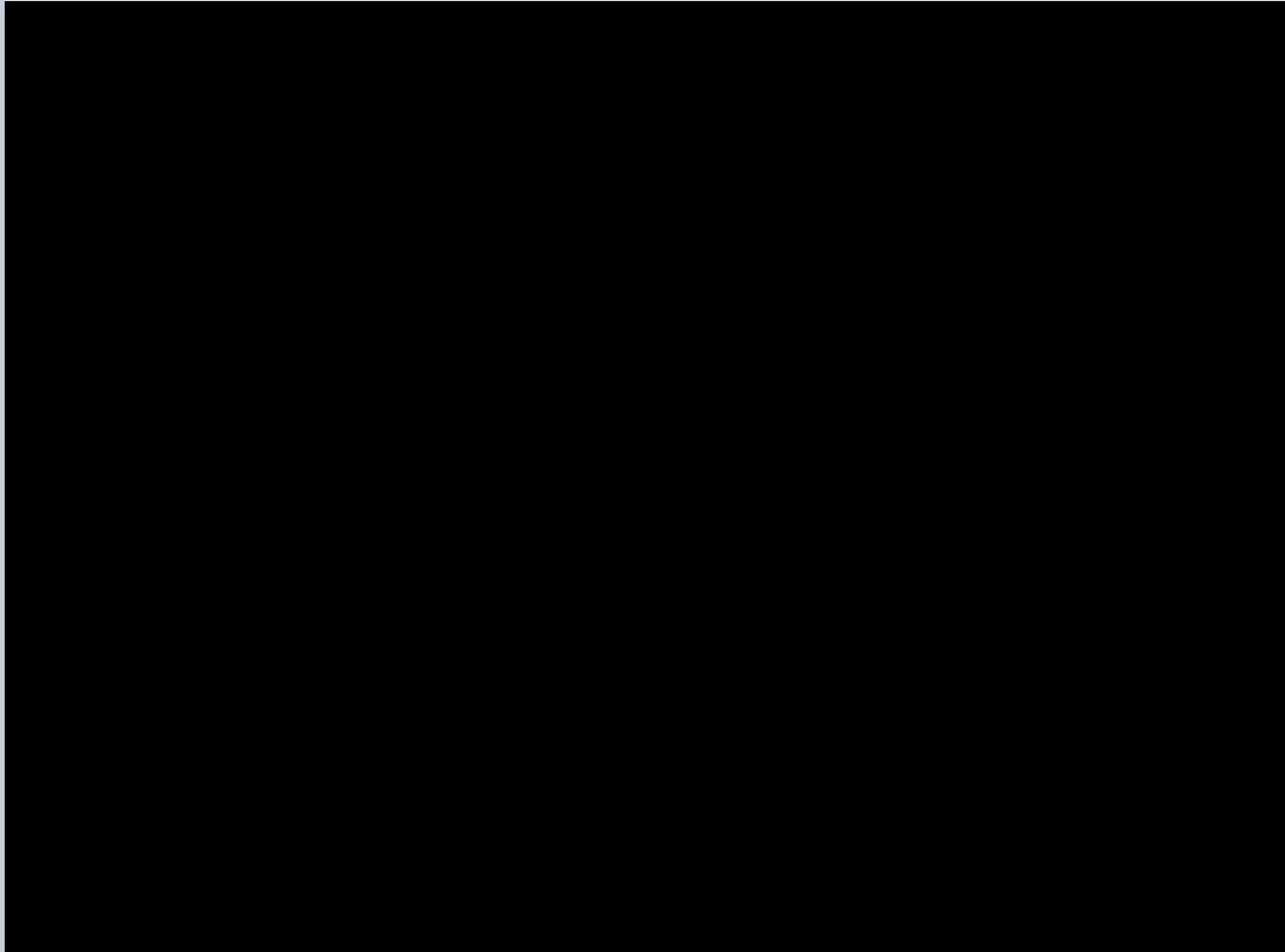


# Ohio Department of Mental Health Community Mental Health Medicaid Benefits Training

**JUNE 2011**

# A Message from Director Tracy J. Plouck

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# Welcome

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- Introductions
- Overview
- Agenda
  - Budget Overview
  - Medical Necessity
  - Mental Health Benefits, Covered Services & Limitations
  - CPST Reimbursement
  - Web Portal
  - Prior Authorization
  - Questions & Answers

