

Mental Health and Chemical Dependency Medicaid Provider Manual



Addictions and Mental Health Division
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Forward

The Addictions and Mental Health Division (AMH) designed the “Mental Health and Chemical Dependency Medicaid Provider Manual” as a resource for both Department of Human Services (DHS) approved providers and those interested in becoming an approved provider.

This manual contains information on how to request enrollment as a DHS approved provider of mental health or addictions services, definitions on commonly used terms and acronyms, billing instructions, and other items useful for providers. The AMH provider manual is intended for use in conjunction with applicable Oregon Administrative Rules, state statutes and federal regulations.

Mental Health and Chemical Dependency providers should contact the Division of Medical Assistance Programs (DMAP) Provider Services for billing questions. Provider Services can be reached by calling toll free at (800) 336-6016 or Salem direct line at (503) 378-3697.

The Addictions and Mental Health Division Provider Manual furnishes providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements. However, it is the Provider’s responsibility to read, be familiar with and meet all requirements described in the Oregon Administrative Rules.

DHS Internet Addresses

DHS recently implemented a subscription service that enables you to be notified by email whenever the content changes on one of our Web pages.

Among the pages you can subscribe to are the pages for AMH's administrative rules, proposed rule changes, provider notices, client notices, OHP eligibility reports, managed care enrollment reports, FFS fee schedule, quarterly reports, and many more. It's easy and FREE to use. Just click on the envelope icon on one of our pages, or on the "eSubscribe" button on the DHS home page: <http://egov.oregon.gov/DHS/>. "Provider Matters" is an excellent resource on updated MMIS functionality.

DIRECTIONS (aide in navigation) TO USEFUL INFORMATION		
From the DHS Home Page, Click On:	Agency/Program Web Page:	Description/Information Regarding:
Medicaid Management Information System (MMIS)	Oregon Health Plan (OHP)	<ul style="list-style-type: none"> • Active functions • User manual • Prior Authorizations • Eligibility
Medical Assist. Program	Oregon Health Plan (OHP)	<ul style="list-style-type: none"> • Data and Publications • Tools for Policymakers, Providers & Staff • OHP Policies
From Medical Assist Program, click on "Data and Publications"	Oregon Health Plan (OHP)	<ul style="list-style-type: none"> • Policies/Reports • FAQs/Forms • Managed Care
From Medical Assist Program, click on "Tools for Providers"	Oregon Health Plan (OHP)	<ul style="list-style-type: none"> • Contacts/HIPAA • Prioritized list, fees, & rates • Provider rules, reports, etc.
From Medical Assist Program, click on "Tools for Providers," then "New Providers"	Oregon Health Plan (OHP)	<ul style="list-style-type: none"> • How to be an OHP Provider • Provider Rules & Guidelines • Billing Tips (Handbooks and Handouts); submission of claims, and claim forms
Mental Health	Addictions and Mental Health Division (AMH)	<ul style="list-style-type: none"> • Program contacts • Evidence-based practices • Publications & reports • Tools for Policymakers & Providers (user manuals) • Research & data
Addiction	Addictions and	<ul style="list-style-type: none"> • Treatment, Prevention &

	Mental Health Division (AMH)	Gambling Services <ul style="list-style-type: none">• Resource & Data Center• Tools for Policy Makers & Providers (user manuals)
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Definition of Terms

Addictions and Mental Health Division (AMH) – The division of the Department of Human Services responsible for the administration of Oregon’s policy and programs for mental health and chemical dependency prevention, intervention and treatment services.

Automated Voice Response (AVR) – The AVR is the system that replaced the Automated Information System (AIS). Like AIS, the AVR, is a phone based system, allowing providers to complete automated inquiries on client eligibility, benefits, service limitations, managed care enrollment and third-party resources using a touch-tone telephone.

Center for Medicare and Medicaid Services (CMS) – CMS is the Centers for Medicare & Medicaid Services. Formerly known as the Health Care Financing Administration (HCFA), we are the federal agency responsible for administering the Medicare, Medicaid, CHIP (Children's Health Insurance), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs. Additional information regarding CMS and its’ programs is available at <http://www.cms.hhs.gov/>.

