Ohio | Department of Medicaid

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TO: Contracted OhioRISE Plan, Aetna Better Health of Ohio
OhioRISE Care Management Entities

FROM: Dawn Puster, Deputy Director
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DATE: June 23, 2023

SUBJECT: Updated Guidance about CME Billing Codes and ICC/MCC Activity Reporting

The Department is issuing this memo to provide additional clarification on how care coordination activities can be documented and reported for claim submissions. Claims for care coordination activities include two components: a billing code specific to the level(s) of care coordination provided and activity codes documenting the activities that comprised the Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC) service.

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.

OhioRISE Care Coordination Billing

- Billing Provider: Care Management Entities (CMEs) must have the "ORE" specialty added to the CME's Ohio Department of Medicaid (ODM) enrollment to submit claims for the billing codes below
- Rendering Provider: Required on the claim. Must have an NPI and Medicaid ID, be affiliated with the billing CME in ODM's Provider Network Management (PNM) system and be a Rendering Provider Type listed below
- Billing for ICC or MCC may begin on the date of first ICC/MCC outreach to child/family
- When submitting claims, CMEs have the option to submit activity codes (see ICC/MCC Activity Reporting table) documenting the types of encounters for ICC/MCC fidelity purposes on the same, or a separate, claim.

ICC/MCC Coding Information

Service	Rendering Provider Type	Procedure Code	Procedure Modifier - REQUIRED	Unit Value	Date of service
Moderate Care Coordination (MCC) – Full Month	MD/DO CNS CNP PA PSY LISW LIMFT LPCC LICDC Lic school PSY LSW LMFT LPC LCDC II, III Psy assistant SW-T SW-A MFT-T C-T CDC-A QMHS CMS	T2022	U1	1 month	Entire calendar month, ex: 7/1/2023 - 7/31/2023
Moderate Care Coordination (MCC) – Partial Month		T2022	U2	1 service day	Number of service days in calendar month
Intensive Care Coordination (ICC) – Full Month		T2023	U1	1 month	Entire calendar month, ex: - 7/1/2023 - 7/31/2023
Intensive Care Coordination (ICC) – Partial Month		T2023	U2	1 service day	Number of service days in calendar month
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used				
Billing Notes	• Date of service for first month of billing should be the date of initial outreach/engagement • GT modifier is required when service rendered via telehealth • Any valid ICD-10 diagnosis code may be used • Procedure modifier is REQUIRED; do NOT use a practitioner modifier on ICC/MCC claims				

OhioRISE Care Coordination Activities with Timeframes Currently Outlined in Rule

Ohio Administrative Code rule 5160-59-03.2, describes ICC and MCC care coordination activities including, but not limited to, the following:

- Offering initial face-to-face contact within two calendar days of conducting initial outreach contact for ICC
- Offering an initial face-to-face contact within seven calendar days of conducting initial outreach contact for MCC
- Completing an Initial Comprehensive Assessment within 14 days of the youth's referral to ICC/MCC;

- Completing a Comprehensive CANS assessment within 30 days of referral to ICC/MCC and every 90 days thereafter or if there is a change in circumstances;
- Convening and facilitating a Child and Family team (CFT) meeting within a thirty-calendar day period;
- Developing a crisis and safety plan within 14 calendar days of referral to ICC/MCC;
- Developing and reviewing the Child and Family-Centered Care Plan (CFCP) with the Child and Family Team every 30 days for ICC and every 60 days for MCC;
- Monitoring the CFCP to ensure services are delivered in accordance with the plan.

CME Documentation

As CME care coordinators are completing care coordination activities during the month, they should have a mechanism for documenting all activities in their electronic health record (EHR) for quality purposes. For example, all face-to-face interactions, phone calls, outreach to families, CFT meetings, and other documentation as outlined in the CME manual, and in paragraph (G) of OAC rule 5160-59-03.2 (below) should be documented to account for those activities for each member during the time they are receiving care coordination services. It is the responsibility of each CME to provide quality reviews of documentation within their own Care Coordination programs.

Section G (below) of OAC rule 5160-59-03.2 describes requirements for care coordination documentation in the Care Management Entity's Electronic Health Record (EHR).

