of

Developmental Disabilities (DODD) screening (additional information is available at https://dodd.ohio.gov/providers/initial-renewal-certification/certification-recertification).

Effective October 1, 2022 all provider enrollment applications must be submitted using Ohio Medicaid's new Provider Network Management (PNM) module, https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx. The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service functions. For more information about the PNM please visit https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing/pnm-centralized-credentialing.

ODM requires that providers add a provider specialty to their provider enrollment type to bill for some new and enhanced services under the OhioRISE program. Several new provider specialties associated with the implementation of the OhioRISE program are available. This includes providers of behavioral health services to children and youth up to age 21 who are interested in billing for the following new and enhanced services:

- Behavioral Health Respite
- Child and Adolescent Needs and Strengths (CANS) Assessments
- Intensive Home-Based Treatment (IHBT), which includes IHBT, Multi-Systemic Therapy (MST), and Functional Family Therapy (FFT)
- Intensive and Moderate Care Coordination
- Mobile Response and Stabilization Service (MRSS)
- OhioRISE Waiver Transitional Services and Supports
- OhioRISE Waiver Out-of-Home Respite

For providers who are enrolled with ODM who do not anticipate providing any of the new and enhanced services outlined above, no changes are necessary. However, providers should still check that the contact information, service location(s), and affiliation information are correct in the PNM module. Keeping this information up to date will allow providers to contract with the OhioRISE plan and the managed care organizations (MCOs), and to receive important communications from ODM.

Instructions for Currently Enrolled Providers: Providers who are currently enrolled as Ohio Medicaid providers who have the appropriate certification or documentation to provide any of the services found in the table below can request the addition of the new specialty to their existing Medicaid ID in the PNM module. This requires the provider or practitioner to upload documentation pertinent to the addition of the specialty.

Instructions for New Providers: Providers not currently enrolled as Ohio Medicaid providers who are eligible for and would like to bill for services provided, please enroll via the PNM module. For more information about enrolling as a Medicaid provider, visit the following link: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing/about-pnm

Please refer to the table found below and the draft rules (linked in each section below) for additional information about documentation necessary for addition of each of the new specialties.

Table 1-2: OhioRISE Provider Specialties				
Specialty	**Delivery System(s)**	**Description**	**Provider Types for Specialty Addition**	**Required Documentation***
ORC – CANS Assessor (Ohio Children's Initiative Child and Adolescent Needs and Strengths Assessor)	Ohio Medicaid Managed Care Organizations: • AmeriHealth • Anthem BCBS • Buckeye Community Health Plan • CareSource Ohio • Humana • Molina Healthcare of Ohio • United HealthCare Community Plan of Ohio OhioRISE (Aetna Better Health of Ohio) Fee-for-Service	Ohio Children's Initiative CANS assessors certified through the Praed Foundation who have completed live Ohio Children's Initiative CANS training For more information, visit the OhioRISE CANS Resources page	Rendering Provider Type:** • Physician • Physician Assistant • Social Worker • Non-Agency RN/LPN • Psychologists/School Psychologist • Clinical Counselor • Marriage and Family Therapist • Chemical Dependency Counselor • Clinical Nurse Specialist (CNS) • Nurse Practitioner (NP) • Paraprofessional • Care Management Specialist Billing Provider Type: • Hospital • Psychiatric Residential Treatment Facility (PRTF)	Praed Foundation certification in the Ohio Children's Initiative CANS
ORM – MRSS (Mobile Response and Stabilization Service)	Ohio Medicaid Managed Care Organizations: • AmeriHealth • Anthem BCBS • Buckeye Community Health Plan • CareSource Ohio • Humana • Molina Healthcare of Ohio • United HealthCare Community Plan of Ohio OhioRISE (Aetna Better Health of Ohio) Fee-for-Service	MRSS agencies with appropriate certification from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) OAC 5160-27-13	Billing Provider Type: • Community Mental Health Agency • SUD Agency • Hospital	MRSS Certification from Ohio Mental Health and Addiction Services (OhioMHAS) OAC 5122-29-28

847 – IHBT (Intensive Home Based Treatment includes IHBT, MST, and FFT)	OhioRISE (Aetna Better Health of Ohio)	Entities with current IHBT certification from OhioMHAS OAC 5160-59-03.3	Billing Provider Type: • Community Mental Health Agency • Hospital	IHBT Certification from OhioMHAS OAC 5122-29-28
ORE – OhioRISE Care Management Entity (CME)	OhioRISE (Aetna Better Health of Ohio)	OhioRISE CMEs contracted with the OhioRISE plan to provide Care Coordination services OAC 5160-59-03.2	Billing Provider Type: • Community Mental Health Agency • Professional Medical Group • Waivered Services Organization (Care Management Entity)	Documentation of selection/contracting with the OhioRISE plan (Aetna Better Health of Ohio) to provide CME services
OHR – OhioRISE BH Respite and/or OhioRISE Waiver Transitional Services and Supports (TSS)	OhioRISE (Aetna Better Health of Ohio)	Providers contracted with the OhioRISE plan to provide Behavioral Health Respite services OAC 5160-59-03.4	Billing Provider Type: • Community Mental Health Agency • SUD Agency • Waivered Services Organization (DODD community respite) • Waivered Services Individual (includes DODD certified informal respite providers) • Non-Agency Personal Care Aid (includes DODD certified informal respite providers, family/natural supports, foster care) Rendering Provider Type (if not employed by the above entities and is providing as a Family/Natural Support): • Independent behavioral health practitioners	Attestation statement that the provider is contracting with the OhioRISE plan (Aetna Better Health of Ohio) and has the appropriate training to provide BH Respite and/or TSS services
		Providers contracted with the OhioRISE plan to provide OhioRISE Waiver TSS	Billing Provider Type: • Community Mental Health Agency • SUD Agency	

		OAC 5160-59-05.2	• Waivered Services Organization (DODD homemaker/personal care services) • Waivered Services Individual (DODD homemaker/personal care services) • Non-Agency Personal Care Aid (DODD homemaker/personal care services) Rendering Provider Type (if not employed by the above entities): • Independent behavioral health practitioners	
ORR – OhioRISE Waiver Out-of-Home Respite	OhioRISE (Aetna Better Health of Ohio)	Entities contracted with the OhioRISE plan to provide OhioRISE Waiver Out-of-Home Respite OAC 5160-59-05.1	Billing Provider Type: • Community Mental Health Agency (Class 1 Residential Facility) • Non-State Operated ICF/IDD • Waivered Services Organization (Community Respite)	Attestation statement that the provider is contracted with the OhioRISE plan (Aetna Better Health of Ohio) to provide Out-of-Home Respite services
*Required documentation refers to documentation submitted specific to the specialty being requested. Providers must also provide documentation specific to the provider type under which they enroll in Ohio Medicaid **Must be affiliated with a Community Mental Health Agency, SUD Agency, or Care Management Entity (CME) or be an independent behavioral health practitioner, in accordance with OAC 5160-8-05; RNs, LPNs and Peer Specialists may add the CANS specialty if they are dually licensed as another behavioral health provider type (e.g., QMHS)				

Section 2: Billing Information

Third Party Payer (TPP) Coordination of Benefits (COB)

Certain OhioRISE covered services are subject to Ohio's early and periodic screening, diagnostic and treatment (EPSDT) benefit in accordance with Ohio Administrative Code (OAC) rules 5160-1-14 and 5160-1-16. Therefore, services deemed to meet the EPSDT criteria by ODM (including the new and enhanced services described above) are subject to payment by the youth's enrolled MCO or the OhioRISE plan and are not required to first be submitted for payment by a TPP. Additional TPP resources are available on https://bh.medicaid.ohio.gov/manuals > Billing and IT Resources > Third-Party Liability Resources.