# BUDGET OVERVIEW

Angie Bergefurd

# Philosophy - We All Agree:

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- People should have treatment services which are medically necessary & appropriate
- In order to recover, people need behavioral health treatment AND better overall health, housing, employment, social opportunities...
- The Mental Health Act was focused on the right philosophy – community-centered treatment – but has been underfunded
- Financial predictability & sustainability is key
- Locally generated resources should be available for local priorities
- Common sense government seeks to reduce/eliminate unfunded mandates and arduous regulation

# The Mental Health Budget:

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- Emphasizes direct services to individuals with severe mental illness
- Continues the efficient & effective operation of six regional psychiatric hospitals
- Protects community medication subsidy & continues to serve approximately 15,000 people
- Enables GRF non-Medicaid community subsidy to be used to address local priorities

# Major Reforms Include:

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- Medicaid responsibility is shifted to the State of Ohio (funding & management)
- Cost containment strategies for Medicaid based on data
- Revisions to Medicaid community mental health benefit package in FY 13 in order to address gaps & better coordinate physical & behavioral health care
- Financing for hospitals, Medicaid and community non-Medicaid is supported by a new line item structure
- The Department of Mental Health takes responsibility for the management of the RSS housing subsidy program and the licensure of adult care facilities, bringing these programs under management of one agency to better coordinate
- Block Grant use will be reformed in order to emphasize direct services

# Funding Proposal for FY 12/13

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- We are proposing three separate ODMH line items for FY 12 to support the goals of Medicaid elevation and the development of an integrated approach for behavioral and physical health care
- Replace the 408 line item with the following line items:
  - • 501 – Used to pay the state’s Medicaid match obligation in FY 12
  - • 412 – Used to pay for state hospital operations and any related commitment costs for alternatives to hospital care
  - • 505 – Used to allocate non-Medicaid funds, previously associated with 404, 408, and 505

# Medicaid Line 501 Funding Proposal

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- ODMH will allocate and commit sufficient dollars to meet each Board's Medicaid match obligation
  - This will include cost containment rules to focus on high priority areas and reduce overall costs
- In FY 12, Boards will reimburse providers and process claims for Medicaid through MACSIS, as they have done in the past
- Boards will be held harmless from the effects of Medicaid match to their other revenue sources, e.g., levy, non-Medicaid, block grant
- This line item will be used in FY 12 only; in FY 13, the appropriation shifts to JFS ALI 600-525
- ODJFS will pay providers directly for Medicaid services in FY 13

# Medicaid Cost Containment – Short Term

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- Based on data analysis in conjunction with provider, consumer & board representatives
- Analysis, approach and process was collaborative, but no consensus reached
- Data-informed policy decisions
- Preferable strategy compared to across the board cuts
- Experience of other states used as resource

# Medicaid Cost Containment – Short Term

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- Cost containment strategies for Medicaid based on data:
  - service utilization limits
  - payment modifications
- Children entitled to all medically necessary services per Medicaid EPSDT requirements

# Proposed Mental Health Benefits

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Service	Benefit	Percentile of Consumers Within the Benefit	Adult FY Averages	Kids FY Averages
CPST	104 hrs.	96-97 <sup>th</sup>	Ind. – 18.2 hrs* Gp. – 26.9 hrs*	Ind. – 16.7 hrs. ** Gp. – 21.8 hrs. **
Pharm. Mgt.	24 hrs.	Just under 99 <sup>th</sup>	3.2 hrs.	2.8 hrs.
Counseling	52 hrs.	97 <sup>th</sup>	Ind. – 6.6 hrs. Gp. – 16.5 hrs	Ind. - 10.1 hrs. Gp. - 25.5 hrs
Dx Assess – MD	2 hrs.	95 <sup>th</sup>	.95 hrs.	1.2 hrs.
Dx Assess	4 hrs.	90-95 <sup>th</sup>	1.7 hrs.	2.2 hrs.
Partial Hosp.	60 days	65 <sup>th</sup>	27 days	77 days

