BH Managed Care Discussion – Billing and Coding Webinar Agenda
August 8, 2023

11:00 Resources, Updates, and Discussion

- **Key Resources**
  - Current BH Provider Manual (12/19/2022)
  - OhioRISE Provider Manual (12/9/22)
  - CME Manual (6/21/22)
  - ODM Press Release (7/21/23)
  - ODM Press Release (7/28/23)
  - Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
  - If you do not receive MITS Bits, be sure to subscribe for MITSBits and sign up for the BH Newsletter.

SFY 24-25 Medicaid Provider Rate Increase Update

On July 14th, 2023, the Ohio Departments of Medicaid (ODM), Mental Health & Addiction Services (OhioMHAS), Developmental Disabilities (DODD), and Aging (ODA) provided a briefing for stakeholders about the investments in Behavioral Health, Home and Community Based Services (HCBS), and Community Services contained in the SFY 24-25 budget, as well as timeline and processes for implementing provider rate increases. The Departments' highlighted the priorities of the SFY 24-25 budget, which include:

1. Helping Ohio's children get a better start in life.
2. Unprecedented support for mothers and children through the creation of the New Department of Children & Youth.
3. Significant incentives and policies to improve quality of home nursing care.
4. Historic investment in mental health services and infrastructure.
5. 988 Crisis Line funding.
6. Economic and Job development.
7. Historic increase in rates for essential healthcare and community support services.

Medicaid Rate Increases:
ODM is beginning the process of establishing provider rate increases, which will be used to ensure workforce stability and greater access to care for Medicaid recipients through increased wages and needed workforce support. ODM outlined priorities and the processes they aim to implement provider rate increases. Director Corcoran expressed an understanding of the urgency across all provider systems to get these resources into service delivery to stabilize the workforce challenges. ***As a caveat, Director Corcoran stressed that the percentage increases discussed are approximations based on aggregated data for appropriation and planning purposes, that actual rates by service/CPT***

code may vary depending on the state plan or waiver methodology that must be used, and the intent is to infuse the full allocation into provider rates for each HCBS systems.

The process to finalize rate increases will vary dependent upon whether the services are provided under waivers or non-waiver/state plans. ODM's goal is to obtain CMS approval for waiver service increases by November 12th, 2023. Non-waiver and state plan service increases will follow the public notice and rulemaking/JCARR process. The target effective date (which is subject to change) for both waiver and non-waiver/state plan service rate increases is January 1st, 2024.

ODM has developed a HB 33 Provider Rate Tracking document that provides a high-level overview of the operational issues that must be addressed and timelines for administrative rules, state plan, and/or waiver filings that will be necessary. The community BH provider rates are listed in the first line of the tracking document. Of importance, the baseline allocation includes the 10% baseline increase for community BH services (PT 84/95) proposed by the Governor plus the additional BH/HCBS direct care funding allocated in the House and sustained in the final budget. As previously shared, ODM is targeting an effective date for rate increases on January 2024, which will include rule filing with JCARR in mid-October simultaneously with updating federal state plan amendments.

OhioMHAS and ODM are collaborating to design and develop the specific rate increases for community BH services. A portion of the rate increases will be targeted toward community BH services provided by "Direct Care" workforce as directed by HB 33. OhioMHAS and ODM will be seeking feedback from providers as the rate work unfolds. Initial draft clearance rules are anticipated to be shared in August so there is ample time for review, feedback, and revision before the October JCARR filing.

Additionally, ODM and OhioMHAS provided an update about the new policy and rule work that will be used to support the new Mental health Peer Support Service. ODM & OhioMHAS anticipates rule and policy work to implement the new MH Peer Support Service will be completed by April 2024. This is due to the need to factor in additional IT changes and timelines as well as clinical/programmatic policy work. This work will build upon the OhioMHAS enhanced peer support rules to establish Medicaid policy and reimbursement. There is $30 million included in the budget to support this new service.

The briefing also walks through each state agencies' priorities, the process for updating HCBS and Aging service waivers and timelines for these services. The Ohio Council appreciates the state agencies' commitment to addressing the pressing demand for services and workforce challenges and the next steps to invent these hard sought appropriations through the budget process into provider rates.

PNM eLicense Terminations

The Ohio Department of Medicaid shared additional information related to the previous June communications regarding provider license update requirements in the PNM. ODM is

federally required to verify provider licenses monthly and conducts this through verification with eLicense. If a provider's license in the PNM is not updated to match their license in eLicense, the provider will be terminated from Medicaid and will be unable to bill for services. This termination process is most commonly impacting CDCAs due to the CDCA-PRE license and the change in license number when upgrading their license. However, this could happen anytime a provider has a license number change that is not updated in the PNM.

The PNM is designed to insert the new license date in the PNM when a license is renewed if the license number is the same. Providers should not have to update the license date span for providers who maintain the same license number when renewing their license, but it is a requirement to update this information at license renewal for all licensed providers. The listed primary contact in the PNM will receive a license expiration notice by email 30 days in advance of the license expiration listed in the PNM.

Keeping information up to date is a condition of the Ohio Medicaid Provider Agreement and a fundamental eligibility requirement for licensed practitioners. The most recent e-license verification will take place on **July 29. ODM confirmed they will run this monthly on the last Saturday of the month.** It is imperative that new licenses be added or updated for providers prior to the next e-license automated verification, or they will be terminated, and billing organizations will not be reimbursed for services rendered.

For more information
For questions regarding this notice, please call the Integrated Helpdesk (IHD) at 800-686-1516 and select option 2; option 2 for provider enrollment. Representatives are available 8 a.m.-4:30 p.m. Eastern Time Monday-Friday.

PNM Refresher Trainings and Updated Claims and PA FAQ

The Ohio Department of Medicaid announced an updated Claims and PA FAQ and additional opportunities for PNM refresher trainings. Registration is open through the LMS for the **August 16-23** PNM module refresher trainings. The training schedule is available. This is an opportunity to send staff for training and to ask questions. Training module topics include:

- Account administration and dashboard
- New enrollment
- Affiliations
- Updates
- Revalidation

Effective 8/9/23 the PNM will add a reporting option to download a list of your organization's dashboard to an excel or PDF report.

PNM System Administrator Change Request Form

The Ohio Department of Medicaid published a form for providers to request a change to their system administrator in the PNM. Each Medicaid ID can only have one active

administrator. If a provider moves to another organization or you have a staffing change that would require changes in PNM administrators ODM requires approval from the provider to change the administrator. Organizations should send the completed form to pnmsupport@medicaid.ohio.gov with the subject link "Administrator Change Request".

PNM Provider Update Email Template

Template emailed to: MEDICAID_PROVIDER_UPDATE@medicaid.ohio.gov

When to use the template:

1. Request Medicaid enrollment effective date be backdated
2. Add secondary or tertiary credentials to existing enrollment
3. Add or update education markers for paraprofessional provider types
4. Change specialty effective dates if you are unable to do so within the PNM yourself

Remember to attach supporting documentation for your request. (i.e. If you are adding a QMHS to a CDCA – you must submit a POE letter along with a copy of the provider's education/degree)

Hello,

Please update the following provider's record:

Provider Name	
Provider NPI	
Provider ID #	
Requested Action	
Requested Action Effective Date	
Supporting Document(s) Attached	

Please Note: *This request is unable to be completed using the self-service features within the PNM. ODM assistance is needed to complete this request.*

PNM/EDI Support

- PNM questions call 1-800-686-1516, option 2

- EDI questions
    - Related to 999, 824, or TA1 rejections call 1-800-686-1516, option 4 or email OMESEDISupport@medicaid.ohio.gov with the information below:
        - EDI 837 file name submitted by the trading partner
        - Trading partner ID (from the clearinghouse or billing company)
    - Related to any other rejection, call the payer
- Trading partner support guide

  Every clearing house works differently. OMES EDI works with more than 500 clearing houses. So, it is most important for them to get specific information to narrow research to assist any call or email. Their system is connected to the clearinghouses and they send an acknowledgement on every step of claims to trading partners. Clearinghouses should assist provider for any rejection as OMES EDI explain errors.

  OMES EDI will also help providers if they have all information they need to research. As per our inquiries every day most of the providers do not have the necessary information and calls end up with frustration. In these cases, they request providers have their clearinghouse contact OMES EDI to better assist.

Medicaid Annual Open Enrollment Information

Ohio Department of Medicaid (ODM) announced resources for annual managed care open enrollment, which allows Medicaid members the opportunity to select a new plan.

Open enrollment for the 2024 plan year runs from November 1 through November 30. A new plan can be selected by using the Ohio Medicaid Consumer Hotline Portal at www.ohiomh.com or by contacting the Ohio Medicaid Consumer Hotline at 800-324-8680**.** Representatives are available 7am – 8pm Monday - Friday and Saturdays 8am – 5pm.

Medicaid members who want to stay with their current healthcare plan, do not have to take any action during open enrollment.

Open enrollment letters will be mailed from Ohio Medicaid between July and November to notify members of the open enrollment period, plans available, and how to change their plan.

During this same period that Ohio Medicaid is sending open enrollment reminders, Medicaid membres may also receive an Ohio Medicaid renewal packet. Renewing eligibility for Medicaid is separate and different from open enrollment. Members who receive a renewal packet, must complete it to keep coverage. To learn more, visit https://medicaid.ohio.gov/stakeholders-and-partners/covidunwinding/members/members.

Resources available to help members select a plan or answer questions

- The Ohio Medicaid Consumer Hotline website provides a variety of information about managed care plans and allows Medicaid members to change their plan online.
- The Health Plan Comparison provides an overview of the services that all managed care plans provide, and specific value-added services provided by each individual plan. This document is updated regularly to keep a complete list of benefits, and a new version will be available in September.
- The Find a Provider search tool can help identify which managed care plans providers are contracted or "in network" with.
- **Each managed care plan has a member website** to learn more about their approach to serving Ohio Medicaid managed care members:
    - AmeriHealth Caritas Ohio, Inc.
    - Anthem Blue Cross and Blue Shield.
    - Buckeye Health Plan.
    - CareSource Ohio, Inc.
    - Humana Healthy Horizons in Ohio.
    - Molina HealthCare of Ohio, Inc.
    - UnitedHealthcare Community Plan of Ohio, Inc.
- The open enrollment frequently asked questions (FAQ) provides answers to the most common questions related to open enrollment.
- The Ohio Medicaid managed care member FAQ provides answers to the most common questions related to the managed care program.

The Ohio Medicaid Consumer Hotline at 800-324-8680 is available for questions or assistance.

As a reminder, providers cannot tell clients which plan to choose. However, you can provide your clients with these resources and inform them of which plans you are in network with.

2024 Medicare Physician Fee Schedule Proposed Rule

On July 13, 2023 the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2024. Comments can be submitted electronically at https://www.regulations.gov/ by 5pm on Monday September 11, 2023. The CMS fact sheet outlines many proposed changes, the items impacting behavioral health providers are included below.

Behavioral Health Services - Adding Counselors and Therapists as Eligible Providers

For CY 2024, CMS is implementing Section 4121 of the Consolidated Appropriations Act (CAA), 2023, which provides for Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. Counselors and therapists will have to be independently licensed, like social workers are required to be currently, to enroll as Medicare providers. The proposed definition of counselor and therapist is on page 331-333 of the proposed rule. Additionally, CMS is proposing to allow addiction counselors that meet all of the applicable requirements to be an MHC to enroll in Medicare as MHCs. ***CMS is proposing to allow MFTs and MHCs to enroll in Medicare after the CY 2024 Physician Fee Schedule final rule is published later this year, and they would be able to bill Medicare for services starting January 1, 2024, consistent with statute.***

CMS is also implementing Section 4123 of the CAA, 2023, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) furnished on or after January 1, 2024. Section 4123 of the CAA, 2023 specifies that the payment amount for these psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (Psychotherapy for crisis; first 60 minutes) and 90840 (Psychotherapy for crisis; each additional 30 minutes — List separately in addition to code for primary service), and any succeeding codes.

Additionally, CMS is proposing to allow the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. Health Behavior Assessment and Intervention codes are used to identify the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems. Proposing to allow a wider range of practitioner types to furnish these services would allow for better integration of physical and behavioral health care, particularly given that there are so many behavioral health ramifications of physical health illness.

CMS is also proposing an increase in the valuation for timed behavioral health services under the PFS. Specifically, they are proposing to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which they are proposing to implement over a four-year transition. This proposal, if finalized, would begin to address potential distortions that may have occurred in valuing time-based behavioral health services in the past.

Finally, CMS is specifically seeking comment on ways they can continue to expand access to behavioral health services and requesting information on digital therapies, including digital cognitive behavioral therapy.

The Ohio Council is working with ODM on providing details on how the addition of counselors and therapists will impact the TPL bypass list and coordination of benefits and will share more information with members as it becomes available.

Telehealth Services under the PFS

CMS is proposing to implement several telehealth-related provisions of the CAA, 2023, including the temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home; the expansion of the definition of telehealth practitioners to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists; the continued payment for telehealth services furnished by RHCs and FQHCs using the methodology established for those telehealth services during the PHE; delaying the requirement for an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs; and the continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024.

CMS is proposing that, beginning in CY 2024, telehealth services furnished to people in their homes be paid at the non-facility PFS rate to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.

CMS is proposing to continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024. They believe that extending this definition of direct supervision through December 31, 2024, would align the timeframe of this policy with many of the previously discussed PHE-related telehealth policies that were extended under provisions of the CAA, 2023. CMS is soliciting comments on whether they should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, they are interested in input from interested parties on potential patient safety or quality concerns when direct supervision occurs virtually.

Collectively, these proposed policies, if finalized, would continue many of the flexibilities that practitioners have had during the PHE to furnish telehealth services until the end of 2024, as per statutory requirements. Telehealth services, both audiovisual and audio-only, have enabled individuals in rural and underserved areas to have improved access to care.

Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)

For CY 2024, CMS is proposing coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. Specifically, they are proposing to pay separately for

Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. While these care support staff have been able to serve as auxiliary personnel to perform covered services incident to the services of a Medicare-enrolled billing physician or practitioner, the services described by the proposed codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists.

Principal Illness Navigation services are to help people with Medicare who are diagnosed with high-risk conditions (for example, mental health conditions, substance use disorder, and cancer) identify and connect with appropriate clinical and support resources. ***CMS is further clarifying that the community health workers, care navigators, peer support specialists, and other such auxiliary personnel may be employed by Community-Based Organizations (CBOs) as long as there is the requisite supervision by the billing practitioner for these services, similar to other care management services.***

Opioid Treatment Programs (OTPs)

CMS is proposing to extend current flexibility for periodic assessments that are furnished via audio-only telecommunications through the end of CY 2024. CMS would allow OTPs to bill Medicare under the Part B OTP benefit for furnishing periodic assessments via audio-only telecommunications when video is not available to the beneficiary, to the extent that use of audio-only communications technology is permitted under the applicable SAMHSA and DEA requirements at the time the service is furnished, and all other applicable requirements are met. CMS believes extending these flexibilities by an additional year (through CY 2024) may promote continued beneficiary access for these services by minimizing potential disruptions to services due to the end of the COVID-19 PHE. This extension would also better align telehealth flexibilities for OTPs with telehealth flexibilities authorized for certain other settings under the CAA, 2023.

Plan Specific Updates/Issues

- Anthem – Anthem is hosting summer provider orientation sessions on 8/9/23 at 2pm and 9/18/23 at 1pm. To register for either date, click here. Additionally, Anthem shared information on their claims escalation, dispute, appeal process.
- Molina – Molina is hosting provider orientation and billing trainings more information is available in their August Provider Bulletin

Provider Issues and Escalation:

- Continue to send specific claims issues and examples (ICNs) directly to the MCPs and escalate if no response within 72 hours. (***MCO Escalation Contact List***)
- ODM Escalation via the **ODM Managed Care Provider Complaint Form: https://providercomplaints.ohiomh.com/**

Please use the MCP escalation contact and report unresolved issues directly to ODM – ODM uses these complaints to track and understand provider complaints.
This process is the best opportunity to document the extent of the continuing billing and payment issues. If you have an assigned ODM primary contact person – use them!

- **Ohio Department of Insurance:** Complaints about failure to follow basic insurance processes, credentialing issues, and timely payment can be lodged with ODI, more information is on ODI's provider complaint page.

  Additionally, ODI created a MH & SUD Benefits Toolkit with helpful information for consumers who want to file a complaint and providers who want to file a complaint on behalf of a consumer or anonymously.

- **Open Discussion: Specific Issues or Concerns**

NEXT WEBINAR:

- **Ohio Council Monthly Billing Webinar - Tuesday September 12, 2023 from 11:00am-12:30pm. Click here to register.**

12:30 Adjourn

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HISTORICAL INFORMATION

AUGUST 2022

- **Ohio Medicaid's Next Generation Staggered Implementation Plan**

ODM announced it will begin to launch its Next Generation Medicaid program beginning July 1, 2022, with the implementation of OhioRISE, a coordinated care program for children with complex behavioral health needs. Other Medicaid procurement initiatives will be implemented in the following months on a staggered basis to keep the focus on the individual and honor member choice to allow for a smooth transition. This staggered start also ensures continuity of care, limits confusion, and reduces complexities surrounding the anticipated end of the federal public health emergency (PHE) and provides the necessary time for provider testing and training.

The phased implementation will occur in three stages:

- Stage 1: On July 1, **OhioRISE** began to provide coordination and specialized services to help children and youth with behavioral health needs who receive care across multiple systems. This builds on the work already underway including the selection and launch of a statewide network of community-based care management entities, the design and build of a centralized technology for the Child and Adolescent Needs and Strengths assessment tool, transition grant funding to Care Management Entities (CMEs) and MRSS providers (Mobile Response and Stabilization Services) to launch new OhioRISE services and support provider and workforce development; and the completion of extensive community and provider training sessions.
    - As a reminder, OhioRISE is a Medicaid program for youth under 21 with severe BH needs. Youth enrolled in OhioRISE will have 2 Medicaid plans. OhioRISE for all BH services (with the exception of ED services) and their original MCO for all physical health services. ODM created this guidance that outlines which plan is responsible for which type of service. Medicaid members in OhioRISE will still have one Medicaid card. See below for the example Molina shared last week.

- Stage 2: On October 1, 2022, Centralized Provider Credentialing will begin through the Ohio Medicaid Enterprise System (OMES) Provider Network Management (PNM) module, which will reduce administrative burden on providers. Also, the Single Pharmacy Benefit Manager (SPBM) will begin providing pharmacy services across all managed care plans and members.
- Stage 3: On December 1, 2022, ODM will finish implementing the Next Generation program with all seven Next Generation managed care plans beginning to provide healthcare coverage under the new program. ODM will also complete the OMES implementation including the Fiscal Intermediary (FI) which will simplify and streamline the provider process for submitting claims and prior authorizations.

With the delay of the implementation of the Fiscal Intermediary, claims for OhioRISE must be sent directly to Aetna. Aetna hosted training sessions for providers detailing the claims submission process, the slides are available. **For Aetna OhioRISE, the clearinghouses they use to accept claims submissions are Change Healthcare and Office Ally – providers are NOT able to submit claims directly though Availity.** Availity is the provider portal for Aetna/OhioRISE only. Providers may use Availity to check claims status, remittance advices, appeals, authorizations, etc., but they cannot submit claims via Availity. Providers contracting with a clearinghouse to bill claims should ensure their clearinghouse is compatible with Change Healthcare or Office Ally. Aetna/OhioRISE (payer ID 45221). However, provider should be aware that Change Healthcare's service portal, ProviderNet, has recently experienced an outage starting mid-July. Access to some services are now back online effective 8/8/22. The ProviderNet portal is now available, with features being limited to view and download EOP and 835/ERA.

- **Only existing, authenticated users of ProviderNet can be verified and regain access.**
- New enrollments are not being accepted at this time, with no date of restoration .
- Email Change Healthcare at WCO.Provider.Registration@ChangeHealthcare.com.
- See the specific request process on the providernet.adminisource.com/Start.aspx.

Is your organization experiencing issues with billing to Aetna for OhioRISE?
To keep up to date with the Next Generation of Ohio Medicaid, visit managedcare.medicaid.ohio.gov and subscribe to ODM's email updates here. Questions can be sent to ODMNextGen@medicaid.ohio.gov.

- **ODM Next Generation Stage 2 Training & PNM Updates**

PNM Access/Registration
On July 20, the Ohio Department of Medicaid (ODM) hosted a webinar outlining the next two phases of the staggered implementation of the Next Generation of Medicaid. The Next Generation Medicaid strategy includes the implementation of the Ohio Medicaid Enterprise System (OMES) which will replace most functionalities in MITS. OMES includes several modules including the Provider Network Management (PNM) module, the Fiscal Intermediary (FI), and the Single Pharmacy Benefit Manager (SPBM). After all phases of the Next Generation of Medicaid are implemented, providers will no longer utilize MITS for provider enrollment, claims submission, or prior authorization. The slides and recording from the training are now available on the ODM Next Generation Provider website. Information on the PNM start on slide 17.

The PNM is the new Medicaid provider enrollment and data management system that will replace MITS. An OH|ID will be required to access the PNM October 1. However, this is only necessary for staff who need access to the system to complete provider enrollment, provider credentialing, eligibility verifications, or prior authorizations. If you have staff who manage the enrollment/credentialing for your Medicaid providers, only those staff will need an OH|ID. Staff who already have an OH|ID, will be able to connect using their existing account either through the PNM pre-registration period or at go-live (10/1/22). The PNM pre-registration period is August 15 - September 23.

How do I access the PNM Pre-Registration tool?

Please visit **https://pnm-preregistration.omes.maximus.com** to access the PNM Pre-Registration tool directly. You can also access the PNM pre-registration tool through a link on the **PNM & Centralized Credentialing page**. From there, you will be able to begin the pre-registration process. For providers who have already created an OH|ID, the pre-registration process will only take a few minutes as you will simply connect your existing account to the PNM module.

What should I do if I don't have an OH|ID yet?

The PNM Pre-Registration tool will automatically redirect you to the OH|ID account creation site, but you can also create an OH|ID in just a few minutes using the steps below:

1. Go to myohio.gov.
2. Fill in the appropriate fields with user information and create account.
3. An email confirmation will be sent following registration.
4. Once you have logged in, please fill in the required fields with the correct security information and address any error messages that appear if you complete the security questions unsuccessfully.

Provider Credentialing

Starting October 1, new credentialing requirements for Medicaid providers will become effective as outlined in ODM's new credentialing rule (5160-1-42). This rule implements national credentialing standards for **independently licensed providers and certain facilities** and will be required as part of centralized credentialing and the transition to the PNM. This rule provides the process and requirements ODM, or its credentialing designee, will follow for applicable providers that require credentialing for their specific provider type.

ODM plans to align initial credentialing for independently licensed providers already enrolled with Medicaid with the provider's Medicaid revalidation date and is currently planning to resume provider revalidation beginning October 1. Providers will receive a letter from ODM 90 days in advance of their revalidation date and organizations can check the ODM Provider Revalidation website, which will include a list of upcoming provider revalidations once the process resumes. Independently licensed providers will complete one application in the PNM that will cover both the credentialing and enrollment/revalidation requirements. Providers can prepare for the credentialing process now by ensuring independently licensed practitioners have established profiles with the Council for Affordable Quality Health (CAQH), as this is a requirement of the ODM credentialing rule.

PNM Provider Training

In preparation for PNM (Stage 2) go-live October 1, 2022, ODM is offering a variety of training options including self-paced, virtual, and in-person training options. Absorb, the Learning Management System (LMS), is where you will access the self-paced training and sign up for the virtual and/or in-person sessions. All BH providers are encouraged to sign up for these training opportunities.

Training sessions are scheduled to begin August 1, 2022, and you must create an account in the LMS to ensure you have access to all training sessions, answer forms, and PNM resources in advance. Behavioral Health Organizations will sign up using the following link https://ohiopnm.myabsorb.com?KeyName=bhorgprovider. Please email ohiotrainingteam@maximus.com with any questions regarding training sessions or additional information.

MITS Blackout Period
Effective August 1, 2022, ODM stopped accepting **NEW** provider enrollment applications the MITS Provider Enrollment System to allow for transition of information to the PNM. Beginning August 31, all provider demographic and agent maintenance **update** functionality will be closed for conversion of data in MITS. Enrolled providers should update their demographic information in MITS by August 30 or plan to hold updates until October 1. During the second phase of implementation, providers will continue to be directed to MITS for fee-for-service claims submission and prior authorizations, and to check Medicaid member eligibility.

As outlined above, the temporary pause for new Medicaid provider enrollment will be from August 1 to September 30, and the temporary pause in making changes to currently enrolled providers will be from August 31 to September 30. ODM shared that their current provider enrollment rule 5160-1-17.4 states that the effective date of a new provider agreement may be made retroactive for up to 12 months prior to the date of application if the provider was properly licensed or certified, and it is anticipated that ODM will backdate those provider enrollments during this time frame.

Effective October 1, 2022, all provider enrollment applications must be submitted using Ohio Medicaid's new Provider Network Management (PNM) portal. After its implementation, the PNM portal will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service. We are awaiting confirmation from ODM on the anticipated timeframe for provider enrollment applications to be approved in through the PNM. For more information about PNM and trainings, please visit: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

PNM OhioRISE Provider Enrollment Transition Process: August 1 – September 30

New OhioRISE Medicaid Provider Enrollment (Entity or Individual Rendering Provider)

- Provider contacts Aetna at ohrise-network@aetna.com to identify providers needing new Medicaid provider enrollment.
- Aetna works with provider to gather necessary provider contracting and/or application forms, screening forms, and required documentation. Upon completion of application materials, Aetna sends completed documents to ODM via secure email.
- ODM completes required screening and database reviews and determines Medicaid enrollment.
- If at any time the provider doesn't pass screening, ODM will issue appropriate notice with appeal/due process.
- Before 8/31: ODM will issue welcome letter for providers passing the screening process. Aetna will also be copied. The Provider Master File (PMF) will be updated with new provider active Medicaid enrollment and shared with Aetna/OhioRISE and all Medicaid MCOs. Providers may send claims upon payer update from PMF.
- On & After 8/31: ODM will notify the provider via e-mail their application passed screening with the expected enrollment date based on the application. Aetna will be copied. ODM will HOLD the welcome letter and Medicaid Provider number will be

issued after 10/1. ODM will send a provider supplemental file to Aetna and all Medicaid MCOs weekly with provider information. Providers may send claims upon payer update from the supplemental file.
- After 10/1: ODM will manually update the PNM with backdated provider enrollment date from September, issue Welcome letter and Medicaid ID, and send PMF to Aetna/OhioRISE and all Medicaid MCOs.

Currently Enrolled OhioRISE Provider Updates and Adding OhioRISE Specialties

- Before 8/31: Providers will continue to use the MITS provider portal to update affiliations, add credentials, and update contact information as usual. To add an OhioRISE specialty, providers should email ODM at Medicaid_Provider_Update@medicaid.ohio.gov and include the appropriate documentation for each OhioRISE specialty. See the OhioRISE Provider Enrollment and Billing Guidance document (Section 1).
- On & After 8/31: Provider contacts Aetna at ohrise-network@aetna.com to identify providers needing to add OhioRISE specialties and include the provider NPI, Ohio Medicaid ID, and required documents per the OhioRISE Enrollment and Billing Guidance document. Aetna will review and confirm appropriate information is included then e-mail the ODM provider enrollment team. ODM will review the provider request, complete any required screening and notify the provider via e-mail and copy Aetna of approval with expected enrollment date. ODM will send a provider supplemental file to Aetna and all Medicaid MCOs weekly with updated provider information. Providers may send claims upon payer update from the supplemental file.
- After 10/1: ODM will manually update the PNM with backdated provider specialty enrollment date from September and send the updated PMF to Aetna/OhioRISE and all Medicaid MCOs.

- **ODM Next Generation Stage 3 Claims Submission Transition Updates**

Prior Authorizations
Until ODM begins accepting prior authorization requests through the OMES PNM portal on December 1, 2022, prior authorizations will continue to be submitted following the prior authorization submission guidance outlined by the applicable MCO. Once the OMES modules go live in stage 3, prior authorizations will be submitted through the PNM. Additional details about training for stage 3 are forthcoming.

Submitting Claims (information starts on slide 58)
Until December 1, 2022, provider claims will continue to be submitted to each Medicaid MCO according to the MCO billing guidance. On December 1st, ODM will begin accepting claims through the Ohio Medicaid Enterprise System (OMES) modules – the PNM portal for managed care claims, and the Single Pharmacy Benefit Manager (SPBM) module for pharmacy claims. The PNM, SPBM and EDI are all OMES modules. EDI will be accessed by trading partners and the PNM and SPBM include the portal capabilities for providers. Only authorized trading partners will be able to exchange EDI transactions. Providers who wish to become their own trading partner will be able to enroll after the Stage 3 go-live. The

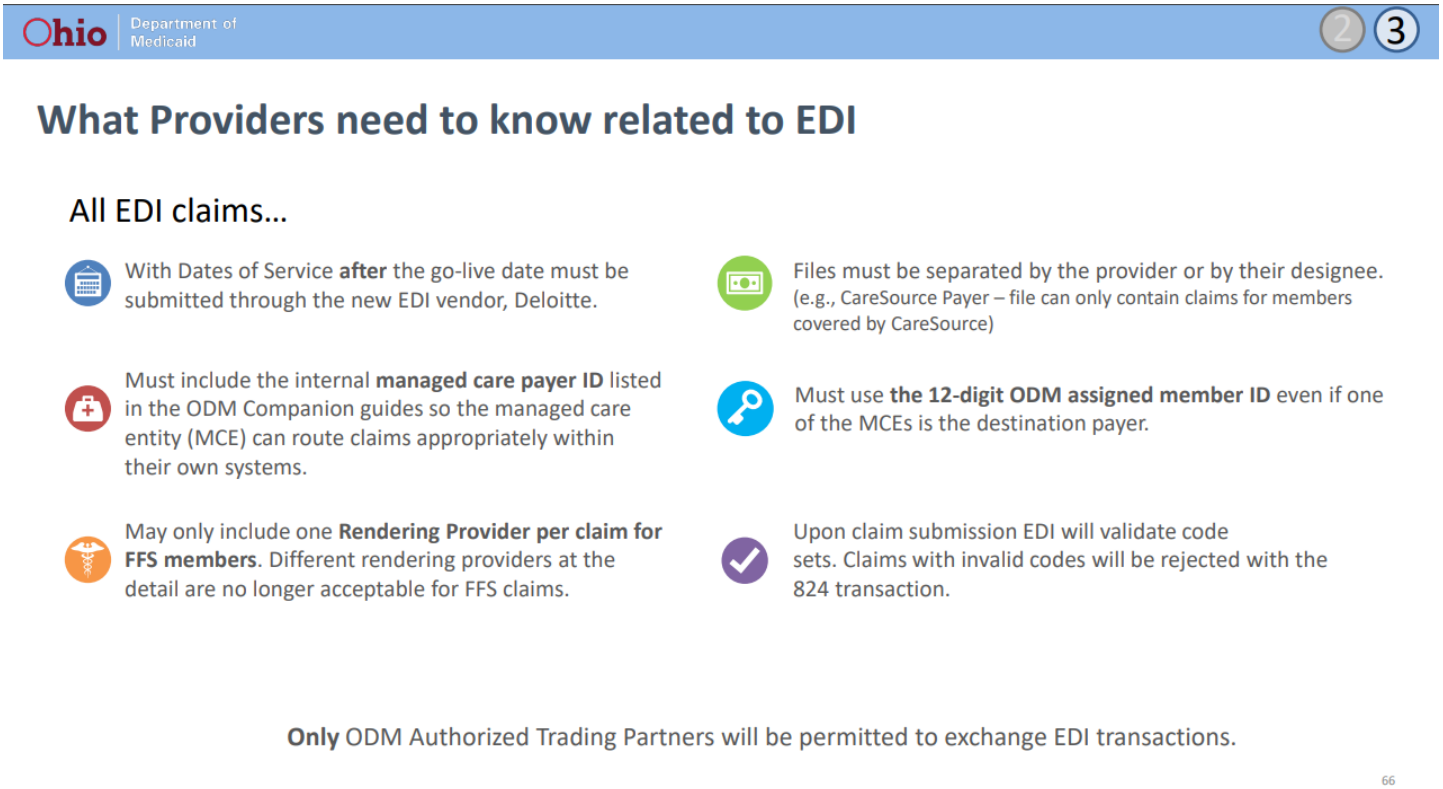
Fiscal Intermediary (FI) is used in the "back end" by ODM to collect data from items submitted through EDI or PNM; neither trading partners nor providers interact directly with the FI.