"(G) Care coordination documentation will include:

(1) Care coordination activities set forth in paragraphs (C)(1) and (C)(2) of this rule will be identified on claims submitted in accordance with rule 5160-26-05.1 of the Administrative Code;

(2) Progress notes to document the care coordination activities described in this rule, including face-to-face and telehealth meetings with the youth and the youth's family and/or collateral contacts;

(3) An individual crisis and safety plan for each youth receiving ICC or MCC;

(4) A back-up plan for each youth receiving ICC or MCC who is enrolled in the OhioRISE 1915(c) waiver;

(5) Assessments and child and family-centered care plans, including specifications for standard assessment and plan elements in CME's electronic health records; and

(6) Upon transition of a youth from ICC or MCC to a different care coordination tier, the CME will document the circumstances regarding transition."

Please see the following memos issued previously that provide information on care coordination activities and timing:

1. Memo that clarifies referrals and timelines specific to care coordination activities, including information specific to referrals made within the first 90 days of the OhioRISE program (July 1, 2022 to September 29, 2022):

   https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/74fad55f-e745-495d-a0f5-7bea85ecf287/Care+Coordination+Timeframe+Memo.pdf?MOD=AJPERES&CVID=odraFIN

2. Memo that provides information about care plan review processes and information on meeting the requirement to complete crisis and safety plans under certain circumstances:

   https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/7fef897a-af18-4178-a8a9-24ad9db7d78c/CFCP+and+Crisis+Safety+Plan+Updates.pdf?MOD=AJPERES&CVID=ooi8nOC

CMEs working to engage new members within 90 days following <u>initial</u> referral for ICC/MCC services.

- CMEs should conduct initial engagement work within the timeframes outlined in the care coordination rule.
- CMEs will receive a series of up to three referrals for ICC/MCC services. In total, CMEs have a maximum of 90 days to engage the member and gain consent for care coordination services. Referrals occur as follows:
    - An initial referral after determining someone needs ICC or MCC services
    - A second referral if the member has not yet been engaged after 30 days following the first referral, and
    - A third referral if the member has not yet been engaged after another 30 days.
- CMEs may consider billing during each of the referral periods, for a total of 90 days of service, as they work to engage children/youth and their caregivers.
    - To consider billing for a member the CME has not yet successfully engaged during this time period, a CME should consider how they are completing or documenting inability to complete the care coordination activities outlined in the care coordination rule.
    - As suggested in the CME program manual, CMEs should consider making three outreach attempts on different days and times during each 30-day period following referral to maximize engagement activities. Per the guidance in the CME Program Manual, a CME would make at least nine engagement attempts over a 90-day period: three engagement efforts in the initial 30-day period, three engagement attempts in the first 30-day extension period, and three engagement attempts in the final 30-day extension period.
    - After 90 days from initial referral, if care coordination engagement and consent are not received, the member will need to be sent to Aetna for continued persistent outreach. After being referred back to Aetna for persistent outreach, the CME no longer holds responsibility for the member's care coordination and cannot bill for care coordination services.

- If Aetna makes contact with a member in persistent outreach status and receives care coordination consent, the members that need ICC or MCC services will be referred back to the CME for care coordination. Upon receiving the referral, the CME can engage in care coordination activities and consider appropriate billing for those services.

CMEs working to <u>re-engage</u> members following ICC/MCC services.

- CMEs can bill for 30 days of continued outreach when trying to re-engage with family and youth
- After 30 days CMEs may return the member to Aetna or continue outreach for another 60 days <u>without billing</u>
- If at any point after 30 the CME is able to re-engage the family and youth, the CME may start billing again
- At the 90-day mark with no engagement, the CME must return the member to Aetna for persistent outreach

Quality reporting For CMEs

The Care Management Entity (CME) manual provides guidance related to reporting for ICC and MCC activities. Reporting of CME care coordination activities on claims documents that the CME performed the ICC/MCC care coordination activities in the rule and helps collect data that is important to measure the fidelity of service rendered to OhioRISE members. The activities noted in the ICC/MCC Activity Reporting table are reported on claims to describe the monthly activities provided by the CME for ICC and MCC services. The CME Manual provides guidance related to ICC High Fidelity Wraparound Model Fidelity and MCC Wraparound Informed Principles that guide OhioRISE Care Coordination. While reported on claims, these activities are paid at $0, because the activities are assumed in the monthly ICC/MCC care coordination rate. The activity codes are used to monitor quality of services and fidelity to the OhioRISE care coordination model.