Certified Alcohol and Drug Counselor (CADC) – As defined in OAR 415-051-0057, a certified or licensed person who meets the following minimum qualifications as documented by the provider:

- (a) 1,000 hours of supervised experience in alcohol/drug abuse counseling;
- (b) 150 contact hours of education and training in alcoholism and drug abuse related subjects; and
- (c) Successful completion of a written objective examination or examination or portfolio review by the certifying body.
- (d) Licensure/Registration: For treatment staff holding a health or allied provider license, such license/registration shall have been issued by one of the following state bodies and the staff person must possess documentation of at least 60 contact hours of academic or continuing professional education in the treatment of alcohol and drug-related disorders:
 - (1) Board of Medical Examiners;
 - (2) Board of Psychologist Examiners;

- (3) Board of Clinical Social Workers;
- (4) Board of Licensed Professional Counselors and Therapists; or
- (5) Board of Nursing.

Chemical Dependency Services (CD) – Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with the ASAM PPC-2R criteria. Programs or individuals who have a current license or letter of approval from the Addictions and Mental Health Division must provide services.

Client Process Monitoring System (CPMS) – The Client Process Monitoring System was implemented by AMH during the 1981-83 biennium and provides information that services are being delivered by community providers supported by public funds in compliance with Legislatively approved budget and statutory mandates. The system also provides data on the performance of community programs and program evaluation. Data collected is used in determining reimbursable service days and offsetting revenue sources in various Mental Health programs. Additional information about CPMS is located at

http://www.oregon.gov/DHS/mentalhealth/publications/cpmsmanual_ad.pdf

Current Procedural Terminology (CPT) – The Physicians' Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting services and procedures performed by health care providers as published by the American Medical Association (AMA). CPT definitions are proprietary to the AMA; therefore, the definitions will not be included in the provider manual or its attachments.

Community Mental Health Program (CMHP) – The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a local Mental Health Authority, operated in specific geographic areas of the state under the intergovernmental agreement or direct contract with the DHS Addictions and Mental Health Division. In many case this is the county mental health department.

Diagnostic Statistical Manual (DSM) – Diagnostic and statistical manual published by the American Psychiatric Association.

Division of Medical Assistance Programs (DMAP) – The division within the Department of Human Services responsible for coordinating Medical Assistance programs, including the Oregon Health Plan (OHP) Medicaid Demonstration Project and the Children’s Health insurance Program (CHIP). DMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays DMAP providers.

Electronic Eligibility Verification Service (EEVS) – Vendors of medical assistance eligibility information that have met the legal and technical specifications of DMAP in order to offer eligibility information to enrolled providers of DMAP.

Fee-For-Service Provider (FFS) – Health care providers who bill for each service provided and are paid by DMAP for services as described in the DMAP rules.

Fully Capitated Health Plan (FCHP) – Prepaid Health Plans that contract with DMAP to provide capitated services under the Oregon Health Plan.

International Classification of Diseases (ICD) – A revision of the International Classification of Diseases Clinical Modification, including volumes, as revised annually.

Health Care Common Procedure Coding System (HCPCS) – This system is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies.

Health Services Commission (HSC) – The HSC is an eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.

Licensed Medical Practitioner (LMP) – Defined in OAR 309-16-0005 (36) as a person who meets the following minimum qualifications:

- (a) Holds at least one of the following educational degrees and valid licensures:
 - (A) Physician licensed to practice in Oregon;
 - (B) Nurse Practitioner licensed to practice in Oregon; or
 - (C) Physician's Assistant licensed to practice in Oregon; and

- (b) Whose training, experience and competency demonstrate the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.
- (c) See ISSR for language

Medicaid Management Information System (MMIS) - The mechanized claims processing and information retrieval system that all states are required to have according to section 1903(a)(3) of the Social Security Act and defined in regulation at 42 CFR 433.111. All states operate an MMIS to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization. More information can be accessed at <http://www.oregon.gov/DHS/mmis/index.shtml>

Medical Care Identification – This card identifies the individual as being Medicaid eligible at the time the card was issued as well as other pertinent information such as identification number, prepaid health plan enrollment and benefit package.