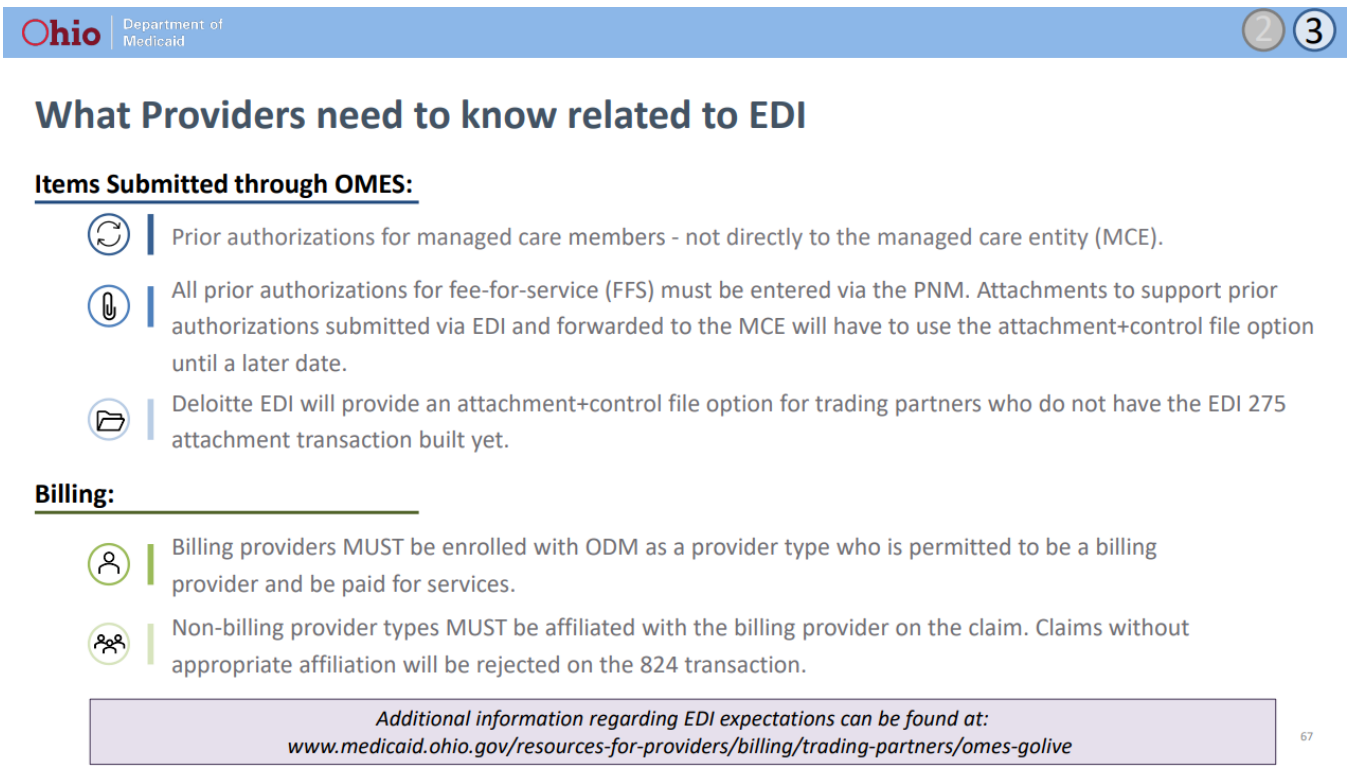
Starting December 1, 2022, Medicaid Managed Care (including OhioRISE) and FFS claims will be submitted through the PNM. (*As a reminder, MyCare Ohio claims and prior authorizations are not included in this transition and will continue to be sent to the MyCare Ohio managed care plan*).

Upon submission of claims and prior authorizations by providers and trading partners to the Provider Network Management (PNM) portal or Electronic Data Interchange (EDI), Fiscal intermediary (FI) will facilitate processing for these transactions. In coordination with EDI, FI will assist in transitioning claims and authorizations to Ohio Medicaid's managed care entities as well as receive updates back from those organizations so providers can receive appropriate updates, making the process more transparent and efficient. The Fiscal Intermediary will also provide ODM with greater insight into claims and prior authorizations requests, allowing ODM to more effectively identify and address trends.

Payments related to FFS recipients will be coming from Medicaid through the Fiscal Intermediary. MCEs are still responsible for processing, adjudicating and paying claims related to managed care recipients. Pharmacy claims related to managed care recipients will come from the SPBM.

EDI Module (information starts on slide 64)
Only authorized trading partners will be able to exchange EDI transactions. EDI claims transactions must only contain claims destined for the same payer (ODM/FFS or the MCE). Each payer has specific identifiers that must be included in the file so that EDI will know where to direct the claims for adjudication. Those identifiers are available in the EDI companion guides (Future OMES Encounters). Providers who wish to receive the 835 Electronic Remittance Advice (ERA) must enroll for the 835 with ODM. If you are already enrolled for FFS, you do not need to re-enroll. We recommend providers that are using a clearinghouse, reach out to their vendor to ask about their preparations for working with ODM and the FI.





- **ODM Next Generation MCP Comparison Tool**

To assist Ohio Medicaid managed care members in choosing which Next Generation plan is the best fit for their healthcare needs, the Ohio Department of Medicaid has introduced the

Next Generation Health Plan Comparison document. The Next Generation Health Plan Comparison document provides an overview of the services that all Next Generation managed care plans provide, and specific value-added services provided by each individual plan.

Current Ohio Medicaid managed care members who do not select a plan will stay with their current plan, with the exception of Paramount members. Paramount Advantage Medicaid has been acquired by Anthem Blue Cross and Blue Shield (Anthem). Anthem is working with Paramount Advantage to continue providing healthcare coverage and Medicaid members will continue receiving healthcare coverage through Paramount Advantage until the Next Generation managed care plans begin providing healthcare coverage on 12/1/22. At that time Anthem will be their Next Generation managed care plan. Medicaid members do not need to take any action to begin receiving healthcare benefits through Anthem and there will be no disruption in care. All Ohio Medicaid managed care members can select a different plan at any time until the end of open enrollment through Nov. 30.

- **SUD Residential Treatment Notification of Admission Form**

The Ohio Department of Medicaid (ODM) has released a standardized form and process for providers of residential treatment for substance use disorders (SUD) to notify managed care entities (MCE) that a Medicaid member has been admitted for treatment.

The form was developed by a workgroup of the SUD 1115 Waiver Stakeholder Advisory Committee including SUD residential treatment providers, Medicaid MCEs, SUD advocacy organizations, and staff of ODM and the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

The goals of using the form are:

- To notify MCEs of the admission of one of their members to SUD residential treatment;
- To connect MCEs with SUD residential providers to assist with care coordination and discharge planning as early as possible;
- To notify SUD residential providers if the client had previous SUD residential stays in the same calendar year, which may necessitate prior authorization for the current stay.

Although the use of this new form is voluntary, ODM strongly recommends its use to support improved client care coordination between MCEs and SUD providers.
The standardized process associated with using the form is:

1. The SUD residential provider will complete sections I and II of the SUD Residential Treatment Notification of Admission Form within 48 hours of admission and submit it to the member's MCE using the contact information on the form;
2. MCEs will complete Section III of the form and return it to the provider within 24 hours.

Questions regarding the new form and process may be submitted to: BH-Enroll@medicaid.ohio.gov.

- **Ohio Department of Insurance "Understanding MH Insurance Benefits" Webinar**

The Ohio Department of Insurance's new Mental Health Insurance Assistance Office is conducting free, live webinars in August to help consumers and healthcare professionals understand the mental health and substance use disorder insurance benefits that may be in a consumer's health plan, the role insurance may play in receiving treatment, and provide an overview of the new Mental Health Insurance Assistance Office.

During the webinars, department experts will explain how the department regulates mental health and substance use disorder insurance benefits. They will help consumers and healthcare professionals understand how to determine these benefits in a health plan. And they will provide a tutorial about the department's mental health and substance use disorder insurance benefits information and services, including how to file a complaint and appeal a denied claim.

The webinars:

- Consumer Tips for Understanding Mental Health Insurance Benefits
  - Aug. 16, 12 p.m. – 1 p.m.; Register
- **Understanding Mental Health Insurance Benefits for Healthcare Professionals**
  - Aug. 23, 12 p.m. – 1 p.m.; Register (Geared to behavioral health providers, billing staff, and other administrative professionals)

Department mental health insurance experts are available at 1-855-GET-MHIA, getmhia@insurance.ohio.gov and www.insurance.ohio.gov/getmhia .

- **Down-Coding of E/M Claims**

We have been informed by several members and billing partners that there has been a resurgences in down-coding of E/M codes by insurance plans, specifically Anthem and Aetna. This has become a new utilization management practice, where the plan will review selected E/M claims to "determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is higher than the E/M code level supported on the claim." If they determine E/M code level submitted is higher than the E/M code level supported on the claim they automatically down-code it without requesting documentation from providers. Providers must then appeal these claims.

We are in discussion with ODM related to the Aetna MyCare downcoding. In the meantime, if you are experiencing this issue, we recommend the following:

- Make sure you have appropriate documentation to support the code billed and if so, then appeal the impacted claims with the plan.
- Review the plan's claims or provider manual for a policy on down-coding.
- Review your contract with the plan to ensure this is not included in your contract.
- Contact the plan's provider relations department in writing (letter/email) requesting written details of their policy and how they are determining a lower code without first reviewing clinical documentation. Explain you are a behavioral health provider, and your clients often have more complex needs leading to higher levels of E/M codes. Indicate you are following federal and contractual obligations to code the services you bill in accordance with the service level provided and can provide documentation upon request. Include any information on the number of claims and time this is taking to emphasize the administrative burden.

- Consider if a complaint to ODI is appropriate (see the link for details on appropriate complaints). This could be appropriate for a contract complaint if the plan is regulated by ODI.

- **OhioRISE Program Launch**

As you know, the OhioRISE program launched Friday 7/1/22. The Ohio Department of Medicaid (ODM) is committed to making the launch and ongoing implementation of the OhioRISE program as smooth as possible. Representatives on ODM's, Aetna's, and the Ohio Medicaid's managed care organizations' help desk hotlines are prepared to assist providers with all OhioRISE-related questions.

For Ohio Medicaid-related questions, please contact ODM's Integrated Help Desk (IHD) at 800-686-1516, which is available Monday through Friday 8 a.m.-4:30 p.m. IHD's Interactive Voice Response System (IVR) provides 24/7/365 access to information regarding client eligibility, claim and payment status, and provider information. Agents on the IHD hotline will be able to assist with issues and questions related to:

- Using the Child and Adolescent Needs and Strengths (CANS) assessment tool and CANS IT system.
- Medicaid Information Technology System (MITS).
- General Medicaid member eligibility questions.
- General Medicaid payment/billing questions and issues.
- Enrolling as an Ohio Medicaid provider.

For OhioRISE specific-questions, please contact Aetna's OhioRISE Provider Experience Help Line at 833-711-0773 (option 2), which is available Monday through Friday 7 a.m.-8 p.m. OhioRISE Provider Experience Help Line representatives are available to assist you with issues and questions related to:

- Contracting with Aetna/as an OhioRISE Plan provider.
- OhioRISE member claims, payment/billing questions and issues.
- OhioRISE member prior authorization.
- Verifying a member's OhioRISE eligibility.

ODM has expressed appreciation that providers contracted with ODM and Aetna to deliver OhioRISE's new and enhanced services to enrollees, and continue to encourage additional providers to consider offering care to OhioRISE enrollees by enrolling as a Medicaid provider with appropriate specialties and contracting with Aetna. Until Ohio Medicaid's Next Generation Program is fully implemented later this year, providers must submit claims and prior authorizations for youth enrolled in OhioRISE directly to Aetna. ODM's OhioRISE Provider Enrollment and Billing Guidance provides service-level information about billing Aetna for the new and enhanced services as well as guidance about submitting claims to Aetna for existing services. Aetna's provider training and ODM's Module 3 training are additional resources available to help providers obtain appropriate reimbursement for behavioral health services rendered to OhioRISE enrollees.

As a reminder, providers must be contracted with Aetna for OhioRISE. However, in the first 90 days of the program, Aetna will pay claims regardless of contract status. After

9/30/22, if a provider is not contracted with Aetna for OhioRISE and bills a claim, this claim will be denied. It is important for providers serving youth to begin the contracting process if you have not done so already.

ODM is hosting OhioRISE implementation office hours to provide opportunities for providers and stakeholders to raise additional questions to OhioRISE subject matter experts to help implement and operationalize the program. **All community partners and providers are invited to attend these office hours available each Tuesday from 2-3 p.m. starting July 5 to August 30.**

Meeting Date and Time	**Meeting Link**
Every Tuesday from 2-3 p.m. starting July 5 to August 30	Click here to join

Additionally, to assist members with this implementation and necessary changes, The Ohio Council in collaboration with the Child & Adolescent Behavioral Health Center of Excellence created an OhioRISE operations implementation checklist. This resource outlines the operational and billing changes organizations should consider, links to OhioRISE resources, and contact information for the CMEs and Aetna teams.

For more information and regular updates about the OhioRISE launch visit the OhioRISE Launch Information page of the OhioRISE webpage. Additional resources for OhioRISE community partners and providers can be found on the Resources for Community Partners and Providers page of the OhioRISE webpage.

- **Opportunities for Collaboration between Behavioral Health Providers and OhioRISE Care Management Entities**

As the OhioRISE program ramps up, ODM wants to alert BH providers that an OhioRISE Care Management Entity (CME) may reach out for assistance connecting with an OhioRISE member to engage them in the wraparound care coordination process. For example, the CME may ask you to provide contact information for an OhioRISE member if the information they have on file for a new enrollee seems to not be valid. Due to the PHE, Medicaid members have not had to recertify for Medicaid and ODM may not have the best contact information for OhioRISE enrollees. BH providers can help with this effort by making these connections. If your organizational privacy practices allow for exchange of information for care coordination, you do not need a release of information to provide information to Aetna or the CMEs. This chart provides additional information about some of types of interactions that may occur between behavioral health treatment providers and OhioRISE Care Coordinators from CMEs and Aetna.

- **CANS Assessors Still Needed**

The Ohio Department of Medicaid (ODM) shared the August and September Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) training dates for those who would like to pursue Ohio Children's Initiative CANS assessor certification. ODM launched OhioRISE (Resilience through Integrated Systems and Excellence), Ohio's

first-ever highly specialized behavioral health program for children and youth with complex behavioral health needs who are served by Medicaid, on July 1. The OhioRISE program uses the Ohio Children's Initiative CANS tool to establish eligibility and support ongoing care planning. We encourage organizations providing services to youth to consider adding this service.

- **Managed Care Plan Specific Updates**
  - CareSource & Buckeye – Pharmacy Denials due to no Contract for currently contracted organizations/providers
  - Paramount – claims payment
  - Plan specific issues/concerns?

SEPTEMBER 2022

- **Ohio Medicaid's Next Generation Implementation – OMES**

What is OMES? - The Next Generation Medicaid strategy includes the implementation of the Ohio Medicaid Enterprise System (OMES), which is a modular system that will support the goals of modernization and replace MITS. OMES has several modules, including the Provider Network Management (PNM) module, the Electronic Data Interchange (EDI) module, and the Single Pharmacy Benefit Manager (SPBM) portal. After October 1st, providers will no longer utilize MITS. Providers will only be able to access Medicaid Information Technology System (MITS) through the Provider Network Management (PNM) module effective October 1. Once logged on to PNM, providers will be automatically redirected to MITS functionality for secure portal functions that are still within MITS. After December 1, all remaining MITS functionality will be fully integrated within the PNM and the Electronic Data Interchange (EDI) if utilizing a trading partner.

- **ODM Next Generation Stage 2 Training & PNM Updates**

ODM Next Generation Overview Training

ODM hosted the Next Generation Ohio Medicaid Program Provider Overview Webinar in July, which covered the changes Ohio Medicaid providers can expect, including an overview of the transition to the Ohio Medicaid Enterprise System (OMES) modules, training plans and dates, and where providers can receive communications from ODM throughout the Next Generation transition and staggered implementation. The slides and recording from the training are now available on the ODM Next Generation Provider website. Additionally, ODM has shared the FAQ from the training. We encourage you to review these materials.

PNM Provider Training

In preparation for PNM (Stage 2) go-live October 1, 2022, ODM is offering a variety of training options including self-paced, virtual, and in-person training options. Absorb, the Learning Management System (LMS), is where you will access the self-paced training and sign up for the virtual and/or in-person sessions. All BH providers are encouraged to sign up for these training opportunities.

Behavioral Health Organizations will sign up using the following link https://ohiopnm.myabsorb.com?KeyName=bhorgprovider. There are also trainings on how to navigate the individual provider profiles, to have those trainings added to your account email ohiotrainingteam@maximus.com, this email can also be used to send questions regarding training sessions or request additional information.

An OH|ID will be required to access the PNM October 1. However, this is only necessary for staff who need access to the system to complete provider enrollment, provider credentialing, eligibility verifications, or prior authorizations. If you have staff who manage the enrollment/credentialing for your Medicaid providers, only those staff will need an OH|ID. Staff who already have an OH|ID, will be able to connect using their existing account either through the PNM pre-registration period or at go-live (10/1/22). **The PNM pre-registration period is August 15 - September 23.**

How do I access the PNM Pre-Registration tool?
Please visit **https://pnm-preregistration.omes.maximus.com** to access the PNM Pre-Registration tool directly. You can also access the PNM pre-registration tool through a link on the **PNM & Centralized Credentialing page**. From there, you will be able to begin the pre-registration process. For providers who have already created an OH|ID, the pre-registration process will only take a few minutes as you will simply connect your existing account to the PNM module.

What should I do if I don't have an OH|ID yet?
The PNM Pre-Registration tool will automatically redirect you to the OH|ID account creation site, but you can also create an OH|ID in just a few minutes using the steps below:

5. Go to myohio.gov.
6. Fill in the appropriate fields with user information and create account.
7. An email confirmation will be sent following registration.
8. Once you have logged in, please fill in the required fields with the correct security information and address any error messages that appear if you complete the security questions unsuccessfully.

During the PNM trainings, it was shared that PNM administrators will need to link the organizational and individual Medicaid IDs for all practitioners to their accounts for individuals to populate in the PNM under that administrator. We are advocating with ODM to make changes to the system to reduce this administrative burden. At this time, the process is currently for PNM administrators to link individual practitioners to their account and we encourage providers to take the steps to link individual practitioners during the pre-registration period. Additionally, it was shared that during the pre-registration process individual practitioners will link, but the full list of providers for an administrator will not show up until you are able to login to the PNM on 10/1/22.

Another aspect of the PNM providers should consider is that individual practitioners can only have one administrator assigned. Now that the agent role has been updated to include an enrollment agent option (based on your feedback in the pilot training and the PNM trainings) this should not be as difficult as it seemed initially. However, this will pose complications for individual providers working at multiple organizations. Anyone can request to be an agent for a provider, but this is a nuance to be aware of within the system.

Additionally, it was shared during PNM trainings that providers with multiple credentials/provider types will need multiple Medicaid IDs. We have verified with ODM that this is not accurate and was a miscommunication by the training staff. Individual practitioners with multiple credentials will be able to enroll only one time (just like in MITS today) and ODM will identify their multiple credentials with the appropriate specialties. Existing providers will be converted as such. The same mapping from provider type to specialties will be used in PNM. Providers that fall within such situations will continue to have the same ability in the PNM. ODM is working with the Maximus training team to correct this part of the training.

Provider Credentialing

Starting October 1, new credentialing requirements for Medicaid providers will become effective as outlined in ODM's new credentialing rule (5160-1-42). This rule implements national credentialing standards for **independently licensed providers** and will be required as part of Medicaid procurement and the effort towards centralized credentialing and the transition to the PNM. This rule provides the process and requirements ODM, or its credentialing designee, will follow for applicable providers that require credentialing for their specific provider type. This rule also identifies the required information needed to complete the credentialing process and details any additional actions necessary on behalf of the provider or facility to complete credentialing. See paragraph (B) of the rule for the list of practitioners required to complete credentialing and paragraph (E) for the information required. See paragraph (C) of the rule for the list of facilities required to complete credentialing and paragraph (F) for the information required.

ODM will align initial credentialing for independently licensed providers with the provider's Medicaid revalidation date and is currently planning to resume provider revalidation beginning October 1. Notification will be sent in the PNM 120 days in advance of the revalidation/credentialing date and reminders will be sent every 30 days. Additionally, the PNM dashboard will allow you to sort your linked providers by revalidation date. ODM's plan is to disperse revalidations over the timeframe allowed by CMS, meaning not all providers will revalidate/credential at the start of the process. Independently licensed providers will complete one application in the PNM that will cover both the credentialing and enrollment/revalidation requirements. Providers can prepare for the credentialing process now by ensuring independently licensed practitioners have established profiles with the Council for Affordable Quality Health (CAQH), as this is a requirement of the ODM credentialing rule.

Medicaid Provider Enrollment Pause/Alternate Behavioral Health Provider Enrollment Process Effective 8/31/22

In preparation for the October 1, 2022, launch of the new Provider Network Management (PNM) module, ODM stopped accepting new provider enrollment applications through the MITS Provider Enrollment System effective August 1, 2022.

In recognition of the unique enrollment needs of community behavioral health (BH) and other OhioRISE providers that may be onboarding new staff during this transition period, ODM, the Medicaid Managed Care Organizations (MCOs), and the OhioRISE plan have partnered to develop a limited special enrollment process for provider types 84 and 95

available until September 30, 2022. This process will allow new community BH and OhioRISE practitioners to be screened for Medicaid enrollment so organizations can begin billing Medicaid MCOs, the MyCare plans, and the OhioRISE plan for services before the new PNM is launched and the full enrollment process can be completed.
The process is optional and intended to assist providers for whom a delay in enrolling new staff in Ohio Medicaid may cause BH services access concerns. Providers may elect to wait until after October 1, 2022, to initiate new practitioner enrollment in the PNM.

This guidance replaces previous guidance about OhioRISE Provider Enrollment During System Transition issued by ODM effective August 31, 2022.

Provider Eligibility for Special Enrollment During Transition

This special enrollment process is limited to the enrollment of new individual practitioners affiliated with an existing community BH provider type 84 (mental health agency) or type 95 (substance use disorder treatment agency) and providers enrolling because they intend to provide services to OhioRISE enrollees.
This process is NOT available to any of the following:

- Providers that have already requested OhioRISE Provider Enrollment During System Transition through Aetna OhioRISE.
- Individual practitioners not affiliated with Ohio Medicaid provider types 84 or 95 or those practitioners who are not enrolling to provide services to OhioRISE plan enrollees.
- Except for specialties specific to new services affiliated with the OhioRISE program, practitioners that are currently enrolled and affiliated with a provider type 84 or 95 that are seeking to add or change a practitioner specialty.
    - See instructions for OhioRISE provider specialty additions on pages 3 and 4.
- Practitioners that have criminal convictions to disclose.
    - The screening for such instances requires background checks and deeper review of exclusionary periods that cannot be accommodated with this special process.
    - These providers should submit a new application for enrollment on or after October 1, 2022, in the new PNM system. However, the effective date can be backdated for up to 12 months from the application date and NPI enumeration date as long as the relevant provider criteria are met.
- Providers who only are seeking to bill Medicaid fee-for-service.

Guidelines for Temporary Enrollment

Eligible providers seeking to use the temporary enrollment process proceed as follows:

1. Providers complete paper applications using forms ODM 05160 and ODM 10283. All paper applications must be completed on the ODM 05160 form and the accompanying ODM form 10283 (provider agreement) must be signed by the applicant. These forms should be submitted by email to the PE mailbox (Medicaid_Provider_Update@medicaid.ohio.gov) using the subject line "BH and OhioRISE provider special enrollment."
2. ODM will review the application for completeness and verify the applicant is not excluded from participation per state and federal requirements. Please note:
    a. ODM will not be able to manually enter the applicant in the system from August 31 – September 30, 2022, so the provider will not appear in MITS and will not yet have a Medicaid ID in MITS.

b. ODM will be approving the provider on paper for the MCOs, MyCare plans, and OhioRISE plan to accept as rendering providers. Once the provider is approved, ODM will send that provider's information in a supplemental spreadsheet to the MCOs, MyCare plans, and OhioRISE plan each week for integration in their claims system beginning September 8. MCOs, MyCare plans, and the OhioRISE plan will upload the information from the supplemental file into their system within three business days.

3. Until September 30, 2022:
    a. If the applicant successfully passes screening, the provider will be notified via email. The provider's information will be added to a supplemental file that will be shared with the MCOs, MyCare plans, and the OhioRISE plan on a weekly basis beginning September 8. MCOs, MyCare plans, and the OhioRISE plan will upload the information from the supplemental file into their system within three business days.
    b. Providers may submit claims to the relevant MCO, MyCare plan, and the OhioRISE plan upon addition to the MCO, MyCare plan, and/or OhioRISE plan's network.
    c. If the provider does not successfully pass screening, ODM will issue appropriate notice with due process rights to the provider.
4. Beginning October 1, 2022:
    a. ODM will manually enroll the providers screened using the temporary process in the PNM (with a backdated effective date to match the application date or the NPI enumeration effective date) and issue the welcome letter and the Medicaid Provider ID.

Please note that effective Oct. 1, 2022, all new provider enrollment applications, and requests to add new specialties must be submitted using Ohio Medicaid's new Provider Network Management (PNM) module. After its implementation, the PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service updates.

For questions about this process, please reach out to bhenroll@medicaid.ohio.gov and include "BH Special Enrollment" in the subject line ***or contact ODM's Integrated Help Desk (IHD) at 800-686-1516 Monday through Friday 8 a.m.-4:30 p.m. and follow the prompts to Provider Enrollment.***

- **Single Pharmacy Benefit Manager (SPBM) Training**

ODM announced that SPBM Web Portal Training registration is now open. This training is for prescribers, prescriber support staff, pharmacists, and pharmacy support staff.
The public facing SPBM web portal provides instant access to reference materials such as the Unified Preferred Drug List (UPDL) and criteria, the Preferred Diabetic Supply list, the Specialty Drug list, and Quantity Limits list to assist with prescribing medications to Ohio Medicaid managed care members.

The secure SPBM web portal provides a way to check Ohio Medicaid managed care member eligibility, submit pharmacy prior authorizations, and view pharmacy claims and prior authorization history. The portal also includes a secure web chat to quickly speak with the SPBM help desk.

Registration instructions can be found by navigating to https://spbm.medicaid.ohio.gov and selecting the provider tab. Under the provider tab, you will find the associated menu for "SPBM Web Portal Training." Additionally, there are several user guides that may be helpful to review.

- **ODM Next Generation Stage 3 Claims Submission Transition Updates**

Prior Authorizations
Until ODM begins accepting prior authorization requests through the OMES PNM portal on December 1, 2022, prior authorizations will continue to be submitted following the prior authorization submission guidance outlined by the applicable MCO with the exception of pharmacy prior authorizations which will be submitted through the SBPM starting 10/1/22. Once the OMES modules go live in stage 3, prior authorizations will be submitted through the PNM. Additional details about training for stage 3 are forthcoming.

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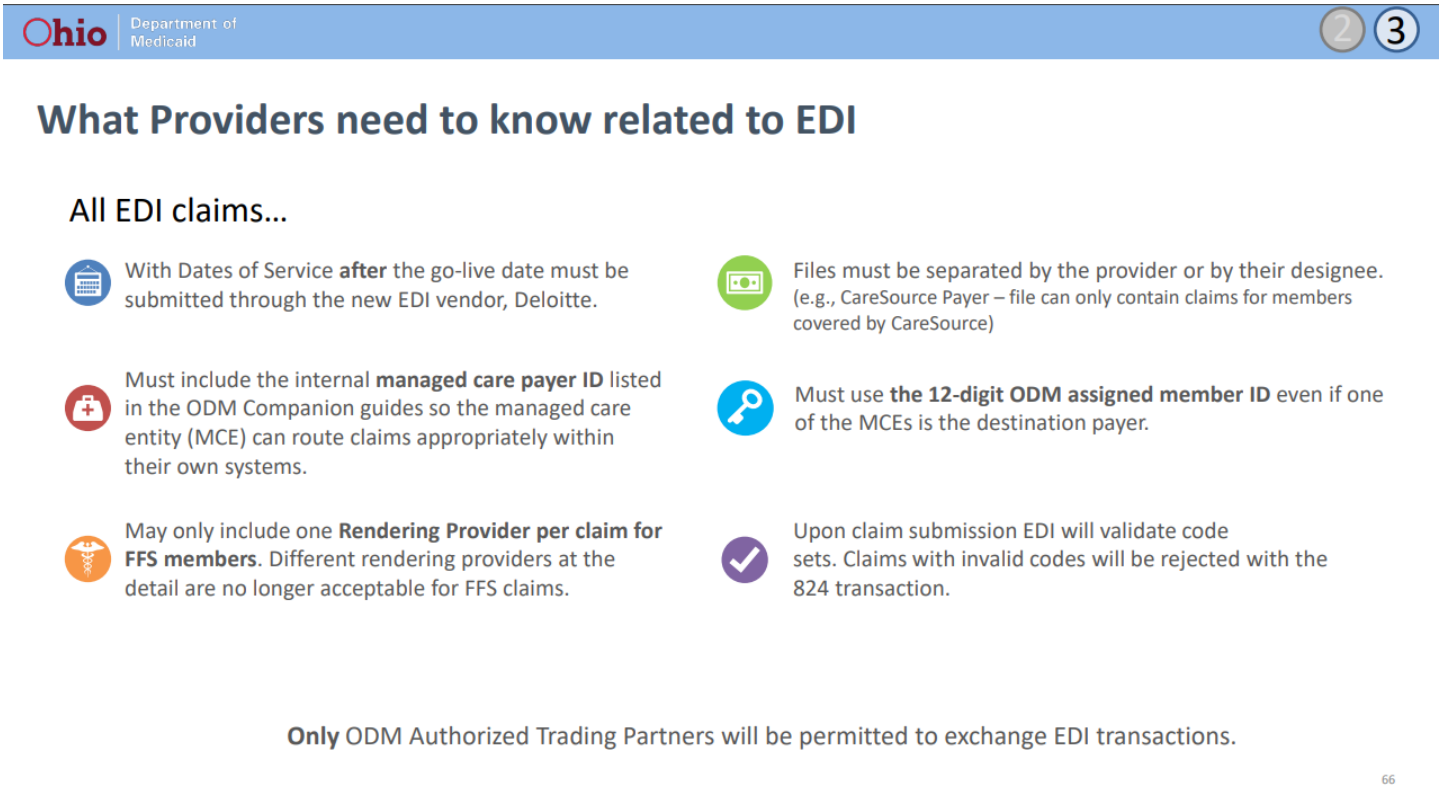
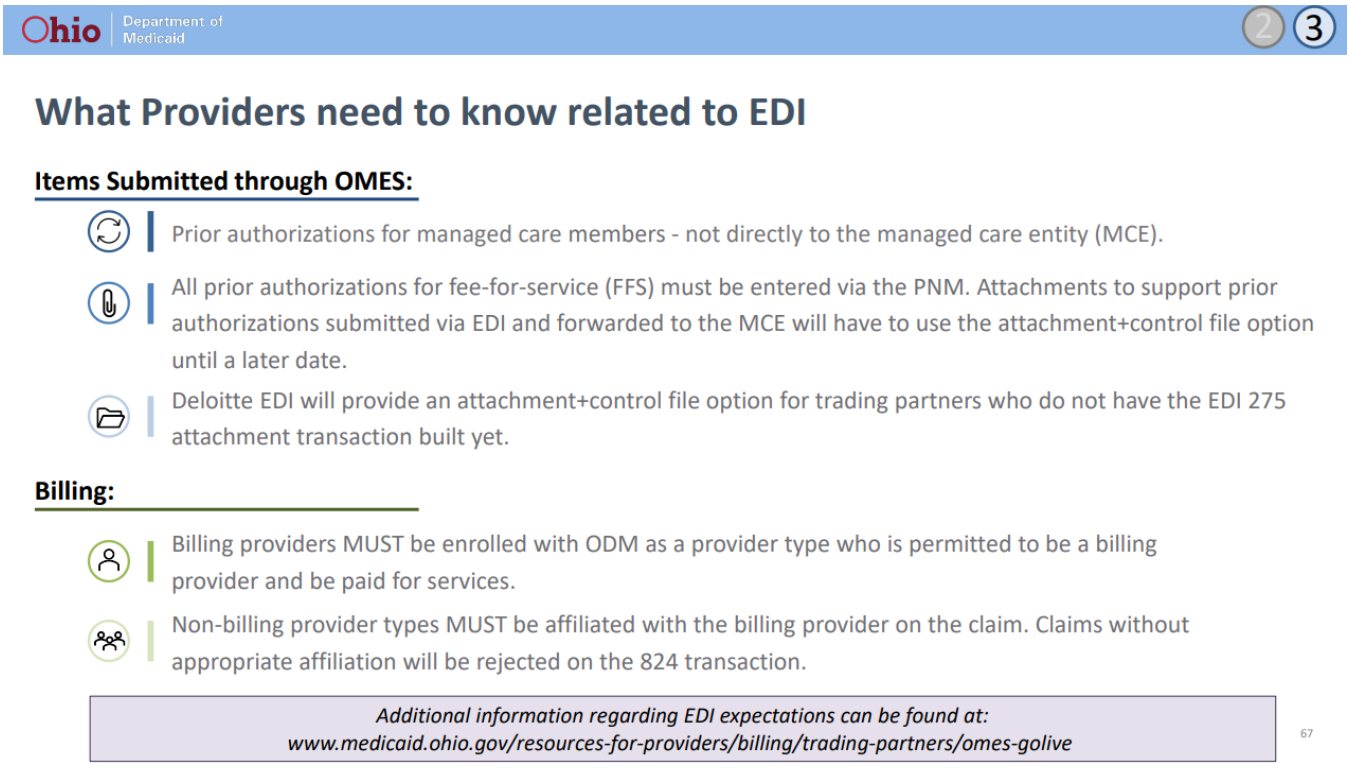
Only authorized trading partners will be able to exchange EDI transactions. EDI claims transactions must only contain claims destined for the same payer (ODM/FFS or the MCE). Each payer has specific identifiers that must be included in the file so that EDI will know where to direct the claims for adjudication. Those identifiers are available in the EDI companion guides (Future OMES Encounters). Providers who wish to receive the 835 Electronic Remittance Advice (ERA) must enroll for the 835 with ODM. If you are already enrolled for FFS, you do not need to re-enroll. We recommend providers that are using a clearinghouse, reach out to their vendor to ask about their preparations for working with ODM and the FI.