The following table is included in the CME Manual and additional clarification has been added to the table which will be reflected in later versions of the CME Manual.

ICC/MCC Activity Reporting

Care Coordination Activities Submitted with ICC/MCC Claims					
Service Component	**Activity**	**Code**	**Procedure Modifier**	**Unit Value**	**Date of Service**
Initial Engagement	Telephonic engagement	G9002	U1	Encounter	Date of encounter
	Text message engagement		U2	Encounter	Date of encounter
	Email engagement		U3	Encounter	Date of encounter
	Mailed letter engagement		U4	Encounter	Date of encounter
	Visit to the home		U5	Encounter	Date of encounter
	Research Activities		U6	Encounter	Date of encounter
Face-to-face contact	Initial contact	G9006	U1	Encounter	Date of encounter
	Monthly contact		-	Encounter	Date of encounter
	Crisis response contact		UC	Encounter	Date of encounter
	Discharge planning contact		UD	Encounter	Date of encounter
Child and Family Teaming	Initial convening and facilitation	G9007	U1	Encounter	Date of encounter
	Additional convening and facilitation (can include collateral contacts)		-	Encounter	Date of encounter
	Crisis convening and facilitation		UC	Encounter	Date of encounter
	Discharge planning convening, facilitation and service engagement		UD	Encounter	Date of encounter
Care Planning	Develop the initial CFCP	G9005	U1	Encounter	Date completed
	Review and update the CFCP	G9009	U1	Encounter	Date of encounter
Consultation	Psychiatric care coordination consultation	G9008	-	Encounter	Date of encounter
Billing Notes	• **GT modifier** is required when activity is completed via telehealth. In this instance, a phone contact can be considered telehealth. • Modifier GT may not be used with G9002. • Procedure modifiers are required, when applicable, based on the activity descriptions in this table. • Do NOT use practitioner modifiers with care coordination activity codes. • If any of the care coordination activities occur on the same date of service (ex: the initial engagement and the initial face-to-face contact occurred in the same visit) report both G codes with the same date of service on the claim.				

Updated Guidance in CME Manual: *These and other updates will be added to the CME manual, but these are being provided in this memo due to recent CME feedback. Changes are highlighted in yellow.*

Overview of Key Steps and Timeframes for ICC and MCC		
Activity	**Tier 3–ICC**	**Tier 2–MCC**
Referral, engagement, and initial face to-face meeting (obtain consent).	Contact within two business days for a routine referral and one business day for a crisis referral to arrange initial face-to-face meeting and provide notification of care coordination tier assignment Offer time for initial face-to-face meeting within two business days of routine referral, OR for crisis referral, as soon as possible and within one business day	Contact within two business days for a routine referral and one business day for a crisis referral to arrange initial face-to-face meeting and provide notification of care coordination tier assignment Offer time for initial face-to-face meeting within seven business days of routine referral, OR for crisis referral, as soon as possible and within one business day
Development of Crisis and Safety Plan	Use of existing safety plan that includes required elements or development of a new plan within 14 calendar days of referral	Same as ICC
Initial Home-based, Supplemental Assessment	Within 14 calendar days of referral	Same as ICC
CANS Assessment If a CANS assessment has been completed within 90 days of enrollment into OhioRISE, it will only need to be updated using the Comprehensive CANS Assessment	Every 90 calendar days and whenever there is a significant change in member's BH needs or circumstances	Same as ICC
Initial CFT and Development of Care Plan	Within 30 calendar days of referral to CME	Same as ICC
Review of Crisis and Safety Plan	During CFT meetings, minimum every 30 calendar days	During CFT meetings, minimum every 60 calendar days
Ongoing CFT Meetings and Care Plan Updates	Minimum every 30 calendar days	Minimum every 60 calendar days and upon discharge from out-of-home placement
*Face-to-Face Contact (minimum)	4 per month	2 per month
Phone Contact (minimum in addition to face-to-face)	1 per week	2 per month
Review of Crisis and Safety Plan	During CFT meetings, minimum every 30 calendar days	During CFT meetings, minimum every 60 calendar days

**Timeframe between each visit should be determined between the care coordinator and family based on the family and youth's current need. The minimum for ICC is 4xs per month. For example, 1 face to face meeting for each consecutive week of the month is not required. However, if a member has been seen 4 times in a month and still needs additional support, the CME should provide that support to the member.*