Determining if a Youth is Enrolled in the OhioRISE Plan (Aetna)

OhioRISE enrollment may occur on any date during the month. Providers can determine if a youth is enrolled in the OhioRISE Plan (Aetna) by submitting an EDI transaction through the trading partner or by following the instructions outlined in the "Member Eligibility Verification" Provider Journey Map after selecting the "6. Provider Journey Maps" tab on this page.

General Billing Information for Submission of Claims to the OhioRISE Plan (Aetna)

- Aetna's electronic payer ID is 45221
- Electronic plan registration should reflect "AETNA-OHIORISE"
- Please see the 'Contracting with the OhioRISE Plan' section on this page for Aetna's contact information.

Aetna OhioRISE does not accept paper claims. Claims can be submitted via EDI or online through ConnectCenter. ConnectCenter is Aetna OhioRISE's provider claims submission portal via Change Healthcare (formerly known as Emdeon). The Aetna OhioRISE office location is: 7400 W Campus Road, New Albany, OH 43054. Providers can call 1-833-711-0773, option #2 to check on claim status.

Prior Authorization and Approval of OhioRISE Services

OhioRISE care coordinators working within the OhioRISE plan or Care Management Entities (CMEs) will work with children/youth and their child and family teams (CFTs) to understand the individual needs of each child/youth and to develop a plan of care that meets their needs. Most behavioral health benefits covered under the OhioRISE plan do not require prior authorization or prior approval of services before they can be provided to children and youth enrolled in the program.

For a limited set of OhioRISE services, prior approval or prior authorization of care from the OhioRISE plan will be required. The table below lists the services for which prior approval or prior authorization will be required. The OhioRISE plan's clinical coverage policies will outline medical necessity requirements for each of the services that require prior approval or prior authorization. Care coordinators will work to understand which services a child/youth may need that require prior approval or prior authorization.

- **A service that requires prior approva**l uses the child and family care plan (CFCP) process. Care coordinators submit all CFCPs to the OhioRISE plan for review.

- Services requiring prior approval must be documented in detail on the child and family-centered care plan (CFCP), and the CFCP must be approved by the OhioRISE plan prior to the child/youth receiving the service and the provider billing for the service.
- Care coordinators will understand services requiring prior approval, work to ensure these services are considered by the child and family team (CFT), and when appropriate work to include providers of these services in the CFT.
- After developing the CFCP with the CFT, the care coordinator submits the CFCP to the OhioRISE plan.
- For services that require prior approval before they can be provided/reimbursed, the OhioRISE plan must concur with the CFCP – this concurrence serves as approval to provide and bill for the services that must be approved using the CFCP process.
- The OhioRISE plan may concur with the CFCP, or they may request more information and/or follow-up discussion(s) with the care coordinator to improve the quality of the CFCP prior to issuing a concurrence.
- If CFCP questions remain, the OhioRISE plan may issue a notice of non-concurrence, and the care coordinator will need to amend the CFCP and resubmit.
- Once a CFCP including these services is reviewed and concurrence (approval) is issued by the OhioRISE plan, the services may be used by the member and billed by the provider.

- **A service that requires prior authorization, with the exception of Psychiatric Residential Treatment Facility (PRTF) services, uses the provider-initiated prior authorization request process**
  - Providers of these services must request and receive authorization from the OhioRISE plan prior to billing for the service.
  - Process follows the traditional provider-initiated prior authorization request pathway.
  - Care coordinators will understand services requiring prior authorization, work to ensure these services are considered by the CFT, and when appropriate work to include providers of these services in the CFT and include these services on the CFCP.
- **Psychiatric Residential Treatment Facility (PRTF) service prior authorizations are submitted by the OhioRISE care coordinator using the 'PRTF Request Form' link in FamilyCare Central.**
  - The OhioRISE plan will make a medical necessity determination within three business days of receiving the PRTF Request Form and supporting documentation in FamilyCare Central.
  - If medical necessity is met, the OhioRISE plan will match a youth to the clinically appropriate PRTF and email the PRTF provider the 'PRTF Approved Authorization Provider Notification Letter' indicating that the OhioRISE plan has approved a prior authorization for admission by the provider.
  - If a PRTF is outreached by anyone seeking admission for whom the PRTF provider has not received the 'PRTF Approved Authorization Provider Notification Letter,' the provider should outreach Aetna at OhioRISEPRTFCoordinator@aetna.com.

For services subject to the prior approval and prior authorization processes, if the OhioRISE plan denies, reduces, terminates, or suspends an approval or authorization for the service, this constitutes an

adverse benefit determination that can be appealed in accordance with rule 5160-26-08.4 of the Ohio Administrative Code.

Table 2-1: OhioRISE Services Requiring Prior Approval or Prior Authorization

<table>
<tr><th colspan="4">OhioRISE services requiring <u>prior approval</u>
through Aetna's child and family care plan review process</th></tr>
<tr><td colspan="4">• Primary Flex Funds – budget authority
• OhioRISE 1915(c) Waiver Services
  ○ Secondary Flex Funds – budget authority
  ○ Transitional Services and Supports
  ▪ Initial service approval on care plan is for up to 72 hours. Additional hours of service may be approved on subsequent care plan updates.
  ○ Out-of-Home respite
  ▪ A maximum of 90 calendar days of the service can be approved and used per 365 days.</td></tr>
<tr><th colspan="4">OhioRISE services requiring <u>prior authorization</u> through traditional provider-initiated request
Aetna's clinical coverage policies will outline medical necessity criteria for prior authorizing these services</th></tr>
<tr><td colspan="4">• Inpatient hospital treatment for psychiatric and/or substance use disorder primary diagnoses when the OhioRISE plan (Aetna) is the primary payer
• Psychiatric Residential Treatment Facility (PRTF) services
• Electroconvulsive Therapy (covered by OhioRISE as part of the outpatient hospital behavioral health benefit)
• SUD Partial Hospitalization (H0015 TG)</td></tr>
<tr><th colspan="4">OhioRISE services with soft billing limitations
<u>Prior authorization</u> through traditional provider-initiated request will be required for continued coverage beyond these limitations</th></tr>
<tr><th>Service</th><th>Code</th><th>Benefit Period</th><th>Continued Coverage Authorization Requirement</th></tr>
<tr><td>Intensive Home-Based Treatment (IHBT)</td><td>H2015</td><td rowspan="3">Enrollment span</td><td rowspan="3">Up to 180 days per person. Prior Authorization is required for additional service.</td></tr>
<tr><td>Multi-Systemic Therapy (MST)</td><td>H2033</td></tr>
<tr><td>Functional Family Therapy (FFT)</td><td>H2015 Modifier: TF</td></tr>
<tr><td>Assertive Community Treatment</td><td>H0040</td><td>Enrollment span</td><td>Up to 180 days per person. Prior Authorization is required for additional service.</td></tr>
<tr><td>Behavioral Health Respite</td><td>S5150, S5151</td><td>Calendar year</td><td>Up to 50 days per person. Prior Authorization is required for additional service.</td></tr>
<tr><td>Mobile Response and Stabilization</td><td>S9482</td><td>MRSS episode</td><td>Prior authorization is needed for stabilization services rendered more than</td></tr>
</table>