- **ODM Next Generation MCP Comparison Tool**

To assist Ohio Medicaid managed care members in choosing which Next Generation plan is the best fit for their healthcare needs, the Ohio Department of Medicaid has introduced the Next Generation Health Plan Comparison document. The Next Generation Health Plan Comparison document provides an overview of the services that all Next Generation managed care plans provide, and specific value-added services provided by each individual plan.

Current Ohio Medicaid managed care members who do not select a plan will stay with their current plan, with the exception of Paramount members. Paramount Advantage Medicaid has been acquired by Anthem Blue Cross and Blue Shield (Anthem). Anthem is working with Paramount Advantage to continue providing healthcare coverage and Medicaid members will continue receiving healthcare coverage through Paramount Advantage until the Next Generation managed care plans begin providing healthcare coverage on 12/1/22. At that time Anthem will be their Next Generation managed care plan. Medicaid members do not need to take any action to begin receiving healthcare benefits through Anthem and there will be no disruption in care. All Ohio Medicaid managed care members can select a different plan at any time until the end of open enrollment through Nov. 30.

- **Ohio Department of Insurance "Understanding MH Insurance Benefits" Webinar**

The Ohio Department of Insurance's new Mental Health Insurance Assistance Office conducted a webinar last month. The slides from the webinar are available and cover the

consumer complaint and appeal processes. The training also announced the new Mental Health Insurance Assistance office, this is partnership between ODI, RecoveryOhio, OhioMHAS, Medicaid, DAS and the Department of Labor to assist Ohioans experiencing issues with mental health and substance use disorders treatment and services through insurance.

Anyone can contact the ODI MHIA office to ask questions or report complaints related to insurance coverage of behavioral health services. ODI is a complaint driven department, so they need to be made aware of problems in order to further investigate issues. Department mental health insurance experts are available at 1-855-GET-MHIA, getmhia@insurance.ohio.gov and www.insurance.ohio.gov/getmhia .

- **Down-Coding of E/M Claims**

We have been informed by several members and billing partners that there has been a resurgences in down-coding of E/M codes by insurance plans, specifically Anthem and Aetna. This has become a new utilization management practice, where the plan will review selected E/M claims to "determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is higher than the E/M code level supported on the claim." If they determine E/M code level submitted is higher than the E/M code level supported on the claim they automatically down-code it without requesting documentation from providers. Providers must then appeal these claims.

We are in discussion with ODM related to the Aetna MyCare downcoding. In the meantime, if you are experiencing this issue, we recommend the following:

- Make sure you have appropriate documentation to support the code billed and if so, then appeal the impacted claims with the plan.
- Review the plan's claims or provider manual for a policy on down-coding.
- Review your contract with the plan to ensure this is not included in your contract.
- Contact the plan's provider relations department in writing (letter/email) requesting written details of their policy and how they are determining a lower code without first reviewing clinical documentation. Explain you are a behavioral health provider, and your clients often have more complex needs leading to higher levels of E/M codes. Indicate you are following federal and contractual obligations to code the services you bill in accordance with the service level provided and can provide documentation upon request. Include any information on the number of claims and time this is taking to emphasize the administrative burden.
- Consider if a complaint to ODI is appropriate (see the link for details on appropriate complaints). This could be appropriate for a contract complaint if the plan is regulated by ODI.

UPDATE: Aetna MyCare has updated their policy to exclude BH providers from downcoding. If you are experiencing this issue with commercial plans, we recommend reporting this issue to ODI.

- **OhioRISE**

As a reminder, providers must be contracted with Aetna for OhioRISE. However, in the first 90 days of the program, Aetna will pay claims regardless of contract status. After

9/30/22, if a provider is not contracted with Aetna for OhioRISE and bills a claim, this claim will be denied. It is important for providers serving youth to begin the contracting process if you have not done so already. Additionally, if you serve clients under 21, you should consider a process for regular eligibility determinations. An inpatient psychiatric hospitalization will automatically enroll Medicaid recipients under 21 into OhioRISE.

ODM created guidance for behavioral health providers interested in rendering BH respite services available through OhioRISE. The guidance includes the general requirements providers must meet to provide BH respite services, the eligible provider types of the service, how to enroll with Medicaid as a provider of BH respite prior to and after 10/1/22, and the documentation requirements for BH respite services.

ODM is hosting OhioRISE implementation office hours to provide opportunities for providers and stakeholders to raise additional questions to OhioRISE subject matter experts to help implement and operationalize the program. **All community partners and providers are invited to attend these office hours available each Tuesday from 2-3 p.m. ODM has indicated they will continue these weekly office hours through the month of September and will consider extending them further if there are regular questions/attendance.**

Meeting Date and Time	Meeting Link
Every Tuesday from 2-3 p.m.	Click here to join

- **Managed Care Plan Specific Updates**
  - Paramount – Paramount sent letters to network providers explaining their members new ID cards that are Anthem branded in preparation for the 10/1/22 SPBM launch. However, claims will continue to be sent to Paramount. The new Member ID card is the first card distribution to Paramount Advantage members that contains only the Anthem logo. As ODM continues to roll out the Next Generation Ohio Medicaid program, Member ID cards will continue to reflect new information for each phase.
  - Plan specific issues/concerns?

- **AMA 2023 E&M Coding Updates**

The American Medical Association (AMA) has released changes to the CPT Evaluation and Management (E/M) codes and guidelines, set to go into effect Jan. 1, 2023. These changes build on the revisions to office/outpatient E/M codes in 2021 that emphasized medical decision-making and sought to reduce documentation burden. The AMA hosted a webinar reviewing these changes. 2023 changes behavioral health organizations should implement include:

- Updates to the Medical Decision Making Table
- History and exam are no longer used to select the level/code, but are required components of the service
- Deletion of direct patient contact prolonged service codes (99354-99357). These services will now be reported through the codes created in 2021, office prolonged

service code (99417) or the code created by CMS (G2212 – for Medicare or Medicaid).

- 99417 may not be used with psychotherapy services. This means there will no longer be a prolonged services code that can be used with 90837 starting in January 2023.

OCTOBER 2022

- **ODM Next Generation Stage 2 - PNM Implementation**

We understand many providers are experiencing issues related to the Ohio Medicaid Provider Network Management (PNM) implementation. We recognize your frustration and want to ensure you are aware of the currently identified issues, opportunities to report PNM issues and seek technical assistance. Below are identified issues ODM has communicated related to the PNM.

Provider Revalidation Notice

Ohio Medicaid providers may have received a revalidation notice to renew their provider agreement with the Ohio Department of Medicaid. The 30-day, 60-day, or 90-day revalidation notices were sent out in error and providers should disregard the message. The 120-day revalidation notice was sent as expected and providers should proceed with the steps located on the notice, as it is valid.

Issues with extra screens for Behavioral Health Providers

PNM is currently experiencing a known issue where dependently licensed providers are being required to enter information for credentialing purposes. This includes Education & Training, Malpractice Claims History, Malpractice Insurance, and Work History. As this issue has been identified, ODM is actively working to correct this error to reduce needed data entry for non-credentialled providers. As a reminder, for individual providers, credentialing is only required for licensed providers who are able to practice independently under state law.

Issues with access to MITS through the PNM

ODM is aware that there is an issue when accessing MITS through the Provider Network Management module and are working quickly to resolve this issue. For Medicaid eligibility verification, we have confirmed with ODM that the 270/271 process is functional with MCOs and fee-for-service Medicaid. Additionally, provider can check eligibility through the MCO's provider portals or by calling the IHD.

The "Select Provider" button on the Provider Network Management (PNM) Module has been disabled

Maximus has disabled the "Select Provider" button on the PNM. When available, this button allows provider administrators to obtain assignment of a Medicaid ID for their provider account. ODM became aware of a potential security issue and are providing full support to Maximus as they work to correct the issue.

While this is being corrected, to assign Medicaid IDs to Administrator accounts in the PNM module, providers will need **to *call the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Call representatives will confirm provider credentials prior to updating the system. Representatives are available during the following dates and times:
Today through Friday, October 14

- Monday-Friday 7 a.m. – 7 p.m.
- Saturday 8 a.m. – 5 p.m.

Monday, October 17 and ongoing

- Monday-Friday 8 a.m. – 4:30 p.m.

ODM indicated they recognize that the wait times are inconvenient, and they are actively adding support representatives to assist with this process. Providers can also contact the IHD by email at IHD@medicaid.ohio.gov and can ask questions and report issues to OhioTrainingTeam@Maximus.com.

IMPORTANT guidance on claims and payments for PNM module and MITS

The Provider Network Management (PNM) module is currently experiencing intermittent connectivity interruptions with the Medicaid Information Technology System (MITS). ODM is working with their vendors, Maximus and Gainwell, to resolve the issue as quickly as possible and to improve help desk wait times.

In light of this issue and to ensure providers receive payment in alignment with Ohio Medicaid's normal adjudication cycle, the Ohio Department of Medicaid (ODM) will **process an advance estimated Medicaid claims payment to all providers who may have experienced issues submitting claims** between October 1 and October 7, 2022, at 5 p.m. ET.

This process applies to any providers that **billed through the portal for FFS claims using direct data entry** such as independent providers, private ICFIIDs, and any other group practitioners or providers that bill using direct data entry. **This does not apply** to claims submitted via trading partners to EDI, which continues to operate and adjudicate claims as normal.

The Advance Estimated Medicaid Claims Payment will be determined as follows:

- **Assess average weekly payment amount.**
  - ODM will analyze claims submitted to MITS for the three (3) months preceding October 1 to determine the provider's weekly average payment.
  - ODM will take the weekly average payment and multiply that amount by two (2).
- **Calculate advance payment amount.**
  - ODM will then determine if the provider successfully submitted claims in MITS from October 1 to October 7 at 5 p.m. ET. If so, ODM will subtract the total amount successfully billed from the estimated advance payment.
  - The resulting amount will be the advance payment amount the provider receives.
- **Issue payment.**

- Providers receiving advance payments will only receive one payment containing both the submitted claims and the advance payment amount. **Remittance advices will properly notate the advance payment compared to the claims payment.**
- Regarding timing for payment: in alignment with the normal payment schedule, on Friday, October 14, 2022 (due to Monday, October 10, 2022, being a State holiday), providers will receive the estimated payment and, if applicable, their normal payment for claims.
- Payments will be made to providers via EFTs or paper checks will be mailed; the method of payment will be consistent with the provider's normal payment method.

Example: Advance Estimated Medicaid Claims Payment
To calculate an advance payment for Provider A, ODM will do the following:

- **Assess average weekly payment amount.**
  - During the three (3) months preceding October 1, Provider A's average weekly portal average claims payment was $100.
- **Calculate advance payment amount.**
  - Provider A's average three (3) month payment multiplied by two is $200.
  - Provider A successfully submitted claims from October 1 – October 7, 2022, in MITS that total $25.
  - The advance payment ODM will issue is $200 minus $25, which equals $175.
- **Issue payment.**
  - Provider A receives Medicaid payments by EFT.
  - On October 14, 2022, Provider A will receive one EFT payment for $200. This reflects:
    - $175 advance payment.
    - $25 normal payment for successfully submitted claims.

ODM appreciated your patience during this time as they work to resolve PNM's intermittent connectivity interruptions with MITS. If you have additional questions, please contact Medicaid@medicaid.ohio.gov.

Additionally, the Ohio Council has been tracking issues identified by our members and attending the Maximus Ask Me Anything Sessions to gather information and additional issues. During these session Maximus staff have been sharing some PNM workarounds while the system issues are being resolved. You can access the list of issues reported by our members and the slides from Maximus HERE.

Maximus will continue hosting twice daily Ask Me Anything sessions this week. These offer a Q&A session designed as an open forum to answer any questions and report issues about the PNM system after the system launches.

Link to Ask Me Anything Session

Passcode: askme
Zoom Meeting ID: 934 0777 0658

You can use the link above to attend any of the sessions, enrollment is not necessary to attend

These sessions will be held on the following dates and times:
(You do not need to register for a specific session and can attend any and all sessions listed, using the link above)
Monday, October 10th 10:00am - 11:00am
Monday, October 10th 1:00pm - 2:00pm
Tuesday, October 11th 10:00am - 11:00am
Tuesday, October 11th 1:00pm - 2:00pm
Wednesday, October 12th 10:00am - 11:00am
Wednesday, October 12th 1:00pm - 2:00pm
Thursday, October 13th 10:00am - 11:00am
Thursday, October 13th 1:00pm - 2:00pm
Friday, October 14th 10:00am - 11:00am
Friday, October 14th 1:00pm - 2:00pm

Additionally, Maximus has added topic specific post-implementation refresher courses to the LMS, which do require registration. These post-implementation courses include additional AMA sessions that continue into next two weeks and do not require registration.

Link to Ask Me Anything Session
Passcode: askme
Zoom Meeting ID: 916 3221 1909

You can use the link above to attend any of our sessions, enrollment is not necessary to attend

These sessions will be held on the following dates and times:
(You do not need to register for a specific session and can attend any and all sessions listed, using the link above)
Monday, October 17th 1:00pm - 2:00pm
Tuesday, October 18th 1:00pm - 2:00pm
Wednesday, October 19th 1:00pm - 2:00pm
Thursday, October 20th 1:00pm - 2:00pm
Friday, October 21st 1:00pm - 2:00pm

Monday, October 24th 1:00pm - 2:00pm
Tuesday, October 25th 1:00pm - 2:00pm
Wednesday, October 26th 1:00pm - 2:00pm
Thursday, October 26th 1:00pm - 2:00pm
Friday, October 28th 1:00pm - 2:00pm

- **Provider Credentialing**

Effective October 1, credentialing requirements for Medicaid providers became effective as outlined in ODM's new credentialing rule (5160-1-42). This rule implements national credentialing standards for **independently licensed providers** and is required as part of Medicaid procurement and the effort towards centralized credentialing and the transition to the PNM. This rule provides the process and requirements ODM, or its credentialing

designee, will follow for applicable providers that require credentialing for their specific provider type. This rule also identifies the required information needed to complete the credentialing process and details any additional actions necessary on behalf of the provider or facility to complete credentialing. See paragraph (B) of the rule for the list of practitioners required to complete credentialing and paragraph (E) for the information required. See paragraph (C) of the rule for the list of facilities required to complete credentialing and paragraph (F) for the information required.

ODM will align initial credentialing for independently licensed providers with the provider's Medicaid revalidation date and is currently planning to resume provider revalidation beginning October 1. When the PNM works as designed, the notification will be sent by the PNM 120 days in advance of the revalidation/credentialing date to the contact email listed in the PNM and reminders will be sent every 30 days. Additionally, the PNM dashboard will allow you to sort your linked providers by revalidation date. ODM's plan is to disperse revalidations over the timeframe allowed by CMS, meaning not all providers will revalidate/credential at the start of the process. Independently licensed providers will complete one application in the PNM that will cover both the credentialing and enrollment/revalidation requirements. Providers can prepare for the credentialing process now by ensuring independently licensed practitioners have established profiles with the Council for Affordable Quality Health (CAQH), as this is a requirement of the ODM credentialing rule.

- **Single Pharmacy Benefit Manager (SPBM) Implementation**

The SPBM also went live on October 1, with far fewer reported issues. The public facing SPBM web portal provides instant access to reference materials such as the Unified Preferred Drug List (UPDL) and criteria, the Preferred Diabetic Supply list, the Specialty Drug list, and Quantity Limits list to assist with prescribing medications to Ohio Medicaid managed care members.

The secure SPBM web portal provides a way to check Ohio Medicaid managed care member eligibility, submit pharmacy prior authorizations, and view pharmacy claims and prior authorization history. The portal also includes a secure web chat to quickly speak with the SPBM help desk.

Provider enrollment instructions can be found by navigating to https://spbm.medicaid.ohio.gov and selecting the provider tab. Additionally, there are several user guides that may be helpful to review.

- **ODM Next Generation Stage 3 Claims Submission Transition Updates**

Prior Authorizations

Until ODM begins accepting prior authorization requests through the OMES PNM portal on December 1, 2022, prior authorizations will continue to be submitted following the prior authorization submission guidance outlined by the applicable MCO with the exception of pharmacy prior authorizations which will be submitted through the SBPM starting 10/1/22. Once the OMES modules go live in stage 3, prior authorizations will be submitted through the PNM. Additional details about training for stage 3 are forthcoming.

Submitting Claims (information starts on slide 58)
Until December 1, 2022, provider claims will continue to be submitted to each Medicaid MCO according to the MCO billing guidance. On December 1st, ODM will begin accepting claims through the Ohio Medicaid Enterprise System (OMES) modules – the PNM portal for managed care claims, and the Single Pharmacy Benefit Manager (SPBM) module for pharmacy claims. The PNM, SPBM and EDI are all OMES modules. EDI will be accessed by trading partners and the PNM and SPBM include the portal capabilities for providers. Only authorized trading partners will be able to exchange EDI transactions. Providers who wish to become their own trading partner will be able to enroll after the Stage 3 go-live. The Fiscal Intermediary (FI) is used in the "back end" by ODM to collect data from items submitted through EDI or PNM; neither trading partners nor providers interact directly with the FI.

Starting December 1, 2022, Medicaid Managed Care (including OhioRISE) and FFS claims will be submitted through the PNM. (*As a reminder, MyCare Ohio claims and prior authorizations are not included in this transition and will continue to be sent to the MyCare Ohio managed care plan*).

Upon submission of claims and prior authorizations by providers and trading partners to the Provider Network Management (PNM) portal or Electronic Data Interchange (EDI), Fiscal intermediary (FI) will facilitate processing for these transactions. In coordination with EDI, FI will assist in transitioning claims and authorizations to Ohio Medicaid's managed care entities as well as receive updates back from those organizations so providers can receive appropriate updates, making the process more transparent and efficient. The Fiscal Intermediary will also provide ODM with greater insight into claims and prior authorizations requests, allowing ODM to more effectively identify and address trends.

Payments related to FFS recipients will be coming from Medicaid through the Fiscal Intermediary. MCEs are still responsible for processing, adjudicating and paying claims related to managed care recipients. Pharmacy claims related to managed care recipients will come from the SPBM.

EDI Module (information starts on slide 64)
Only authorized trading partners will be able to exchange EDI transactions. EDI claims transactions must only contain claims destined for the same payer (ODM/FFS or the MCE). Each payer has specific identifiers that must be included in the file so that EDI will know where to direct the claims for adjudication. Those identifiers are available in the EDI companion guides (Future OMES Encounters). Providers who wish to receive the 835 Electronic Remittance Advice (ERA) must enroll for the 835 with ODM. If you are already enrolled for FFS, you do not need to re-enroll. We recommend providers that are using a clearinghouse, reach out to their vendor to ask about their preparations for working with ODM and the FI.

Ohio | Department of Medicaid

What Providers need to know related to EDI

All EDI claims…

- With Dates of Service **after** the go-live date must be submitted through the new EDI vendor, Deloitte.
- Files must be separated by the provider or by their designee. (e.g., CareSource Payer – file can only contain claims for members covered by CareSource)
- Must include the internal **managed care payer ID** listed in the ODM Companion guides so the managed care entity (MCE) can route claims appropriately within their own systems.
- Must use **the 12-digit ODM assigned member ID** even if one of the MCEs is the destination payer.
- May only include one **Rendering Provider per claim for FFS members**. Different rendering providers at the detail are no longer acceptable for FFS claims.
- Upon claim submission EDI will validate code sets. Claims with invalid codes will be rejected with the 824 transaction.

Only ODM Authorized Trading Partners will be permitted to exchange EDI transactions.

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Ohio | Department of Medicaid

What Providers need to know related to EDI

Items Submitted through OMES:

- Prior authorizations for managed care members - not directly to the managed care entity (MCE).
- All prior authorizations for fee-for-service (FFS) must be entered via the PNM. Attachments to support prior authorizations submitted via EDI and forwarded to the MCE will have to use the attachment+control file option until a later date.
- Deloitte EDI will provide an attachment+control file option for trading partners who do not have the EDI 275 attachment transaction built yet.

Billing:

- Billing providers MUST be enrolled with ODM as a provider type who is permitted to be a billing provider and be paid for services.
- Non-billing provider types MUST be affiliated with the billing provider on the claim. Claims without appropriate affiliation will be rejected on the 824 transaction.

Additional information regarding EDI expectations can be found at:
www.medicaid.ohio.gov/resources-for-providers/billing/trading-partners/omes-golive

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- **ODM Next Generation Webinar Follow Up**

After the ODM Next Generation Provider Webinar, ODM sent follow up emails answering questions submitted that were not included in the FAQ. See below for questions pertinent to BH providers.

There is an ODM FAQ that indicates that the FI will store TPL data. Can it be assumed that the FI will be considered the "source of truth" when there is a conflict between what is in the FI and what the MCP has listed?

- The FI is to be considered the source of truth for TPL when there is a conflict between FI and an MCO. The process will remain the same as it does today. When there is a conflict, an email can be sent to TPL@medicaid.ohio.gov to review the TPL and work with the MCO if their information is not up-to-date.

Just to be clear, all Medicaid (FFS and MCE) transactions after December 1 will go through PNM?

- No, after December 1, all Medicaid transactions (FFS and MCE) must be submitted either by direct data entry into the Provider Network Management (PNM) module or by a trading partner/clearinghouse using EDI.

How will the new system know that we are both a group and a trading partner so that we can submit claim files?

- Trading partners who are already authorized to submit claims to ODM will use their same trading partner number to submit their files using EDI. If the trading partner has not engaged with the new EDI vendor, Deloitte, please reach out to usomesedisupport@deloitte.com with your trading partner number so we can make sure your connectivity is in place.

Will the managed care organizations (MCOs) be expected to follow a consistent set of modifiers and remit (CARC/RARC) codes across all plans? Or will they be permitted to individualize use of claims modifiers and remit codes?

- Managed care organizations (MCO) have been asked to limit the number of differences across the enterprise. Plans should use the most appropriate CARC/RARC to report the results of the claim adjudication.

I currently use all portals ex: UHC's own provider portal, I am no longer allowed to use any other portal but this one to do my work?

- All claims for all Medicaid members, including those that are covered by the managed care organizations (MCO), must be direct data entered through the new Provider Network Management (PNM) module or submitted via Electronic Data Interchange (EDI) by an authorized trading partner. The PNM module becomes your one front door for all direct data-entered claims and prior authorizations. Rather than visiting multiple portals, you can send everything through this one module.

Is this information being shared with clearinghouse/partners?

- Yes, trading partners/clearinghouses are aware of these changes. However, those who will take ownership of the changes depends on your agreement with your

clearinghouse. Please reach out to any of the entities who assist in submitting your claims.

If you only submit FFS claims, will you submit your claims only to ODM with an Ohio Medicaid payer ID or will you still put CareSource for example as the payer and use their payer ID when submitting to your trading partner?

- If you only submit fee-for-service (FFS) claims, you will use the same payer ID used currently. If you have claims for members covered under a managed care organization (MCO), it must either be direct data entered through the new Provider Network Management (PNM) module or submitted via Electronic Data Interchange (EDI) by an authorized trading partner. The file must use the appropriate Payer ID and Receiver ID so the file can be routed to the designated MCO.

For claims with DOS prior to go live date, will these be billed directly to the Managed Care Plans as they are now?

- Yes, claims with dates of service (DOS) prior to the December 1 should be handled in the same way they are handled today.

Additionally, ODM began working with a small group of BH providers for the phase 3 implementation and testing. They shared theses slides to answer initial questions.

What questions do you have about the phase 3 implementation?

- **Medicaid ID Cards**

All Medicaid managed care members are now receiving new member ID cards in the mail from their current MCO. This new member card will reflect that, beginning October 1, pharmacy benefits for members enrolled in managed care will be covered by the SPBM. Members who do not receive their new member ID card in the mail should contact their current MCO.

Managed care members should bring their new ID card to the pharmacy when filling prescriptions. Members who do not have the new member ID card by October 1 can still bring their old ID card to their pharmacy and let the pharmacy know they are a part of Ohio Medicaid and have an old ID. After October 1, pharmacies will need to submit claims to Gainwell Technologies. Also after October 1, pharmacy providers and members may contact Gainwell Technologies by phone at 1-833-491-0344 24 hours a day, seven days a week.

As a reminder, Paramount sent letters to network providers explaining their members new ID cards that are Anthem branded in preparation for the 10/1/22 SPBM launch. However, claims will continue to be sent to Paramount. The new Member ID card is the first card distribution to Paramount Advantage members that contains only the Anthem logo. As ODM continues to roll out the Next Generation Ohio Medicaid program, Member ID cards will continue to reflect new information for each phase.

- **OhioRISE**

As a reminder, providers must be contracted with Aetna for OhioRISE. However, in the first 90 days of the program, Aetna will pay claims regardless of contract status. After 9/30/22, if a provider is not contracted with Aetna for OhioRISE and bills a claim, this claim will be denied. It is important for providers serving youth to begin the contracting process if you have not done so already. Additionally, if you serve clients under 21, you should consider a process for regular eligibility determinations. An inpatient psychiatric hospitalization will automatically enroll Medicaid recipients under 21 into OhioRISE.

ODM is hosting OhioRISE implementation office hours to provide opportunities for providers and stakeholders to raise additional questions to OhioRISE subject matter experts to help implement and operationalize the program. **All community partners and providers are invited to attend these office hours available each Tuesday from 2-3 p.m. ODM has indicated they will continue these weekly office hours through the end of the calendar year.**

Meeting Date and Time	Meeting Link
Every Tuesday from 2-2:30 p.m.	Click here to join

- **ARPA- HCBS 2nd Payment**

As a reminder, the initial ARPA-HCBS payment providers received was the initial installment. At the end of calendar year (CY) 2022, ODM will reconcile a provider's total claims to actual CY22 claims experience and a final relief payment will be calculated. This was required by CMS in order to avoid a situation where a provider may be "overpaid". There is no action required on the part of the provider during this reconciliation process. ODM will work with the plans at the beginning of CY23 on this final installment of relief. ODM will send out an announcement when the final installments are prepared and post the final amount of payment to the dashboard. ODM has indicated the timing of this second payment will likely be in late February or March to allow for the claims run out for CY22. CMS is requiring ODM to know the total claims value for CY22 to calculate the second payment amount.

- **ODM System Updates to Reflect FY23 ICD-10 Coding Changes**

The Ohio Department of Medicaid (ODM) issued Medicaid Advisory Letter (MAL) # 664 announcing updates to their claims payment system to reflect the annual updates in the International Classification of Diseases, 10th revision (ICD-10) which will be effective October 1, 2022. CMS updates ICD-10 codes annually. The changes to codes and the 2023 ICD-10-CM Official guidelines for coding and reporting should be used for patient encounters occurring from October 1, 2022 through September 30, 2023. Chapter 5 in each resource contains the changes and guidance for coding mental, behavioral, and neurodevelopmental disorders. There are several updates to Chapter 5 (F01-F99) of the

ICD-10 that members should consider for implementation starting October 1st. Additionally, there are new Z-codes in Chapter 21 which reflect various social determinants of health, including transportation insecurity and material hardship.

- Plan Specific Issues/Other Issues
  - Molina sent a provider bulletin on 9/30/22 indicating effective 11/1/22 they will begin requiring same day services modifiers (25, 59, XE, XS, XP, XU).
  - Anthem announced their Ohio Medicaid Provider Orientation
  - AmeriHealth Caritas announced their new provider orientation.

    In-person orientation sessions, 10 a.m. - noon or 1 - 3 p.m.
    Click here [clt1461611.bmetrack.com] to sign up
    Oct. 18 - Deer Park Library, Room A, 4020 E. Galbraith Road, Cincinnati
    Oct. 19 - Engineers Club, 110 E. Monument Avenue, Dayton

    Virtual orientation via Zoom, 10 a.m. - 11 a.m.