***Face to Face Contact is considered a broad term that may include, but is not limited to, telehealth, check-ins with a family, dropping by a family's home or meeting before a child and family team meeting. It is not time-specific and is driven by family and youth need.*

Sample Scenarios and Questions

Scenario 1

An OhioRISE member is receiving treatment in a Qualified Residential Treatment Program (QRTP) and is enrolled in ICC. The care coordinator meets with the youth in the QRTP during the first week of the month (G9006); with the family in the home the second week of the month (G9006); with a potential step-down provider in the community to coordinate services upon return home during the third week of the month (G9007 UD); and with the school to get youth enrolled upon return from residential during the last week of the month (G9007 UD). Additionally, the care coordinator provides the appropriate amount of phone contacts (G9006 GT) for ICC during the month. The CME provides care coordination services for the member for the entire month, therefore bills for the entire month of ICC services. Additionally, the care coordinator documents their successful face to face contacts, phone contacts and service engagement activities. Here's an example for the care coordination and activity reporting for the month described:

- Intensive Care Coordination = T2023 U1 with full month as date of service (DOS)
- Face to Face Contacts = G9006 x2 with dates of contacts
- Phone calls = G9006 GT x4 with dates of phone calls
- Service Engagement = G9007 UD x2 with dates of engagement

Scenario 2

An OhioRISE member is currently receiving ICC. The youth is living at home with their family and the care coordinator has been able to consistently meet with the youth or the family four times a month in the home or the community. It is the end of the month, and Mom reports the youth has been sick and they would like to skip their fourth face-to-face meeting this week and will follow up next week. The care coordinator documents their three successful face-to-face contacts (G9006), and the four phone contacts for the month (G9006 GT). Additionally, the care coordinator documents the one attempted face to face contact and barriers to being able to meet with the family for the fourth time during the month in their EHR. The claim for the month would include:

- Intensive Care Coordination = T2023 U1 with full month as DOS
- Face to face Contacts = G9006 x3 with dates of contacts
- Phone calls = G9006 GT x4 with dates of calls

Scenario 3

Family calls for CME services 6/1/23. Care coordinator conducts and submits the CANS to the CANS IT System that day and results indicate Tier 2. Per family choice, the care coordinator conducts Initial Comprehensive Assessment (Supplemental Assessment) on the same day.

Billable to Aetna OhioRISE				Billable to MCO or FFS Medicaid		
Billing Code	Modifier	Description	DOS	Billing Code	Description	DOS
G9002	U5	Initial Engagement	6/1/2023	H2000	CANS	6/1/2023
H2000	TG	Initial Comprehensive/ Supplemental Assessment	6/1/2023			
T2022	U1	MCC	6/1-6/30/2023			
Other reportable ICC/MCC activities and associated DOS for each activity						

Scenario 4

A youth is engaged in Intensive Care Coordination

- On 6/16/23:
  - In the morning, the care coordinator has a call with the youth who has been involved in ICC: G9006 GT
  - A CFT meeting is held later that day: G9007
    - The Care Plan was reviewed and updated during the CFT meeting: G9009 U1
    - The CFT meeting was a F2F meeting/contact: G9007
- On 6/17/23:
  - The care coordinator has call with a CFT member who was not able to attend the CFT meeting to provide updates: G9007 GT
  - The care coordinator contacts IHBT Provider agency to make a referral: G9007 UD
  - Care coordinator has a call with parents later that evening: G9006 GT

Billable to Aetna OhioRISE			
Billing Code	Modifier	Description	DOS
G9006	GT	Face-to-face contact (Monthly contact) via telehealth	6/16/2023
G9007		Child and Family teaming (Additional convening and facilitation)	6/16/2023
G9009	U1	Care planning (Review and update the CFCP)	6/16/2023
G9006		Face-to-face contact (Monthly contact)	6/16/23
G9007	GT	Child and Family teaming (Additional convening and facilitation to include collateral contacts)	6/17/23
G9007	UD	Child and Family teaming (Discharge planning, convening, facilitation and service engagement)	6/17/23
G9006	GT	Face-to-face contact (Monthly contact) via telehealth	6/17/23
T2023	U1	ICC	6/1-6/30/2023
Other reportable ICC/MCC activities and associated DOS for each activity			

Scenario 5: To clarify the following concern submitted by a CME: "Community referrals result in CC services being provided, but not captured or billable until client is on the MAF. This results in delay in some service delivery to families and creates additional administrative burden for CC to document required G-code activities and is in some ways a data integrity issue as to what is really happening."