Service (MRSS) - Stabilization Service			six weeks from the completion of mobile response.
Psychiatric Diagnostic Evaluations	90791, 90792	Calendar Year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization is required for additional service.
Psychological Testing	96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Calendar Year	Up to 20 hours/encounters per patient per calendar year for all psychological testing codes. Prior authorization is required for additional service.
Screening Brief Intervention and Referral to Treatment (SBIRT)	G0396, G0397	Calendar Year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization is required for additional service.
Alcohol or Drug Assessment	H0001	Calendar Year	2 assessments per patient per calendar year per billing agency. Prior authorization is required for additional service.
TBS Group Per Diem	H2020	Calendar Year	1 per day. Prior authorization is required for an additional per diem service to the same client on the same day.
SUD Residential	H2034, H2036	Calendar Year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. This applies to first two stays. Third and subsequent stays in the same year require prior authorization from the first day of admission.
SUD Peer Recovery	H0038	Calendar Year	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached

Practitioner Abbreviations

Practitioner abbreviations are used in the service charts provided in the remaining sections of this document. The chart below may be used as a reference to these abbreviations:

Table 2-2: Practitioner Abbreviations

Practitioner Abbreviations Key			
MD/DO	Physician	**LSW**	Licensed social worker
CNS	Clinical nurse specialist	**LMFT**	Licensed marriage and family therapist
CNP	Certified nurse practitioner	**LPC**	Licensed professional counselor
PA	Physician assistant	**LCDC II or LCDC III**	Licensed chemical dependency counselor II or III
RN	Registered nurse	**SW-A**	Social worker assistant
LPN	Licensed practical nurse	**SW-T**	Social worker trainee
PSY	Psychologist	**MFT-T**	Marriage and family therapist trainee
LISW	Licensed independent social worker	**C-T**	Counselor trainee
LIMFT	Licensed independent marriage and family therapist	**CDC-A**	Chemical dependency counselor assistant
LPCC	Licensed professional clinical counselor	**CMS**	Care management specialist
LICDC	Licensed independent chemical dependency counselor	**QMHS**	Qualified mental health specialist
Lic school PSY	Board licensed school psychologist	**QMHS +3**	Qualified mental health specialist with 3 years' experience
PSY assistant	Psychology assistant, intern or trainee	**PRS**	Certified peer supporter
WVR	Waivered Services Individual	**PCA**	Non-Agency Personal Care Aide

Practitioner Modifiers

Aetna does not require practitioner modifiers on the following types of claims, unless the rendering practitioner holds multiple licenses or credentials with differing scope of practice (see section below).

- Community mental health agency claims (provider type 84)
- Community substance use disorder treatment provider claims (provider type 95)
- Care Management Entity (CME) claims
- Other professional and behavioral health services reimbursed in accordance with Appendix DD of Ohio Administrative Code (OAC) rule 5160-1-60 (this includes BH services rendered by providers other than community MH/SUD agencies)

- Outpatient hospital claims submitted for Enhanced Ambulatory Patient Group (EAPG) reimbursement

In alignment with ODM fee-for-service policy, Aetna requires practitioner modifiers on outpatient hospital claims submitted for Outpatient Hospital Behavioral Health (OPHBH) reimbursement. Aetna's OPHBH practitioner modifier requirements will mirror ODM's fee-for-service requirements for dates of service through 12/31/2023. For outpatient hospital claims, relevant OPHBH modifiers are found at the following link: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services

Practitioners with multiple licenses or credentials

Consistent with ODM fee-for-service, Aetna will require rendering practitioners holding multiple licenses or credentials with differing scopes of practice to use ODM's requirements for enrollment and claims submission, including:

- Provider enrollment with a multi-license specialty
- Rendering provider reporting their additional licensure/credentials on claims
- Use of modifiers as described in the ODM Behavioral Health Provider Manual and identified on ODM's dual licensure grid, which can be found on https://bh.medicaid.ohio.gov/manuals.

Practitioner modifiers are not typically required, however, a practitioner modifier may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information. Use the table below for all professional claims requiring practitioner modifiers for providers enrolled with multiple licenses/credentials, when reporting the additional secondary licensure/credentials on claims.

Table 2-3: Practitioner Modifiers*

Practitioner	Modifier	Practitioner	Modifier
LPC	U2	**QMHS** (Masters)	HO
LCDC II or LCDC III	U3	**QMHS** (3 yrs experience)	UK
LSW	U4	**CMS** (High School/Associates)	HM
LMFT	U5	**CMS** (Bachelors)	HN
PSY assistant, intern or trainee	U1	**CMS** (Masters)	HO
CDC-A	U6	**PRS** (High School/Associates)	HM
C-T	U7	**PRS** (Bachelors)	HN
SW-A	U8	**PRS** (Masters)	HO
SW-T	U9	**WVR** (High School/Associates)	HM
MFT-T	UA	**WVR** (Bachelors)	HN
QMHS (High School/Associates)	HM	**WVR** (Masters)	HO
QMHS (Bachelors)	HN		

*Applicable to community behavioral health and CME billing. For outpatient hospital claims, relevant OPHBH modifiers valid for dates of service through 12/31/2023 are found at the following link: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services.

OhioRISE Mixed Services Protocol

The OhioRISE Mixed Services Protocol was developed to define financial responsibility for behavioral health services provided to youth who are enrolled in the OhioRISE plan. The protocol includes those services that are covered by both the OhioRISE plan and the MCO and excludes the enhanced or new services that are only covered by the OhioRISE plan. Financial responsibility for behavioral health services provided to youth who are not enrolled in the OhioRISE plan remains the responsibility of the recipient's managed care organization or fee-for-service Medicaid.

Providers can use the OhioRISE Mixed Services Protocol to identify to which entity claims should be submitted if a youth is enrolled in the OhioRISE plan. Services are defined in the column on the left, while the entity to which the claim should be routed, dependent on the date of service, is in the righthand column.

Services always covered by the OhioRISE plan when youth are enrolled include those billed by:

- Community mental health and community substance use disorder (SUD) agencies (Ohio Medicaid provider type (PT) 84 and 95)
- Psychiatric hospitals (Ohio Medicaid PT 02)

The following services are included in the OhioRISE Mixed Services Protocol, as they may be covered by the OhioRISE plan or the MCO (or fee-for-service Medicaid), depending on the youth's date of enrollment in the OhioRISE plan:

- Child and Adolescent Needs and Strengths (CANS) Assessment
- Mobile Response and Stabilization Service (MRSS)

Child and Adolescent Needs and Strengths (CANS) Assessment

The CANS is completed at prescribed intervals or whenever there is a significant change in a member's condition or circumstances. CANS assessors should aim to conduct minimally invasive practice and maintain the best interest of youth/caregivers throughout the assessment process. Accordingly, assessors should not over-assess youth/caregivers or ask them to tell their stories multiple times. The Ohio Children's Initiative CANS assessment and the state CANS IT system supports the practice of building upon what we already know about the youth/caregiver's story and avoiding over-assessment. Prior to engaging the youth/caregiver in the CANS assessment process, the CANS assessors should access the CANS IT System to determine if a recent CANS assessment has been completed with the youth/caregiver. If a recent CANS assessment is available in the CANS IT system, the assessor should use their professional judgement to determine if an update needs to occur or if the most recent assessment can be used.