*\*Daily average for adult CPST service is .92 hrs. individual and 1.7 hrs. group*

*\*\*Daily average for kids CPST service is .99 hrs. individual and 1.6 hrs. group*

# Proposed Mental Health Benefits Changes Based on Constituent Feedback

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- **CPST Payment Policy**
  - From 1 hour to 1.5 hours
    - ✦ Group & Individual CPST separate
- **Partial Hospitalization**
  - ✦ From 30 days to 60 days before prior authorization is required
- **Adult Services**
  - Prior authorization for CPST & Partial Hospitalization beyond limits
- **Children/Adolescent Services**
  - Prior authorization for CPST & Partial Hospitalization beyond limits

# Questions...

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- Answers...

# MEDICAL NECESSITY

Terry R. Jones

# Medical Necessity Overview

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- Rehabilitation Option
- Medical Necessity
- The Golden Thread

# Medicaid Funding

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- In Ohio, Medicaid funds behavioral healthcare services through the Rehabilitation Option
- The Rehabilitation Option is often known as the “Rehab Option” or the “Medicaid Rehabilitation Option (MRO)”
- The MRO/Rehab Option pays for services rather than programs

# Medicaid and Rehabilitative Services in Ohio

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Rehabilitation services are defined in federal law at 42 CFR 440.130 as:

- “any medical or remedial services (provided in a facility, home or other settings) recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for the maximum reduction of physical or mental disability and *restoration* of the individual to the **best possible** functional level” (*emph. added*)

# Medicaid Billing

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- Providers bill for rehabilitative services on a client by client basis
- Services provider can bill are based on the client's assessed needs as outlined in a mental health assessment, ISP and the actual services that are delivered

# Clear Guidance

20

- The Rehab Option provides clear guidance for delivering, billing, and documenting services
- Services must be related to a mental health diagnosis that is identified in a mental health assessment, with goals and objectives specified on an individualized service plan and must be “medically necessary”

# What is Medical Necessity?

21

“Medically necessary mental health services refer to those mental health services, including but not limited to:

- preventive,
- diagnostic,
- therapeutic,
- rehabilitative and
- palliative interventions,

provided for the symptoms, diagnosis and treatment of a particular disease.”

# 5101:3-1-01 Medicaid: Medical Necessity

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- A) “Medical necessity” is a fundamental concept underlying the Medicaid program. Physicians, dentists, and limited practitioners render, authorize, or prescribe medical services within the scope of their licensure and based on their professional judgment regarding medical services needed by an individual. “Medically necessary services” are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

# More on Medical Necessity

23

A medically necessary service must:

- Meet generally accepted standards of medical practice
- Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome
- Be appropriate to the intensity of service and level of setting

# More on Medical Necessity

24

- Provide unique, essential, and appropriate information when used for diagnostic purposes
- Be the lowest cost alternative that effectively addresses and treats the medical problem
- Meet general principles regarding reimbursement for Medicaid covered services found in rule 5101:3-1-02 of the Administrative Code

# Medical Necessity: Why is it Important?

25

- Medicaid and other 3rd party insurers provide the majority of the funding available to pay for rehabilitative and other mental health services
- Medical necessity is the underlying concept under which payment decisions are made

# Medical Necessity- Payer Perspective

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- Is it considered to be a medical service as opposed to a non-medical service?
- Is it considered to be a rehabilitative service or non-rehabilitative service?
- Is it considered to be a cost-effective?

# Medical Necessity: Who Cares?

27

What about accrediting bodies?

- Medical necessity is a payment concept
- Medical necessity and quality of care are linked
- Treatment should be provided in the least restrictive environment, considering the safety of the consumer and their current status (signs, symptoms, functioning)
- Very concerned about: consumer and family choice and participation in ISP and treatment implementation

# Documenting Medical Necessity

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- Documentation is required by all payers
- OAC 5101:3-1-27 “...all Medicaid providers are required to keep such records as are necessary to establish medical necessity and to fully disclose the basis for the type, extent, and level of the services provided”

# Clear Guidance for Documentation

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- Documentation focuses on the interventions delivered to meet the goals and objectives and the consumer's progress toward meeting the identified goals and objectives.