    Oct. 18 - Click here [clt1461611.bmetrack.com] to register

    Nov. 1 - Click here [clt1461611.bmetrack.com] to register

    Nov. 15 - Click here [clt1461611.bmetrack.com] to register

    Nov. 29 - Click here [clt1461611.bmetrack.com] to register

    Dec. 13 - Click here [clt1461611.bmetrack.com] to register

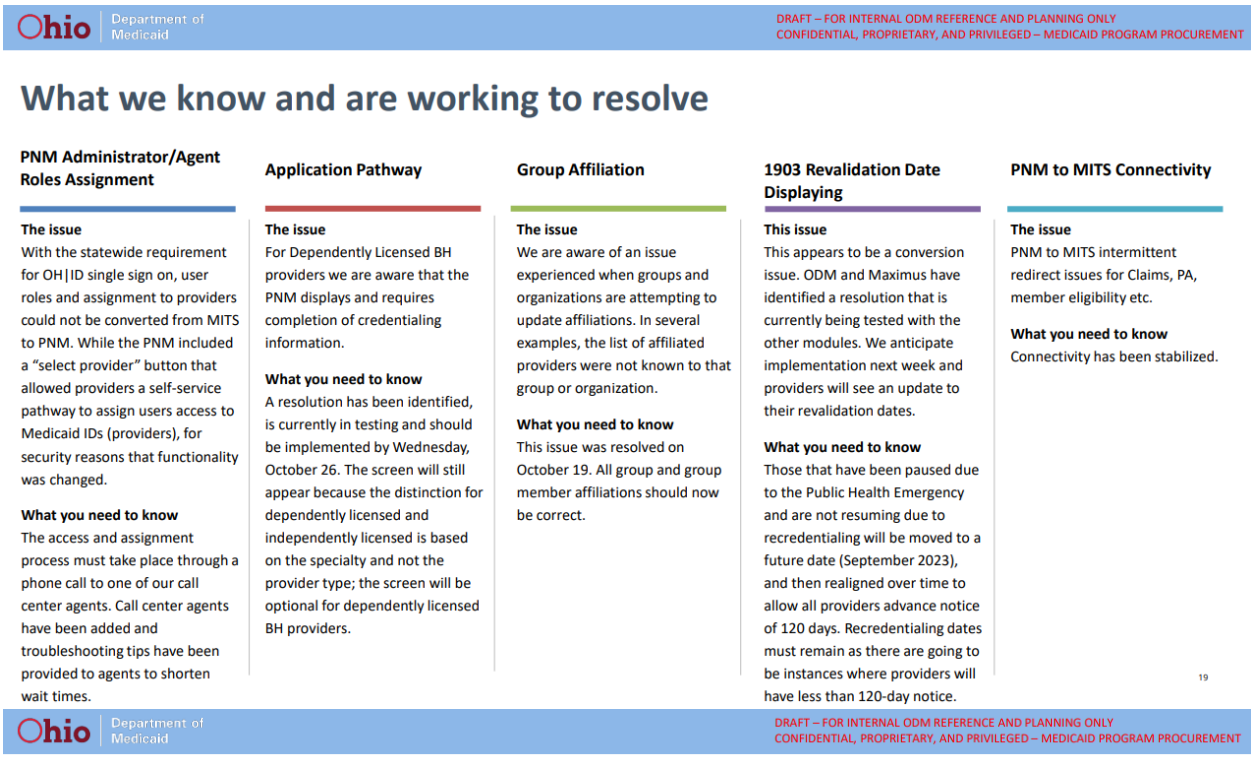
  - ODM Form 10294 – SUD residential form MCO process

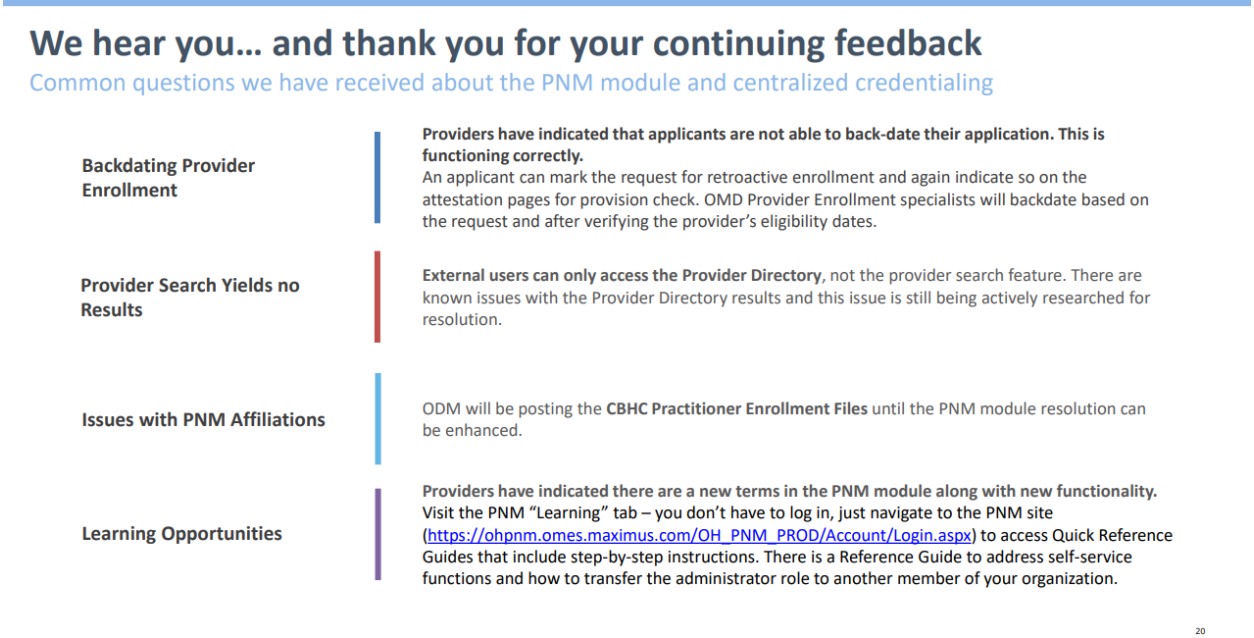
NOVEMBER 2022

- **ODM Next Generation Stage 2 - PNM Implementation**

The Ohio Council is tracking a number of issues related to the 10/1/22 implementation of the PNM. We have communicated these issues to ODM and encourage providers to continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m.

During the opening session of our annual conference, Director Corcoran shared updates on known issues and potential timelines for fixes to the PNM. See slides 18-20.





Currently, eligibility verification and PA in MITS are more stable than previously but there are ongoing periods of intermittent availability. ODM shared the following guidance for providers receiving errors when attempting to connect to MITS through the PNM.

- Please take the following steps to see if you are still receiving the same error message.
    1. Please clear your browsing cookies and history from your internet browser. Please refer to this document.
    2. Please access the PNM portal through the "My Apps" on the OHID website (https://ohid.ohio.gov/wps/portal/gov/ohid/login). If not available in your apps,

please search "PNM" in the app store. The portal has a better connection to the MITS redirect when accessing through the app.

3. Once logging into PNM through the app, please use the link for guidance on of to access the self-service functions: https://ohpnm.omes.maximus.com/OH_PNM_PROD/pages/DownloadFile.aspx?catId=Learning&mode=inline&id=af8e5cd3-5631-4e0f-bc99-83d74992b851
4. If you still receive that error message, contact the IHD.

The waiver on PA for Medicaid FFS was removed effective 10/15/22 so providers need to request PA for FFS members for services 10/15 and later.

Updated Community Behavioral Health Center Practitioner Enrollment Files Available

The Ohio Department of Medicaid (ODM) has resumed producing the weekly CBHC practitioner enrollment files as of October 15, 2022. To access the CBHC files, providers should visit the Medicaid Behavioral Health website and navigate to the "Enrolling Practitioners in Medicaid" section.

Provider and Agency Revalidation

Provider revalidation notices included individual providers and organizational providers that will need to be updated in the next 120 days. These notices were sent to the email contact listed in the PNM on 10/1. Once the application is completed and submitted in the PNM, changes cannot be made to the provider until the application has been processed by ODM. This is important for organizational providers revalidating because this means you will not be able to affiliate new providers with the organization during this time.

Provider Type Changes

For providers that are currently enrolled as a paraprofessional, e.g. QMHS, but need to upgrade and change to new provider type, e.g. a CDCA/QMHS, you should do the following:

- In the QMHS provider enrollment, under enrollment action selections choose "request disenrollment"
- Wait for the approval from ODM
- Complete the new provider CDCA application under provider type 54 and add the QMHS as a secondary specialty

Providers with license upgrades, e.g. LSW to LISW, do not need to follow this process since the provider type is the same. Disenrollment is only required when changing provider types.

We continue to encourage members to take advantage of the Maximus refresher trainings and Ask me Anything sessions as another option to have questions answered or report issues. These are available in the MyAbsorb Learning Management System. Although the dates/times are not listed Maximus has continued the daily 1p.m. Ask Me Anything sessions using the same link in MyAbsorb. These sessions do not require registration.

Link to Ask Me Anything Session

Passcode: askme

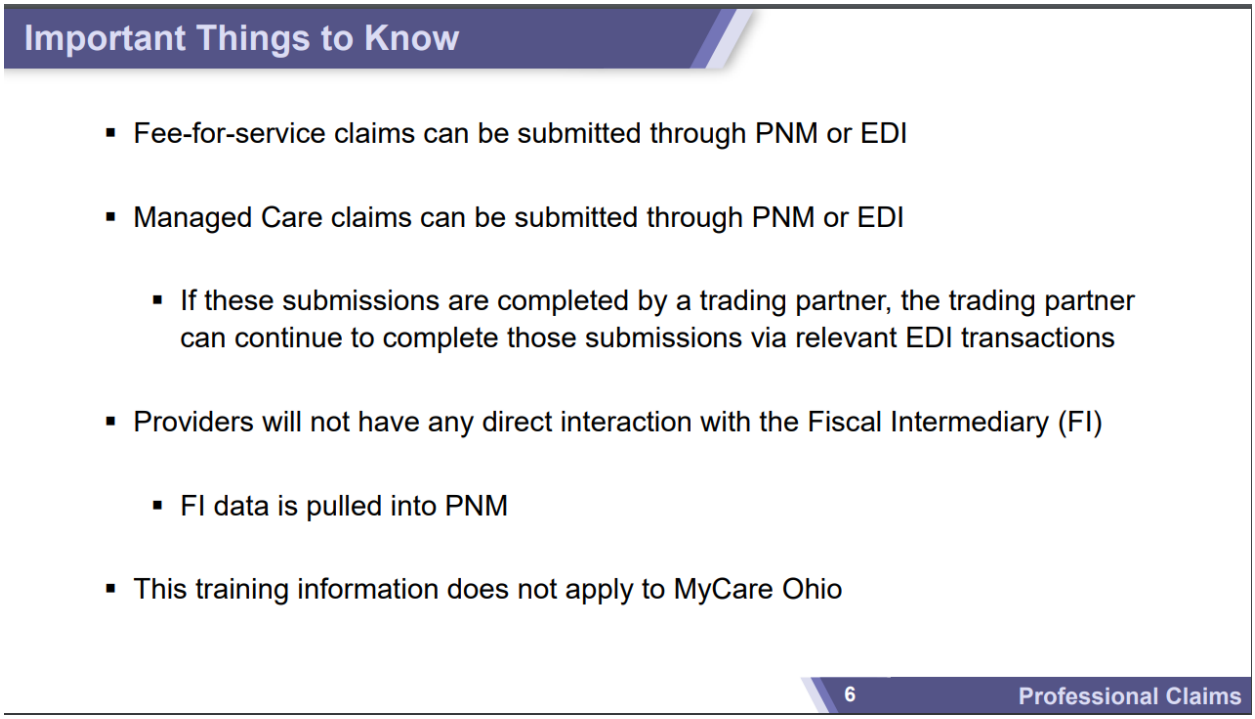
Zoom Meeting ID: 916 3221 1909

- **Phase 3 Training Available**

Provider Network Management (PNM) training sessions, are available for registration in the Learning Management System (LMS), Absorb. The training schedule has been posted and is available on the Next Generation website. There are virtual and in-person options.

Training module topics will include the following:

- Fee-for-service and Managed Care Claims Submission (Dental, Institutional, and Professional). **this is specific to organizations direct data entering claims into PNM.** There is a separate training outside of the LMS for Trading Partner/EDI submissions.



Claims submitted through PNM will be adjudicated in real-time. Claims submitted through EDI will be adjudicated in "near real time".

- Fee-for-service and Managed Care Prior Authorization Submission. - Prior authorization requests must be sent via EDI X12 278 transaction **or** through the PNM Portal starting 12/1/22. Once this phase goes live, you will no longer send MCO PAs directly to the MCO.

Important Things to Know

- Fee-for-service prior authorizations can be submitted through PNM or EDI
- Managed care prior authorizations can be submitted through PNM or EDI
  - If these submissions are completed by a trading partner, the trading partner can continue to complete those submissions via relevant EDI transactions
- Providers will not have any direct interaction with the Fiscal Intermediary (FI)
  - FI data is pulled into PNM
- This prior authorization training information does not apply to MyCare Ohio or Single Pharmacy Benefit Manager (SPBM)

6 Prior Authorization

-
- Fee-for-service and Managed Care Eligibility Inquiry.

Eligibility Responses

Fee-for-Service Members	• A full eligibility response will be provided that will include information regarding specific services covered and availability of remaining units against a service limit.
Managed Care Entity Members	• A limited eligibility response will be provided that indicates if a member has eligibility for the dates requested. • For full eligibility details, contact the Member's Managed Care Entity.

8 Eligibility

- Fee-for-service and Managed Care Provider Financials/Remittance Advice. - FI is only creating RA for FFS claims which will be transferred into PNM. MCEs will provide RA for their claims, and it will be stored in the PNM. PNM will not have historical MCE RA, only RA from 12/1 going forward for MCEs. All payers will make their own payments. FFS payments will be made by Gainwell, each MCE is

responsible for processing, adjudicating and paying their claims. Payment information for all providers will be available via PNM or trading partner.

Behavioral health organizations will have varied changes related to the phase 3 changes to claims submission depending on their claims submission method (submitting claims via clearinghouse, submitting claims as a trading partner, or a combination of both).

ODM sent a communication to trading partners on 11/3/22 with the following information on changes for EDI claims.

Important changes for all EDI claims

With the launch of the new EDI vendor, Deloitte, changes in claim submission will be required for the trading partners to exchange transactions in the new EDI. Please note that MyCare is **not** included in the Next Generation program and will continue to be submitted using the current processes. **Key changes are as follows:**

- Billing providers must be enrolled with ODM as a provider type who is permitted to be a billing provider and be paid for services. Non-billing provider types must be affiliated with the billing provider on the claim. **Claims without appropriate affiliation will be rejected on an 824 transaction.**
- Dates of service after December 1 must be submitted through the new EDI vendor.
- Fee-for-service (FFS) claims may only include one Rendering Provider per claim. Different rendering providers at the detail are no longer acceptable for FFS claims.
- Each claim must include the internal managed care payer ID listed in the ODM Companion guides so the managed care entity (MCE) can route claims appropriately within their systems.
- Each claim must also use the 12-digit, ODM-assigned member ID even if one of the MCEs is the destination payer.
- Separate files must be submitted using the Receiver ID assigned by ODM for each plan, e.g., a CareSource Payer file can only contain claims for members covered by CareSource.
    - Please see the companion guides for a list of Receiver IDs.
- Providers who wish to receive an 835 Electronic Remittance Advice (ERA) must use the ODM-06306 835 Designation form to choose the ODM-authorized trading partner to receive the 835 on their behalf. Providers who are already enrolled for the 835 with ODM do not need to re-enroll. Please note that this enrollment will also direct all 835s from the Medicaid managed care plans.
- Upon claim submission, EDI will validate code sets. Claims with invalid codes will be rejected with an 824 transaction.
- Deloitte EDI will provide an attachment+control file option for trading partners who do not have the EDI 275 attachment transaction built yet.

Important changes for all EDI prior authorizations

Beginning December 1, all prior authorizations (PA) for FFS must be entered via the Provider Network Management (PNM) module. MyCare prior authorizations will continue to be submitted using the current processes. Prior authorizations for members covered by the managed care entities can be submitted either using the PNM module or by using the EDI 278 transaction in the new EDI.

Additionally, attachments that are submitted to the new EDI to support PAs and forwarded to the MCE must use the attachment+control file option. Deloitte EDI will provide an attachment+control file option for trading partners who do not have the EDI 275 attachment transaction built yet.

Information about the PNM module

For awareness, when the new EDI launches, providers will still have the option to direct data enter (DDE) their claims. DDE will be accessible to providers via the PNM on December 1.

Additional information regarding EDI expectations can be found at https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/omes-golive.

Information for Providers submitting Claims via a Clearinghouse

Only trading partners will be able to submit to the EDI module. We recommend providers that are using a clearinghouse, reach out to their vendor to ask about their preparations for working with ODM and the FI. Thanks to Chelsea Kohler from Behavioral Health Billing Solutions for the list of suggested questions to ask your clearinghouse related to this transition.

Example Questions to ask your clearinghouse:

1. Will your clearinghouse require us to submit different 837 files for each payer with the new payer ID at the ISA08? Or will your clearinghouse split out based on the payer ID we submit in the 2010BB loop?
    a. If your clearinghouse will split out, does the payer ID in the 2010BB loop need to be the new payer IDs listed in the companion guide? For example, if I send a claim with 31114 at the 2010BB loop for a date of service after 12/1, how will your clearinghouse react to this claim? Will I need to submit pre-12/1 date of service claims with 31114 and post-12/1 date of service claims with 0003150 at the 2010BB?
    b. If your clearinghouse will split out, will the ISA08 remain as it is currently set up or will there be any changes required?
2. For any 12/1 or after claim, will we receive the snip 7 edits as payer rejections, or will there be clearinghouse edits in place to reject things like invalid 12-digit MMIS based on format? Are you adding any additional edits?
3. Will your clearinghouse be doing outreach to send the 6306 835 designation form ODM06306fillx.pdf (ohio.gov) to clients who do not currently receive their FFS Medicaid 835s through your clearinghouse?
4. Is there anything else we need to do to our files, billing configuration and/or ERA retrieval to prepare?

Trading Partner Resources

ODM sent information to trading partners last month on phase 3 changes and hosted a webinar for trading partners covering the changes.

Important changes with new EDI

Some changes will be required for the trading partners to exchange transactions in the new EDI beginning December 1. Key changes are as follows:

- The trading partner/clearinghouse will exchange EDI transactions with ODM in the X12 EDI compliant format(s).
- The Receiver ID in the ISA08 must represent the payer who will ultimately receive the EDI transaction.
- Each 837-claim transaction must only contain claims destined for the same receiver and payer (e.g., if the receiver is Managed Care Plan A, then all claims within that file must be for members covered by Managed Care Plan A). Claims for members not covered by that plan will either be rejected by the plan in the 277CA or denied on the provider's remittance.
- The Payer ID 2010BB NM109 must also include the appropriate value for the claim(s) being submitted (e.g., if the claim is for vision services, each plan has designated payer identifiers that must be used to route the claim internally). See Section 7 of the Companion Guide(s) for more information.
- Providers who wish to receive an 835 Electronic Remittance Advice (ERA) must use the ODM06306 835 Designation form to choose the ODM authorized trading partner to receive the 835 2 on their behalf. Providers who are already enrolled for the 835 with ODM do not need to reenroll. Please note that this enrollment will direct all 835s from the Medicaid managed care plans as well.
- Trading partners will no longer receive one 835 file with all providers within a single file. If a trading partner represents multiple providers who receive payment on the same financial cycle, there will be one 835 per Pay-To-Provider.

Additional changes will also be needed for EDI transactions to ensure they reach the right end point, allowing the receiver to return the proper response. ODM has created new companion guides for trading partners. Please visit the trading partner website at https://medicaid.ohio.gov/resources-forproviders/billing/hipaa-5010-implementation/companion-guides and choose the tab labeled "Future OMES FFS (Trading Partners)." Please be aware the companion guides are subject to change. When changes are made, new companion guides will be posted on Fridays and changes will be listed in Section 12 Change Summary.

Actions needed by trading partners

There are a few actions that trading partners can take now:

- Migrate your connection from the current EDI vendor to Deloitte as soon as possible to ensure no disruption to your ability to exchange EDI transactions on December 1. Please contact Deloitte at usomesedisupport@deloitte.com to begin the migration process.
- Be on the lookout for further communications about important dates to know as we transition to the new EDI.

The slides from the Ohio Medicaid EDI/OMES Trading Partner webinar and corresponding FAQ are now available.

Trading partners must complete a Connectivity Form In order to begin submitting EDI transactions to Deloitte. If you have not completed a Connectivity Form, please contact usomesedisupport@deloitte.com.

Ohio Medicaid members currently receiving healthcare benefits through Paramount Advantage will continue to receive healthcare benefits through that plan until the December 1 launch of the implementation of Next Generation managed care plans. Unless a member chose another plan by the October 1 launch, they will be enrolled with Anthem Blue Cross and Blue Shield on the December 1 launch of the implementation process. Current Paramount members can select a different plan at any time during the member transition and enrollment period. The Fee-for-Service pool of new Medicaid enrollees that enrolled from 3/1/22-11/30/22 will be distributed between AmeriHealth and Humana.

What questions do you have about the phase 3 implementation?

- **OhioRISE**

As a reminder, providers must be contracted with Aetna for OhioRISE. However, in the first 90 days of the program, Aetna will pay claims regardless of contract status. After 9/30/22, if a provider is not contracted with Aetna for OhioRISE and bills a claim, this claim will be denied. It is important for providers serving youth to begin the contracting process if you have not done so already. Additionally, if you serve clients under 21, you should consider a process for regular eligibility determinations. An inpatient psychiatric hospitalization will automatically enroll Medicaid recipients under 21 into OhioRISE.

ODM is hosting OhioRISE implementation office hours to provide opportunities for providers and stakeholders to raise additional questions to OhioRISE subject matter experts to help implement and operationalize the program. **All community partners and providers are invited to attend these office hours available each Tuesday from 2-3 p.m. ODM has indicated they will continue these weekly office hours through the end of the calendar year.**

Meeting Date and Time	Meeting Link
Every Tuesday from 2-2:30 p.m.	Click here to join

- **MyCare Ohio Conversion Charter and Principles**

Earlier this month, ODM Director Maureen Corcoran shared information on the Next Generation Managed Care Conversion Charter and Principles for MyCare Ohio. With the expiration of Ohio's MyCare demonstration authority, CMS promulgated a new rule that informs what Ohio can do to continue offering integrated care to individuals who are dually

eligible and must navigate both Medicare and Medicaid, and gives additional time to Ohio, if needed, to transition the MyCare program in a thoughtful and seamless manner. There are a total of 258,149 Ohioans who are dually eligible, with 201,030 with full dual eligibility and 68% of them enrolled in MyCare. The current MyCare demonstration will end no later than December 31, 2025.

The Conversion Charter linked above, outlines the similarities and differences between the current MyCare demonstration project and the new plan in detail on page 7. ODM proposes to transition MyCare Ohio to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) and will require fully aligned enrollment in a companion Medicaid managed care plan (MMC) subject to the Next Generation program requirements, in the same geographic territories as they exist in MyCare today, serving individuals 21 years of age and older. The benefit package will remain the same, recognizing that each of the managed care plans provides value added benefits. The choice to opt in or opt out of Medicare managed care will remain. Self-direction will be streamlined, making it amenable to greater use by individuals. Care coordination has a variety of issues that will be discussed, and modifications considered. For example, the large number of younger individuals who have significant mental health needs, while benefiting from the integration of their care, may require changes to the care coordination model to meet their needs.

- **ARPA- HCBS 2nd Payment**

As a reminder, the initial ARPA-HCBS payment providers received was the initial installment. At the end of calendar year (CY) 2022, ODM will reconcile a provider's total claims to actual CY22 claims experience and a final relief payment will be calculated. This was required by CMS in order to avoid a situation where a provider may be "overpaid". There is no action required on the part of the provider during this reconciliation process. ODM will work with the plans at the beginning of CY23 on this final installment of relief. ODM will send out an announcement when the final installments are prepared and post the final amount of payment to the dashboard. ODM has indicated the timing of this second payment will likely be in late February or March to allow for the claims run out for CY22. CMS is requiring ODM to know the total claims value for CY22 to calculate the second payment amount.

- **CMS CY23 Physician Fee Schedule Final Rule** – On 11/1/22 CMS released the final CY23 Physician Fee Schedule rule applicable to Medicare recipients. Key highlights applicable to BH providers include:
    - Telehealth Flexibility Extensions: CMS is extending a number of flexibilities implemented under the Public Health Emergency (PHE) for a 151-day period after the expiration of the PHE. Including the geographic restrictions, audio-only provisions, and delaying the in-person visit requirements for mental health services rendered via telehealth.
        - Note for mental health telehealth services: For beneficiaries who initiated mental health care via telehealth during the PHE or during the 151-day period after the PHE ends, there is no immediate in-person requirement

because the patient is consider "established." These beneficiaries will therefore need to meet the requirement of an annual in-person visit with their mental health practitioner ("so long as any such subsequent telehealth service is furnished by the same individual physician or practitioner (or a practitioner of the same sub-specialty in the same practice) to the same beneficiary").

- Additionally, it is important to remember the Consolidated Appropriations Act of 2022 provided exceptions for Medicare telehealth services, such as no geographic limitations and certain audio-only services for mental health and substance use disorder services, including opioid use disorder.
    - Beneficiaries can still receive mental health and substance use services via telehealth in their homes (and certain other "residence-like" locations) after the end of the PHE and the 151-day post-PHE period. Beneficiaries can also utilize audio-only services if all other requirements are met. In circumstances where the patient does not have the capability or has not consented to two-way/audio-video technology, audio-only technology for mental health and substance use disorder services, including opioid use disorder, is permitted so long as all other requirements are met.
        - CMS finalized the proposal to allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person. These claims will require the modifier "95" to identify them as services furnished as telehealth services. Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends.

- CMS is allowing behavioral health clinicians to offer services incident to a Medicare practitioner under general (rather than direct) supervision. Licensed professional counselors and marriage and family therapists are now able to bill incident to Medicare practitioner for their services.
    - This creates an exception to supervision requirements, allowing other BH providers to provide behavioral health services while being under general supervision rather than "direct" supervision. Practically speaking, this means that these behavioral health practitioners will be able to provide services without a doctor or nurse practitioner physically on site, expanding access to behavioral health services like counseling and cognitive behavioral therapy in additional communities, particularly rural or underserved communities where care can be hard to find.
    - The Final Rule amends the requirements for behavioral health providers under the "incident to" regulations to allow behavioral health services to be governed by the general supervision (instead of direct supervision) of a physician or nonphysician practitioners (NPP) when

services are provided by auxiliary personnel incident to services of a physician or NPP. CMS clarifies that payment for the provision of services by Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) under Medicare can only be made indirectly through "incident to" billing. LPCs and LMFTs may perform services as auxiliary personnel "incident to" and under the direct supervision of a physician or NPP.
        - CMS will not define "behavioral health services" for the purposes of this regulation and indicates that providers are in the best position to determine whether a service is a behavioral health service. However, CMS does note that it generally understands behavioral health services to include "any service furnished for the diagnosis, evaluation, or treatment of a mental health disorder, including substance use disorders (SUD)."
        - CMS indicates that although it did not amend the definition of auxiliary personnel in this Final Rule, other clinician types (such as those that participate in providing behavioral health treatment services) who meet all requirements for auxiliary personnel (§ 410.26) could satisfy the definition of auxiliary personnel. CMS does not, however, specify which clinician types it believes meets the requirements of auxiliary personnel.
        - We are awaiting guidance from ODM on how this will impact the TPL bypass list which is currently under review as required by CMS.
    - Medicare will allow opioid treatment programs to use telehealth to initiate treatment with buprenorphine for patients with opioid use disorder.
    - CMS is also clarifying that opioid treatment programs can bill for opioid use disorder treatment services provided through mobile units, such as vans, in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA) guidance.
    - For more information
        - CMS Press Release
        - CMS CY23 PFS Fact Sheet
        - Updated CMS BH Blog
        - National Council Summary

- **AMA 2023 E&M Coding Updates – 99354-55**

The American Medical Association (AMA) has released changes to the CPT Evaluation and Management (E/M) codes and guidelines, set to go into effect Jan. 1, 2023. The AMA hosted a webinar reviewing these changes. 2023 changes behavioral health organizations should implement include:

- Deletion of direct patient contact prolonged service codes (99354-99357). These services will now be reported through the codes created in 2021, office prolonged service code (99417) or the code created by CMS (G2212 – for Medicare or Medicaid).

- 99417 may not be used with psychotherapy services. This means there will no longer be a prolonged services code that can be used with 90837 starting in January 2023.
- 99354-99357 are being deleted from the CPT coding manual completely. They will no longer be available to bill starting 1/1/23. See page 37 of the guidelines AMA released and slide 52 of the AMA webinar slides.

Does your organization use 99354-55? Will this have a significant impact on your revenue?

DECEMBER 2022

- **ODM Next Generation Stage 2 - PNM Implementation**

The Ohio Council is continuing to track issues related to the 10/1/22 implementation of the PNM. We have communicated these issues to ODM and encourage providers to continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m.

Additionally, we are conducting a survey to gather information from our members related to the cash flow impact of the PNM Phase 2 implementation. If your organization has not already responded, please do so by COB today!

Provider and Agency Revalidation

Provider revalidation notices were sent to providers, included individual providers and organizational providers that will need to be updated in the next 120 days. These notices were sent to the email contact listed in the PNM on 10/1. Once the application is completed and submitted in the PNM, changes cannot be made to the provider until the application has been processed by ODM. This is important for organizational providers revalidating because this means you will not be able to affiliate new providers with the organization during this time.

Provider Type Changes

For providers that are currently enrolled as a paraprofessional, e.g. QMHS, but need to upgrade and change to new provider type, e.g. a CDCA/QMHS, you should do the following:

- In the QMHS provider enrollment, under enrollment action selections choose "request disenrollment"
- Wait for the approval from ODM
- Complete the new provider CDCA application under provider type 54. **To add the secondary specialty, you will need to submit a request to the Provider Enrollment mailbox at: Medicaid_Provider_Update@medicaid.ohio.gov. in that request you will need to provide the providers name, NPI and a description of the request along with supporting documentation.**

Providers with license upgrades, e.g. LSW to LISW, do not need to follow this process since the provider type is the same. Disenrollment is only required when changing provider types.

BH Specific PNM Refresher Training
A PNM virtual refresher training is available for behavioral health providers, scheduled for Wednesday, December 14, 1-3 p.m. Eastern time (ET). This virtual training session is designed to cover common processes that users have experienced issues within PNM since the system launched on October 1st. This session will discuss how to complete these processes in PNM and discuss requirements that the Ohio Department of Medicaid has regarding enrollment and credentialing approval. This course will focus specifically on the processes for behavioral health providers. Training module topics will include the following:

- Eligibility Rule & Guideline Reminders.
- Workflows.
- Changing Provider Types and/or Adding Specialties.
- Initiating a New Provider Application.
- Completing Updates.
- Who to Contact to Resolve Issues?

Absorb, the Learning Management System (LMS), is where you will sign up for this virtual session. If you do not have an account in the LMS, it's important that you create one to ensure you have access to all training sessions, answer forms, and a variety of PNM resources.

What issues is your organization continuing to experience with the Phase 2 launch of PNM?

- **Phase 3 Implementation Delayed to 2/1/23**

The Ohio Department of Medicaid (ODM) sent notice to providers on 11/15/22 that the Phase 3 implementation will be delayed until 2/1/23 We appreciate ODM listening to the concerns of providers and committing to thorough testing prior to the Phase 3.

What does this mean for providers?

Based on the feedback ODM received and their commitment to carefully transitioning, they will not implement the new Next Generation managed care plans and the full Ohio Medicaid Enterprise System (OMES) launch on December 1. The new lineup for implementation is as follows:

- On February 1, 2023, ODM will launch the Next Generation managed care plans and program requirements, including exciting improvements that will support members in accessing the healthcare services and supports they need. ODM will also implement the new Electronic Data Interchange (EDI), increasing transparency and visibility of member care and services.

    - This means Paramount will remain a plan until 2/1/23, when the Phase 3 launch is currently scheduled.

- Subsequently, ODM will fully launch OMES modules to provide streamlined processes for claims, prior authorizations, and other administrative tasks for providers.

Providers should continue conducting business as you do today on and after December 1 – including the processes, procedures and systems used today to submit claims, prior authorizations and complete other administrative functions.

Please reach out to the Next Generation mailbox with questions. Thank you for your continued partnership and support of the Next Generation Ohio Medicaid program.

Rendering Provider on Professional Claims Submissions

ODM is providing additional clarification relevant to EDI-related claims submissions on February 1 and later concerning rendering providers. **ODM will require one rendering provider per claim at the header level, rather than the detail level, for professional claims for both fee-for-service (FFS) and managed care recipients** in order to ensure claims can be properly priced and paid. Examples of claims submissions with the rendering practitioner are as follows:

- A client receives one service during the visit. The rendering practitioner's NPI is recorded in the header field on the claim. The service is recorded at the detail level on the claim without the rendering practitioner's NPI.

- A client receives multiple services from the same rendering practitioner during the visit. The rendering practitioner's NPI is recorded in the header field on the claim. Each service is recorded at a separate detail level without a rendering practitioner NPI.

- The client receives multiple services, each from a different rendering practitioner during the visit. The billing provider must create separate claims for each service provided by each rendering practitioner during the visit. Each claim must record the rendering practitioner NPI at the header level on each claim, and the service they rendered to the client is recorded at the detail level.

There is one exception to this rule for services provided by FFS Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers. FQHC/RHC claims submitted to ODM for payment may include multiple rendering providers at the detail level because ODM pays FQHC/RHC providers based on an encounter. In these specific scenarios multiple rendering providers on a claim will not cause a pricing/paying issue because the rendering providers are not utilized in determining payment for FFS FQHC/RHC wraparound claims. For additional guidance related to

FQHC/RHC providers, please review the Medicaid Advisory Letter located here: Medicaid Advisory Letter 622.

We have been in communication with ODM to understand this change, as this was not what has been shared previously. Until the 12/2/22 press release was sent, this change was only for FFS claims. The survey we are conducting also asks questions about how this change will impact your organization. If your organization has not done so already, please submit your response to this survey by COB today.

On February 1, 2023 the seven Next Generation managed care plans will begin serving Medicaid managed care members. Members with Paramount who do not select a new plan will be assigned to Anthem. At the same time, ODM's new Electronic Data Interchange (EDI) and the Fiscal Intermediary (FI) will go live.

What can providers expect on February 1?

Of the February 1 launch, the new EDI and FI will impact providers the most. As we phase in these new system components, some of your day-to-day processes will change while some will remain the same. Read on to understand how you will be affected.

Claims and prior authorization (PA) submitted through trading partner/clearinghouse

- ODM's new EDI begins accepting trading partner fee-for-service (FFS) and managed care claims.
- Provider claims submitted to trading partners must include the Medicaid member ID (MMIS).
    - Medicaid ID should be obtained with each encounter.
    - Member eligibility can be verified using the ID through the Provider Network Management (PNM) module, which redirects to MITS.
- For professional claims, only one rendering provider is allowed per claim. Individual claims must be submitted for services rendered by different providers. (See exceptions for Federally Qualified Health Centers and Rural Health Clinics in "Rendering Provider on Claims Submissions.")