Mental Health Organization (MHO) – A Prepaid Health Plan under contract with the Addictions and Mental Health Division to provide mental health services as capitated services under the Oregon Health Plan. MHOs can be Fully Capitated Health Plans, community mental health programs or private behavioral organizations or combinations thereof.

Mental Health Services (MH) – Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for mental health issues for clients or their family members. Services are provided by programs or individuals who have a current license or certificate of approval from the Addictions and Mental Health Division.

National Provider Identifier (NPI) – The standard, unique health identifier for health care providers. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the NPI. Adult Foster Homes licensed through the Addictions and Mental Health Division is not required to have an NPI number.

Oregon Health Plan (OHP) – The Medicaid demonstration project, which

expands Medicaid eligibility to eligible Oregon Health Plan clients. The Oregon Health Plan relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

Plan of Care (POC) -- A Plan of Care (POC) is a tool within the Medicaid Management Information System (MMIS) that is used to authorize certain types of Medicaid services. A Plan of Care is based on an assessment and identifies services that have been authorized to meet an individual's identified needs.

Prepaid Health Plan (PHP) – A managed health, dental, chemical dependency or mental health care organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs) or Chemical Dependency Organizations (CDOs).

Prior Authorization (PA) -- A Prior Authorization (PA) is a tool within the Medicaid Management Information System (MMIS) that is used to authorize some mental health rehabilitative services for specific populations. A PA identifies both approved services and the time period for which the provision of services is authorized. Prior authorizations are given based on the medical appropriateness of services.

Prioritized List of Health Services – The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

Provider – An individual, facility, institution, corporate entity or other organization, which supplies medical, dental, mental health or chemical dependency services or medical and dental items.

Qualified Mental Health Associate (QMHA) – Defined in OAR 309-16-0005 (58) as a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following

minimum qualifications:

- (a) A bachelor's degree in a behavioral sciences field; or
- (b) A combination of at least three years' relevant work, education, training or experience; and
- (c) Has the competencies necessary to:
 - (A) Communicate effectively;
 - (B) Understand mental health assessment, treatment and service terminology in order to apply the concepts; and
 - (C) Provide psychosocial skills development and implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

Qualified Mental Health Professional (QMHP) – Defined in OAR 309-16-0005 (59) as a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the provider:

- (a) Graduate degree in psychology;
- (b) Bachelor's degree in nursing and licensed in Oregon;
- (c) Graduate degree in social work;
- (d) Graduate degree in a behavioral science field;
- (e) Graduate degree in recreational, art, or music therapy; or
- (f) Bachelor's degree in occupational therapy and licensed in Oregon; and
- (g) Whose education and experience demonstrate the competencies to identify precipitating events; gather histories of mental and physical disabilities; alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family and/or group therapy within the scope of his or her practice.

Introduction

The Division of Medical Assistance Programs (DMAP) is the Department of Human Services office responsible for coordinating the Medical Assistance Programs, including the Oregon Health Plan Demonstration.

The Addictions and Mental Health Division (AMH) is the Department of Human Services office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention and treatment service.

Oregon Administrative Rule (OAR) 410-120-1210 describes the Oregon Health Plan's (OHP) benefit packages and delivery system.

Most OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Managed Care Organization (MCO). A managed care organization may be a Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO) or a Chemical Dependency Organization (CDO).

Clients, who are not enrolled in a Prepaid Health Plan (PHP), receive services on a(n) "open card" or "fee-for-service (FFS)" basis. Outpatient mental health services are provided through Community Mental Health Programs or their subcontractors; and chemical dependency treatment services are provided through local alcohol/drug treatment providers, subject to limitations and restrictions in individual program rules. The provider will bill DMAP directly for any covered service and will receive a fee for the service provided.

The Medical Care Identification card specifies the client's status.

Medicaid Management Information System (MMIS)

Oregon operates a MMIS to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization. The system went live in December 2008 with select function capability. New functions are being added in phases. More information can be accessed at:
<http://www.oregon.gov/DHS/healthplan/docs/pa-web.pdf>

General Information for Mental Health (MH) and Chemical Dependency (CD) Services

Provider Enrollment

Consistent with Oregon Administrative Rule (OAR) 410-120-1260, providers must obtain a billing or performing provider number to receive reimbursement from the Division of Medical Assistance Programs (DMAP). The performing provider number is often referred to as the DMAP number. OAR 410-120-1260 (4) states an individual or organization must meet applicable licensing and/or regulatory requirements set forth by Federal and State Statutes, Regulations and Rules to be enrolled and to bill as a provider.