# Documenting Medical Necessity of Rehabilitation:

30

- Service focus is on teaching not providing – cueing, reminding, training, overcoming barriers
- “Medical necessity” is based on functional criteria

# Guidance for Mental Health Providers

31

Rules that are incorporated into medical necessity for payment purposes:

- Consumer must be able to be an active participant in their treatment
- Consumer must have sufficient cognitive ability to benefit from the treatment

# Additional Guidance for Mental Health Providers:

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- Documentation must be clear about the consumer's participation in treatment:
- Besides being present during the intervention- what else occurred?
- Evidence that the plan has been developed with the active participation of the client
- Progress notes must document the services that were provided

# Determination of Medical Necessity

33

- Medical necessity is determined by the presence of a diagnosis that requires mental health treatment as established in the mental health assessment.

# Medical Necessity: Where Does it Begin?

34

Starts with a qualified professional conducting the mental health assessment:

- Assessment: clinical and functional
- Clinical Formulation: support for diagnosis
- Diagnosis – necessary for all payers
- Determination of level of care
- Ordering treatment
- Scope of license issues

# Medical Necessity

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- Appropriately Qualified Clinician
- Clinically Appropriate Services and Interventions
- Delivered at appropriate Intensity and Duration
- As Directed by an Individualized Service Plan
- Designed to Improve functioning and symptoms or prevent their worsening
- Based on Assessed Needs and an Approved Diagnosis

# The Golden Thread

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## Mental Health Assessment

- Determine and justify diagnoses
- Identify the symptoms, consumer personal goals, stressors, strengths, skills and functional deficits, etc.
- Establish baselines
- Justify type and intensity of services based on individual client need, which should be different for every client, and this should be reflected in the assessment
- Prioritize areas of need and recommend services

# The Golden Thread

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- Service Plan Goals
- Service Plan Objectives
- Interventions
- Progress Notes

# The Golden Thread

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## Service Plan Goals

- Address the needs identified in the mental health assessment

# The Golden Thread

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## Service Plan Objectives

- Measurable changes in consumer behavior/symptoms that are steps to meeting the specified goal

# The Golden Thread

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## Interventions:

- Service/Modalities + intensity appropriate to accomplish the objective
- Interventions to assist the client in their goals are considered “medically necessary”, when documented in relationship to their mental health symptoms.
  - Medically necessary services must be documented as such to be Medicaid reimbursable.
  - Documentation that a service has been provided is not sufficient to document medical necessity.

# The Golden Thread

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## Progress Notes

- Tied to ISP goals and objectives
- Describe the intervention specified in the service plan
- Progress toward the specified goals and objectives
- Recommendations for modifications to the ISP, if applicable

# Did We.....

42

- Did we help the client prioritize goals?
- Did we identify barriers and facilitators to the client's goals, and begin addressing barriers through skills teaching and/or supportive intervention with client to teach/model/cue a skill?
- Did we revisit progress and identify which skills need more work and which skills client can now utilize with some independence?
- Does it all relate back to MH issues that brought the client to our program in the first place?

# Consumer & Recovery Focus

43

- Within the rules, the MRO encourages a focus on recovery and consumer-centered services
- Consumer goals and needs will drive the priorities within the ISP
- Consumers will be reviewing their services and their progress toward goals with providers on a regular basis
- Consumers must participate and work towards measurable goals with the right amount of provider support

# Last Words about the Golden Thread

44

- The “Golden Thread” is the real connection between the assessed consumer needs, strengths, preferences and personal goals and the individual service plan and services provided

# The Golden Thread: Summary

45

- Clinical needs are identified through the mental health assessment
- Clinical needs are transferred to the consumer's Individual Service Plan
- Progress toward goals are documented in the consumer's progress notes

# The Medicaid Goal For Services

46

- In all situations, the ultimate goal is to reduce the scope, duration and intensity of medical care to the least intrusive level possible which sustains health
- Medicaid goal is to deliver and pay for medically necessary, clinically appropriate, Medicaid-covered services that would contribute to the treatment goal(s)

# Key Questions to Ask in Service Delivery

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- How is what I am doing with the client any different than what their neighbor, family member, or other helpful person might do for/with them?
- Why did this activity require the intervention of a mental health professional?