Valid Ohio Medicaid Billing Provider Types for CANS:

- Community Mental Health Agency (PT 84)
- SUD Agency (PT 95)
- OhioRISE Care Management Entity (PT 45, 84, 95, 50 or 21)
- Hospitals (PT 01 and 02)
- PRTF (PT 03)
- Professional Medical Groups (PT 21)

- Clinics (PT 50)
- Independent Billing Providers in accordance with 5160-08-05:
    - Physician (PT 20)
    - Physician Assistant (PT 24)
    - CNS (PT 65)
    - CNP (PT 72)
    - LICDC (PT/PS 54/540)
    - Psychologist/Licensed School psych (42/420 / 42/421)
    - LIMFT (PT/PS 52/520)
    - LISW (PT/PS 37/370)
    - LPCC (PT/PS 47/474)

Requirements for Billing:

- Rendering practitioner must be appropriately certified and trained in the administration of the Ohio Children's Initiative CANS assessment
- The rendering practitioner must have an NPI, be enrolled in Medicaid, add the "ORC" specialty to the Ohio Medicaid enrollment and be affiliated with the billing provider
- Hospitals and PRTFs add the "ORC" specialty to the hospital or PRTF enrollment, and ensure staff administering the Ohio Children's Initiative CANS are appropriately certified and trained
- CANS assessments must be entered in Ohio's CANS IT system to establish and maintain OhioRISE eligibility

Table 2-4: Child and Adolescent Needs and Strengths (CANS) Assessment

Service effective date 7/1/2022

CANS Billing Chart for Claims Billed by Community BH Agencies and CMEs to the OhioRISE Plan (Aetna) Requires the addition of the "ORC" specialty to the rendering provider's enrollment					
Service	**Rendering Provider**	**Billing Code**	**Rate (dates of service 7/1/2022-12/31/2022)**	**Rate (dates of service 1/1/2023 – 12/31/2023)**	**Rate (dates of service on or after 1/1/2024)**
Child and Adolescent Needs and Strength (CANS) Assessment	MD/DO	H2000	$341.60	$527.25	$594.47
	PA CNS CNP	H2000	$211.74	$324.67	$366.07
	PSY LPCC LISW LIMFT LICDC Lic school PSY	H2000	$112.86	$170.43	$192.16
	LPC LSW LMFT LCDC II LCDC III	H2000	$109.38	$165.00	$186.04
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS QMHS +3 CMS	H2000	$98.31	$147.72	$166.55
Unit Value	Per Assessment (Brief or Comprehensive)				
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used				
Billing Instructions	• If the CANS is completed over multiple dates of service, the claim date of service is the date the CANS was completed • Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth. • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes," when used in accordance with coding guidelines				

The billing chart above is specific to those billed by Ohio Medicaid Provider types 84, 95, and CMEs to Aetna for CANS assessments. In accordance with the OhioRISE Mixed Services Protocol, Aetna is responsible for CANS assessments administered the day following OhioRISE enrollment. Therefore,

providers will submit claims for CANS assessments completed before or on the date of OhioRISE enrollment to the youth's Medicaid Managed Care Organization (MCO) or fee-for-service Medicaid. Providers should consult the relevant MCO or review the Behavioral Health Provider Manual for fee-for-service billing instructions.

Other relevant billing providers will follow the claims submission policies consistent with their billing provider type.

Other eligible billing providers include:

- Hospitals (PT 01 and PT 02)
    - Staff administering the Ohio Children's Initiative CANS must be appropriately certified and trained
    - Hospitals must add the "ORC" specialty to their hospital enrollment
    - Bill dates of service through 12/31/2023 in accordance with OAC 5160-2-76 and use the code set and billing instructions for OPHBH at the following: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services.
- Independent Behavioral Health Practitioners (PT 20, 24, 37, 42, 47, 52, 54, 65, 72)
    - Must be appropriately certified and trained
    - Must add the "ORC" specialty to their Ohio Medicaid enrollment
    - Bill in accordance with OAC 5160-8-05 and 5160-1-60.

Mobile Response and Stabilization Service (MRSS)

Information about service descriptions, eligibility, clinical criteria and limitations can be found in OAC rules 5160-27-13 (ODM) and 5122-29-14 (OMHAS). The MRSS Practice Standards and other provider resources can be found on the OhioMHAS MRSS site: https://mha.ohio.gov/community-partners/early-childhood-children-and-youth/resources/mobile-response-stabilization-services.

Valid Ohio Medicaid Billing Provider Types:

- Community behavioral health agency (PT 84)
- Community SUD agency (PT 95)
- Hospitals (PT 01 and PT 02)

Requirements for Billing:

- Addition of the "ORM" specialty to the primary Ohio Medicaid billing provider type
- The rendering practitioner must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider
- MRSS hourly and 15-minute codes cannot be billed for time spent administering a CANS assessment during an MRSS event

Table 2-5: MRSS Crisis Mobile Response

Service effective date 7/1/2022

MRSS Crisis Mobile Response Billing Chart for Community Agencies (PT 84 and 95) to the OhioRISE Plan (Aetna) Requires the billing provider have the "ORM" specialty				
Service	**Rendering Provider**	**Billing Code**	**Rate (dates of service 7/1/2022 through 12/31/2023)**	**Rate (dates of service on or after 1/1/2024)**
Crisis Mobile Response	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9485	$476.64	$537.41
	LPC LSW LMFT LCDC II LCDC III	S9485	$466.34	$525.80
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS QMHS +3 CMS	S9485	$432.63	$487.79
	PRS	S9485	$365.55	$412.16
Unit Value	Per diem			
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used			
Billing Information	• Billed on the date the initial mobile response is initiated by the MRSS provider; or to report the MRSS team's first encounter after the crisis response is initiated* • Code can be billed by all practitioners participating in the initial mobile response • May not be billed more than once in the Mobile Response period • Do not use for follow-up after the initial mobile response • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes," when used in accordance with coding guidelines Telehealth allowed in accordance with MRSS practice standards - GT modifier is required when service rendered via telehealth.			

* For MRSS providers using an external entity that is not part of the MRSS billing provider agency to support 24/7 coverage, as allowed during an MRSS provider's first year of initial certification, there may

be situations where the external entity initiates the crisis response prior to handing off to the MRSS provider. When this occurs, the MRSS provider will use the initial Crisis Mobile Response code S9485 to report services provided during the MRSS team's first encounter with the youth/family after hand-off from the external entity who initiated the crisis response. If the external entity is a Medicaid provider, the external entity may bill for any Medicaid-covered services rendered prior to handing-off to the MRSS team (e.g. psychotherapy for crisis). After the first encounter by the MRSS team reported using the initial Crisis Mobile Response code S9485, subsequent services rendered by the MRSS team during the mobile response phase are billed using the Crisis Mobile Response Follow-up code, S9484.