What is not changing February 1?

- FFS PAs will continue to be submitted to the PNM module.
- Managed care PAs will continue to be submitted to each plan using their existing processes.
- The new EDI will not accept PAs of any kind.

Portal submitted claims and all prior authorizations

What are the key changes on February 1?

- All Next Generation plans will have portals for direct data entry.
- MMIS ID will be the identifying number used for FFS claims processing.

What is not changing February 1?

- Continue using managed care plan portals to direct data enter claims and PAs.

- Plan eligibility will continue to be accessed through MCO portals.
- Continue using the PNM module, which redirects to MITS, as you do today to submit, adjust, and search FFS claim and PA information.

- **OhioRISE**

Medicaid Payment Rates for CANS Assessments Will Increase January 1, 2023
Effective for dates of service January 1, 2023, and after, ODM will be increasing the payment rate for CANS assessments. The updated rates will be reflected in the revised Appendix to OAC rule 5160-27-03, the Medicaid Behavioral Health Provider Manual and the OhioRISE Provider Enrollment and Billing Guidance prior to January 1, 2023.

Is your organization experiencing any issues related to Aetna/OhioRISE?

Is your organization experiencing issues related to billing/receiving payment for MRSS services to any MCO (not related to PNM enrollment delays)?

- **ODM Unit Limit Denials/Reduced Payments**

ODM identified an internal system issue impacting FFS claims resulting in a payment error that caused underpayments for some Medicaid service codes when a certain number of units were exceeded. This affected claims with dates of service on or after October 1, 2022. Behavioral health codes listed below were impacted when billed with more than the specified number of units.

CPT/HCPCS	Service Name	Units Greater Than
H0004	SUD Individual Counseling	4
H0005	SUD Group Counseling	2
H0036	CPST	4
H0038	Peer Support	8
H2012	TBS Group Service Hourly	3
H2015	Intensive Home-Based Treatment/Functional Family Therapy	4
H2017	Psychosocial Rehabilitation	4
H2019	Therapeutic Behavioral Service	4
H2033	Multi-Systemic Therapy	8

Limits on the number of service units for these codes were implemented in error. MITS billing logic for fee-for-service (FFS) claims has been corrected to match ODM policy. ODM is working with Medicaid managed care organizations (MCO) to assess and correct any affected claims for MCO members. **Agencies with affected FFS claims may void and resubmit the claims or submit claims adjustments**. ODM has posted User guidance on how to void or adjust claims on the BH.Medicaid.Ohio.gov website. Agencies needing additional assistance may call the ODM Provider Call Center at 800-686-1516 Option 7 to speak with an agent.

- **ARPA- HCBS 2nd Payment**

As a reminder, the initial ARPA-HCBS payment providers received was the initial installment. At the end of calendar year (CY) 2022, ODM will reconcile a provider's total claims to actual CY22 claims experience and a final relief payment will be calculated. This was required by CMS in order to avoid a situation where a provider may be "overpaid". There is no action required on the part of the provider during this reconciliation process. ODM will work with the plans at the beginning of CY23 on this final installment of relief. ODM will send out an announcement when the final installments are prepared and post the final amount of payment to the dashboard. ODM has indicated the timing of this second payment will likely be in March at the earliest to allow for the claims run out for CY22. CMS is requiring ODM to know the total claims value for CY22 to calculate the second payment amount.

- **CMS CY23 Physician Fee Schedule Final Rule** – On 11/1/22 CMS released the final CY23 Physician Fee Schedule rule applicable to Medicare recipients. The Final Rule amends the requirements for behavioral health providers under the "incident to" regulations to allow behavioral health services to be governed by the general supervision (instead of direct supervision) of a physician or nonphysician practitioners (NPP) when services are provided by auxiliary personnel incident to services of a physician or NPP. CMS clarified that payment for the provision of services by Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) under Medicare can only be made indirectly through "incident to" billing because CMS does not have the authority to add them as practitioners. However, they are hoping to expand access by is changing the supervision requirements to make it more accessible to bill under the existing CMS incident to provisions by allowing general supervision. (this is outlined on page 489-490 of the rule).

The definitions of auxiliary personnel, general and direct supervision are outlined here. LSWs/LPCs/MFTs will be able to bill under general supervision and any practitioner that meets the definition of auxiliary personnel will as well. While CMS did specifically name counselors/MFTs in their rule as an example, they did not make changes to the definition of auxiliary personnel nor did they specify which clinician types meet the requirements of auxiliary personnel, so that will be up to agency policy to determine/document. The CMS incident to requirements, including eligible NPPs for incident to billing are outlined here on page 81, please note that you cannot bill Medicare incident to an LISW, this is a common misconception. **You must still follow the incident to guidelines, aside from the direct supervision requirements.** To be covered incident to the services of a physician or other practitioner, services and supplies must be:

1. An integral, although incidental, part of the physician's professional service (see §60.1);
2. Commonly rendered without charge or included in the physician's bill (see §60.1A);

3. Of a type that are commonly furnished in physician's offices or clinics (see §60.1A);
4. Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §60.1B).

For more information:

- CMS Press Release
- CMS CY23 PFS Fact Sheet
- Updated CMS BH Blog
- National Council Summary

- **AMA 2023 E&M Coding Updates – 99354-55**

The American Medical Association (AMA) has released changes to the CPT Evaluation and Management (E/M) codes and guidelines, set to go into effect Jan. 1, 2023. The AMA hosted a webinar reviewing these changes. 2023 changes behavioral health organizations should implement include:

- Deletion of direct patient contact prolonged service codes (99354-99357). These services will now be reported through the codes created in 2021, office prolonged service code (99417) or the code created by CMS (G2212 – for Medicare or Medicaid).
  - 99417 may not be used with psychotherapy services. This means there will no longer be a prolonged services code that can be used with 90837 starting in January 2023.
  - 99354-99357 are being deleted from the CPT coding manual completely. They will no longer be available to bill starting 1/1/23. See page 37 of the guidelines AMA released and slide 52 of the AMA webinar slides.

We have reached out to ODM to determine the impact of the deletion of 99354/55 for BH providers and have asked they consider CBHCs to continue billing this code beyond 1/1/23. At this time we do not have an answer to this request as ODM is pulling data to determine the impact. Providers should continue planning for this change for 1/1/23, unless otherwise informed by ODM or The Ohio Council.

- **Plan Specific Updates/Issues**
  - Molina – identified an issue with claims denying related to POS 11. This will be added to their December CPSE report.
  - Molina - Molina's contracted vendor, Change Healthcare, will be sunsetting their ProviderNet portal as of Jan. 1, 2023. More information is available here. Availity Essentials (Availity) is now the official secure provider portal for Molina providers

JANUARY 2023

- **Key Resources**
  - Current BH Provider Manual (12/19/2022)
  - OhioRISE Provider Manual (9/30/22)

- CME Manual (6/21/22)
- ODM Press Release (12/16/22)
- ODM Press Release (12/22/22)
- 2/1/23 Launch Resources (12/23/22)
- ODM Press Release (1/5/23)
- MITS Bits/BH Bulletin (12/19/22)
- PNM Refresher Training Slides (12/14/22)
- Trading Partner Training Slides (12/19/22)
- EDI Training Slides (1/6/23)
- Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
- If you do not receive MITS Bits, be sure to subscribe for MITSBits and sign up for the BH Newsletter.

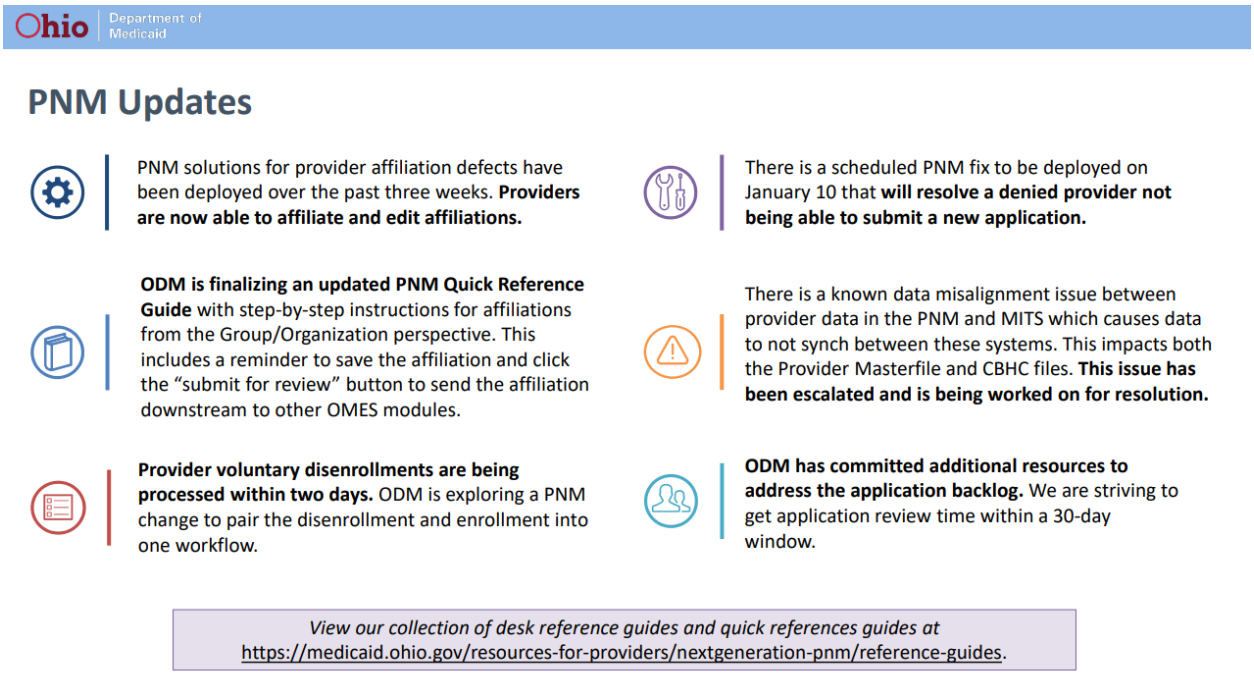
- **ODM BH Provider Manual Updates**

The Ohio Department of Medicaid shared updates to the Behavioral Health Provider Manual which became effective 1/1/23. The updated manual includes several updates:

- Revised Medicaid payment rates for the administration of the Child and Adolescent Needs Survey (CANS). (This change aligns with recent updates to OhioRISE provider guidance.)
- Clarification that Mobile Response Stabilization Service (MRSS) may not be billed for time spent administering the CANS assessment. (This change aligns with recent updates to OhioRISE provider guidance)
- Discontinuation of prolonged services codes (99354 and 99355) for psychotherapy services beginning January 1, 2023, and after. This follows the new CPT/HCPCS guidance from the American Medical Association (AMA) beginning January 1, 2023.
    - Providers should refer to AMA and National Correct Coding Initiative (NCCI) guidance with regard to billing psychotherapy codes for dates of service on or after January 1, 2023. CPT coding guidance and NCCI edits allow for 2 units of 90837 by the same practitioner, same day for the same client. If a client receives 106 minutes or more of psychotherapy, then 2 units of 90837 can be billed.
- Discontinuation of CPT code 99343, Evaluation & Management Home Visit, presenting problems moderate to high severity, typically 45 minutes. This change also follows guidance of the AMA.
- Codes added for several provider administered pharmaceuticals on Table 2-9

- **ODM Next Generation Stage 2 - PNM Implementation**

The Ohio Council is continuing to track issues related to the 10/1/22 implementation of the PNM. We have communicated these issues to ODM and encourage providers to continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m. **If the help desk is unable to resolve your issues, you can request a one-on-one technical assistance session by contacting PNMCommunications@medicaid.ohio.gov.**



Provider and Agency Revalidation

Provider revalidation notices are sent to the email contact(s) listed in the PNM. Some functionalities in the PNM do not work once the provider is within 120 days of revalidation. In order to bypass this, you should start the revalidation, you do not have to complete it the same day but selecting "begin revalidation" will allow you to complete functions such as affiliating staff with the organization. Once the application is completed and submitted in the PNM, changes cannot be made to the provider until the application has been processed by ODM. This is important for organizational providers revalidating because this means you will not be able to affiliate new providers with the organization during this time.

Organization providers are required to pay a fee at revalidation. The fee can be waived if your organization paid the Medicare fee in the past 2 years. That is outlined on page 2, and in ODM rule, see paragraph G.

BH Specific PNM Refresher Training

The slides from the 12/14/22 BH Refresher training are available and a recording of the training is posted in the LMS as well. Additionally, January 2023 refresher trainings on the PNM have been added to the Maximus Learning Management System. The training schedule has been posted and is available on the Next Generation website.

Since the launch of the Provider Network Management (PNM) module on October 1, several affiliation issues have been identified and applicable fixes have been deployed.

Tips and reminders

Below is a list of tips and reminders intended to assist you in navigating the PNM module:

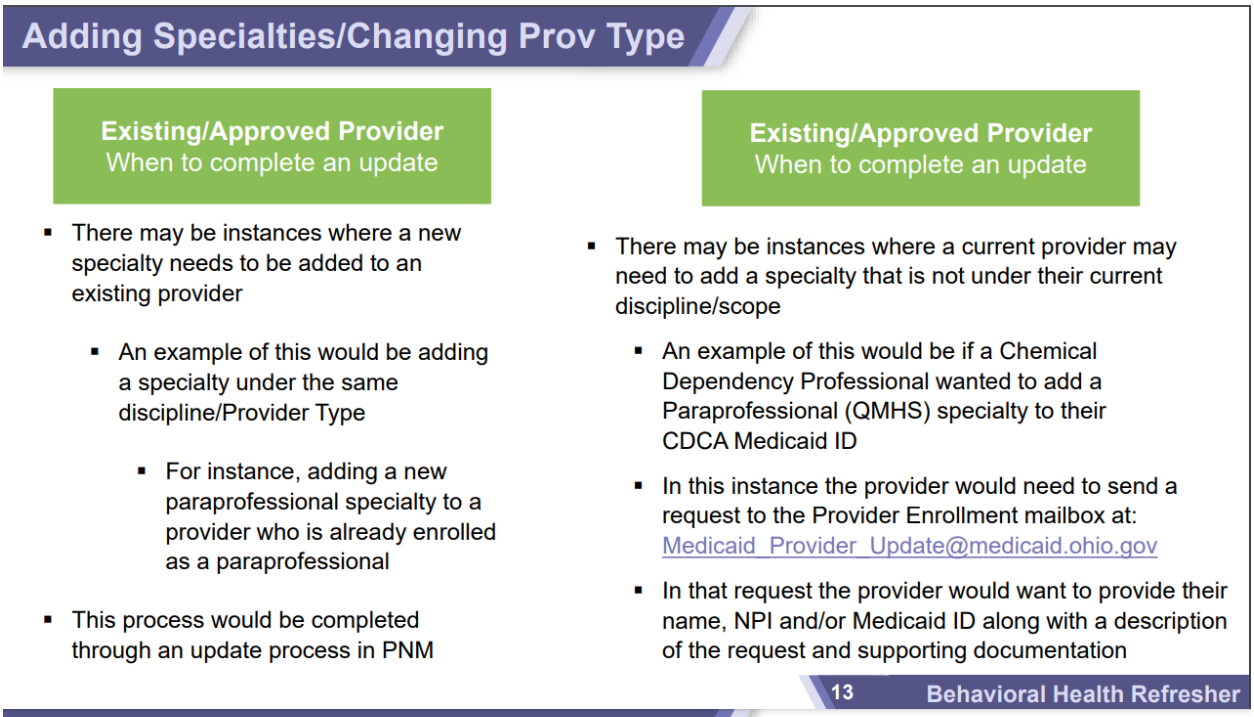
1. Rendering providers must be affiliated to the billing organizations for specific provider types, this includes Behavioral Health organizations, Federally Qualified Health Centers (FQHCs), and professional medical groups. This does not happen automatically once an individual provider is enrolled, it is an action that must be completed in the PNM.

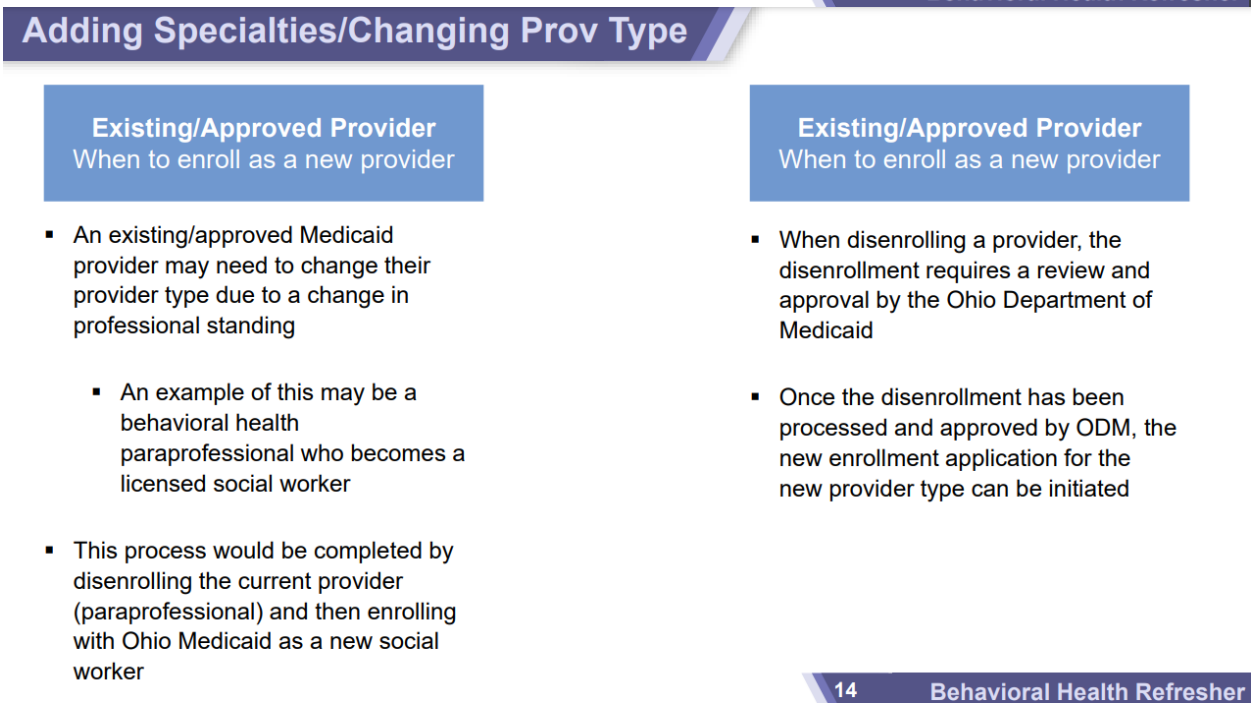
2. Actions taken in the PNM module begin a workflow that, when completed, sends the updated transaction downstream to the other Ohio Medicaid Enterprise System (OMES) modules. These modules include the single pharmacy benefit manager (SPBM) and Medicaid Information Technology System (MITS).
3. In all self-service updates, which include the establishment of affiliations, please remember to complete the workflow by clicking the <SAVE> button for each of the affiliation updates, then clicking the <SUBMIT FOR REVIEW> button. This last step will ensure the transaction is sent downstream to the other modules and subsequently completed. This allows the affiliation to be finalized.
4. If you started an affiliation and it remains highlighted in yellow on the affiliations page, it may be best to simply cancel that transaction by clicking on the red "x." From there, create a new affiliation, save it, then submit for review. It's possible that a provider organization started the affiliation during the period when PNM fixes were deployed, causing the transaction to be stuck.

Reference guides

The PNM reference guides provide step-by-step instructions for various PNM actions and are continuously being updated. Click the "Learning" Tab in the top menu of the PNM application to access "User Guides" and "Quick Reference Guides." Please note you do not need to be logged in to access this menu.

Provider Type Changes





Provider Affiliation

Many organizations have indicated having difficulty affiliating enrolled providers with their organization. Having the employing agency perform the affiliation of individual practitioners is the recommended best practice – fewer steps than if the individual affiliates with the agency. This process is outlined in detail in the 12/14 slides, starting on slide 37. If that process is not working for you, reach out to the IHD. Additionally, there is a known issue with the synchronization of data from the PNM to MITS resulting in issues with the PMF which is sent to MCOs. If a provider is showing as affiliated with your organization in

the PNM, but you are receiving denials from an MCO, it is likely due to that issue. ODM is aware of this issue and has escalated it for resolution.

- **UPDATE: Reconciling October 14 FFS Advance Payments**

Ohio Medicaid will begin recouping advanced provider payments made October 14 that were offered due to connectivity issues between systems. Providers that billed through the portal using direct data entry and received an advance payment will see recoupment on the December 22 payment.

Remittance advices will note the recoupment, distinguishing it from the standard claims payments. The recoupment will continue to offset in future payment cycles until it is recovered in full. Click here for more information.

- **2/1/23 Next Generation Provider Webinar**

ODM will be hosting a 1-hour webinar to share information on the changes Ohio Medicaid providers can expect in the next implementation scheduled for 2/1/23, including an overview of the transition to the Next Generation managed care plans, Electronic Data Interchange, and Fiscal Intermediary. Additionally, they will discuss key changes and where resources are available to assist providers in the transition.

The webinar will also be made available as a recording on the Resources for Providers webpage of the Ohio Medicaid Next Generation website.

Webinar Title	Webinar Date / Time	Registration Link
Next Generation February 1 Launch Provider Webinar	**Thursday, January 19** **3 - 4 p.m. ET**	Click here to register

- **Phase 3 Implementation - 2/1/23**

On February 1, 2023, the seven Next Generation managed care plans will begin serving Medicaid managed care members. Members with Paramount who do not select a new plan will be assigned to Anthem. At the same time, ODM's new Electronic Data Interchange (EDI) and the Fiscal Intermediary (FI) will go live. The Next Generation Ohio Medicaid Program Overview document provides a detailed summary of the Next Generation initiatives. Additionally, the Ohio Medicaid Managed Care Provider frequently asked question (FAQ) document answers several questions.

What can providers expect on February 1?

Of the February 1 launch, the new EDI and FI will impact providers the most. As we phase in these new system components, some of your day-to-day processes will change while some will remain the same. Read on to understand how you will be affected.

Claims and prior authorization (PA) submitted through trading partner/clearinghouse

- ODM's new EDI begins accepting trading partner fee-for-service (FFS) and managed care claims.

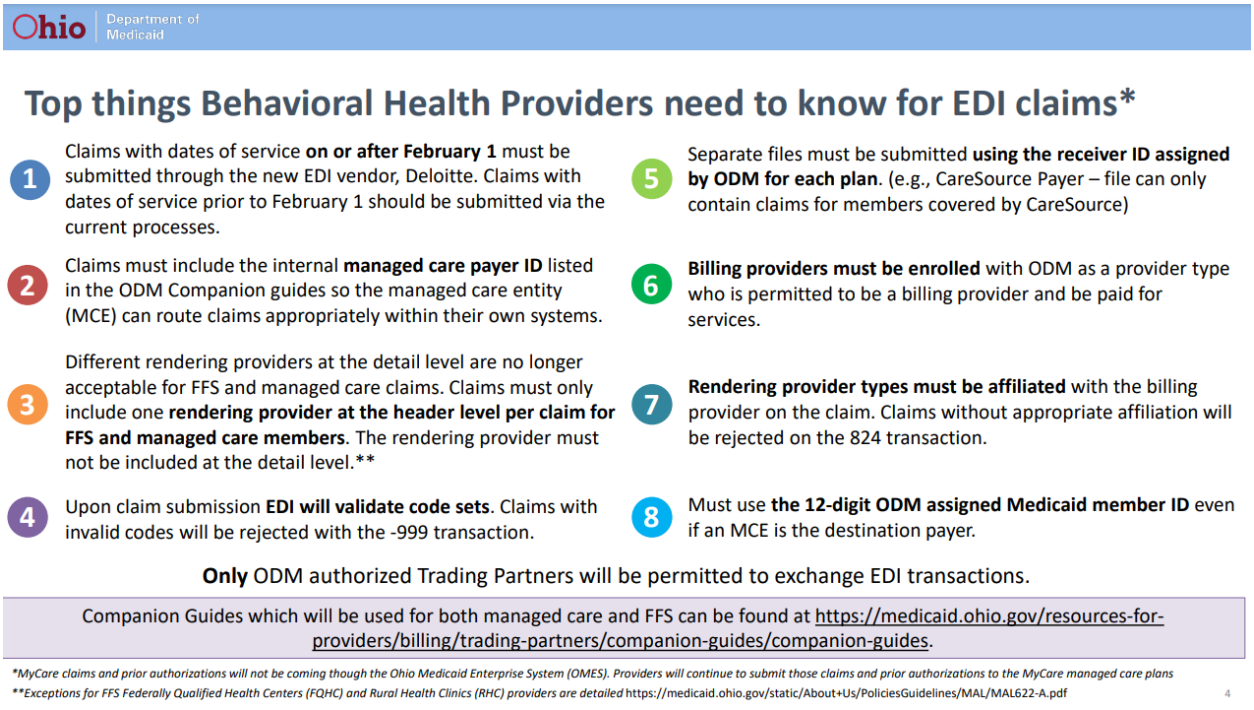
- Provider claims submitted to trading partners must include the Medicaid member ID (MMIS).
    - Medicaid ID should be obtained with each encounter.
    - Member eligibility can be verified using the ID through the Provider Network Management (PNM) module, which redirects to MITS.
- For professional claims, only one rendering provider is allowed per claim. Individual claims must be submitted for services rendered by different providers.

What is not changing February 1?

- FFS PAs will continue to be submitted to the PNM module.
- Managed care PAs will continue to be submitted to each plan using their existing processes.
- The new EDI will not accept PAs of any kind.

In the following months ODM will fully launch the OMES PNM and EDI modules to provide streamlined processes for claims, PAs, and other administrative tasks for providers. PNM claims and prior authorizations and EDI trading partner transactions do not include MyCare Ohio plans.

Ohio Medicaid providers can reach out to the help desk at 800-686-1516 or IHD@medicaid.ohio.gov. or review the February 1 Ohio Medicaid Provider Help Desk One-Pager.



EDI Module 8 Things to Know – Updated

ODM made updates to the previously communicated information on EDI changes. Regarding #5, we confirmed with ODM that providers must submit claims with a date of

service on or after 2/1/23 to the new EDI module. However, it is permissible to send claims with a date of service prior to 2/1/23 to the EDI module **if** the claims file structure meets all the new requirements for the EDI, which includes the new payer IDs, MMIS, and receiver IDs. This is applicable to all MCOs, except Paramount. Providers also have the option of submitting claims with a date of service prior to 2/1/23 to the MCO through their current process, this is required for Paramount claims. ODM made this change to allow greater flexibility for providers when billing claims prior to 2/1/23.

Additionally, ODM shared detailed information with Ohio Council members on the required EDI changes. The slides from that presentation are available here. Slides 2-11 cover the EDI changes.

Organizations working with a clearinghouse to submit claims, should be in communication with their clearinghouse regarding the 2/1/23 changes and what their vendor expects from their organization when submitting claims. Organizations that are authorized trading partners with ODM, should make the required changes outlined in the companion guides and engage in testing with Deloitte, usomesedisupport@deloitte.com ODM hosted a webinar for authorized trading partners on the changes and testing requirements. The slides are available as is a recording of the 12/19/22 webinar. A trading partner checklist is available on slide 25 of steps to take prior to 2/1/23.

On February 1, 2023, Ohio Department of Medicaid (ODM) will implement the new Electronic Data Interchange (EDI) module as part of the Next Generation program. Please take a moment and read through this email for the top eight things you need to know about the new EDI. **To view the new information from our last issue please see here.**

#1: The new EDI, supported by the vendor Deloitte, is replacing the current EDI.

On February 1, the new EDI will be the exchange point for trading partners on all claims-related activities including claim status and eligibility. All trading partner claims must be submitted directly to the EDI, regardless of whether the member is receiving benefits through Medicaid fee-for-service (FFS) or one of the Next Generation managed care plans. Please note that MyCare is not included in the Next Generation program and will continue to use current processes.

Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal. All managed care prior authorizations will continue to be submitted to the respective managed care portals or through their respective processes. Additionally, FFS direct data entered claims and prior authorizations will continue to be submitted through the Provider Network Management (PNM) module via a link to Medicaid Information Technology System (MITS).

#2: There is a change in policy about rendering providers on claims.

For EDI-related claims submissions, **ODM now requires one rendering provider per claim at the header level**, rather than the detail level, for professional claims for both FFS and managed care recipients. Different rendering providers at the detail level are no

longer acceptable. Exceptions for FFS Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers are detailed in the Medicaid Advisory Letter 622.

#3: Provider claims submitted to trading partners must use the ODM-assigned Medicaid member ID (MMIS).

The Medicaid ID should be obtained with each visit. The Medicaid ID must be used on all EDI claim submissions. Member eligibility can be verified using the PNM portal, which redirects to MITS, or using the 270 /271 eligibility transaction in EDI.

#4: There will be system downtime leading up to February 1.

As we transition to the new EDI, there will be system downtime for processing of trading partner claims. They are as follows:

- **January 25-31**: There will be an FFS (837 P/I/D) claims transition period.
- **January 30-31**: There will be a member and claim inquiry blackout.

During this time ODM will not accept claims submitted via trading partners. Please work with your trading partner to discuss any changes or impacts to your submissions.

#5: *New Information* Pay attention to claims date of service when submitting for adjudication.

Claims with dates of service on or after February 1 must be submitted through the new EDI vendor, Deloitte. Claims with dates of service prior to February 1 should be submitted via the current processes.

#6: Check that your trading partner is authorized to work with ODM.

All clearinghouses or trading partners who are already authorized to submit claims to ODM will continue to have access to submit claims on behalf of providers. Please contact your trading partner to ensure they are ready to transition.

#7: Each managed care claim must include the internal managed care payer ID and a receiver ID.

All managed care claims submitted through the new EDI must include the internal managed care payer ID and a receiver ID. Please see the ODM Companion Guides for a full list of the updated receiver and payer IDs or see slides 6-7 for the MCO receiver and payer IDs. Please note the payer and receiver IDs for FFS claims have not changed.

#8: Providers must submit attachments in the original method of claim submission.

Claim attachments must be submitted via the same method as the claim submission. For example, for a claim submitted via DDE, an attachment must also be done using DDE. For EDI transactions, please work with your trading partner on how to upload attachments. This is similar to the adjustment policy detailed in the December 12 edition of the ODM Press.

- **OhioRISE**

Medicaid Payment Rates for CANS Assessments increased January 1, 2023 -
Effective for dates of service January 1, 2023, and after, ODM increased the payment rate for CANS assessments. The updated rates are reflected in the revised Appendix to OAC rule 5160-27-03, the Medicaid Behavioral Health Provider Manual and the OhioRISE Provider Enrollment and Billing Guidance.

Is your organization experiencing any issues related to Aetna/OhioRISE?

- **Telehealth Clarification**

The OhioMHAS rule and ODM rule, when read in their totality, allow for all OhioMHAS and ODM eligible providers to deliver services via telehealth when delivered by OhioMHAS certified entities. Specifically, 5160-1-18 (B)(2)(j) includes community BH providers as defined in 5160-27-01, which is all PT 84/95. Then, 5160-1-18 (D)(21) includes all services covered under 5160-27, which is all community BH services. OhioMHAS rule 5122-29-31 lists all the services that are eligible to be provided via telehealth when delivered by a OhioMHAS certified provider. HB 122 codified these telehealth provisions in statute and requires certain health professional licensure boards to adopt rules that support telehealth services for individuals licensed under those boards. This is outlined further in ORC 5119.368 which permits telehealth services when provided by OhioMHAS certified agencies.

- **Federal FY23 Omnibus Provisions**

On 12/29/22 the federal FY23 Omnibus package was signed into law. This legislation includes several provisions that will impact billing Medicare for services that previously were contingent upon the Public Health Emergency.

Telehealth Flexibilities Extended

Telehealth flexibilities extended permanently:

- Medicare reimbursement for mental health telehealth services (including audio-only services in some cases), provided that there is an in-person visit within the first six months of an initial telehealth visit and every 12 months thereafter (with certain exceptions). Implementation of this in-person requirement is delayed until Jan. 1, 2025.