# Key Questions to Ask in Service Delivery

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- What skills did I teach, model, cue, or monitor in this intervention? - focus of intervention needs to be on teaching, not “doing for” the client
- Why am I providing this service?
- What is it about the client’s illness that prevents them from performing this activity on their own?

# Working with Long Term Clients

49

- Is the frequency, duration and intensity of care modified according to client progress?
- Does the ISP reflect that? Has it been revised to reflect changes/improvements, etc.?
- Consistent with good clinical care and supported by federal language which outlines CMS expectations

# Non-Response/Failure to Engage

50

- If an individual is not responding to treatment as it is being offered, it is incumbent that the provider changes their treatment approach (ISP)

# Paradigm Shift

51

- Too often, we are accustomed to “doing for” and not teaching skills that move someone from dependence to independence
- Traditional approaches to community mental health emphasized “Do anything the client needs you to do” or “Do whatever is necessary for the client...”

This is inherently in conflict with:

- Current regulatory requirements associated with Medicaid as a payer, compared with block grants and other grant funding to serve this population.
- The Recovery Model
- Service Limits

# Paradigm Shift

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- We weren't taught to document and bill in a Medicaid environment
- We were taught to provide services by following what supervisors and colleagues modeled for us
- If we change the way we are interacting with clients to reflect a teaching modality, provision and documentation of services has never been easier...
- With the advent of service limits, a major ideological shift in our approach to Medicaid mental health service delivery needs to occur

# Questions

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- Answers.....



# Break

Please return in 15 minutes...

# **COMMUNITY MENTAL HEALTH MEDICAID BENEFITS**

Kathy Cluggish

# Community Mental Health Medicaid Benefits

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- Benefit Package
- CPST Payment Policy Change
- Use of the “SC” Modifier
- Web Portal
- Prior Authorization

# Proposed Mental Health Medicaid Benefits

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- New statewide Medicaid service limits will be implemented.
- The limits apply across providers/board areas.
- The proposed service limits will be:
  - 104 hours (416 units) of CPST per fiscal year.
  - 24 hours (24 units) of Pharmacologic Management per fiscal year .
  - 52 hours (208 units) of Individual/Group Counseling per fiscal year.
  - 2 hours (2 units) of Diagnostic Assessment by an physician per fiscal year.
  - 4 hours (4 units) of Diagnostic Assessment by a non-physician per fiscal year.
  - 60 days of Partial Hospitalization per fiscal year.

# Mental Health Medicaid Benefits

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- For all services to children (except partial hospitalization and CPST), a “soft” authorization process will be used to bypass the service limits.
- The “soft” authorization is implemented by putting the modifier code “SC” in the modifier 3 position on the 837P claim line.
- The “SC” modifier can be used for children to bypass the service limits for:
  - 90862 – Pharmacologic Management
  - H0004 – Counseling
  - H0031 and 90801 – Assessment
- For partial hospitalization (S0201) and CPST (H0036) for both children and adults, a prior-authorization will be required to allow additional services.

# CPST Payment Policy

59

- CPST payment policy change will be implemented July 1, 2011
- The first 90-minutes (6 units) of Individual CPST and the first 90-minutes (6 units) of Group CPST billed by a provider will be reimbursed using the lesser of the provider's UCC or the Medicaid fee schedule rate
- Subsequent units will be reimbursed at 50% of the Medicaid fee schedule rate or the provider's UCC, whichever is less
- This does not mean that there is a 90 minute daily limit on CPST service

# CPST Examples

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- The agency shall bill the community Medicaid program its usual and customary charge for the Medicaid covered service.