The billing chart above is specific to those billed by Ohio Medicaid Provider types 84 and 95 to the OhioRISE plan (Aetna) for MRSS services. In accordance with the OhioRISE Mixed Services Protocol, Aetna is responsible for MRSS services beginning the day of OhioRISE enrollment. Therefore, providers will submit claims for MRSS services completed before the date of OhioRISE enrollment to the youth's Medicaid Managed Care Organization (MCO) or fee-for-service Medicaid. Providers should consult the relevant MCO or review the Behavioral Health Provider Manual for fee-for-service billing instructions.

Hospitals certified to provide this service should use the code set and billing instructions for OPHBH valid for dates of service through 12/31/2023 at the following: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services.

Table 2-6: MRSS Crisis Mobile Response Follow Up

Service effective date 7/1/2022

MRSS Crisis Mobile Response Follow-Up Billing Chart for Community Agencies (PT 84 and 95) to the OhioRISE Plan (Aetna) Requires the billing provider have the "ORM" specialty				
Service	**Rendering Provider**	**Billing Code**	**Rate (dates of service 7/1/2022 through 12/31/2023)**	**Rate (dates of service on or after 1/1/2024)**
Crisis Mobile Response Follow-Up	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9484	$139.92	$157.76
	LPC LSW LMFT LCDC II LCDC III	S9484	$136.49	$153.89
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS QMHS +3 CMS	S9484	$125.25	$141.22
	PRS	S9484	$102.89	$116.01
Unit Value	Per hour			
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used			
Billing Information	• Billed for follow-up activities during the mobile response phase (up to 72 hours from the initial mobile response) • Dates of service should be within 3 calendar days of the initial mobile response • The initial mobile response (S9485) code must be billed before this code can be billed • Code can be billed by all practitioners participating in the follow up response • Can be billed on the same date of service as the initial response if the initial response concluded and follow-up activities were provided later the same date • Code may not be billed for time spent administering the CANS assessment • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes," when used in accordance with coding guidelines • Telehealth allowed - GT modifier is required when service rendered via telehealth			

The billing chart above is specific to those billed by Ohio Medicaid Provider types 84 and 95 to the OhioRISE plan (Aetna) for MRSS services. In accordance with the OhioRISE Mixed Services Protocol, Aetna is responsible for MRSS services beginning the day of OhioRISE enrollment. Therefore, providers

will submit claims for MRSS services completed before the date of OhioRISE enrollment to the youth's Medicaid Managed Care Organization (MCO) or fee-for-service Medicaid. Providers should consult the relevant MCO or review the Behavioral Health Provider Manual for fee-for-service billing instructions.

Hospitals certified to provide this service should use the code set and billing instructions for OPHBH valid for dates of service through 12/31/2023 at the following: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services.

Table 2-7: MRSS Stabilization Service

Service effective date 7/1/2022

MRSS Stabilization Service Billing Chart for Community Agencies (PT 84 and 95) to the OhioRISE Plan (Aetna) Requires the billing provider have the "ORM" specialty				
Service	**Rendering Provider**	**Billing Code**	**Rate (dates of service 7/1/2022 through 12/31/2023)**	**Rate (dates of service on or after 1/1/2024)**
MRSS Stabilization Service	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9482	$34.95	$39.41
	LPC LSW LMFT LCDC II LCDC III	S9482	$34.01	$38.35
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS QMHS +3 CMS	S9482	$30.92	$34.86
	PRS	S9482	$24.77	$27.93
Unit Value	Per 15 minutes			
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used			
Billing Information	• The initial mobile response (S9485) code must be billed before this code can be billed • Code can be billed by all practitioners providing the stabilization service • Requires prior authorization to extend beyond 6 weeks from the end of the de-escalation phase • Cannot be billed for youth enrolled in IHBT, MST, FFT or ACT • Code may not be billed for time spent administering the CANS assessment • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes," when used in accordance with coding guidelines • Telehealth allowed - GT modifier is required when service rendered via telehealth			

The billing chart above is specific to those billed by Ohio Medicaid Provider types 84 and 95 to the OhioRISE plan (Aetna) for MRSS services. In accordance with the OhioRISE Mixed Services Protocol,

Aetna is responsible for MRSS services beginning the day of OhioRISE enrollment. Therefore, providers will submit claims for MRSS services completed before the date of OhioRISE enrollment to the youth's Medicaid Managed Care Organization (MCO) or fee-for-service Medicaid. Providers should consult the relevant MCO or review the Behavioral Health Provider Manual for fee-for-service billing instructions.

Hospitals certified to provide this service should use the code set and billing instructions for OPHBH valid for dates of service through 12/31/2023 at the following: www.Medicaid.ohio.gov > Resources for Providers > Fee Schedules & Rates > Outpatient Hospital Behavioral Health Services.

Services Only Available through OhioRISE

The services in this section are services that, for youth for whom these services are medically necessary, would meet the OhioRISE enrollment criteria. Therefore, these services are available only in the OhioRISE benefit plan and will always be billed to the OhioRISE plan. These services include:

- Care Management Entity Services:
  - Intensive Care Coordination
  - Moderate Care Coordination
  - Initial Supplemental Assessment
- Intensive Home-Based Treatment:
  - Multi-Systemic Therapy
  - Functional Family Therapy
  - Intensive Home-Based Treatment
- Behavioral Health Respite
- Primary Flex Funds
- Psychiatric Residential Treatment Facility Services
- OhioRISE 1915(c) Waiver Services:
  - Transitional Services and Supports
  - Out-of-Home Respite
  - Secondary Flex Funds
- Inpatient Behavioral Health Treatment

Care Management Entity (CME) Services

OhioRISE contracted CMEs should refer to the OhioRISE CME Manual, which is posted on the OhioRISE Resources for Community Partners and Providers Website, for information about the policies, services, and billing criteria specific to CMEs. CME covered services include Intensive Care Coordination, Moderate Care Coordination, and the Initial Supplemental Assessment, as described in OAC rule 5160-59-03.2. Information about CANS assessments (which includes OhioRISE 1915(c) Waiver level-of-care assessments), which may be provided by CME-based assessors, is included in this document.

Intensive Home-Based Treatment (IHBT)

The IHBT umbrella encompasses three distinct services: Multi-systemic therapy (MST), functional family therapy (FFT), and base IHBT. Information about service descriptions, eligibility, clinical criteria, and limitations can be found in OAC rules 5160-59-03.3 (ODM) and 5122-29-28 (OMHAS).