Telehealth flexibilities extended for two years through 12/31/24:

- Expanding the originating site to include any site at which the patient is located, including the patient's home;
- Extending the ability for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to furnish telehealth services;
- Delaying the in-person requirement for mental health services furnished through telehealth; and
- Extending coverage and payment for audio-only telehealth services

Telehealth flexibilities available through the calendar year in which the PHE ends:

- Virtual presence for direct supervision is available through the end of the calendar year the PHE ends, though CMS continues to consider comments regarding this issue for potential future PFS rulemaking.

Telehealth flexibilities impacting **all services** and ending immediately when the PHE ends:

- During the COVID public health emergency, HHS Office for Civil Rights (OCR) applied enforcement discretion to telehealth providers, allowing them to utilize any non-public facing remote communication product, even if they don't fully comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). OCR has recently clarified in a FAQ document that the enforcement discretion will remain in effect until the Secretary of HHS declares that the public health emergency no longer exists, or upon expiration date of the declared PHE. OCR will issue a notice to the public when it is no longer exercising its enforcement discretion.
- During the emergency, providers were able to prescribe controlled substances without an in-person examination. This flexibility will expire with the end of the PHE, requiring providers to adhere to strict rules. In most cases this will require a patient to be located in a doctor office or hospital registered with the DEA to be prescribed a controlled substance via telehealth. A proposed rule would create an additional permanent exception for prescribing buprenorphine in an Opioid Treatment Program (OTP) but has not yet been finalized.

Counselors & Therapists added as Medicare Providers effective 1/1/24
This legislation will add independently licensed marriage and family therapists and counselors as Medicare providers effective 1/1/24. This is outlined on page 1443 of the omnibus legislation linked above. There is not yet a timeline for when eligible counselors and therapists will be able to initiate the Medicare enrollment process. It will likely take several months for CMS to draft the policies pertaining to counselors and therapists to begin the process of enrolling. This is separate legislation from the previously discussed CMS CY23 PFS rule which relaxed the supervision requirements to general supervision for incident to billing (see detailed explanation in next bulleted section) and became effective 1/1/23.

- **CMS CY23 Physician Fee Schedule Final Rule**

On 11/1/22 CMS released the final CY23 Physician Fee Schedule rule applicable to Medicare recipients. The Final Rule amends the requirements for behavioral health providers under the "incident to" regulations to allow behavioral health services to be governed by the general supervision (instead of direct supervision) of a physician or nonphysician practitioners (NPP) when services are provided by auxiliary personnel incident to services of a physician or NPP. CMS clarified that payment for the provision of services by Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) under Medicare can only be made indirectly through "incident to"

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5. An integral, although incidental, part of the physician's professional service (see §60.1);
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8. Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §60.1B).

For more information:

- CMS Press Release
- CMS CY23 PFS Fact Sheet
- Updated CMS BH Blog
- National Council Summary

- **ARPA- HCBS 2nd Payment**

As a reminder, the initial ARPA-HCBS payment providers received was the initial installment. At the end of calendar year (CY) 2022, ODM will reconcile a provider's total claims to actual CY22 claims experience and a final relief payment will be calculated. This was required by CMS in order to avoid a situation where a provider may be "overpaid". There is no action required on the part of the provider during this reconciliation process. ODM will work with the plans at the beginning of CY23 on this final installment of relief. ODM will send out an announcement when the final installments are prepared and post the final amount of payment to the dashboard. ODM has indicated the timing of this second payment will likely be in March at the earliest to allow for the claims run out for CY22. CMS is requiring ODM to know the total claims value for CY22 to calculate the second payment amount.

FEBRUARY 2023

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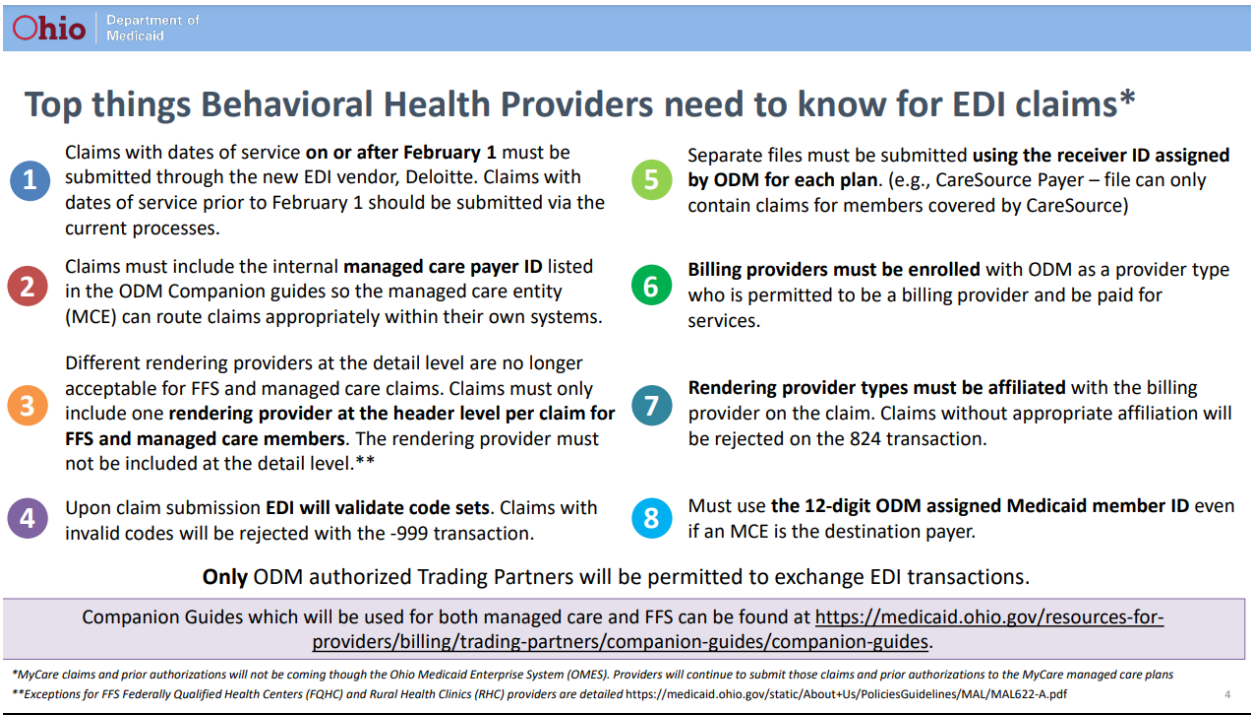
  - OhioRISE Provider Manual (12/9/22)
  - CME Manual (6/21/22)
  - ODM Press Release (1/20/23)
  - ODM Press Release (1/27/23)
  - ODM Press Release (2/1/23)
  - ODM Press Release (2/10/23)
  - 2/1/23 Provider Help Desk
  - 1/31/23 Pause on Provider Revalidation Notice
  - PNM Refresher Training Slides (12/14/22)
  - Trading Partner Training Slides (12/19/22)
  - EDI Training Slides (1/6/23)
  - Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
  - If you do not receive MITS Bits, be sure to subscribe for MITSBits and sign up for the BH Newsletter.

- **ODM Next Generation Phase 3 Implementation**

On February 1, 2023, the seven Next Generation managed care plans began serving Medicaid managed care members. Members with Paramount who did not select a new plan were assigned to Anthem. Additionally, on February 1, the EDI became the new exchange point for trading partners on all claims-related activities, to provide transparency and visibility regarding care and services. The FI, in conjunction, assists in routing managed care claims submitted to the EDI and adjudicates and pays fee-for-service (FFS) claims submitted to the EDI.

The Next Generation Ohio Medicaid Program Overview document provides a detailed summary of the Next Generation initiatives. Additionally, the Ohio Medicaid Managed Care Provider frequently asked question (FAQ) document answers several questions. In the following months, ODM will fully launch the OMES PNM and EDI modules to provide streamlined processes for claims, PAs, and other administrative tasks for providers. PNM claims and prior authorizations and EDI trading partner transactions do not include MyCare Ohio plans.

ODM has shared that they have received and processed claims through EDI to the MCOs. The MCOs have reported they are receiving and adjudicating claims through EDI. However, some providers are experiencing issues with claims submission. The EDI issues are more complex to diagnose than PNM issues as there are several junctures where there could be an issue (provider, clearinghouse, EDI, and the MCO).



Reminders on Claims Submission to EDI

- Claims must contain the 12-digit Medicaid Member ID (MMIS) for FFS and MCO claims.
- Claims with a DOS prior to 2/1/23 can be submitted to EDI, but should follow the new format.
- Claims must be sent using the new payer and receiver IDs for the MCOs.
- MCOs have 21 days to pay claims, we do not anticipate they will pay slower than previously, but some of the plans had edits in place they needed to change post-implementation that may be impacting the speed of claims payment.
- The Next Generation managed care program changes **do not apply** to MyCare Ohio plans. MyCare claims are not to be sent to EDI, providers should continue following the process in place prior to 2/1/23 for MyCare plans.
- If you use a clearinghouse, consult with your clearinghouse on any specific decisions/rules they put in place that may impact your claims submission or need to change these items in your EHR/claims files.
- Check that your clearinghouse is in active status with ODM re: phase 3 readiness.

Claim submission and adjudication reminders.

Where do you submit claims?

For providers who utilize direct data entry (DDE):

- FFS claims submitted using DDE continue to be submitted from a Medicaid Information Technology System (MITS) portal page accessed via a link in the Provider Network Management (PNM) module. FFS claims submitted through the PNM module continue to be paid by OAKS, the State of Ohio's accounting system.
- Managed care claims submitted using DDE should be processed through the applicable managed care entity (MCE) portal.

For providers who utilize a trading partner:

- All managed care and FFS claims submitted by trading partners are submitted through the new EDI. Providers with a trading partner should confirm their trading partner has completed all required connectivity activities with Deloitte, the new EDI vendor.

Where do you submit claim attachments?

- All managed care attachments are handled by the applicable MCE. Providers should work with each MCE to submit attachments following the process outlined by that MCE.
- FFS claim attachments are submitted from a MITS portal page accessed via a link in the PNM module. Trading partners do not submit attachments on behalf of providers.

Where do you edit claims?

Edits to claims, including adjustments and voids, are submitted utilizing the same method (MCE portal, MITS page accessed via the PNM module, or through a trading partner utilizing the new EDI) as the original claim submission.

Where do you go for more information on claims?

For claims submitted but not yet paid:

- If a trading partner submitted the claim through the new EDI and the claim was passed to the MCE, including claims sent from Ohio Department of Medicaid (ODM) to the MCE for adjudication, the provider should visit the applicable MCE's portal.
- FFS claims submitted but not yet paid are not visible to providers. These claims will not be visible in the PNM module until a future system release.

For paid claims:

- All payers' .pdf remittance advices (RA) are available to providers on the PNM portal. This includes MITS, FI, and MCO RAs.
- If a provider is enrolled with ODM to receive an 835, that enrollment applies to both FFS and MCO activity. 835s from all payers are delivered by the trading partner.

Additional information on claim submission for providers who utilize trading partners.

With the launch of the new EDI, changes in the claim submission process are required for trading partners to exchange transactions in the new EDI. Providers should work with their trading partners to determine the changes that may be needed to their systems and staff training. A few important changes for providers who utilize trading partners to note are as follows:

- For EDI-related claims submissions, ODM now requires one rendering provider per claim at the header level, rather than the detail level, for professional claims for both FFS and managed care recipients. Different rendering providers at the detail level are no longer acceptable. Exceptions for FFS Federally Qualified Health Center

(FQHC) and Rural Health Clinic (RHC) providers are detailed in the Medicaid Advisory Letter 622.

- Provider claims submitted to trading partners must include the Medicaid member ID (MMIS). Member eligibility can be verified using the ID through the PNM module, which redirects to MITS.
- Each managed care claim must include the new internal managed care payer ID and a receiver ID. FFS claims also require a payer and receiver ID but they remain the same. If you submit your own claims through the EDI, please refer to the ODM 837P Companion Guide for the updated receiver and payer IDs list.

Initial Expected EDI Processing Timelines

Fee-for-Service Transactions

- 999/824: Within 12 hours.
- FFS 277CA: Within 24 hours.
- FFS 835: Sent weekly on Wednesdays for claims processed by the prior Friday at 5 P.M. Eastern Time (ET).
- FFS 270/271 Member Inquiry Real-Time: Within 20 seconds.
- FFS 270/271 Member Inquiry Batch: For 270s submitted by 9 P.M. ET, 271s will be returned by 7 A.M. ET the following business day.
- FFS 276/277 Claim Inquiry Real-Time: Within 20 seconds.
- FFS 276/277 Claim Inquiry Batch: For 276s submitted by 9 P.M. ET, 277s will be returned by 7 A.M. ET the following business day.

Steps for Resolving EDI issues.

- Organizations working with a clearinghouse to submit claims.
    - Contact your clearinghouse regarding the 2/1/23 changes to determine if the issue is on the provider side, the clearinghouse, EDI, or MCO.
    - If you are unable to resolve the issue through changes to your claim structure or with your clearinghouse, then contact the MCO (if applicable), and then ODM via the IHD at 800-686-1516 or IHD@medicaid.ohio.gov. When contacting the IHD be as specific as possible regarding the issue you are experiencing.
- Organizations that are authorized trading partners with ODM and submitting their own claims to EDI.
    - Review the companion guides to ensure your claims are in compliance with the new requirements.
    - Contact ODM for EDI support, use the **new email account** **OMESEDISupport@medicaid.ohio.gov** or contact the EDI Call Center at 800-686-1516, option 4. When contacting the IHD be as specific as possible regarding the issue you are experiencing.

What issues is your organization experiencing related to EDI specifically (not clearinghouse level issues)?

- **Prior Authorization**

Since February 1, all managed care prior authorizations must be submitted to the managed care portal via the applicable managed care entity (MCE) guidance, which may include portal entry or other through another electronic process. For fee-for-service prior authorizations, providers will continue the current process by logging into the PNM module, where, after selecting the "prior authorizations" button, you will be automatically redirected to MITS.

New MCO PA Process

- AmeriHealth uses Navinet or fax

UM Fax: 1-833-329-6411 UM Phone: 1-833-735-7700

Providers will also be able to submit requests through Navinet, the provider portal. Information about Navinet and registration can be completed at the link below. https://www.amerihealthcaritasoh.com/provider/resources/navinet.aspx

- Anthem uses Availity or fax 1-866-577-2183
- Humana uses Availity. No fax option.

- **MCO External Medical Review Process**

The new MCO provider agreement with ODM includes an option for an external medical review (EMR) of MCO determinations. EMR is the review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organization (MCO)'s and/or the OhioRISE (Resilience through Integrated Systems and Excellence) plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. When a provider receives a prior authorization denial, the first step they should take is to request a peer-to-peer review.

Only services denied, limited, reduced, suspended, or terminated for lack of medical necessity by a Medicaid MCO and/or the OhioRISE plan are eligible for EMR. This includes claims submitted to the MCO and/or OhioRISE plan which have been denied for lack of medical necessity. EMR is not currently available for MyCare Ohio, Single Pharmacy Benefit Manager (SPBM), or fee-for-service (FFS) Medicaid programs. Prior to requesting an EMR, providers must first appeal or dispute the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCO and/or the OhioRISE plan's internal provider appeal or claim dispute resolution process.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to the EMR entity together with the required supporting documentation. Providers must upload the request form and all supporting documentation to the EMR entity's provider portal located at https://ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access). The request for an EMR must be submitted to the EMR entity within 30 calendar days of the written notification from the MCO and/or the OhioRISE plan that either the first level of internal prior authorization appeals or first level of provider claim dispute process has been completed.

Resources for this new process are posted at https://medicaid.ohio.gov/resources-for-providers/managed-care and include a summary grid, process map, and FAQ.

- **Pause on Provider Revalidation**

The Ohio Department of Medicaid (ODM) is pausing provider agreement revalidations/recredentialing by pushing out all pending provider revalidation due dates in the Provider Network Management (PNM) module by 180 days.

The update will apply to all providers who have not begun the revalidation process, including those that currently display the "Begin Revalidation" button. This indicates the provider has already entered their 120-day period before the revalidation is due. Dates were to be officially pushed out in the system last week starting on 2/6/23. Once the dates are pushed out by 180 days, all providers will still have a 120-day notice before a revalidation or recredentialing is due.

What action do I need to take?

- If you **do not see the "Begin Revalidation" button** in the provider record, you do not need to do anything. The update will move the dates out another 180 days.
- If you **do have the "Begin Revalidation" button**, this means you are within the current 120-day window for revalidation.
- If you **have not started, please do not click on the "Begin Revalidation" button**. Once the deployment takes place during the week of February 6, that button will disappear if you have not launched the revalidation workflow.

EXCEPTION: Please note that if you have already started a revalidation, it must be completed and submitted as this change cannot be applied to providers that are currently in the revalidation workflow.

- **PNM Affiliations**

ODM released an Affiliations Quick Reference Guide, showing step-by-step instructions related to affiliation within the PNM for providers to enter an affiliation as a new individual practitioner and how to confirm, add, and remove an individual practitioner's affiliation from an organization.

Affiliations to a group/organization/agency can be made through either the individual practitioner's application/record or through the group/organization/agency's application/record.

1. An individual will need to have the Medicaid ID of the group/organization/agency to request affiliation to that entity. **Entering that information DOES NOT automatically affiliate the practitioner to the group/organization/agency.**
2. The group/organization/agency needs to have the individual practitioner's first name, last name, NPI, and choose a rendering location for the provider to affiliate them under the group.

Affiliations made through the individual practitioner's application will remain in 'pending approval' status until the group/organization/agency confirms the affiliation of the individual practitioner. Any individual practitioners who are 'pending approval' will be highlighted in yellow.

1. This must be completed by the group/organization/agency completing an update in PNM (under the group's Medicaid ID) and accessing the Group, Organization & Hospital Affiliations page.
2. The Administrator of the group/organization/agency's Medicaid ID (or an Agent with the Enrollment Agent action) can initiate and complete an update in PNM.
3. When successfully completed, the Affiliation Status shows 'Confirmed' meaning you have confirmed the individual practitioner is an affiliate of the group/organization/agency.
4. In all self-service updates, which include the establishment of affiliations, please remember to complete the workflow by clicking the <SAVE> button for each of the affiliation updates, then clicking the <SUBMIT FOR REVIEW> button. This last step will ensure the transaction is sent downstream to the other modules and subsequently completed. This allows the affiliation to be finalized.

A Welcome Letter does not include whether a provider is affiliated with a group/organization/agency. The Welcome Letter indicates that a provider is enrolled in Ohio Medicaid. A Welcome Letter is sent to an individual practitioner regardless of if a group/organization/agency has confirmed that practitioner's affiliation with them.

To remove a practitioner as an affiliate, an update must be completed under the group/organization/agency's record by entering an end date.

This QRG and previous QRGs are posted on the PNM Learning tab.

Providers should continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m. **If the call center representatives are not able to assist you immediately, they should take your contact information and an ODM team member will respond promptly with direct assistance, as needed**. If they do not offer to do this, request it. **If the help desk is unable to resolve your issues and you do not receive a response as requested, you can request a one-on-one technical assistance session for PNM related issues by contacting PNMCommunications@medicaid.ohio.gov.**

- **Updated Billing Guidance on 2 units of 90837**

Upon further consultation with a coding expert and ODM, CPT coding guidance allows providers to bill a second unit of 90837 after 91minutes. The original guidance provided on how to use the codes (and corresponding time guidance) took into consideration the CPT sequence pattern 90832, 90834 and 90837 and those time considerations. However, using JUST the CPT definition providers can apply the past the mid-point rule in order to bill the second unit. Providers should anticipate this either not get paid by other payers (other than Medicaid/Medicaid MCO) or at minimum it will flag the provider for an audit, if billing multiple units occurs frequently.

- **Plan Specific Updates/Issues**

- AmeriHealth – shared the provider section of their website, which includes:
    - Member ID cards
    - Claims and billing
    - Prior authorizations

  AmeriHealth Caritas Ohio network providers will also receive concierge service from a dedicated account executive.
    - A listing of AE by region can be found here.
    - For patient support and questions, call Member Services, 24/7 at: 1-833-764-7700 (TTY 1-833-889-6446).
    - You can also reach provider services at 1-833-644-6001 or email ohioproviderservices@amerihealthcaritasoh.com.
- Buckeye – posted their Next Generation policies on a special Next Gen Policies page. This includes ODM-Approved Clinical, Pharmacy and Behavioral Health policies.
- Molina – Molina fixed an internal edit issue related to claims with a DOS prior to 2/1/23 denying when sent through EDI. Molina lifted this edit on 2/10/23 and will automatically reprocess any impacted claims.

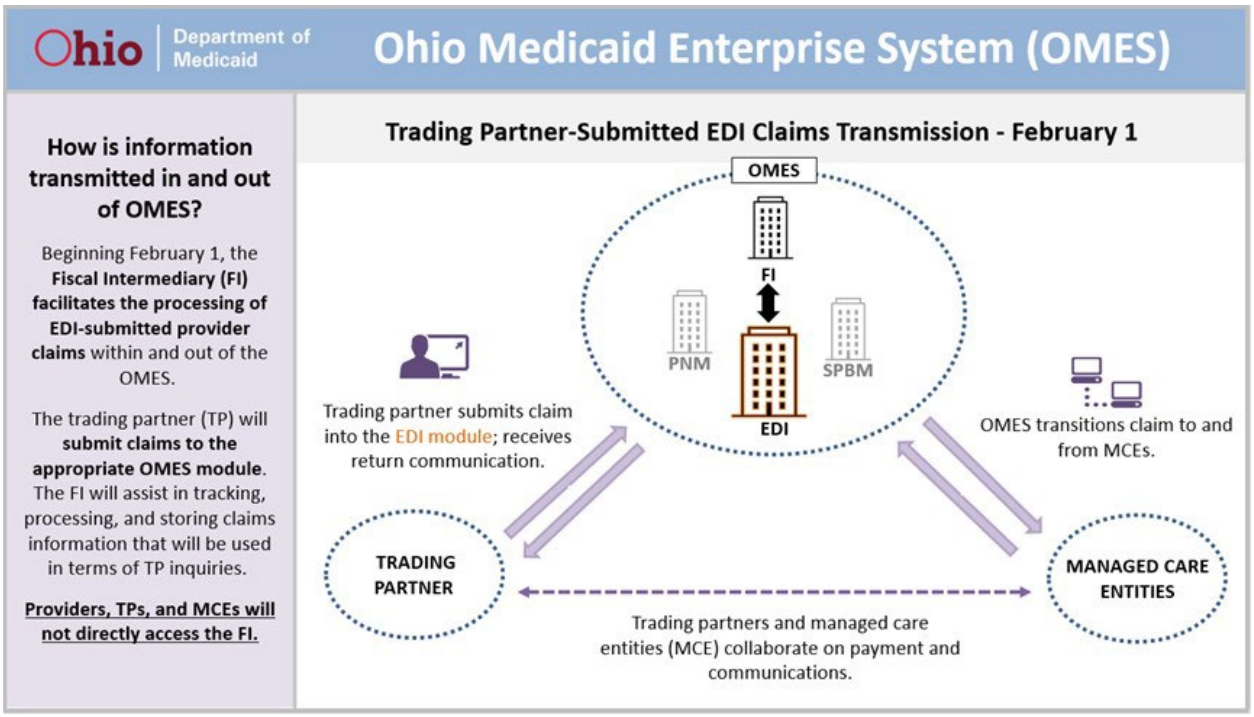
MARCH 2023

OMES Overview

The Next Generation Medicaid plan was developed at the direction of Governor DeWine and with guidance from the Centers for Medicare and Medicaid Services (CMS) and includes a transition to a modular system called the Ohio Medicaid Enterprise System (OMES). OMES includes all the modules, operated by various vendors, that make up this new modular system.

The OMES modules include:

- Single Pharmacy Benefit Manager (SPBM) for pharmacy claims operated by Gainwell. Providers have access to the SPBM.
    - SPBM FAQ
- Provider Network Management (PNM) for provider enrollment/affiliation and direct data entry of claims, operated by Maximus. Providers have access to PNM.
    - PNM FAQ
- Electronic Data Interchange (EDI) for all Medicaid EDI HIPAA X12 transactions, operated by Deloitte. EDI is only accessible to trading partners.
    - EDI Trading Partner FAQ
- Fiscal Intermediary (FI) to process and store data on all claims and adjudicate Medicaid fee-for-service claims, operated by Gainwell. FI is only accessible to ODM.
    - FI FAQ



Fee-for-service claims submission update

Ohio Department of Medicaid (ODM) announced a claims payment issue impacting fee-for-service (FFS) claims submitted on or after February 1, 2023, by community mental health agencies (provider type 84) and substance use disorder agencies (provider type 95). This claims payment issue is resulting in incorrect payment amounts for certain billing codes. ODM is working with our vendor to resolve the issue as quickly as possible. During this time, providers may continue to submit claims, or providers may elect to hold claims until the issue is resolved.

Once resolved, all impacted claims will be reprocessed with the correct payment amount. Any underpayments or overpayments made as a result of the error will be adjusted through the reprocessing cycle. Providers will not be required to resubmit claims. Please note this issue only impacts FFS claims submitted on or after February 1, 2023.

Payments from Gainwell

Gainwell is the vendor for the FI and the FI adjudicates fee-for-service claims on behalf of ODM, providers will receive payments from Gainwell for any FFS Medicaid claims and pharmacy claims since Gainwell also operates the SPBM. Some providers experienced an issue with the EFT information related to FFS claims and received paper checks from Gainwell. Providers should check that their banking information is listed in the PNM, if it is not then organizations should add this information. If you are unable to resolve this issue through the PNM, contact the Interactive Help Desk at 1-800-686-1516 or IHD@medicaid.ohio.gov.

Important notice regarding incorrect Payer ID for managed care claims

With the Next Generation program launch of the new Electronic Data Interchange (EDI) and the Fiscal Intermediary (FI), how providers submit and access claims has adjusted. With these new processes, Ohio Department of Medicaid (ODM) has observed a common issue in submitting managed care claims.

Currently, some managed care claims are being processed as fee-for-service (FFS) due to an incorrect Payer ID listed on the claim. As a result, these claims are denying with one of the following error messages:

- PCP is solely responsible for service: pay as capitated.
- 24: Charges are covered under a capitation agreement/managed care plan.
- Recipient services covered by HMO plan.
- 'MMISODJFS' is the Payer ID for fee for service only.

Providers should work with their trading partner to resubmit the impacted claims. Please refer to page 17 of the 837P Companion Guide for the correct Payer IDs for managed care claims and resubmit denied claims via the EDI.

Preventing 271 Failures & Resources for Interpreting Coverage Codes

The following data conditions have been observed in some 270 requests received by OMES. These will cause the 270 to fail and Trading Partners will not get a 271.

- REF02: should be 9 digits (SSN) and should not include any additional digits/characters when REF01=SY
- REF01: Avoid using EO as a qualifier.
- ST/SE: Transaction control numbers should be unique and not repeated within one GS/GE
- Spaces/Special Characters should not be sent after NM109 values

No trailing spaces should be sent in any data element unless it is to meet a required length in accordance with the TR3 guidelines.

OMES has been processing the 270 requests. Although 24 hours is the standard time to receive a 271 after submission of a 270, if you have not yet received a 271 after 3 days of submitting a 270, please resubmit.

The following resources can be used to interpret the new eligibility codes and acronyms. Reference these new resources when reviewing the 271 Health Care Eligibility Benefit Inquiry and Response transaction type.

- 271 Crosswalk - This crosswalk can be used to cross reference the 271 eligibility codes with their definitions
- 271 Acronym Guide - This guide can be used to define acronyms used for the 271.

Fee-for-service claims reprocessing

Some fee-for-service (FFS) claims had been rejected on the 277CA due to the following edits. To fix this issue, these edits have been relaxed in Fiscal Intermediary (FI) and the impacted claims are being reprocessed. **Providers and trading partners do not need to resubmit the impacted claims.** The edits below have been relaxed in the Fiscal Intermediary (FI) and the impacted claims have been successfully reprocessed. Respective 277CAs have been sent to the impacted trading partners' **outbound** folders.

- SNIP 4 edit: Value of element DTP02 is incorrect. Value 'DT' cannot be used when CLM05-01 is '21'.
- SNIP 2 edit: Value of element N403 is incorrect. Expected value for ZIP code is 9 digits.
- SNIP 5 edit: Value of element N403 is incorrect. Expected value is from external code list – ZIP Code (51) when country is US.
- SNIP 7 edit: The Release Information Code must have a value of Y.
- SNIP 4 edit: Admitting Diagnosis may be used only when claim involves inpatient admission.
- SNIP 4 edit: 2310C N3/N4 must be different from 2010AA N3/N4 (837D).
- SNIP 4 edit: 2310E N3/N4 must be different from 2010AA N3/N4 (837I).
- SNIP 4 edit: 2310E NM1 must be different from 2010AA NM1 (837I).
- SNIP 4 edit: 2310C N3/N4 must be different from 2010AA N3/N4.
- SNIP 4 edit: 2310C NM1 must be different from 2010AA NM1.
- SNIP 4 edit: Loop 2310E (Service Facility Location Name) is used. It should not be used when loop 2010AA is used with the same information.
- SNIP 2 edit: Validate ZIP code is 9 digits
- SNIP 2 edit: Validate ZIP code length is always 5 or 9 digits

EDI backlog complete

Ohio Medicaid Enterprise System (OMES) has successfully resolved the overall Electronic Data Interchange (EDI) file processing backlog. Normal file processing schedules are being resumed.
Trading partners should expect the following processing timeframes for the initial period following February 1.

Fee for Service Transactions:

- 999/824 – Within 12 hours.
- FFS 277CA – Within 24 hours. •
- FFS 835 – Sent weekly on Wednesdays for claims processed by the prior Friday at 5 p.m. Eastern Time (ET). 3
- FFS 270/271 Member Inquiry Real-Time: Within 20 seconds.
- FFS 270/271 Member Inquiry Batch: For 270's submitted by 9 p.m. ET, 271's will be returned by 7 a.m. ET the following business day.
- FFS 276/277 Claim Inquiry Real-Time: Within 20 seconds.
- FFS 276/277 Claim Inquiry Batch: For 276's submitted by 9 p.m. ET, 277's will be returned by 7 a.m. ET the following business day.

Managed Care Transactions:
Response times vary by MCE. Please contact the MCE directly if you have not received a file or have questions or concerns about the results on the file.

Claims status category and status codes (277CA and 276/277 transactions)

Ohio Department of Medicaid (ODM) is aware of confusion surrounding the Claim Status Category Codes and Claim Status Codes returned on the 277CA and 276/277 transactions. The code set ID 507 and 508 are returned to trading partners and providers in the STC segment of the 277CA and 277 Claim Status Response to identify the status of claims.

Providers and trading partners should use code sets 507 and 508 found on the X12 website to help determine the status of their claims. ODM has used these same code sets in the Unsolicited 277 transactions prior to the February 1, 2023 go-live. ODM is now using a broader selection of code sets to improve communication about the status of provider claims. Please be sure to bookmark the code listing on the X12 website so you may refer to it often.

ODM-06306 835 designation processing

Due to the launch of the new Electronic Data Interchange (EDI) on February 1, there has been a delay in the processing of Ohio Department of Medicaid (ODM) 06306 forms. Providers can complete an 06306 form to elect their trading partner to receive their 835 Electronic Remittance Advice (ERA) on their behalf. Beginning with the payment date of March 23, trading partners who have submitted a change or new enrollment for the 835 ERA will begin seeing the information for those providers.

Useful tips for successfully submitting 06306 enrollment forms:

- If the provider was already receiving 835s from ODM prior to February 1, no re-enrollment is needed.
- Enrollment includes fee-for-service and Next Generation managed care remittances.
- Refer to the ODM-06306 835 instructions. Please pay careful attention to the following sections:
    - Section I: The provider name (group provider account) should match the OH-Medicaid provider ID (individual provider account) in Section II; this is a required field.
    - Section II: The National Provider Identifier (NPI), tax ID should match the 7-digit Medicaid provider ID; this is a required field. The trading partner number mentioned should match the trading partner name in Section V.
    - Section IV: The Tax Identification Number (TIN) mentioned should match the TIN that is mentioned in Section II.
    - Section VI: Please verify the "Reason for Submission" before submitting the form. The "Requested ERA Effective Date" **cannot** be backdated.

Bridge Funding Opt-In

ODM released a communication regarding EDI Claims and Bridge Payments for certain providers who are submitting claims through EDI. All community BH providers (PT 84/95) will be eligible to apply to receive bridge funding. Hospitals, nursing homes and pharmacy providers are NOT eligible for bridge funding nor are providers using direct data entry to submit claims to ODM FFS or any of the Medicaid MCOs.