	Units Billed	Billed Amt.	UCC	MCD Rate	Rate for Units 1-6	Units 1-6 Paid Amt.	MCD Rate @ 50%	Rate for Units 7-8	Units 7-8 Paid Amt.	TOTAL PAID
1	8	160.00	20.00	21.33	20.00	120.00	10.67	10.67	21.34	141.34
2	8	240.00	30.00	21.33	21.33	127.98	10.67	10.67	21.34	149.32
3	8	80.00	10.00	21.33	10.00	60.00	10.67	10.00	20.00	80.00

# CPST Examples

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- Scenario 1: Provider's usual and customary charge (UCC) is less than the Medicaid fee schedule rate, so the first 6 units are paid at the provider's UCC. Since 50% of the Medicaid fee schedule rate is less than the provider's UCC of \$20, units 7-8 are paid at 50% of the Medicaid fee schedule rate which is \$10.67
- Scenario 2: Provider's UCC is more than the Medicaid fee schedule rate so the first 6 units are paid at the Medicaid fee schedule rate. Since 50% of the Medicaid fee schedule rate is less than the provider's UCC of \$30, units 7-8 are paid at 50% of the Medicaid fee schedule rate which is \$10.67
- Scenario 3: Provider's UCC is less than the Medicaid fee schedule rate so the first 6 units are paid at the UCC. Since 50% of the Medicaid fee schedule rate is more than the provider's UCC of \$10, units 7-8 are paid at the provider's rate of \$10.00

# Provider Web Portal

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- The Provider Web Portal will be available July 1, 2011
- The web portal will allow provider staff to access “real time” data regarding the benefit (units), units billed and remaining units
- “Real Time” data refers to services that have already been billed to MACSIS and does not represent services provided but not yet billed
- “Remaining units” **does not** guarantee payment
- All units have been converted to hourly units, except for services that are billed by the day

# Provider Web Portal

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- Each Medicaid provider will have a **Primary Username** that will be the same as their ODJFS Medicaid 7 digit ID number
  - *Dual MH/AoD providers are assigned separate Medicaid Provider Numbers*
  - *Dual providers will have two primary accounts; one for AoD and one for MH*
- The initial password for the **Primary Username** will be – A0000xxxx; where xxxx = the last four digits of the provider’s Federal tax ID number
- It will be the responsibility of the primary user, similar as with the ODJFS provider portal, to assign additional (secondary) users
  - There can be up to 99 secondary users
- The **Secondary Username(s)** will be the ODJFS Medicaid 7 digit ID number followed by a sequence number, starting with “-1”. Example: 1234567-1, 1234567-2, etc.
- The initial password for the **Secondary Username(s)** will be – S0000xxxx, where xxxx = last four digits of the Federal tax ID number

# Provider Web Portal

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- All users will be prompted to change their password after their initial login
- The **Account Information** screen is used to add/delete secondary users, change your personal account information and change your password
- The **Client Eligibility and Benefit Information** screen is where providers view a client's benefit, usage and remaining units

# Provider Web Portal

## Log-in Screen

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**Ohio** | Department of Alcohol & Drug Addiction Services



**Ohio** | Department of Mental Health

Sign in

Username:

Password:

Type the characters you see in the picture below and then select the Login button

7r800

If the image is illegible, refresh the browser to get a new one

Quick Link to

ODMH and ODADAS Medicaid Provider Portal

Account information

[I can't access my account](#)

**DISCLAIMER:** This ODMH and ODADAS Medicaid provider web portal is solely intended for benefit look-up and can NOT be used as a Medicaid eligibility verification tool. Medicaid eligibility verification can be done by accessing the ODJFS Medicaid Provider Web-Portal at <https://medicaidremit.ohio.gov/default/home.jsf>

- First time users:
  - Enter your **Username** and **Password**.
  - Type the characters that appear in the highlighted box in the space provided.
  - The ODMH and ODADAS Medicaid Provider Portal is checked by default.
  - Click the **Login** button.

# Provider Web Portal

## Change Your Password Screen

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Ohio

Department of Alcohol &  
Drug Addiction Services



Ohio

Department of  
Mental Health

### Change your ODMH and ODADAS Medicaid Provider Portal Password

Enter your current password and then choose your new password. Click **Save** when you're done.

**Please Note:** To better protect your account, make sure that your password is memorable for you but difficult for others to guess. Do not share your password with anyone, and never use the same password that you've used in the past. For security purposes, your new password must be a minimum of **9** and **maximum of 15** characters long. The password should not start with uppercase **A** or **S**. the password must contain at least **one uppercase letter and one number**. Maximum number of times a specific character can be **repeated sequentially is 4**(remember that your password is case sensitive).