Valid Ohio Medicaid Billing Provider Types:

- Community Mental Health Agency (PT 84)
- General Hospital (PT 01)
- Psychiatric Hospital (PT 02)

Requirements for Billing:

- Addition of the “847” specialty to the primary Ohio Medicaid billing provider type
- For claims submitted by the community mental health agency, the rendering practitioner must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider

Table 2-8: Intensive Home-Based Treatment (IHBT)

Intensive Home-Based Treatment (IHBT) Applicable to billing by Ohio Medicaid PT 84 with the "847" provider specialty					
Service	**Rendering Provider**	**Billing Code**	**Procedure Modifier**	**Rate (dates of service 7/1/2022 through 12/31/2023**	**Rate (dates of service on or after 1/1/2024)**
Multi-Systemic Therapy for Juveniles (MST)	LISW LPCC LIMFT PSY	H2033		$42.24	$47.63
	LSW LPC LMFT	H2033		$41.10	$46.34
Functional Family Therapy for Juveniles (FFT)	LISW LPCC LIMFT PSY	H2015	TF	$34.98	$39.44
	LSW LPC LMFT	H2015	TF	$34.05	$38.39
Intensive Home Based Treatment (other than MST or FFT)	LISW LPCC LIMFT PSY	H2015		$38.60	$43.52
	LSW LPC LMFT	H2015		$37.57	$42.36
	QMHS QMHS +3 PSY assistant SW-A SW-T MFT-T C-T	H2015		$34.21	$38.57
	PRS	H2015		$27.51	$31.02
Unit Value	Per 15 minutes				
Permitted POS	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99				
Billing Notes	• Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes," when used in accordance with coding guidelines • GT modifier is required when service rendered via telehealth				

The IHBT billing chart above is specific to those billed by community mental health agency providers. Other allowed billing providers, General Hospitals and Psychiatric Hospitals holding appropriate IHBT certification by the Ohio Mental Health and Addiction Services (Ohio Medicaid Provider Types 01 and 02

with the '847' specialty), should follow the claims submission policies consistent with ODM's website (Resources for Providers > Billing > Fee Schedules and Rates > Schedules and Rates > Outpatient Hospital Behavioral Health Services) valid for dates of service through 12/31/2023.

Behavioral Health Respite

Information about service descriptions, eligibility, clinical criteria and limitations can be found in OAC rule 5160-59-03.4.

Valid Ohio Medicaid Billing Provider Types:

- Community Mental Health Agency (PT 84)
- SUD Agency (PT 95)
- Waivered Services Organization (PT 45) with DODD Community Respite certification
- Waivered Services Individual (PT 55) with DODD informal respite provider certification
- Non-Agency Personal Care Aid (PT 25) with DODD informal respite provider certification, family and natural supports or foster care, as described in OAC 5160-59-03.4
- Independent Billing Providers in accordance with 5160-08-05 who are also providing BH respite as a family or natural support:
    - Physician (PT 20)
    - Physician Assistant (PT 24)
    - CNS (PT 65)
    - CNP (PT 72)
    - LICDC (PT/PS 54/540)
    - Psych/Licensed School psych (PT/PS 42/420 / 42/421)
    - LIMFT (PT/PS 52/520)
    - LISW (PT/PS 37/370)
    - LPCC (PT/PS 47/474)

Requirements for Billing:

- Addition of the "OHR" specialty to the primary Ohio Medicaid billing provider type
- The rendering practitioner must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider if the billing provider is a PT 84 or 95

Table 2-9: Behavioral Health Respite

Service effective date 7/1/2022

<table>
<tr><th colspan="6">Behavioral Health Respite
Billing Provider is required to have the “OHR” Specialty</th></tr>
<tr><th>Service</th><th>Billing Provider</th><th>Rendering Provider</th><th>Billing Code</th><th>Agency Rate (effective for Dates of Service On or After 1/1/2023)</th><th>Independent Provider Rate (All DOS on/after 7/1/2022)
Agency Rate for Dates of Service 7/1/22-12/31/2022)</th></tr>
<tr><td>Behavioral Health Respite (15 minutes up to 3 hours)</td><td rowspan="2">Community Mental Health Agency

Community SUD Provider

Waivered Services Organization

Non-Agency Personal Care Aid

Waivered Services Individual

Independent Practitioner</td><td rowspan="2">MD/DO
PSY
PA
CNS
CNP
LISW
LIMFT
LPCC
LICDC
Lic school PSY
LSW
LMFT
LPC
LCDC II, III
Psy assistant
SW-T
SW-A
MFT-T
C-T
CDC-A
QMHS
QMHS+3
PRS
CMS
WVR
PCA</td><td>S5150</td><td>$20.83</td><td>$7.50</td></tr>
<tr><td>Behavioral Health Respite (Per Diem 3+ hours)</td><td>S5151</td><td>$250.00</td><td>$90.00</td></tr>
<tr><td>Unit Value</td><td colspan="5">S5150: Per 15 minutes, up to 3 hours
S5151: Per diem (3+ hours)</td></tr>
<tr><td>Permitted POS</td><td colspan="5">Any valid place of service code, except POS 02 or 10, may be used</td></tr>
<tr><td>Billing Notes</td><td colspan="5">• May be provided for up to 50 days without prior authorization
• Must be planned in the Child and Family-Centered Care Plan (CFCP)
• Cannot be provided on the same DOS as the OhioRISE Waiver Out-of-Home Respite service
• Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including “Z-codes,” when used in accordance with coding guidelines</td></tr>
</table>

OhioRISE Primary Flex Funds

Information about service descriptions, eligibility, clinical criteria, and limitations can be found in OAC rules 5160-59-03.5 and 5160-59-05.3

Valid Ohio Medicaid Billing Provider Types:

- Managed Care Organization Panel Provider Only (PT 19)
- Waivered Services Organization (PT 45)

Requirements for Billing:

- Entity contracted with the OhioRISE Plan to serve as the FMS
- Addition of the "FMS" specialty to the billing primary Ohio Medicaid provider type

Table 2-10: Flex Funds

Effective date 7/1/2022

OhioRISE Flex Funds Requires the addition of the "FMS" specialty				
Service	**Billing Provider**	**Billing Code**	**Procedure Modifier**	**Rate**
Primary Flex Funds	Financial Management Service	T2028		Up to $1500/365 days
OhioRISE 1915(c) Waiver Secondary Flex Funds	Financial Management Service	T2028	UB	Up to $3000/365 days
OhioRISE 1915(c) Waiver Emergency Flex Funds	Financial Management Service	T2028	UD	Emergency funds up to $2000/365 days
Unit Value	Varies by good/service			
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used			
Billing Notes	• Primary Flex Funds and Secondary Flex Funds must be included on child and family-centered care plan (CFCP) approved by the OhioRISE Plan prior to provision of care/services • Secondary Flex Funds can only be used after Primary Flex Funds are exhausted • Emergency Flex Funds can only be used after Primary and Secondary Flex Funds have been exhausted • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes"			

Psychiatric Residential Treatment Facility (PRTF)

Information about service description, eligibility, clinical criteria, and limitations can be found in OAC rules 5160-59-03.6.

Valid Ohio Medicaid Billing Provider Type:

- Psychiatric Residential Treatment Facility (PT 03)

Requirements for Billing:

- Entity contracted with the OhioRISE Plan as a PRTF
- Facility service level as defined in OAC 5160-59-03.6:
    - Base – Serving youth in a facility that does not meet any of the criteria in the next three bullets.
    - Base MI/ID - Serving youth with cooccurring behavioral health and intellectual or developmental disabilities.
    - Cottage - Serving youth in a separate, detached building of six or fewer beds.
    - Cottage MI/ID - Serving youth with cooccurring behavioral health and intellectual or developmental disabilities in a separate, detached building of six or fewer beds.