DMAP enrolled providers may submit claims for services provided to Medicaid eligible clients. Prospective providers may call DMAP Provider Enrollment at (800) 422-5047 for assistance with the application process. Facility-based providers may contact the AMH Adult Medicaid Specialist at (503) 947-5032 for assistance. Providers should not serve Medicaid eligible clients prior to issuance of a DMAP provider number.

National Provider Identifier (NPI)

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the NPI. It creates a national, standard set of unique health identifiers for health care providers. All providers of medical service other than AMH licensed adult foster homes are required to obtain an NPI. The NPI also allows for indicators of a provider's specialty or focus in the treatment provided. The most up to date information on the NPI is available at the DHS NPI website:

http://www.oregon.gov/DHS/healthplan/tools_prov/mpi.shtml

Taxonomy Code Use

In some cases because of the way a provider has enumerated with NPPES or the way DHS has set up the provider contract taxonomy code must be used when submitting claims electronically (HIPAA formats or web portal). Please contact either your AMH Enrollment Specialist at 503-947-5528 or Provider Services at 800.336.6016 if you have any questions on whether a taxonomy code is required in your case.

Chemical Dependency Provider Enrollment Process

For a provider to receive reimbursement for chemical dependency treatment of Medicaid eligible clients, it is necessary to obtain a specialized provider number with a “03” designation from DMAP. To request enrollment as a provider of chemical dependency treatment services to OHP members and a “03” designation provider number, providers must submit the following to DMAP:

- ❑ Completed DMAP Provider Application Form 3119 for Chemical Dependency
- ❑ Copy of current Letter of Approval or Licensure issued by AMH to provide chemical dependency services.

The AMH standards for the Letter of Approval or Licensure of a chemical dependency provider may be found in OAR 415-12-0000 to 0090. Prospective providers should contact AMH at (503) 947-5349 to obtain an application packet. Providers must obtain an AMH License or Letter of Approval prior to completing the DMAP Provider Application Form 3119.

Please send the enrollment packet to:

**DMAP Provider Services
500 Summer St NE, E44
Salem, OR 97301-1079**

If you have questions about the enrollment process, please call (503) 947-5528.

Mental Health Service Provider Enrollment Process

For an individual or organization to provide mental health services and bill for Medicaid eligible members, the provider must have a contract with either a managed Mental Health Organization (MHO), the Community Mental Health Program (CMHP)/Local Mental Health Authority (LMHA) within a county, or a direct contract with AMH and a specialized provider number entered in the system as provider type “33”.

The MHO or the CMHP/LMHA provides oversight and assures compliance with applicable administrative rules and standards.

Information required for enrollment as a provider of mental health services is outlined below.

Providers who want to provide services for Medicaid eligible members enrolled with a MHO must submit the following information:

- ❑ Completed DMAP Provider Application (form 3117-Agency; 3114-Professional)
- ❑ Copy of current licensure or Letter/Certificate of Approval issued by AMH.
- ❑ Copy of signature page of contract with the MHO
- ❑ Cover referral letter from the MHO requesting enrollment as a DMAP Provider.

Providers who want to provide services only to Medicaid eligible fee-for-service clients, i.e., those who are not enrolled in managed care MHOs, must submit the following information:

- ❑ Completed DMAP Provider Application (form 3117-Agency; 3114-Professional)
- ❑ Copy of applicable license(s) or AMH Certificate of Approval
- ❑ Community Mental Health Program (CMHP) referral cover letter requesting your enrollment as a DMAP Provider of Fee-For-Service billing
- ❑ Copy of signature page of contract with the CMHP
- ❑ Description of Medical Supervision process, per OAR 309-016-0075
- ❑ Description of Clinical Supervision process, per OAR-309-016-0077
- ❑ Description of Clinical Record standards, per OAR 309-016-0080
- ❑ Fee Schedule based on cost allocation plan
- ❑ Quality Improvement and Utilization Review procedures
- ❑ Procedures for billing third party resources prior to Medicaid
- ❑ Assurance of adherence to requirements of the 1964 Civil Rights Act and the 1990 Americans with Disabilities Act
- ❑ Procedures for retaining clients records seven years and financial records for three years after the ending of services
- ❑ Procedures for maintaining the confidentiality of client records, in accordance with applicable state and federal laws, rules, and regulations
- ❑ Agreement to comply with applicable provisions of OAR 309-016-0000 *et seq*, OAR 309-032-0950 *et seq*, and OAR 410-120-0000 *et seq*.

- Signature of individual applicant or organization's Director certifying accuracy of the information submitted

Application forms are within the 3100 series and can be accessed at:
<http://egov.oregon.gov/DHS/healthplan/forms/main.shtml>

Program contacts for both MHOs and CMHPs can be found on the DHS website: <http://egov.oregon.gov/DHS/mentalhealth/contacts.shtml>

Please send the enrollment packet to:

**DMAP Provider Services
500 Summer St NE, E44
Salem, OR 97301-1079**

If you have questions about the enrollment process, please call (503) 947-5528.

Eligibility Verification

Providers must verify the following client information prior to providing services:

- (1) Eligibility for Medical Assistance coverage;
- (2) Eligibility for the proposed service, based on the Medicaid benefit package;
- (3) Whether the client is enrolled in a PHP or is FFS.

How to Determine Client Eligibility

- (1) Verify and copy the individual's medical care identification card;
-- AND --
- (2) Automated Voice Response
 - Call DMAP's Automated Voice Response (AVR) at (866) 692-3864 (a user manual can be found at: http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml#avr);-- OR --
- (3) MMIS Web Portal
 - Web portal can be found at - <https://www.oregon.gov/medicaid/ProdPortal/Default.aspx>;-- OR --
- (4) Contract with a vendor to confirm eligibility. DMAP contracts with vendors to provide Electronic Eligibility Verification Services (EEVS) for Medicaid Providers. You may obtain a list of current DMAP contracted EEVS vendors at: http://egov.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml
 - ✓ Please contact each vendor for information on available services and associated costs.

Prior Approval Prior Authorization

- FFS mental health outpatient service for clients residing in a residential treatment home or facility require prior authorization if billed with an “HK” modifier.

Adult HK or “high risk” rehabilitative services are rehabilitative mental health services provided on a fee-for-service basis to individuals who have been approved by the Addictions and Mental Health Division (AMH) for mental health services. Regulations related to Medicaid payment for rehabilitative mental health services are identified in Oregon Administrative Rules (OAR), Division 16, 309-016-0000 through 309-016-0450. Adults eligible for HK rehabilitative mental health services are those considered at risk for multiple acute hospitalizations or long-term treatment at the Oregon State Hospital due to symptoms of a serious psychiatric disorder.

To obtain a Prior Authorization, the provider may submit a Prior Authorization Request Form through the web portal (<https://www.or-medicaid.gov/ProdPortal/Default.aspx>); or

The provider may submit a Prior Authorization Request Form including a valid mental health assessment and the Integrated Services and Supports Plan to:

Addictions and Mental Health Division (AMH)
ATTN: AMH Adult Medicaid Specialist
500 Summer Street NE, E-86
Salem, OR 97301-1118; or

The provider may fax the required documentation to (503) 947-5546.

Plan of Care

- Personal Care service for clients residing in an adult foster home or residential treatment home or facility requires prior approval.
 - To obtain prior approval, the provider must submit a Plan of Care Request Form via fax to 503-945-5869 or via mail to:

**Addictions and Mental Health Division
ATTN: AMH Adult Medicaid Specialist
500 Summer St NE, E-86
Salem, OR 97301-1118**

- Notwithstanding HK billed outpatient services covered in the first bullet, FFS Mental Health and FFS Chemical Dependency outpatient services do not require prior approval, unless specified in the Oregon Health Plan MH/CD Medicaid Procedure Codes and Reimbursement Rates Tables (<http://egov.oregon.gov/DHS/mentalhealth/tools-providers.shtml>).
- For PHP enrolled clients, providers must contact the appropriate PHP for program coverage, prior authorization and billing information before providing services. Failure to follow the rules established by the PHP for mental health or chemical dependency services may result in a denial of payment. See OAR 410-141-0420 (5) and (6).
- DMAP will not pay a provider for provision of services for which a PHP has received a capitated payment unless otherwise provided for in OAR 410-141-0120.