Enter your **Current Password**:

Choose a **New Password**:

Confirm your **New Password**:

- Enter your current password.
- Choose a new password making sure it contains the minimum requirements.
- Re-enter your new password in the **Confirm your new password** box.
- Click the **Save** button.
- A confirmation message will appear indicating your new password has been saved and you will be returned to the login screen.

# Provider Web Portal

## Log-in Screen

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**Ohio** | Department of Alcohol & Drug Addiction Services



**Ohio** | Department of Mental Health

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Sign in

Username:

Password:

Type the characters you see in the picture below and then select the Login button

7 r 8 0 0

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- Returning users:
  - Enter your **Username** and **Password**.
  - Type the characters that appear in the highlighted box in the space provided.
  - The ODMH and ODADAS Medicaid Provider Portal is checked by default.
  - Click the **Login** button.

# Provider Web Portal

## Client Eligibility and Benefit Information Screen

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**Client Eligibility and Benefit Information** ✕

File

Selection Criteria

Client # :   As of Date:

I have a 42 C.F.R. Part 2 Release of Information that authorizes me to access State of Ohio and/or ODADAS information (Y/N):

Benefit Allocation and Usage

Description of Benefit and Time Frame (All units are hourly including Used & Remaining)	Allocated	Used	Remaining

- Enter the client's **UCI** in the first box and the person number of **00** in the second box.
- The **As of Date** will default to today's date; this can be changed by manually entering the desired date.
- To view Mental Health only, enter **N**. To view both Mental Health and Drug and Alcohol information enter a **Y** in the **42 C.F.R.** box (provided you have a release form).
- Click the **Submit** button.

# Provider Web Portal

## Client Eligibility and Benefit Information Screen

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### Client Eligibility and Benefit Information

File

Selection Criteria

Client #:   As of Date:

**SUBJECT, TEST.**

I have a 42 C.F.R. Part 2 Release of Information that authorizes me to access State of Ohio and/or ODADAS information (Y/N):

#### Benefit Allocation and Usage

Description of Benefit and Time Frame (All units are hourly including Used & Remaining)	Allocated	Used	Remaining
LIMIT MH ASSESSMENT BY NON-PHYS TO 4 HOURS (4) UNITS PER FY	4.00	.00	4.00
LIMIT MH ASSESSMENT BY PHYS TO 2 HOURS (2 UNITS) PER FY	2.00	3.00	.00
LIMIT MCD COUNSELING TO 52 HOURS (208 UNITS) PER FY	52.00	.00	52.00
LIMIT MCD PHARM MGMT TO 24 HOURS PER FY	24.00	.00	24.00

- Use the scroll bar on the right to view all of the benefits associated with the client.
- To search on another client, click the **New Search** button and enter the information as before.
- Once you are finished, click the **Logout** button.

# Provider Web Portal

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- Adding/Deleting a Secondary User, Updating Personal Information or Changing your Password

***NOTE:** Only a **Primary User** can add or delete a **Secondary User***

- To access the **Account Information** screen, complete the log-on information and click the button next to **Account Information** before clicking the **Login** button
- The **Account Information** screen will appear

# Provider Web Portal

## Account Information Screen

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Department of Alcohol &  
Drug Addiction Services



Department of  
Mental Health

### Account information

[Sign out](#)

#### Update your Personal information

Last Name:

First Name:

Email Address:

phone number:

Street:

City:

zipcode:

[change your password](#)

Save

User ID	
<input type="checkbox"/>	testusb-1
<input type="checkbox"/>	testusb-2
<input type="checkbox"/>	testusb-3

DELETE

**Please Note:** users should be created sequentially for EX: your user ID-1,user ID-2,you can not create user ID-4 if user ID-3 is available.initial password format should be S0000xxxx(last 4 digits of tax ID).email id should be unique to user.