The ODM Provider Bridge Payment Memo provides specific details about the availability of bridge funding for certain providers sending claims through EDI, provider eligibility, payment expectations, re-payment plans, and timelines for opting in.

TEMPORARY REDIRECTION OF EDI CLAIMS FROM OMES TO MCEs

For the next few months, ODM will temporarily approve ACTIVE trading partners that are having challenges with the Ohio Medicaid Enterprise System (OMES) to submit EDI claims directly to the MCEs for all claims regardless of dates of services. Fee-for-service (FFS) claims will still need to be submitted to the OMES Deloitte EDI vendor. ODM's website contains a wealth of information to assist trading partners (TP) at Trading Partners. ODM is tracking and making information about TPs' engagement publicly available – a regularly updated spreadsheet on the same webpage groups all TPs into the following categories based on their activity and engagement with claims testing, including fee-for-service and managed care claims.

BRIDGE FUNDING - OPTING IN

To be eligible to receive temporary bridge payments, a provider must (1) "opt-in" by providing information to ODM through an on-line form at the following Bridge Funding | Medicaid and (2) meet all additional program eligibility criteria described below. By opting in, a provider will be considered for up to three months of bridge payments (February, March, April), but each provider's eligibility for bridge payments will be determined by

ODM one month at a time based on the criteria outlined below. Opting-in does not require your organization to take the payments if found eligible and your circumstances change.

Opt-In Timeframes: There are two deadlines to opt-in. Both deadlines will allow the provider to be considered for the three months of payment. (Providers may choose the timeframe that works best for your cash flow needs.)

- Providers that opted in using the link above prior to March 3 (first cut-off date) will be considered for the first bridge payout.
- **Providers that opt in by March 17** (second and final cut-off date) will be considered for subsequent payouts.

Payment and Recoupment of Bridge Funding: While the temporary bridge payment option offers an advancement in reimbursement, it is not permanent and advanced payments must be recouped by ODM (for fee-for-service) and the MCEs. The monitoring of claims and the approved bridge payments will be time limited, with a set maximum repayment time.

The initial temporary bridge payment program will be available to support providers with:

- Up to three months of advanced payment (February, March, and April 2023) - assessed and paid on a monthly cadence.
- Receipt of a payment in one month does not guarantee that a future payment will be made.
- This will be followed by a 3-month grace period (May, June, and July 2023) before recoupment begins.
- Recoupment will begin in August 2023, following the three-month grace period.
- There will be a maximum repayment period of 6 months, meaning recoupment must be complete by January 31, 2024.
- All bridge funds will be recouped as accounts receivables against future claim submissions, or in rare cases the provider may be asked to directly repay the payer (FFS or MCE) in part or full.

Qualifying for Bridge Payments: Please note that opting in does not guarantee eligibility to receive bridge payments. Alternatively, being eligible does not require you to accept the payment. Each provider's eligibility for the program will be determined on a monthly basis. ODM may determine that a provider qualifies for participation in one, two, or three months of bridge payments. In addition to opting in, providers must meet all the following conditions during each month to qualify for a payment, including:

1. Evidence that the provider's trading partner (TP) is ACTIVELY working with the new EDI system to submit claims. Bridge funds are not a substitute for claim submission.
2. Active TPs must first attempt to submit provider claims (for dates of services both before and after 2/1) to the MCEs. If the active TP is unable to submit claims directly to the MCEs, the provider must indicate on the opt-in form who their TP is and provide a brief summary explaining why their TP is unable to submit claims directly to the MCE.

3. The provider has experienced at least a 20% reduction in claims payment amount for the month (total across Medicaid FFS and MCEs), compared to the provider's average monthly historical claims amount paid during the previous six months

(July-December 2022). NOTE: only months with paid claims will be included to calculate the average. Providers that only started billing in January or February 2023 should email ODMBridge@medicaid.ohio.gov for assistance with claims submission and bridge payment consideration.

Providers will be eligible for a bridge payment one month at a time. ODM will assess provider's eligibility for each month of the bridge payment program based on the amount they have been reimbursed compared to the historical monthly average.

4. To be eligible for a bridge payment from a payer (FFS or MCE), the provider's reduction in claims payment must also be greater than or equal to $10,000 per payer (FFS or MCE) per BH Provider organizations. Providers will only be eligible for bridge payments from each payer (FFS or MCE) if the amount of the bridge payment is at or greater than that amount.

   Example: CBHC provider A is "owed" $20,000 for April. When apportioned, CareSource "owes" the provider $18,000 and Fee-for Service "owes" the provider $2,000. The provider would only receive one check for $18,000 from CareSource. ODM will be responsible for determining if a provider meets eligibility for a bridge payment from each payer (FFS or MCE).
5. As of October 1, 2022, the provider was satisfying or already satisfied past repayment obligations they negotiated with the MCEs, and they are continuing to work with the MCE(s) on repayment efforts in good faith. Providers may only receive bridge payments from MCEs with which they are in good standing.

Receiving Bridge Payments: If a provider opts in and meets all of the criteria outlined above, they will be eligible to receive a bridge payment equal to the difference between claims payments received by the provider and 90% of their average historical claims payment over the past six months, as long as the payment from ODM or the MCE is greater than $10,000 or $200 for independents.

- Providers will be notified of their eligibility to receive bridge payments by each organization (MCE, or ODM) that will provide bridge funds.
- The MCEs are allowed to require a bridge payment contract with the provider. The MCEs have been working collectively to make the process as smooth as possible for providers.

Temporary redirection of claims from Ohio Medicaid Enterprise System to managed care entities

Ohio Department of Medicaid (ODM) will temporarily approve ACTIVE trading partners that are having challenges with the Ohio Medicaid Enterprise System (OMES) to submit Electronic Data Interchange (EDI) claims directly to the managed care entities (MCE) for all claims regardless of dates of services. Fee-for-service (FFS) claims will still need to be submitted to Deloitte EDI.

ODM is working with MCEs to confirm the ability to successfully receive claims directly from the active trading partners and expects to follow up with additional information regarding the temporary change. In the meantime, trading partners are encouraged to continue submitting managed care claims via OMES.

Important things to note:

1 – Trading partners do not need to establish new connections to OMES or the MCEs. If you send your claims to another entity that connects to OMES or the MCEs that relationship does not need to change. The entity that submits the claims to OMES/MCEs will be the one potentially permitted to revert to the previous submission path.

2 – Prior to February 1, trading partners did not connect directly with the MCEs but rather to their designated vendors such as Availity or CHC. **A new submission route does not need to be created.** These entities will change the dates of services and trading partners that will be accepted by them.

Updates Made to Forms for Medicaid Behavioral Health Services

The Ohio Department of Medicaid (ODM) has updated two forms used by Medicaid behavioral health providers. The updates -- made in collaboration with managed care organizations (MCOs), behavioral health providers, and stakeholders -- are intended to improve clarity and ease of use and reflect the new Next Generation MCOs that began coverage on Feb. 1. The two updated forms are:

1. Ohio Medicaid Authorization Form – Community Behavioral Health - Previously known as the "Uniform PA Form" this document was revised to update the services list and add new MCOs. It was also revised for clarity and ease of use. The updated form can be found on the Managed Care section of the BH.medicaid.ohio.gov website.
2. SUD Residential Treatment Notification of Admission Form - Minor updates made to this form include:
   - Clarification that MCO responses to the form are due within "one business day" of receipt
   - Clinical Contact Name" changed to "Discharge Planner"
   - Addition of new Next Generation Medicaid MCOs and their contact information

   The updated SUD Residential Treatment Notification of Admission Form is available on the ODM Forms webpage by searching for "Substance Use Disorder Residential Treatment Notification of Admission Form.

PHE unwinding

Medicaid Eligibility Redeterminations

Ohio Medicaid Resuming Routine Medicaid Eligibility Operations and Whitepaper.
The Ohio Department of Medicaid held a webinar in January detailing the state's plan for the resumption of Medicaid eligibility redeterminations. ODM began Medicaid eligibility redetermination activities starting 2/1/23. This process includes an ex-parte renewal process using already available data to obtain income information to determine eligibility. Medicaid members who cannot be approved through the ex-parte process will be sent a letter informing them of the need to redetermine their eligibility with their local County

Department of Jobs & Family Services. Medicaid members will receive multiple communications by mail (from ODM and then the local CDJFS) and phone related to the need to redetermine their Medicaid eligibility. If a Medicaid member does not provide the required eligibility redetermination information by 3/10/23, they will receive a termination notice in April and their Medicaid will be terminated effective 4/30/23.

ODM anticipates approximately 200,000 people currently enrolled in Medicaid will no longer meet eligibility criteria. There will be a 90-day retroactive eligibility period for people who are terminated from Medicaid but still meet eligibility criteria and report the required income information. ODM created a partner toolkit with information for Medicaid providers which includes key messages partners can share with Medicaid members related to the redetermination process. It is vital for Medicaid members to ensure their contact information is updated so they receive any communications related to redetermination. Providers are encouraged to share this information with clients and work with their local CDJFS and the MCEs to identify Medicaid members/patients that need to complete the redetermination process.

Prescribing Controlled Substances via Telehealth
As we have shared previously, the Ryan Haight Act requires an in-person visit prior to prescribing of a controlled substance via telehealth. This has been waived through the duration of the PHE. On February 24, 2023, the Drug Enforcement Agency announced proposed rules for prescribing controlled substances via telemedicine after the COVID-19 Public Health Emergency expires on 5/11/23. The proposed rules are open for public comment for thirty days, after which DEA will issue final regulations.

The DEA proposed creating two new limited options for telemedicine prescribing of controlled substances without a prior in-person exam. The options are both complex and more restrictive than what has been allowed for the past three years under the PHE waivers.

The DEA proposes that a practitioner may prescribe a controlled substance after only a telemedicine encounter if the medication is a non-narcotic Schedule III, IV, or V controlled substance (or buprenorphine for treatment of OUD), and the prescription is limited to a 30-day period, starting from the date of first prescription. Prescriptions meeting this criterion are called a "telemedicine prescription." Prescriptions for Schedule II and narcotic Schedule III, IV, and V medications may not be prescribed via a telemedicine-only encounter.
Even for these "telemedicine prescriptions," the patient must have an in-person medical evaluation before they can continue their treatment past the 30-day initiation period. The in-person medical evaluation may be conducted:

- By the prescribing practitioner;
- As part of a two-way exam, where the patient is in the physical presence of another DEA-registered referring provider, and participant participates in an audio-video conference with the prescribing practitioner and the other DEA-registered referring provider; or

- By another DEA-registered referring provider that results in a "qualified telemedicine referral." The DEA defines a "qualified telemedicine referral" as a referral based on an in-person medical evaluation by another DEA-registered referring provider, who then refers the patient to a second DEA-registered practitioner who prescribes the controlled medications based solely on a telemedicine encounter. The referral must include the diagnosis, evaluation, or treatment that was provided to the patient, and examples in the proposed rule suggest the medical record should also be provided. Both the referring practitioner and the prescribing practitioner must document the referral, among other things (see recordkeeping requirements below), in their medical records.
- Once any of the three methods of providing an in-person evaluation occurs, the prescribing practitioner may continue to prescribe the controlled medication without additional in-person evaluations so long as there is a legitimate medical purpose.
- The proposed rules do not include any grandfathering provisions, meaning that all patients who have never had an in-person encounter with their prescribing practitioner must have an in-person exam in order to continue being prescribed medication. For patients who have established a telemedicine relationship during the COVID-19 PHE (now a defined term in the proposed regulation), the patient will have up to 180 days from the date the final rule is published to have an in-person exam (as described above).
- The DEA shared this summary of the proposed telemedicine rules.

These are proposed rules, they are not yet final and there will likely be changes. The Ohio Council will share updated information on these rules as it becomes available.

Telehealth & HIPAA
Additionally, during the PHE HHS waived the requirement for HIPAA compliant telehealth platforms. There currently are no proposed rules to implement changes to the HIPAA requirements post-PHE. Likely, this means HHS intends for this requirement to go back into effect on 5/11/23.

ARPA-HCBS 2nd Payment Update

ODM has submitted the preprints to CMS and is awaiting approval to release the second installment of these provider relief payments. Once approved, ODM will work with the MCOs on distributing the final installment of these relief funds. ODM will post the final amount of payment to the dashboard once it is approved. The payment amount should be similar to the initial amount paid last year, although it could be less since CMS required ODM to reconcile the FY21 estimate against CY22 claims.

Plan Specific Updates/Issues

- AmeriHealth – Some trading partners have not received 277CAs from AmeriHealth, and the underlying issues that caused this have been resolved. 277CAs provide a claim acknowledgment when the Fiscal Intermediary receives the claim. The 277CAs due to trading partners will be sent by March 5.

Next Generation Medicaid Reminders

Reminders on Claims Submission to EDI

- Claims must contain the 12-digit Medicaid Member ID (MMIS) for FFS and MCO claims.
- Claims with a DOS prior to 2/1/23 can be submitted to EDI, but should follow the new format.
- Claims must be sent using the new payer and receiver IDs for the MCOs.
- MCOs have 21 days to pay claims, we do not anticipate they will pay slower than previously, but some of the plans had edits in place they needed to change post-implementation that may be impacting the speed of claims payment.
- The Next Generation managed care program changes **do not apply** to MyCare Ohio plans. MyCare claims are not to be sent to EDI, providers should continue following the process in place prior to 2/1/23 for MyCare plans.
- If you use a clearinghouse, consult with your clearinghouse on any specific decisions/rules they put in place that may impact your claims submission or need to change these items in your EHR/claims files.
- Check that your clearinghouse is in active status with ODM re: phase 3 readiness.

Claim submission and adjudication reminders.

Where do you submit claims?

For providers who utilize direct data entry (DDE):

- FFS claims submitted using DDE continue to be submitted from a Medicaid Information Technology System (MITS) portal page accessed via a link in the Provider Network Management (PNM) module. FFS claims submitted through the PNM module continue to be paid by OAKS, the State of Ohio's accounting system.
- Managed care claims submitted using DDE should be processed through the applicable managed care entity (MCE) portal.

For providers who utilize a trading partner:

- All managed care and FFS claims submitted by trading partners are submitted through the new EDI. Providers with a trading partner should confirm their trading partner has completed all required connectivity activities with Deloitte, the new EDI vendor.

Where do you submit claim attachments?

- All managed care attachments are handled by the applicable MCE. Providers should work with each MCE to submit attachments following the process outlined by that MCE.

- FFS claim attachments are submitted from a MITS portal page accessed via a link in the PNM module. Trading partners do not submit attachments on behalf of providers.

Where do you edit claims?
Edits to claims, including adjustments and voids, are submitted utilizing the same method (MCE portal, MITS page accessed via the PNM module, or through a trading partner utilizing the new EDI) as the original claim submission.

Where do you go for more information on claims?
For claims submitted but not yet paid:

- If a trading partner submitted the claim through the new EDI and the claim was passed to the MCE, including claims sent from Ohio Department of Medicaid (ODM) to the MCE for adjudication, the provider should visit the applicable MCE's portal.
- FFS claims submitted but not yet paid are not visible to providers. These claims will not be visible in the PNM module until a future system release.

For paid claims:

- All payers' .pdf remittance advices (RA) are available to providers on the PNM portal. This includes MITS, FI, and MCO RAs.
- If a provider is enrolled with ODM to receive an 835, that enrollment applies to both FFS and MCO activity. 835s from all payers are delivered by the trading partner.

Additional information on claim submission for providers who utilize trading partners.
With the launch of the new EDI, changes in the claim submission process are required for trading partners to exchange transactions in the new EDI. Providers should work with their trading partners to determine the changes that may be needed to their systems and staff training. A few important changes for providers who utilize trading partners to note are as follows:

- For EDI-related claims submissions, ODM now requires one rendering provider per claim at the header level, rather than the detail level, for professional claims for both FFS and managed care recipients. Different rendering providers at the detail level are no longer acceptable. Exceptions for FFS Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers are detailed in the Medicaid Advisory Letter 622.
- Provider claims submitted to trading partners must include the Medicaid member ID (MMIS). Member eligibility can be verified using the ID through the PNM module, which redirects to MITS.
- Each managed care claim must include the new internal managed care payer ID and a receiver ID. FFS claims also require a payer and receiver ID but they remain the same. If you submit your own claims through the EDI, please refer to the ODM 837P Companion Guide for the updated receiver and payer IDs list.

Steps for Resolving EDI issues.

- Organizations working with a clearinghouse to submit claims.
    - Contact your clearinghouse regarding the 2/1/23 changes to determine if the issue is on the provider side, the clearinghouse, EDI, or MCO.
    - If you are unable to resolve the issue through changes to your claim structure or with your clearinghouse, then contact the MCO (if applicable), and then ODM via the IHD at 800-686-1516 or IHD@medicaid.ohio.gov. When contacting the IHD be as specific as possible regarding the issue you are experiencing.
- Organizations that are authorized trading partners with ODM and submitting their own claims to EDI.
    - Review the companion guides to ensure your claims are in compliance with the new requirements.
    - Contact ODM for EDI support, use the **new email account OMESEDISupport@medicaid.ohio.gov** or contact the EDI Call Center at 800-686-1516, option 4. When contacting the IHD be as specific as possible regarding the issue you are experiencing.

Prior Authorization

Since February 1, all managed care prior authorizations must be submitted to the managed care portal via the applicable managed care entity (MCE) guidance, which may include portal entry or other through another electronic process. For fee-for-service prior authorizations, providers will continue the current process by logging into the PNM module, where, after selecting the "prior authorizations" button, you will be automatically redirected to MITS.

New MCO PA Process

- AmeriHealth uses Navinet or fax

UM Fax: 1-833-329-6411 UM Phone: 1-833-735-7700

Providers will also be able to submit requests through Navinet, the provider portal. Information about Navinet and registration can be completed at the link below. https://www.amerihealthcaritasoh.com/provider/resources/navinet.aspx

- Anthem uses Availity or fax 1-866-577-2183
- Humana uses Availity. No fax option.

PNM

Providers should continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m. **If the call center representatives are not able to assist you immediately, they should take your contact information and an ODM team member will respond promptly with direct**

assistance, as needed. If they do not offer to do this, request it. **If the help desk is unable to resolve your issues and you do not receive a response as requested, you can request a one-on-one technical assistance session for PNM related issues by contacting PNMCommunications@medicaid.ohio.gov.**

APRIL 2023

- **Key Resources**
  - Current BH Provider Manual (12/19/2022)
  - OhioRISE Provider Manual (12/9/22)
  - CME Manual (6/21/22)
  - ODM Press Release (3/24/23)
  - ODM Press Release (3/27/23)
  - ODM Press Release (3/31/23)
  - ODM Press Release (4/6/23)
  - Trading Partner 835 Update (3/31/23)
  - FFS BH Bulletin (2/16/23)
  - 2/1/23 Provider Help Desk
  - Post EDI Launch Important Resources
  - PNM Refresher Training Slides (12/14/22)
  - Trading Partner Training Slides (12/19/22)
  - EDI Training Slides (1/6/23)
  - Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
  - If you do not receive MITS Bits, be sure to subscribe for MITSBits and sign up for the BH Newsletter.

PNM Refresher Trainings

The Ohio Department of Medicaid announced an additional round of PNM refresher trainings. If your organization is continuing to experience issues with the PNM, you are encouraged to attend as this will provide updated information and an opportunity to ask questions and share issues.

Registration is now open for the April 19-26 PNM module refresher training. The training schedule is posted and available on the Next Generation website.

Absorb, the learning management system (LMS), is where you can access virtual and self-paced training sessions.

Training module topics include:

- Account Administration and Dashboard.
- New Enrollment.
- Affiliations.
- Updates & Revalidations.

Provider Network Management Agent roles update

In an effort to enhance security features and align agent roles closer to the needs of users, a Provider Network Management (PNM) module release was scheduled for March 28, 2023. This update will only allow users with the Enrollment Agent role to see "View Provider File." If the agent does not have this role, they will no longer be able to view any of the provider data.

What action do I need to take?

- PNM Administrator
    - Ohio Department of Medicaid (ODM) recommends you review existing Agent assignments to ensure that Agents who need to view provider data to complete their business functions are appropriately assigned the Enrollment Agent role. Access the Quick Reference Guide: Agent Assignment and Actions for detailed instructions on assigning Agent roles.
- PNM Agent
    - Agents currently assigned other roles may need to reach out to their organization's PNM Administrator to be assigned the Enrollment Agent role, e.g., an Agent who is currently assigned a "Claims Submission" or "Eligibility" role will no longer be able to view provider profile data.

Update on electronic remittance advices and 835 processing

Buckeye 835s

Buckeye has resolved the issue with electronic remittance advices (ERA) and 835s not being delivered to trading partners. As of the week of March 20, trading partners have started receiving these files from Buckeye through Ohio Medicaid Enterprise System (OMES).

Aetna 835s

Aetna has resolved the issue with ERAs and 835s not being delivered to trading partners and has regenerated all 835 files since February 1. As of March 30, these are being sent to trading partners via OMES. Additional 835s Ohio Department of Medicaid (ODM) is working closely with our vendors to resolve further issues trading partners are experiencing in receiving 835s from all other sources. ODM will continue to provide updates to trading partners as they resolve these problems.

Fee-for-service claims submission update

Ohio Department of Medicaid (ODM) announced a claims payment issue impacting fee-for-service (FFS) claims submitted on or after February 1, 2023, by community mental health agencies (provider type 84) and substance use disorder agencies (provider type 95). This claims payment issue is resulting in incorrect payment amounts for certain billing codes. ODM is working with our vendor to resolve the issue as quickly as possible. During this time, providers may continue to submit claims, or providers may elect to hold claims until the issue is resolved.

Once resolved, all impacted claims will be reprocessed with the correct payment amount. Any underpayments or overpayments made as a result of the error will be adjusted through the reprocessing cycle. Providers will not be required to resubmit claims. Please note this issue only impacts FFS claims submitted on or after February 1, 2023.

TPL

As a reminder, after the an ODM Next Generation Provider Webinar, ODM sent follow up emails answering questions submitted that were not included in the FAQ. See below for questions pertinent to BH providers.

There is an ODM FAQ that indicates that the FI will store TPL data. Can it be assumed that the FI will be considered the "source of truth" when there is a conflict between what is in the FI and what the MCP has listed?

- The FI is to be considered the source of truth for TPL when there is a conflict between FI and an MCO. The process will remain the same as it does today. When there is a conflict, an email can be sent to TPL@medicaid.ohio.gov to review the TPL and work with the MCO if their information is not up to date.

PHE unwinding

Medicaid Eligibility Redeterminations

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- By the prescribing practitioner;
- As part of a two-way exam, where the patient is in the physical presence of another DEA-registered referring provider, and participant participates in an audio-video conference with the prescribing practitioner and the other DEA-registered referring provider; or
- By another DEA-registered referring provider that results in a "qualified telemedicine referral." The DEA defines a "qualified telemedicine referral" as a referral based on an in-person medical evaluation by another DEA-registered referring provider, who then refers the patient to a second DEA-registered practitioner who prescribes the controlled medications based solely on a telemedicine

encounter. The referral must include the diagnosis, evaluation, or treatment that was provided to the patient, and examples in the proposed rule suggest the medical record should also be provided. Both the referring practitioner and the prescribing practitioner must document the referral, among other things (see recordkeeping requirements below), in their medical records.

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- The proposed rules do not include any grandfathering provisions, meaning that all patients who have never had an in-person encounter with their prescribing practitioner must have an in-person exam in order to continue being prescribed medication. For patients who have established a telemedicine relationship during the COVID-19 PHE (now a defined term in the proposed regulation), the patient will have up to 180 days from the date the final rule is published to have an in-person exam (as described above).
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Tobacco Cessation Services

Does your organization provide tobacco cessation services? If so, do you bill 99406/07 or include it as part of individual psychotherapy (90837)?

Plan Specific Updates/Issues

- CPSE Reports – as a reminder each plan is required to provide a Claims Payment Systemic Errors (CPSE) report. The MCOs are required to post their CPSE report monthly on their website, this information is typically located in the provider section, or on the provider portal. An issue is considered a CPSE when it has the potential to impact 5 or more providers.
- Anthem - Effective July 1, 2023, if you disagree with the outcome of a claim, a Claim Payment Reconsideration, the first step in the Claim Payment Dispute process, must be submitted within 365 days from the date on the EOP unless otherwise required by State law or your Provider or Facility Agreement
- Buckeye - identified an issue where 835 files from Buckeye were not being received by OMES; therefore 835 files sent between 2/17/23 – 3/16/23 may be reprocessed which could cause duplication. Please make staff aware of this possibility to ensure the file is not posted a second time. If you have any questions, please reach out to Provider Services at 866-296-8731.

Next Generation Medicaid Reminders

Reminders on Claims Submission to EDI

- Claims must contain the 12-digit Medicaid Member ID (MMIS) for FFS and MCO claims.
- Claims with a DOS prior to 2/1/23 can be submitted to EDI, but should follow the new format.
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- Check that your clearinghouse is in active status with ODM re: phase 3 readiness.

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- Organizations working with a clearinghouse to submit claims.
    - Contact your clearinghouse regarding the 2/1/23 changes to determine if the issue is on the provider side, the clearinghouse, EDI, or MCO.
    - If you are unable to resolve the issue through changes to your claim structure or with your clearinghouse, then contact the MCO (if applicable), and then ODM via the IHD at 800-686-1516 or IHD@medicaid.ohio.gov. When contacting the IHD be as specific as possible regarding the issue you are experiencing.
- Organizations that are authorized trading partners with ODM and submitting their own claims to EDI.
    - Review the companion guides to ensure your claims are in compliance with the new requirements.
    - Contact ODM for EDI support, use the **new email account** **OMESEDISupport@medicaid.ohio.gov** or contact the EDI Call Center at 800-686-1516, option 4. When contacting the IHD be as specific as possible regarding the issue you are experiencing.

Prior Authorization

Since February 1, all managed care prior authorizations must be submitted to the managed care portal via the applicable managed care entity (MCE) guidance, which may include portal entry or other through another electronic process. For fee-for-service prior authorizations, providers will continue the current process by logging into the PNM module, where, after selecting the "prior authorizations" button, you will be automatically redirected to MITS.

New MCO PA Process

- AmeriHealth uses Navinet or fax

UM Fax: 1-833-329-6411 UM Phone: 1-833-735-7700

Providers will also be able to submit requests through Navinet, the provider portal. Information about Navinet and registration can be completed at the link below. https://www.amerihealthcaritasoh.com/provider/resources/navinet.aspx

- Anthem uses Availity or fax 1-866-577-2183
- Humana uses Availity. No fax option.

PNM

Providers should continue sending questions and identified issues to ODM through the IHD IHD@medicaid.ohio.gov or by calling ***the Ohio Medicaid Integrated Help Desk at 1-800-686-1516 and select option 2, and then select option 3 to speak to a live agent***. Representatives are available Monday-Friday 8 a.m. – 4:30 p.m. **If the call center representatives are not able to assist you immediately, they should take your contact information and an ODM team member will respond promptly with direct assistance, as needed**. If they do not offer to do this, request it. **If the help desk is unable to resolve your issues and you do not receive a response as requested, you can request a one-on-one technical assistance session for PNM related issues by contacting PNMCommunications@medicaid.ohio.gov.**

MAY 2023

ARPA-HCBS 2nd Payment Update

ODM sent a communication to providers regarding the second installment of the ARPA HCBS Provider Relief Payment. The information from the communication is copied below.

Ohio Department of Medicaid (ODM) is pleased to announce that it has received approval from the Centers for Medicare and Medicaid Services (CMS) for the **second half** of the managed care portion of provider relief payments as appropriated by the Ohio General Assembly in H.B. 169. This latest approval impacts the following categories:

- MyCare.
- Hospice.
- Home Health.
- Community behavioral health.
- Non-institutional durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Payments will be distributed via the following methods:

Category	Percentage	Reference Period
MyCare	Approximately 10% of paid claims	Claim period from November 1, 2020, through October 31, 2021
Hospice	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Home Health	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Community behavioral health	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Non-institutional DMEPOS	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021

Medicaid managed care plans will process these payments directly to providers. We are working with them to distribute this final round of funding as quickly as possible.

Note: It is highly likely that providers will receive multiple checks from multiple plans. To determine the totals due by each managed care organization, log into the ARPA Provider Relief Dashboard.

PROVIDER RELIEF DASHBOARD ENSURES TRANSPARENCY, ACCURACY, AND ACCOUNTABILITY

ODM has updated its provider dashboard tool to allow providers to enter their Medicaid billing ID and view ALL payments that will be dispersed to them from Managed Care, and MyCare per H.B. 169. The dashboard details all categories of provider relief from H.B. 169 (ARPA HCBS and non-ARPA/GRF funds) **EXCEPT** for Assisted living (RCFs), PACE, and DODD waiver providers. Providers can access the tableau through the ARPA HCBS page of our website by clicking the LAUNCH button. Linked here: ARPA Provider Relief Dashboard.

VERY IMPORTANT – PLEASE NOTE:

- The managed care preprint relief payment is calculated as 10% of FY21 claims.
- ODM has reconciled provider's total claims to actual CY22 claims experience and determined a final relief payment.
- Based on actual claims experience, some providers will receive more money than originally estimated, some less and fewer will owe money back. It will be up to each managed care plan on how or whether to recover any funds.
- There is no action required on the part of the provider during this reconciliation process.
- We appreciate everyone's patience throughout this process.

Community provider relief payments are contained in Ohio's American Rescue Plan Act Home- and Community-Based Services (ARPA HCBS) plan. Additional information about the Ohio plan can be found here: ARPA HCBS Update | Medicaid (ohio.gov).
For questions about any of these provider payments, please email ProviderReliefInquiries@medicaid.ohio.gov.

PNM Refresher Trainings

The Ohio Department of Medicaid hosted an additional round of PNM refresher trainings last month. The recordings are available on Absorb, the learning management system (LMS) and the slides are included below for your reference.

Training module topics include:

- Account Administration and Dashboard
- New Enrollment
- Affiliations
- Updates & Revalidations

In the updates and revalidations training, Maximus staff indicated that revalidations will be resuming. Providers should anticipate receiving notifications in June for revalidations

that are due in October. The 120-day notice of revalidation will be sent to the email of the primary contact listed for the provider. Additionally, the revalidation date is displayed on the dashboard.

Billing and Rendering Provider Affiliation Edit

On May 2, 2023, OMES EDI implemented a change which caused claims to erroneously reject for E181 – Invalid affiliation between Rendering and Billing provider. Impacted claims would have produced an 824 transaction and HTML report with a reject code of E181.

The issue was caught immediately and reversed on May 3, 2023. Claims submitted during the duration between 5/2, 8pm ET through 5/3, 5pm ET would have received rejects for invalid Rendering and Billing provider affiliation in error.

Trading partners are being requested to resubmit those impacted claims so that they can be reprocessed correctly. ODM apologizes for this error.

FFS 277CA Update

Between February 1 and March 28, the Ohio Medicaid Enterprise System (OMES) experienced an issue in the Fiscal Intermediary (FI) module that caused some trading partners to receive incomplete 277CA files for fee-for-service (FFS) claims submissions. To remedy this issue, between April 26 and April 28, trading partners should have received a 277CA reconciliation report that included the results of the 277CA stage validation outcomes for the claim files submitted February 1 – March 28.

These results were sent to trading partners in a simplified Excel file format. Results were provided as a one-time activity and will be available for 14 days after being delivered to your EDI OUTBOUND folder. A PDF file with instructions on how to read the results were to accompany the 277CA report. Trading partners can use the 277CA reconciliation report to reconcile previously submitted claims and resubmit all rejected claims.

Buckeye 835 files to be sent to the EDI

Starting Friday, April 21, Buckeye will send 835 files for the dates of February 1 – March 20 to the Electronic Data Interchange (EDI). These files are expected to be fully distributed to trading partners by April 28. Please note the 835 files for the dates of February 1 – March 20 have already been distributed via Availity to providers who utilize a trading partner. Providers may choose to ignore these files from Buckeye if they are not needed to reconcile claims. All future 835 files from Buckeye will be sent to trading partners via the EDI, the single repository for all 835 files.

Fee-for-service claims submission

Ohio Department of Medicaid (ODM) announced a claims payment issue impacting fee-for-service (FFS) claims submitted on or after February 1, 2023, by community mental health agencies (provider type 84) and substance use disorder agencies (provider type 95). This claims payment issue is resulting in incorrect payment amounts for certain billing codes. ODM is working with our vendor to resolve the issue as quickly as possible. During this time, providers may continue to submit claims, or providers may elect to hold claims until the issue is resolved.