The Medicaid Policy unit will review the request and supporting documentation. If documents are missing or clarification is needed, the Primary Contact identified on the Prior Authorization Request Form will be contacted by an AMH Adult Medicaid Specialist. The Medicaid Policy Unit will make a decision regarding approval within 10 business days of receiving a complete Prior Approval request. An AMH Adult Medicaid Specialist will enter the status of the Prior Approval into the MMIS. A notification of the outcome will be generated and mailed to the provider.

Urgent/Emergent Requests

No Prior Approval is necessary for crisis services that are offered in response to imminent danger, such as assessment for acute care hospitalization. Urgent rehabilitative services are those services offered in response to an onset or exacerbation of symptoms that require attention within 24 hours to prevent a serious deterioration of an individual's mental health status. Emergent or immediate rehabilitative services are rehabilitative services offered in response to an onset or

exacerbation of symptoms that require attention within 48 hours to prevent a serious deterioration of an individual's mental health status. Prior Approval requests for either urgent and emergent (immediate) rehabilitative mental health services should be submitted via fax to an Adult Medicaid Specialist at (503) 947-5546. Requests, when possible, should be accompanied by supporting documentation including an amended Treatment Plan and the most recent Mental Health Assessment. Documents should demonstrate a change in mental status.

Requests for urgent and emergent (immediate) Prior Approval for mental health rehabilitative services submitted to the AMH Medicaid Policy Unit before 12:00 noon will be responded to by the end of the work day. Requests for urgent and emergent (immediate) Prior Approval for Mental Health Rehabilitative Services submitted to the AMH Medicaid Policy Unit after 12:00 noon will be responded to by noon the following workday. Medicaid Policy Unit staff will enter the status of the PA request into the MMIS. A notification will be generated by the system and mailed to the provider. For urgent and emergent requests, Medicaid Policy Unit staff will contact providers by phone or by fax with the outcome of their request.

To expedite service delivery, Medicaid Policy Unit staff may contact providers by phone with authorization to proceed. Approvals may be post-dated to the day that the request was submitted.

Children's Psychiatric Residential Treatment Services (PRTS)

Prior Approval for children's Psychiatric Residential Treatment Services is done through a third-party review organization for children not enrolled in managed care; the Mental Health Organization completes prior approval for children enrolled in managed care. In both cases a Certificate of Needs (CONs) is completed by a financially neutral party demonstrating the medical necessity of the services.

Documentation

All services must be documented in accordance with OAR ISSR and 410-XXX-XXXX

It is the responsibility of the provider to follow the OAR in effect at the time the service was provided. In general the requirements are:

- ❑ Individual Service Record
- ❑ Assessment
- ❑ Medical Service Records
- ❑ Individual Service and Support Plan (ISSP)
- ❑ Individual Service and Support Planning and Coordination
- ❑ Individual service notes
- ❑ Family Involvement
- ❑ Co-Occurring Disorders
- ❑ Service delivery: All Addictions and Mental Health services and supports will be provided in the least restrictive environment, and will be:
 - (a) Delivered with reasonable promptness;
 - (b) Trauma-informed and trauma-sensitive;
 - (c) Culturally competent;
 - (d) Matched to each individual's level of cognitive and emotional development;
 - (e) Comprehensive, as needed, to achieve desired outcomes.

Reimbursement Requests for Services Rendered

Procedure/Billing Codes

Providers must use the current procedure codes that are in effect on the date of service. Providers are also required to use the current DSM or ICD code when billing for mental health or chemical dependency services. Electronic billing through MMIS requires the use of ICD codes.

Current procedure codes and service criteria are located in the Oregon Health Plan MH/CD Medicaid Procedure Codes and Reimbursement Rates Tables. The provider is responsible for selecting the procedure code that best describes the type of service provided. Specific levels of coverage, frequency limitations and modifiers, when applicable, are also included in the tables. Modifiers listed are used in order to differentiate between similar services in different programs, and may only be used with those codes indicated in the table.