- **Event:** Client referred from community (does not yet have OHR) 5/29/23. The CME care coordinator (CC) completes initial engagement 5/29/23.
    - *Clarification: Scheduling or completing a CANS assessment by itself does not qualify as a member outreach attempt to start MCC/ICC billing. A member outreach needs to include an educational component about the OhioRISE program.*
- **Event:** CC conducts CANS 6/2/23 at 7PM (per family preference). CC enters the CANS into ODM CANS IT system on 6/3/23.
    - **CME ISSUE 1**: ODM system does not allow for CANS effective date, which in this case would have been 6/2/23, and instead indicates CANS date based on entry date of 6/3/23.
      Clarification:
        - *The CANS system uses the submission date as the effective date of the OhioRISE enrollment. Therefore, if the CME completes a CANS on 6/2 and submits it into the CANS IT System on 6/2, then it will have the 6/2 enrollment date, but if it is submitted on 6/3, the OhioRISE effective date will be 6/3.*
        - *Since this is an initial CANS and the youth is not already enrolled in OhioRISE, the claim for the CANS will be submitted to the MCO or Fee-for-Service (FFS) Medicaid (H2000). Per the OhioRISE Mixed Services Protocol, CANS assessments on or before the youth's OhioRISE enrollment date are submitted to the MCO (or FFS) Medicaid, depending on the individual youth's situation.*
- **Event:** Client appears on the Member Alignment File (MAF) with Open Date of 6/5/23.
    - **CME ISSUE 2:** CME unable to bill for 5/29-6/4/23.
      Clarification:
        - *The date the member appears on the MAF, referred to as the Open Date, has no impact on when the CME can bill for ICC/MCC services. A trigger event such as an initial outreach attempt is required to start ICC/MCC billing. The Open Date on the MAF is the date on which the clock starts for required care coordination activities (member outreach, crisis and safety plan, child and family care plan completion, etc.).*
        - *In this scenario, the CME can bill the MCO (or FFS) Medicaid for the CANS assessment (H2000) on the date it was completed, and the CME can initiate billing for initial engagement (G9002 U5) on 6/3/23, the effective date of the youth's OhioRISE enrollment.*
    - **CME ISSUE 3:** CME CC has to complete a CME Initial Engagement Service on 6/5/23 in order for CME to begin billing starting with that date, even though the CC has been meeting and working with the family since 5/29/23.
      Clarification: 5/29 was the referral date for a CANS assessment and the date the CME called to set up the CANS assessment. This is not considered the initial engagement. If the CANS assessment is entered in the CANS IT System and the youth is determined to be

ineligible for OhioRISE, the CME will bill the MCO (or FFS) for the CANS assessment and notify the family they are not eligible for OhioRISE. As noted above, if the CANS indicates the youth is OhioRISE eligible, the CME can initiate billing for initial engagement (G9002 U5) effective the date of OhioRISE enrollment, 6/3/23, if education about the OhioRISE program was provided on the day the CANS was completed.

- **CME ISSUE 4:** CME CC cannot complete the Supplemental Assessment until 6/5/23. *<u>Clarification:</u> The Supplemental Assessment can be completed on 6/3 when the CANS assessment has been submitted into the CANS IT system and the youth is determined to be eligible for OhioRISE enrollment. It is also a separate billable service (H2000 TG).*

Assuming the CANS results in the youth being enrolled in OhioRISE, billing would be as follows:

Billable to Aetna OhioRISE				**Billable to MCO or FFS Medicaid**		
Billing Code	Modifier	Description	DOS	Billing Code	Description	DOS
G9002	U5	Initial Engagement	6/3/2023	H2000	CANS	6/2/2023
H2000	TG	Initial Comprehensive/ Supplemental Assessment	6/3/2023			
T2022 or T2023	U2	ICC or MCC	6/3-6/30/2023			
Other reportable ICC/MCC activities and associated DOS for each activity						

<u>Question 1:</u> When reporting multiple codes for the same visit/contact, can they be submitted as Add On codes?

Response: CMEs billing does not use add-on codes. Each of the appropriate service/activity codes and units would be submitted on the claim for that date of service (DOS).

Questions regarding the above information should be sent to OhioRISEPolicy@medicaid.ohio.gov.