Table 2-11: Psychiatric Residential Treatment Facility (PRTF)

Effective date 11/1/2023

Psychiatric Residential Treatment Facility Requires the addition of the "030" specialty				
Service Level	**Revenue Code**	**Procedure Code**	**Procedure Modifier**	**Rate**
Base	1001	T2048	U1	$799.93
Base – Bed Hold	180			
Base – Therapeutic Pass	183			
Base MI/ID	1001	T2048	U2	$1,036.55
MI/ID – Bed Hold	180			
Mi/ID – Therapeutic Pass	183			
Cottage	1001	T2048	U3	$1,092.60
Cottage – Bed Hold	180			
Cottage – Therapeutic Pass	183			
Cottage MI/ID	1001	T2048	U4	$1,243.85
Cottage MI/ID – Bed Hold	180			
Cottage MI/ID – Therapeutic Pass	183			

Type of Bill = 086X	1st Digit	Enter zero
	2nd Digit (Type of Facility)	8 = Psychiatric Residential Treatment Facility Service
	3rd Digit (Bill Classification)	6 = Residential Facility
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
Unit Value	1 day of service	
Billing Notes	• Submit claims on an 837I format • Rev Code with procedure code and modifier combination above is required on all claims • Treating physician(s) must be enrolled as an Ohio Medicaid provider and listed as the attending provider on the claim • Per OAC 5160-59-03.6, the per diem rate includes reimbursement for: room and board; treatment, therapeutic, and other services described in OAC 5122-41-07; direct care; staffing to support increases in acuity (including individual supports); the services of PRTF staff as attendants during transportation; and transportation of the youth to and from family visits or community outings, as included in the youth's individual plan of care.	

OhioRISE 1915(c) Waiver Services

Youth who qualify for the OhioRISE 1915(c) waiver may receive the following services, as indicated on the youth's child and family-centered care plan:

Secondary Flex Funds

Information about service descriptions, eligibility, clinical criteria, and limitations can be found in OAC rule 5160-59-05.3. Billing information about OhioRISE waiver secondary flex funds are available as described in Table 2-9 above.

Transitional Services and Supports (TSS)

Information about service descriptions, eligibility, clinical criteria and limitations can be found in OAC rule 5160-59-05.2

Valid Ohio Medicaid Billing Provider Types:

- Community Mental Health Agency (PT 84)
- SUD Agency (PT 95)
- Waivered Services Organization (PT 45) with DODD homemaker/personal care services certification
- Waivered Services Individual (PT 55) with DODD homemaker/personal care services certification
- Non-Agency Personal Care Aid (PT 25) with DODD homemaker/personal care services certification
- Independent Billing Providers in accordance with 5160-08-05:
    - Physician (PT 20)
    - Physician Assistant (PT 24)
    - CNS (PT 65)
    - CNP (PT 72)
    - LICDC (PT/PS 54/540)
    - Psych/Licensed School psych (PT/PS 42/420/42/421)
    - LIMFT (PT/PS 52/520)
    - LISW (PT/PS 37/370)
    - LPCC (PT/PS 47/474)

Requirements for Billing:

- Addition of the "OHR" specialty to the primary Ohio Medicaid billing provider type
- The rendering practitioner must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider when the billing provider is a PT 84 or 95

Table 2-12: OhioRISE Waiver Transitional Services and Supports

Effective date 7/1/2022

Transitional Services and Supports Requires the billing provider to have the "OHR" specialty					
Service	**Billing Provider**	**Rendering Provider**	**Billing Code**	**Agency Rate**	**Independent Provider Rate**
OhioRISE Waiver Transitional Services and Supports (15 minutes up to 3 hours)	Community Mental Health Agency Community SUD Provider Waivered Services Organization Non-Agency Personal Care Aid Waivered Services Individual Independent Practitioner	MD/DO PSY PA CNS CNP	H2014	$18.33	$14.58
		LISW LIMFT LPCC LICDC Lic school PSY LSW LMFT LPC LCDC II, III Psy assistant RN LPN	H2014	$15.58	$12.40
		SW-T SW-A MFT-T C-T CDC-A QMHS QMHS +3 PRS CMS WVR PCA	H2014	$13.75	$10.94
OhioRISE Waiver Transitional Services and Supports (Per Diem 3+ hours)	Community Mental Health Agency	MD/DO PSY PA CNS CNP	H2016	$220.00	$175.00

	Community SUD Provider Waivered Services Organization Non-Agency Personal Care Aid	LISW LIMFT LPCC LICDC Lic school PSY LSW LMFT LPC LCDC II, III Psy assistant RN LPN	H2016	$187.00	$148.75
	Waivered Services Individual Independent Practitioner	SW-T SW-A MFT-T C-T CDC-A QMHS QMHS +3 PRS CMS WVR PCA	H2016	$165.00	$131.25
Unit Value	H2014: 15 minutes, up to 3 hours H2016: Per diem (3+ hours)				
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used				
Billing Notes	• The service must be included on child and family-centered care plan (CFCP) and approved by the OhioRISE Plan prior to provision of care. Up to 72 hours of the service can be initially approved • The CFCP must be updated and approved again to continue the service longer than the initial 72 hours				

OhioRISE Waiver Out-of-Home Respite

Information about service descriptions, eligibility, clinical criteria and limitations can be found in OAC rule 5160-59-05.1

Valid Ohio Medicaid Billing Provider Types:

- Community Mental Health Agency (PT 84) licensed as a class one residential facility by OMHAS
- Intermediate Care Facility for Individuals with Intellectual Disabilities (PT 89) certified by ODH as a residential respite provider and an active DODD license
- Waivered Services Organization (PT 45) holding certification for community respite services

Requirements for Billing:

- Addition of the “ORR” specialty to the primary Ohio Medicaid billing provider type

- The rendering practitioner must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider

Table 2-13: OhioRISE Waiver Out-of-Home Respite

Effective date 7/1/2022

OhioRISE Waiver Out-of-Home Respite Requires the billing provider have the "ORR" specialty						
Service	**Billing Provider**	**Rendering Provider**	**Billing Code**	**Procedure Modifier**	**Facility Rate**	**Community Rate**
Out-of-Home Respite (15 minutes up to 3 hours)	Community Mental Health Agency Waivered Services Organization ICF/IID	MD/DO PSY PA CNS CNP LISW LIMFT LPCC LICDC Lic school PSY LSW LMFT LPC LCDC II, III Psy assistant SW-T SW-A MFT-T C-T CDC-A QMHS QMHS +3 PRS CMS WVR	S5150	UB	$19.08	$19.08
Out-of-Home Respite (Per Diem)			H0045	UB	$229.00	$229.00
Unit Value	S5150 UB: 15 minutes, up to 3 hours H0045 UB: Per diem (3+ hours)					
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used, but Out-of-Home respite cannot be provided at the youth's primary billing address.					
Billing Notes	• The service must be included on child and family-centered care plan (CFCP) approved by the OhioRISE Plan prior to provision of care • Cannot be provided on the same date of service as Behavioral Health Respite • Maximum of 90 days per 365 days • One billing provider can bill for Out-of-Home Respite each day					

Information for Community BH Providers

Medicaid covers a behavioral health benefit that includes services provided by agencies certified by the Ohio Department of Mental Health and Addiction Services. The Medicaid community behavioral health benefit package covers certain behavioral health providers that are physically located in states outside of Ohio in accordance with OAC rule 5160-1-11. The behavioral health services provided under this benefit package are covered by and billed to Aetna for OhioRISE enrollees.