Current and prior versions of tables can be accessed at:

<http://egov.oregon.gov/DHS/mentalhealth/tools-providers.shtml>

Place of Service (POS) Codes

Place of service codes (POS) identify the location where the service was provided. POS codes can be found on the last page of the mental health table, and in the footer of the chemical dependency table.

HCPCS Level II Modifiers

Modifiers are alphanumeric codes that serve to further define services and items. Modifiers are required on all billings. Modifier codes can be found in the footer of the mental health and chemical dependency table, as well as in the appendage.

HIPAA

Providers doing business electronically with DHS are required to meet the federal HIPAA-compliant formats. For federal standards go to the Washington Publishing Company web site:

<http://www.wpc-edi.com/content/view/180/223/>

Information related to the DHS requirements may be found at the DHS website at: <http://egov.oregon.gov/DHS/admin/hipaa/index.shtml> and for submission guidelines go to: <http://www.oregon.gov/DHS/edi/resources.shtml#guides>

DHS uses the Website as our main vehicle to communicate HIPAA related information to you. DHS will accept, test and process only the mandated versions of the HIPAA Electronic Data Interchange (EDI) transactions.

Paper Billing

The testing requirement does not apply to paper submitters. DHS will continue to accept paper (manual) claims and other transactions. DHS requires the use of an original (red) CMS 1500 form. Please contact the AMH Adult Medicaid Specialist for retail locations.

Completed forms should be mailed to:

DMAP
PO Box 14955
Salem, OR 97309-4957

Additional information regarding billing instructions, helpful “tips,” and contact information can be found at:
http://egov.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Electronic Billing

DMAP's FFS providers may bill electronically **including the web portal for many providers**. PHP's must submit encounter claims electronically **including the web portal**. Electronic billing submitters must access the DHS website to download the electronic billing format and requirements. **For web portal billing contact Provider Services at 800.336.6016**. DHS will accept, test and process only the mandated versions of the HIPAA Electronic Data Interchange (EDI) transactions as specified in the website.

Claims may be submitted electronically **via secure FTP site**. For more information contact the **DHS** at:

DHS EDI Support at 888.690.9888 or DHS.EDISupport@state.or.us

Payment for Services

According to OAR 410-120-1280 (1)(a), a provider enrolled with the Division of Medical Assistance Programs or a managed care plan under the Oregon Health Plan must not seek payment from a client eligible for Medical Assistance benefit, or from a financially responsible relative or representative of that individual, for any services covered by Medicaid fee-for-service or through contracted managed care plans, including any co-insurance, co-pays, and deductibles, except under the circumstances cited in the rule.

OAR 410-141-0420 (6), Billing and Payment under the Oregon Health Plan, states payment by the PHP to Providers for Capitated Services is a matter between the PHP and the Provider.

A Third Party Resource (TPR) is an alternative insurance resource, other than Medicaid, available to pay for mental health or chemical dependency services on behalf of the medical assistance client. Medicaid is the "payer of last resort". This means other health insurance named in the "Managed Care/Private Insurance/Restrictions" section of the client's Medical Care Identification card must be billed prior to billing DMAP. OAR 410-120-1280 provides guidance on Third Party Resources. OAR 410-120-1230 provides guidance on client co-payments. Questions not answered in rule should be addressed with the Provider Services Unit at (800) 336-6016 or in the Salem area to (503) 378-3697.

Fee-for-service payments are issued through direct billing to DMAP for clients not enrolled with a PHP after any payments from third parties are paid.

In order for a payment to be considered made appropriately, the following criteria must be met:

The individual receiving services must be eligible:

- Medicaid Eligible
- At least 18 years of age.
- Enrolled/ residing in an Extended Care Program with AMH approval

OR

Transitioning from an Extended Care Program with AMH approval
OR

Prioritized for services to adults with serious mental illness and meet the following criteria:

- Has received a variety of community-based treatment modalities over a reasonable period of time.
- Has demonstrated minimal functional improvement in response to treatment.
- Demonstrates either deterioration in functioning or continued impairment in functioning due to mental illness that hinders his or her ability to live safely in the community without intensive services and demonstrates a significant risk of admission to the Oregon State Hospital.