Once resolved, all impacted claims will be reprocessed with the correct payment amount. Any underpayments or overpayments made as a result of the error will be adjusted through the reprocessing cycle. Providers will not be required to resubmit claims. Please note this issue only impacts FFS claims submitted on or after February 1, 2023.

March Bridge Funding Payments

MCOs are currently disbursing the March distribution of the bridge funding payments. Several organizations reported they did not receive a notice for this payment as they did for the February payment. If your organization received an unaccounted for payment in the past 2-3 weeks and you opted into to receive bridge funding, it is likely that payment.

TPL –

As a reminder, after the an ODM Next Generation Provider Webinar, ODM sent follow up emails answering questions submitted that were not included in the FAQ. See below for questions pertinent to BH providers.

There is an ODM FAQ that indicates that the FI will store TPL data. Can it be assumed that the FI will be considered the "source of truth" when there is a conflict between what is in the FI and what the MCP has listed?

- The FI is to be considered the source of truth for TPL when there is a conflict between FI and an MCO. The process will remain the same as it does today. When there is a conflict, an email can be sent to TPL@medicaid.ohio.gov to review the TPL and work with the MCO if their information is not up to date.

PHE unwinding

Medicaid Eligibility Redeterminations

Redetermination Restart (5/1/23) – ODM has resumed the routine annual Medicaid eligibility verification process. May 1st marks the first date that Medicaid members could be terminated for not reporting income information to their local CDJFS. ODM anticipates approximately 220,000 people currently enrolled in Medicaid will no longer meet eligibility criteria. This redetermination process will take place over the next year and not all 220,000

will be terminated at once. If someone is terminated there is a 90-day retroactive eligibility period for people who are terminated from Medicaid but still meet eligibility criteria and report the required income information.

Prescribing Controlled Substances via Telehealth
The Drug Enforcement Administration has asked the White House for more time to finalize draft rules that proposed reinstating stricter limits requiring doctors to evaluate patients in-person before prescribing certain drugs — like Adderall and opioid use disorder treatment — via telehealth. DEA administrator Anne Milgram said on Wednesday that temporarily keeping the pandemic-era flexibilities in place would allow Americans to access needed medications "while we work to find a way forward to give Americans that access with appropriate safeguards." It's unclear how long the extension will last. Further details about the rule will become public after its full publication in the Federal Register. The Ohio Council will continue monitoring this issue and provide more details to members when available.

Telehealth & HIPAA
OCR announced they are providing a 90-calendar day transition period for covered health care providers to come into compliance with the HIPAA Rules with respect to their provision of telehealth. The transition period will be in effect beginning on May 12, 2023, and will expire at 11:59 p.m. on August 9, 2023. OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules that occurs in connection with the good faith provision of telehealth during the 90-calendar day transition period.

Organizations should consider their telehealth policies and procedures when a client does not want to or cannot use their HIPAA compliant telehealth platform. Policies can be updated to outline a process for clients to waive HIPAA specific to telehealth platforms with informed consent and education on the risks.

AMA CPT Editorial Panel Adopts New Office Visit Telemedicine Codes & Eliminates Telephone Codes

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel has released their CPT Editorial Summary of Panel Actions, detailing decisions from their annual meeting. The summary includes acceptance of 17 new E/M office visit codes (9X075-9X091) that are specifically for telemedicine situations **effective January 2025.** Acceptance of these telemedicine specific office visit codes may impact the way providers currently bill for telehealth using codes they would typically use for an in-person office visit and appending either the 95 modifier or 02 or 10 place of service code (depending on the payer) to signify a telehealth modality. The creation of telemedicine specific office visit codes has the potential to change this billing methodology. For example, the reimbursement rates associated with the new codes (i.e., Relative Value Unit (RVU) for Medicare) may be different than the in-person equivalents providers are currently using which could mean lower reimbursement.

Additionally, because the new telehealth office visit codes would have no in-person equivalent service, laws requiring payers to provide coverage and pay at least the same rates for services provided by telehealth as those delivered in-person may become less effective. Payers, such as the Centers for Medicare and Medicaid Services (CMS), utilize the AMA CPT list in determining the codes they cover and reimburse and often adopt changes in their coding and billing instructions soon after the AMA makes a change. It is important to bear in mind that with regard to Medicare reimbursement, federal statute does cite specific Healthcare Common Procedure Coding System (HCPCS) codes (99241-99275, 99201-99215, 90804-90809, and 90862) and any further services that the Secretary deems necessary as telehealth services.

Additionally, telephone evaluation and management codes 99441, 99442 and 99443 are listed as being deleted effective January 2025. Many providers have become accustomed to billing these codes for their telephone visits during the Public Health Emergency (PHE). Although CMS has already indicated that they will end reimbursement for the codes (potentially in 2024), many providers may have been relying on continuing to be able to bill those codes to other commercial payers. The AMA CPT Editorial Panel's removal of 99441-99443 may leave providers uncertain about telephone reimbursement, requiring payers to effectively communicate how to proceed without the codes. For a full list of the AMA CPT Panel Actions in their February meeting, see the full summary.

Plan Specific Updates/Issues

- CPSE Reports – as a reminder each plan is required to provide a Claims Payment Systemic Errors (CPSE) report. The MCOs are required to post their CPSE report monthly on their website, this information is typically located in the provider section, or on the provider portal. An issue is considered a CPSE when it has the potential to impact 5 or more providers.

Molina - The Molina of Ohio Provider Portal will sunset effective May 23, 2023, and providers will no longer be able to access the Molina Provider Portal and its functions directly and must log in via the Availity Essentials Provider Portal. Find additional information in the Molina Legacy Provider Portal Sunsetting Provider Bulletin

JUNE 2023

ARPA-HCBS 2nd Payment Clarification

On May 22nd, ODM provided additional clarification on the ARPA HCBS 2nd Payment Calculation. The department received several questions regarding the calculation method of this second payment and provided the following clarifying details.

Please reference the table below. The initial pool of funds was calculated based on 10% of the value of claims of all eligible providers:

Category	Percentage	Reference period

MyCare	Approximately 10% of paid claims	Claim period from November 1, 2020, through October 31, 2021
Hospice	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Home Health	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Community Behavioral Health	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021
Non-institutional DMEPOS	Approximately 10% of paid claims	Claim period from July 1, 2020, through June 30, 2021

- **This was a fixed pool of funds that were appropriated for distribution. The size of the pool could not be increased.**
- Fifty percent of the pool was distributed in the first round of payments based on each provider's historical claims value, i.e., 5% of the value of each provider's claims. This was an *estimate* and **not** a final calculation.
- Any final, actual payments to providers were required to be based on actual claims experience incurred in January through June (1H) 2022.
- The value of 2022 claims used to calculate final payments was determined by taking the first six months of claims for 2022. This was done to avoid claims lag and issues with claims held up with go-live with new systems.
- Each provider's total payment is based on its contributing share to the calculated total value of claims for 1H 2022, less the amounts the provider received as part of the first round of payments.
- Some providers had greater claims experience in 2022, some had less, so payment amounts will vary based on those differences.

Community provider relief payments are contained in Ohio's ARPA HCBS plan. Additional information about the Ohio plan can be found at ARPA HCBS Update | Medicaid.
For questions about any of these provider payments, please email ProviderReliefInquiries@medicaid.ohio.gov.

Has your organization received your ARPA HCBS payment?

Provider Revalidation Reminders

As a reminder, during the last round of PNM refresher trainings, Maximus staff indicated that revalidations will be resuming. Providers should begin receiving notifications in June for revalidations that are due in October. The 120-day notice of revalidation will be sent to the email of the primary contact listed for the provider (individual or organization provider). Additionally, the revalidation date is displayed on the dashboard.

Some functionalities in the PNM do not work once the provider is within 120 days of revalidation. In order to bypass this, you should start the revalidation, you do not have to complete it the same day but selecting "begin revalidation" will allow you to complete functions such as affiliating staff with the organization. Once the application is completed and submitted in the PNM, changes cannot be made to the provider until the application has been processed by ODM. This is important for organizational providers revalidating because this means you will not be able to affiliate new providers with the organization during this time.

The revalidation process for organizations can take approximately 60 days and requires a site visit. Organization providers are required to pay a fee at revalidation. The fee can be waived if your organization paid the Medicare fee in the past 2 years. That is outlined on page 2, and in ODM rule, see paragraph G.

ODM announced in-person site visits for initial provider enrollments and revalidations will resume July 1, 2023. Site visits had been paused without impacting provider enrollment status due to the PHE. Site visits are part of ODM's provider enrollment screening process and are required by state and federal regulations for certain provider types.

Public Consulting Group (PCG), will be contacting organizations to schedule a site visit, which may be conducted either virtually or onsite. Please be responsive to PCG when they contact you. For questions, please email OH_Provider_Screening@pcgus.com. For more information about provider enrollment and resources check out the Provider Enrollment page.

FFS Medicaid to Begin Using Gainwell for Pharmacy Benefits

Ohio Department of Medicaid (ODM) is transitioning pharmacy benefits for Medicaid Fee-for-Service (FFS) enrollees to the single pharmacy benefits manager (SPBM) on July 1. This transition consolidates oversight of Medicaid pharmacy benefits for managed care and FFS members, giving prescribers and providers one vendor to work with regardless of how their patients are enrolled in Medicaid.

Since October 1, 2022, Gainwell Technologies has served as the SPBM for Ohio Medicaid's managed care population. Beginning July 1, Gainwell will be responsible for:

- Pharmacy point of sale system support.
- Pharmacy prior authorizations.
- Pharmacy claims processing.
- Pharmacy claims review.
- Drug utilization review.
- Payment to pharmacies.
- Member and provider customer service.
- Clinical quality and utilization management.

Individuals enrolled in Medicaid FFS should experience no change to their pharmacy benefit. FFS enrollees will have access to the same pharmacies and medications as they do

today. They will be asked to carry new ID cards, but their individual IDs will remain the same. Additionally, any medication prior authorization that is in place or submitted before July 1 will be honored through its original expiration date.

Beginning July 1, Medicaid FFS prescribers and pharmacies will route claims to Gainwell's new BIN 024251 and PCN OHRXPFFS. This information will be included on the new FFS member ID cards, yet, as mentioned above, they will retain their current member ID numbers.

Pharmacies and pharmacists can find the FFS Pharmacy Reference Guide and Payer Sheet at: Pharmacy Billing Information | pharmacy.medicaid.ohio.gov.
If you have questions about the upcoming transition or the Medicaid pharmacy program, please email MedicaidSPBM@medicaid.ohio.gov.

PNM eLicense Terminations

The Provider Network Management (PNM) module processed a monthly eLicense update on May 28. When that update ran, it only matched current license numbers entered in the PNM module as of that date. As a result, providers with an expired license listed in the PNM module on May 28 were automatically terminated as Medicaid providers.

Immediate action we are taking to resolve this

All providers affected by this process will be reactivated through an automated script that will be performed June 1.

What action do I need to take?

Once reactivated (after June 1), update your new license number in the PNM prior to June 24. If this is not done, there is a risk of being terminated again in next month's eLicense process planned for June 24. To prevent this from occurring in the future, **all licensed Medicaid practitioners must keep their license date spans current in the PNM module.**

Why was this update run?

Ohio Medicaid is required by federal law to assure that all enrolled providers maintain a valid and active license as a condition of Medicaid provider eligibility. In compliance with this, ODM conducts monthly license status verification of all Ohio Medicaid providers.

For more information

For questions regarding this notice, please call the Integrated Helpdesk (IHD) at 800-686-1516 and select option 2; option 2 for provider enrollment. Representatives are available 8 a.m.-4:30 p.m. Eastern time Monday-Friday.

OhioRISE

The Ohio Council will be meeting with ODM and Aetna staff to discuss billing and payment issues for both providers and CMEs. Please share any issues you have been experiencing with billing and payments specifically related to OhioRISE.

TPL –

MITS receives TPL data from various sources and this information is sent to the FI. The MCO's send TPL data to ODM on a weekly basis and ODM sends TPL data to the MCOs on a weekly basis. If there is a discrepancy between a MCO and ODM, this usually could be the result of a timing issue. Discrepancies can be sent to TPL@medicaid.ohio.gov to review. The most common example encountered is a MCO will have a TPL as active and ODM does not have the TPL as active.

Medicaid Eligibility Redeterminations

Redetermination Restart (5/1/23) – ODM has resumed the routine annual Medicaid eligibility verification process. May 1st marks the first date that Medicaid members could be terminated for not reporting income information to their local CDJFS. ODM anticipates approximately 220,000 people currently enrolled in Medicaid will no longer meet eligibility criteria. This redetermination process will take place over the next year and not all 220,000 will be terminated at once. If someone is terminated there is a 90-day retroactive eligibility period for people who are terminated from Medicaid but still meet eligibility criteria and report the required income information.

Summary of Telehealth Rules and Requirements

Generally the expiration of the Public Health Emergency (PHE) *at 11:59 pm on May 11, 2023*, does not have an immediate impact on telehealth broadly. There are two federal rules governing telehealth that will have future implications for providing telehealth services. The proposed DEA rules related to prescribing of controlled substances by telehealth and the required use of a HIPAA compliant platform for telehealth.

DEA Proposed Rule Regarding Prescribing Controlled Substances via Telehealth

On March 1, 2023, the Drug Enforcement Administration (DEA), in concert with the department of Health and Human Services(HHS), issued notices of proposed rulemakings (NPRM) to allow for prescribing of certain controlled medications via telemedicine without an in-person medical evaluation of the patient which would have impacted the ability to prescribe certain controlled substances without an in-person visit. A previously shared summary of the proposed changes in the draft rule is available here. The NPRMs received over 38,000 comments from the public and the DEA, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), is actively reviewing input in order to develop a permanent rule. On May 9th, the DEA and SAMHSA issued the "Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications" —a temporary rule that extends the telemedicine flexibilities adopted during the COVID-19 PHE.

The temporary rule will take effect on May 11, 2023, and extends the full set of telemedicine flexibilities adopted during the COVID-19 PHE for six months—through November 11, 2023. For any practitioner-patient telemedicine relationships that have been or will be established up to November 11, 2023, the full set of telemedicine flexibilities regarding prescription of controlled medications established during the COVID-19 PHE will be extended for one-year—through November 11, 2024. The Ohio Council will continue monitoring this issue and provide additional details to members after the permanent rule is published.

Telehealth - HIPAA Compliance

The Department of Health and Human Services, Office of Civil Rights (OCR) announced they are providing a 90-calendar day transition period for covered health care providers to come into compliance with the HIPAA Rules with respect to their provision of telehealth. The transition period will be in effect beginning on May 12, 2023, and will expire at 11:59 p.m. on August 9, 2023. OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules that occurs in connection with the good faith provision of telehealth during the 90-calendar day transition period. More information including OCR's guidance and frequently asked questions about HIPAA-compliant telehealth practices is available.

Organizations should consider their telehealth policies and procedures when a client does not want to or cannot use their HIPAA compliant telehealth platform. Policies can be updated to outline a process for clients to waive HIPAA specific to telehealth platforms with informed consent and education on the risks.

State Telehealth Rules

As a reminder, commercial insurance and Medicaid plans must cover telehealth in Ohio. Ohio HB122 became effective 3/23/22 and, in part, requires Medicaid and private insurance health plans operating in Ohio to reimburse for telehealth services, including audio-only services, see Sec. 3902.30. B(1) on page 2 which states " A health benefit plan shall provide coverage for telehealth services on the same basis and to the same extent that the plan provides coverage for the provision of in-person health care services" and G(3) on page 14, and Sec. 5164.95. (A) on page 15 define telehealth to include audio only services. Additionally, paragraph B on page 15 requires Medicaid to cover telehealth. The sections in the bill correspond to the ORC sections, for example, Section 3902.30 is a reference to the insurance section of the ORC specific to telehealth. Commercial insurance plans will have varied requirements regarding in-person visits and organizations should check with each plan for those requirements.

The Medicaid rule governing telehealth in Ohio is 5160-1-18. There is an annual in-person requirement for Medicaid, outlined in paragraph C(4). However, an in-person visit is not required to initiate services via telehealth.

The OhioMHAS rule governing telehealth in Ohio is 5122-29-31 and does not have in-person requirements to initiate or continue services via telehealth.

The OhioMHAS rule and ODM rule, when read in their totality, allow for all OhioMHAS and ODM eligible providers to deliver services via telehealth when delivered by OhioMHAS certified entities. Specifically, 5160-1-18 (B)(2)(j) includes community BH providers as defined in 5160-27-01, which is all PT 84/95. Then, 5160-1-18 (D)(21) includes all services covered under 5160-27, which is all community BH services. OhioMHAS rule 5122-29-31 lists all the services that are eligible to be provided via telehealth when delivered by a OhioMHAS certified provider. HB 122 codified these telehealth provisions in statute and requires certain health professional licensure boards to adopt rules that support telehealth services for individuals licensed under those boards. This is outlined further in ORC 5119.368 which permits telehealth services when provided by OhioMHAS certified agencies.

The CSWMFT board rule governing telehealth provided by licensed counselors, social workers, and marriage & family therapists in Ohio is 4757-5-13. There is not an in-person requirement in this rule.

The OCDPB does not currently have a rule governing telehealth.

The Psychology board rule governing telehealth for Ohio psychologists is 4732-17-01 (see paragraph H). This rule does not require in-person services.

The Nursing board does not have specific rules governing telehealth. However, ORC Section 4743.09 outlines the requirements for health care professionals providing telehealth services and does not require an in-person visit generally.

The State Medical Board of Ohio adopted finalized rules for prescribing controlled substances via telehealth. Physicians and physician assistants must also comply with federal prescribing requirements. However, the state rule allows exceptions for prescribing to new patients via telehealth when the patient has a mental health condition, substance use disorder, or when the physician determines it is an emergency situation. Paragraph (E) of the rule 4731-11-09 outlines these exceptions. Federal rules dictating prescribing supersede state rules when they are more restrictive. If the aforementioned finalized DEA rule is less permissive, prescribers will be required to follow the federal rule.

Medicare Telehealth Flexibilities

CMS extended telehealth flexibilities under Medicare for behavioral health through 2024. A summary of these flexibilities is available in a previous communication (please note, the information in this communication regarding HIPAA and DEA prescribing is now out of date, reference the information included in this email for the current status on those items). The list of covered Medicare telehealth services, including allowed audio-only services, is available for download here. Medicare will implement in-person requirements starting 1/1/25, those requirements include an in-person visit within the first six months of an initial telehealth visit and every 12 months thereafter. More information on the implementation of these requirements will be available closer to the effective date. The

Ohio Council will continue following this requirement and share information with members as it becomes available.

Plan Specific Updates/Issues

- Amerihealth - **"AmeriHealth Caritas Ohio Would Like to Hear From You!**
  The purpose of the Voice of the Customer is to gather insight/feedback from providers related to best practices, communication, and education to their patients related to visits. We are also interested to know what is important that we understand related to your experience as a Medicaid provider and if AmeriHealth can do anything to improve. We want to hear from you and learn about your experiences so we can build strong provider partnerships and promote engagement which will lead to improving health outcomes for our members.

  Date: 6/27/23 **Time:** 4:30-5:30pm
  Sign up here: https://amerihealthcaritas.zoom.us/meeting/register/tJUqdO-hrD8qHNYAjWL6bRzHu4kHu4v2fiHA.
- Anthem - Anthem Blue Cross Blue Shield Ohio Medicaid will be hosting Provider Advisory Council (PAC) meetings for providers and associations. To sign up please click the link below and follow instructions. Our first meeting is scheduled for June 14th at 12 PM. Anthem will be hosting these meetings biannually. So, even if you can't attend the first meeting but would like to participate, you should sign up. Provider Advisory Council - Provider News (anthem.com)
  Anthem Summer Provider Orientation Dates
- Buckeye – May25 Reminder to Update Addresses and Affiliations in PNM
- Molina - The Molina of Ohio Provider Portal sunset effective May 23, 2023, and providers will no longer be able to access the Molina Provider Portal and its functions directly and must log in via the Availity Essentials Provider Portal. Find additional information in the Molina Legacy Provider Portal Sunsetting Provider Bulletin

  Molina provider bulletin re: EDI inquiries - For EDI issues that cannot be resolved by the clearinghouse, providers should: Send EDI questions to Molina via a secure email to OHProviderRelations@MolinaHealthcare.com

JULY 2023

- **Key Resources**
  - Current BH Provider Manual (12/19/2022)
  - OhioRISE Provider Manual (12/9/22)
  - CME Manual (6/21/22)
  - ODM Press Release (6/16/23)
  - ODM Press Release (6/23/23)
  - ODM Press Release (6/30/23)
  - ODM Press Release (7/7/23)

- Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
- If you do not receive MITS Bits, be sure to subscribe for MITSBits and sign up for the BH Newsletter.

SFY 24-25 State Budget

Earlier this month, Governor DeWine signed HB 33, implementing Ohio's SFY24-25 budget. We are currently engaging ODM staff to better understand the available resources to support Medicaid BH rate increases generally and the process by which such updates will be developed and implemented across specific services. Rate changes will not be effective until 1/1/24, as ODM rules will need to be updated after the rates are determined. More information and specifics will be shared with Ohio Council members as soon as it becomes available.

PNM eLicense Terminations

The Ohio Department of Medicaid shared additional information related to the previous June communications regarding provider license update requirements in the PNM. ODM is federally required to verify provider licenses monthly and conducts this through verification with eLicense. If a provider's license in the PNM is not updated to match their license in eLicense, the provider will be terminated from Medicaid and will be unable to bill for services. This termination process is most commonly impacting CDCAs due to the CDCA-PRE license and the change in license number when upgrading their license. However, this could happen anytime a provider has a license number change that is not updated in the PNM.

The PNM is designed to insert the new license date in the PNM when a license is renewed if the license number is the same. Providers should not have to update the license date span for providers who maintain the same license number when renewing their license, but it is a requirement to update this information at license renewal for all licensed providers. The listed primary contact in the PNM will receive a license expiration notice by email 30 days in advance of the license expiration listed in the PNM.

Keeping information up to date is a condition of the Ohio Medicaid Provider Agreement and a fundamental eligibility requirement for licensed practitioners. ODM resumed the automated e-license verification on **July 8** and will then run this job on a monthly schedule thereafter. The next e-license verification will take place on **July 29.** It is imperative that new licenses be added or updated for providers prior to the next e-license automated verification, or they will be terminated, and billing organizations will not be reimbursed for services rendered.

For more information

For questions regarding this notice, please call the Integrated Helpdesk (IHD) at 800-686-1516 and select option 2; option 2 for provider enrollment. Representatives are available 8 a.m.-4:30 p.m. Eastern Time Monday-Friday.

Medicaid Provider Revalidation Reminders

As a reminder, provider revalidations are resuming. Providers should be receiving notifications 120-days in advance of the revalidation and at 30 day intervals until the revalidation is completed. The revalidation notice will be sent to the email of the primary contact listed for the provider (individual or organization provider) in the PNM. Additionally, the revalidation date is displayed on the dashboard.

Some functionalities in the PNM do not work once the provider is within 120 days of revalidation. In order to bypass this, you should start the revalidation, you do not have to complete it the same day but selecting "begin revalidation" will allow you to complete functions such as affiliating staff with the organization. Once the application is completed and submitted in the PNM, changes cannot be made to the provider until the application has been processed by ODM. This is important for organizational providers revalidating because this means you will not be able to affiliate new providers with the organization during this time.

The revalidation process for organizations can take approximately 60 days and requires a site visit. Organization providers are required to pay a fee at revalidation. The fee can be waived if your organization paid the Medicare fee in the past 2 years. That is outlined on page 2, and in ODM rule, see paragraph G.

ODM announced in-person site visits for initial provider enrollments and revalidations will resume July 1, 2023. Site visits had been paused without impacting provider enrollment status due to the PHE. Site visits are part of ODM's provider enrollment screening process and are required by state and federal regulations for certain provider types.

Public Consulting Group (PCG) will be contacting organizations to schedule a site visit, which may be conducted either virtually or onsite. Please be responsive to PCG when they contact you. PCG should send you materials to prepare for the visit in advance. Below are examples of what other organizations have received.

- Site Visit Letter
- PCG Informational Flyer
- PCG Site Visit FAQ

For questions, please email OH_Provider_Screening@pcgus.com. For more information about provider enrollment and resources check out the Provider Enrollment page.

Information on 270 search criteria guidelines

The launch of the Electronic Data Interchange (EDI) and the Fiscal Intermediary (FI) included additional security for 270 inquiries to increase the protection of patient information. Trading partners can tailor searches in the more secure environment following the guidance below, to return more member match results. A **minimum of two pieces of information from the following table must be included on the 270 for a successful**

response (e.g., social security number (SSN) and Medicaid Member ID). A successful response is returned on a 271 transaction.

Criteria	Comments
Medicaid Member ID	• Use the member's current Medicaid Member ID in conjunction with other criteria to obtain optimal results and find the appropriate member*.
Social Security Number	• Do not use filler data, which will cause errors and inaccurate results. Sending an inaccurate SSN will result in an AAA error; if the SSN is unknown, do not send the REF segment.
Date of Birth	• Use the correct date of birth (DOB) for accurate matching. If the DOB is not known, do not send it.
Last Name	• Provide the member's full last name to avoid an AAA error response. Avoid using incomplete last names.
First Name	• Use the member's full first name for accurate identification and matching. Avoid using shortened names or nicknames.

* Currently, old Medicaid Member IDs do not work in the 270 searches. Current Medicaid Member IDs must be used in a search. ODM is working to resolve this issue.

Partial, incorrect, or filler data cannot be submitted in any fields. A mismatch in data submitted and data found could result in the return of an AAA error (i.e., member not found) in the 271 instead of the member's eligibility. All information submitted on the 270 is used to validate the member to avoid intentional phishing, help eliminate fraud and ambiguity, and safeguard the member's protected health information (PHI) and personally identifiable information (PII).

Claims Submission and Adjudication Reminders

Where do I submit claims?

If you utilize direct data entry (DDE):

- Submit fee-for-service (FFS) claims using DDE through the Provider Network Management (PNM) module, which redirects to the Medicaid Information Technology System (MITS). The Ohio Administrative Knowledge System (OAKS), the State of Ohio's accounting system, pays FFS claims submitted through the PNM module.
- Submit managed care claims through the applicable managed care entity (MCE) portal.

If you utilize a trading partner:

- Trading partners submit all managed care, and FFS claims through the Electronic Data Interchange (EDI). Gainwell Technologies, the Fiscal Intermediary (FI) vendor, processes and pays FFS claims submitted through the EDI on behalf of ODM.

Where do I submit claim attachments?

- All managed care attachments are handled by the applicable MCE. You should work with each MCE to submit attachments following the process outlined by that MCE.
- You should submit FFS claim attachments through the PNM module. Trading partners do not submit attachments on your behalf.

Where do I edit claims?

- You should submit claim edits, including adjustments and voids, using the same method as the original claim submission. For example, if you submitted via an MCE portal, edits would be made in that MCE portal.

Where do I go for more information on claims?

For portal submitted claims:

- You should use the same method (MCE portal or the PNM portal) as the original claim submission to obtain relevant claim information.
- All payers' .pdf remittance advices (RA) are available to you in the PNM portal. This includes MITS, FI, and managed care organization (MCO) RAs.
- If you are enrolled with ODM to receive an 835, that enrollment applies to both FFS and MCO activity. The trading partner delivers 835s from all payers.

For EDI submitted claims:

- If an MCE is adjudicating the claim, you should visit the applicable MCE's portal.
- **You cannot see EDI submitted FFS claims in the PNM portal, regardless of their status. This is working as designed**.
- All payers' .pdf RAs are available to you in the PNM portal. This includes claims submitted to EDI, PNM, and directly to MCOs.
- If you are enrolled with ODM to receive an 835, that enrollment applies to both FFS and MCO activity. **The trading partner delivers 835s from all payers**.
- Authorized trading partners can submit the 276 Claim Status transaction for more detailed information upon the receipt of the 277 Claim Acknowledgment (277CA).

Additional reminders on claim submission if you utilize a trading partner:

- For EDI-related claims submissions, ODM requires one rendering provider per claim at the header level, rather than the detail level, for professional claims for both FFS and managed care recipients. Different rendering providers at the detail level are not acceptable. Exceptions for FFS Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers are detailed in the Medicaid Advisory Letter 622.
- Claims submitted to trading partners must include the Medicaid member ID (MMIS). The MMIS should be obtained with each visit. Member eligibility can be verified using the MMIS through the PNM module, which redirects to MITS.

- Each managed care claim must include the internal managed care payer ID and a receiver ID. FFS claims also require a payer and receiver ID, but they remain the same. If you submit your own claims through the EDI, please refer to the ODM Companion Guides for the updated receiver and payer IDs list.

PNM Disenrollment Quick Reference Guide

The Provider Network Management (PNM) Disenrollment Quick Reference Guide (QRG) offers step-by-step instructions on disenrolling a provider from Ohio Medicaid within the PNM module. These steps should only be completed if you wish to request the withdrawal of a provider's enrollment with Ohio Medicaid. Once completed, the Medicaid ID assigned to that provider will no longer be active. The Disenrolling a Provider from Ohio Medicaid and other PNM QRGs are available on the PNM Learning tab.

Note: Disenrolling a provider is not the action you should take to remove or manage a provider's affiliation with an organization or group.

Notice regarding duplicate FFS payments

Ohio Department of Medicaid (ODM) has identified an issue where some providers are receiving duplicate payments for fee-for-service (FFS) claims. This occurs when a provider submits FFS claims through both the Provider Network Management (PNM) module, which redirects to the Medicaid Information Technology System (MITS), and through a trading partner via the Electronic Data Interchange (EDI). Currently, these claims are processed independently from one another, resulting in two payments for the same service. One of these two payments is considered an overpayment.

What action do providers need to take?

Providers should return the overpayment by submitting a VOID for one of the duplicate claims. Providers can submit a VOID for one of the duplicate claims by using the same method as the original claim submission. Providers who do not void the overpayment will have future claims payment offset through an accounts receivable. Any amount not collected may be subject to interest and may be certified to the Ohio Attorney General's Office for collection.

Defects impacting delivery of 835 files

Ohio Department of Medicaid (ODM) is aware of issues affecting the provider community's ability to consistently receive fee-for-service (FFS) 835 files since the Fiscal Intermediary (FI) launch on February 1. ODM understands the importance of timely and accurate data exchange and is committed to ensuring a smooth and reliable user experience. Over the last few months, ODM and its vendors have been identifying and correcting 835-related errors. As a result of the fixes, the majority of missing 835 details have been generated. A large batch was released on May 24, followed by a second batch released on June 26, and July 7.

There is one remaining known issue that is currently being addressed. ODM has identified that this issue is primarily affecting hospitals claims. These files cannot be delivered since they failed SNIP edits at the Electronic Data Interchange (EDI). ODM vendors are working on implementing a fix in the coming 2-3 weeks.

PNM/EDI Support

- PNM questions call 1-800-686-1516, option 2
- EDI questions
    - Related to 999, 824, or TA1 rejections call 1-800-686-1516, option 4 or email OMESEDISupport@medicaid.ohio.gov with the information below:
        - EDI 837 file name submitted by the trading partner
        - Trading partner ID (from the clearinghouse or billing company)
    - Related to any other rejection, call the payer
- Trading support guide

Updated Guidance on CME Billing Codes and ICC/MCC Activity Reporting

ODM shared updated guidance with CMEs on billing codes and ICC/MCC activity reporting to be included on claims. Please note the added language that states: "Direction is provided to CMEs through OAC rule, while guidance is provided through the CME Program Manual. State and federal audit findings and financial implications are only connected to rules and laws, while the CME Program Manual is provided to CMEs as guidance for best practices and program implementation purposes." Additionally, the updated guidance clarifies that G9007 should be used for discussions with collateral contacts.

Medicare Telehealth Rate Clarification

Please note, the information quoted below from last month's agenda is out of date. CMS has indicated they will make no changes to telehealth for behavioral health until after calendar year 2024. For more information see the information from CGS on PHE ending:

- Ending the COVID PHE PPT
- Ending the PHE FAQ – indicates to continue using the 95 modifier for telehealth until 12/31/24 and answers other logistical questions re: billing Medicare for telehealth.

"Additionally, the final FY23 PFS rule stated on or after the 152nd day after the PHE has expired (October 10) payment for Medicare telehealth services using either of the Medicare telehealth POS codes would be made at the PFS facility payment rate, in accordance with established PFS policy outside the circumstances of the PHE. CMS to aligned payment for those telehealth services described as taking place in the beneficiary's home, using POS "10" for Medicare telehealth, and those services not provided in a patient's home, using POS "02" for Medicare telehealth, to be made at the same facility payment amount."