Community behavioral health agency employees participating in OhioRISE child and family team meetings may submit claims for covered services (such as CPST or TBS) when active participation in the CFT meeting meets the requirements for the service billed as outlined in chapter 5160-27 of the OAC and billed with the appropriate code as described in the Behavioral Health Provider Manual.

The Behavioral Health Provider Manual provides detailed information about Medicaid covered community behavioral health services, including mental health, substance use disorder, and Opioid Treatment Program services. Provider manual details are applicable for claims submitted to ODM and include:

- CPT/HCPCS codes describing the service
- Service Units
- Eligible rendering practitioners
- Fee-for-service payment rates
- Allowable places of service
- Allowable diagnosis codes
- Practitioner and Procedure modifiers
- Listing of services for which prior authorization is required for fee-for-service

Information for Physicians, Physician Assistants, Clinical Nurse Specialists, Certified Nurse Practitioners and Independent BH Providers

As outlined in the OhioRISE Mixed Services Protocol, services and provider administered drugs rendered by psychiatrists (includes psychiatrists, addiction psychiatrists and child/adolescent psychiatrists), physician assistants supervised by psychiatrists, clinical nurse specialists with a collaborative agreement with a psychiatrist or a certified nurse practitioner with a collaborative agreement with a psychiatrist to youth enrolled in OhioRISE plan are OhioRISE plan covered services billed to Aetna. Services provided by other practitioners of physician services not described earlier in this paragraph remain the responsibility of the MCO or FFS.

Likewise, services rendered by Licensed Psychologists, Licensed Professional Clinical Counselors (LPCC), Licensed Independent Social Workers (LISW), Licensed Independent Marriage and Family Therapists (LIMFT) and Licensed Independent Chemical Dependency (LICDC) Professionals, when billed independently or via a group arrangement (i.e., a professional medical group, clinic) are OhioRISE plan covered services billed to Aetna.

Information for Hospital Providers

Psychiatric Hospitals

Inpatient and outpatient services provided in psychiatric hospitals to individuals enrolled in the OhioRISE plan are always the responsibility of the OhioRISE plan since they are always behavioral health services.

Inpatient Hospital Behavioral Health Stays

The OhioRISE Mixed Services Protocol defines what is considered an inpatient behavioral health stay. Inpatient services that are not defined in the OhioRISE Mixed Services Protocol are the responsibility of the MCO or FFS.

Admission of an individual under age 21 to a hospital for inpatient behavioral health treatment results in enrollment into the OhioRISE plan effective the date of admission. Therefore, all inpatient psychiatric or SUD admissions for individuals under the age of 21 are the responsibility of the OhioRISE plan. All prior authorization requests for inpatient behavioral health stays for individuals under the age of 21 must be submitted to Aetna and will be denied if submitted to the MCO or fee-for-service Medicaid.

Aetna will not have the ability to accept prior authorization requests in its (Availity) prior authorization (PA) system until a member's OhioRISE enrollment has been received from ODM and loaded into their system, but Aetna's utilization management team will support the submission of PA requests for pending members. A hospital may reach out to Aetna for information about submitting a PA request to Aetna before the member is formally enrolled and is visible in all systems via one of the following methods:

- Aetna's Fax # for inpatient hospitalizations is 855-948-3774
- Aetna's Provider Hotline number is 833-711-0773 (option 2)
- Aetna Transition of Care coordinators may be reached at OhioRISETOC@aetna.com

Notification of the inpatient behavioral health admission in the state's CANS IT system triggers the OhioRISE enrollment process. Hospitals should consider having staff trained as Ohio Children's Initiative CANS assessors, so that hospitals may expeditiously enter information about the inpatient behavioral health admission into the CANS IT system to ensure the youth's prompt enrollment into the OhioRISE program for smooth transitions of care and claims submissions.

If the primary diagnosis on the prior authorization request initially indicated Aetna would be responsible for the claim and Aetna authorized the service, and later changes in care delivery result in the APR-DRG becoming the responsibility the MCO, per the OhioRISE Mixed Services Protocol, the MCO will accept the prior authorization approval issued by Aetna and may not require an additional prior authorization request from the hospital. If the reverse is true, Aetna will accept prior authorization approvals from MCOs in situations where the MCO first authorized the service, but the final claim's primary diagnosis and reimbursement APR-DRG identify the claim as Aetna's responsibility, in accordance with the OhioRISE Mixed Service Protocol.

Outpatient Hospital Services

As described in the OhioRISE Mixed Services Protocol, for dates of service through 12/31/2023, with the exception of services provided in the emergency department, labs and vaccines, behavioral health services defined on the Outpatient Hospital Behavioral Health (OPHBH) code list, when billed with a behavioral health primary diagnosis code, are OhioRISE plan covered services billed to Aetna. This

applies regardless of the hospital's chosen billing methodology (Enhanced Ambulatory Patient Groups (EAPG) in accordance with OAC 5160-2-75 or Outpatient Hospital Behavioral Health Services (OPHBH) in accordance with OAC 5160-2-76) for the services. This includes billing for participation in a child and family team when participation meets the requirements for the service billed.

As described in the OhioRISE Mixed Services Protocol, effective for dates of service on or after January 1, 2024, with the exception of emergency department services, outpatient hospital services that group to reimbursement EAPG categories 16, 71 or 72 are OhioRISE plan covered services and should be billed to Aetna. Hospitals with questions about EAPG methodology can reach out to Hospital_Policy@medicaid.ohio.gov. This includes billing for participation in a child and family team when participation meets the requirements for the service billed.

Information for FQHC/RHCs

BH services described in Chapter 5160-28 of the Ohio Administrative Code are paid under the Prospective Payment System (PPS). Generally, BH services represented by H-codes are not covered under the PPS. FQHCs and RHCs providing covered non-PPS BH services may also enroll with Medicaid as a CMHC (PT 84 or 95) to submit claims for these services. FQHC and RHC providers may only submit claims for non-PPS services if the service cannot be claimed as an FQHC or RHC PPS service (e.g., H-code services).

Miscellaneous Notes

In accordance with billing standards, all professional claims require the submission of a place of service code. For a complete list of place of service codes, please see CMS Place of Service Code Set.

For some OhioRISE youth there may not be an established diagnosis at the time of the service (e.g. MRSS, CANS). In these circumstances a "Z-code" ICD-10 diagnosis code may be acceptable for initial presentation, which includes reporting in accordance with national coding standards. Once a relevant diagnosis is established (typically within 30-60 days from initial presentation), the appropriate diagnosis code should be used on the claim to support the service rendered.

Ohio Medicaid covers services provided by practitioners who, under state licensing, require supervision. The types of practitioners who may supervise is determined according to the appropriate licensing board. Please review the Behavioral Health Provider Manual and the appropriate licensing board for information about provider supervision and billing requirements.