### Add Secondary User

User ID:\*

password:\*

Email Address:\*

Last Name:\*

First Name:

phone number:

Street:

City:

zipcode:

\* indicates Required field

Save

# Provider Web Portal

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- **Add a Secondary User**
  - Enter the **User ID**
  - Enter the initial **password**
  - Enter the user's e-mail address
  - Enter the user's **Last Name**
    - × **First Name, phone number, Street, City and zip code are optional**
  - Click the **Save** button
  - A message will appear at the bottom of the screen that says **“user is successfully created”**
  - The new user will need to change their password on their first log-in
- **Delete a Secondary User**
  - Check the box next to the **Secondary User** you want to delete
  - Click the **Delete** button
  - A message will appear that asks if you are sure you want to delete the user – click **Okay** to delete or **Cancel** if you do not want to delete the user
  - A message will appear that says **“user is successfully deleted”**
- **Change your password**
  - From the **Account Information** screen, click on the [change your password](#) link
  - When the screen appears, complete the information to change your password and click the **Save** button
- **Update Personal Information**
  - Make the appropriate changes and click the **Save** button

# **PRIOR AUTHORIZATION**

Terry R. Jones

# Prior-Authorization Proposal

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- ODMH will implement a prior-authorization process for Medicaid partial hospitalization and CPST, for both kids and adults, who need services beyond the benefit limit
- ODMH is working with the Department of Administrative Services to issue an RFP for a statewide vendor to perform the authorization process
- Once a vendor is selected and the process for requesting a prior-authorization is defined, statewide, regional training(s) will be scheduled
- Prior-authorizations will be for the provider requesting the prior-authorization and will be service specific
- Once a prior-authorization is approved, the provider will be given a prior-authorization number
- The prior-authorization number will need to be submitted on the 837P claim line
  - We are finalizing which loop and/or segment on the 837P claim file will need to contain the prior-authorization number

# Prior Authorization Continued

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- The selected vendor will work with ODMH on the medical criteria used to determine appropriateness of the continuation of the covered service. The medical criteria must be consistent with rules 5101:3-1-01 and 5101:3-2-02(B)(14) of the OAC;
- The selected vendor will review and make an initial determination for PH and CPST services within a specified time frame.
- The selected vendor will train Community Mental Health Medicaid providers, ODMH staff, and contractor/sub-contractor staff on the prior authorization review program;
- The selected vendor will maintain a reporting mechanism that meets notification requirements described in OAC rule 5101:3-2-40;
- The selected vendor will monitor and provide suggested updates to the program to ensure that appropriate procedures are reviewed;

# Prior Authorization Continued

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- The selected vendor will develop and implement procedures for all prior authorization review denials including documentation of all reasons for denials or subsequent reversals of determinations
- The selected vendor will issue notices of approvals and denials to the provider/consumer along with the explanation of their rights to a hearing in compliance with OAC chapter 5101:6-2
- The selected vendor will participate in hearings when prior authorization denials are appealed

# Questions

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- Answers.....

# Rule Process

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- ODMH is working with ODJFS on changes to the Ohio Administrative Code (OAC), which will happen via rules promulgated by ODJFS
- Plenty of opportunity is afforded for input on administrative rules. ODJFS has a clearance process and all rules are posted on the JFS website (<http://www.odjfs.state.oh.us/clearances/public/index.aspx>) for feedback before submitted for review by the Joint Committee on Agency Rule Review – JCARR - (<https://www.jcarr.state.oh.us/>)

# Rule Process

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- Anyone can sign up to receive rule clearances via the ODJFS website
- Once submitted to JCARR, agencies must conduct a public hearing to obtain feedback. Finally, the rule will have a public hearing before JCARR itself before it can go into effect

# Rule Process

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- Due to the length of the JCARR process, in some instances ODJFS will also seek emergency rule authority from the Governor to implement changes
- With an emergency rule filing, the rule will go into effect for 90 days, during which time ODJFS will follow the rule process described in the preceding slides

# Contact Information:

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# Resource List

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- MACSIS Helpdesk: [macsissupport@mh.ohio.gov](mailto:macsissupport@mh.ohio.gov)
- Medicaid Mailbox: [Medicaid@mh.ohio.gov](mailto:Medicaid@mh.ohio.gov)
- FAQ Web link: <http://mentalhealth.ohio.gov/assets/medicaid/cost-containment-faqs.pdf>
- DAS Procurement Web Link: <http://procure.ohio.gov>
- JFS Clearance Page:  
<http://www.odjfs.state.oh.us/clearances/public/index.aspx>
- JCARR: <https://www.jcarr.state.oh.us>