The provider delivering services must be eligible:

- Enrolled as a Medicaid Mental Health Provider.
- In receipt of or included in a Certificate of Approval from AMH for the provision of mental health services.
- Services are delivered in compliance with the Integrated Services and Supports rule.

The services offered must meet AMH criteria:

- Services must be identified on an integrated services and supports plan that is in compliance with the Integrated Services and Supports Rule
- Medical appropriateness for services must be demonstrated. This appropriateness must be based on a Mental Health Assessment completed by a QMHP and reviewed, at least annually by an LMP. (OAR 309-016-0080)
- Services must be provided by qualified staff
- Prior Approval must have been obtained for services AMH requires prior approval

Provider Audits

Audits are routinely conducted by the Office of Payment Accuracy and Recovery (OPAR) to verify the accuracy of payments made to providers by

DHS. Audits are conducted in compliance with OAR 410-120-1505. OPAR examines the records to ensure all requirements that must be met for a payment to be considered appropriate have been appropriately documented. AMH Medicaid payments are governed by the AMH Medicaid Payment Rule (OAR xxx-xxx-xxxx through xxxx) and all services by the Integrated Services and Supports Rule (OAR xxx-xxx-xxxx through xxxx).

Provider Appeals

The provider appeals and Administrative Review processes are described in OAR 410-120-1560 through 1700. Please contact the OHP Mental Health Medicaid Policy Analyst at (503) 947-5528

Medicare/Medicaid Medical Assistance Program Claims (Dual Coverage)

In accordance with federal regulations, and as described in Oregon Administrative Rule 410-120-1280, providers must bill third party resources prior to billing the Division of Medical Assistance Programs (DMAP). If a client has both Medicare and Medicaid coverage, providers must bill Medicare first for Medicare covered services. Once Medicare adjudicates the claim, the provider may bill DMAP for amounts that are the patient's responsibility.

Both Medicare-eligible and non-Medicare eligible Mental Health providers are required to submit claims using the DMAP 505 billing form (rather than the CMS 1500 billing form). If you are not a Medicare-eligible provider AMH asks that you state this information on the form (i.e. not covered by Medicare, or not a Medicare provider). **EXCEPTION:** A-Typical providers, such as Adult Foster Homes, use the CMS 1500 to report services provided to dual eligible individuals

Under the circumstances wherein Medicare would never cover the service, not billing Medicare and billing Medicaid using the appropriate 2-digit TPR code is acceptable. Box #9 "Other Insured's name" on the CMS 1500 is the correct place to enter the appropriate 2-digit TPR code. Providers are responsible to document and bill Medicare whether the physician was present on the site or not.

Providers may contact DMAP Provider Services at (800) 336-6016 for assistance in completing the DMAP 505 billing form or other questions regarding a claim.

Medicare providers can increase the efficiency of dual eligible claims processing by providing their Medicare provider number to DMAP Provider Enrollment Services by calling (800) 422-5047.

- **Denied payment?** If you are denied payment for a claim that has crossed-over from Medicare to Medicaid, you must use DMAP Form 505 to be paid correctly.

If Medicare transmits incorrect information to DMAP, and DMAP

denied payment on the claim; or if you billed an out-of-state Medicare carrier or intermediary a provider must use the DMAP 505 form.

- ***Overpayment received? Claim paid incorrectly?*** If you receive an overpayment or a claim has been incorrectly paid by DMAP, for a claim that has crossed-over from Medicare to Medicaid, you must use the DMAP 1036 Individual Adjustment Request form. The DMAP 1036 form has specific requirements for completion so that DMAP staff can process the adjustment request correctly the first time.

“*Helpful Tips*” that will assist you in completing and submitting your DMAP 505 or 1036 claims correctly the first time can be found at:

http://egov.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Employee Education about False Claims Recovery

The Federal Deficit Reduction Act (FDRA) of 2005 requires providers to establish written policies for all employees (including management) and of any contractor or agent of the entity that include detailed information about the False Claims Act and other provisions named in Section 1902(a)(68)(A) of the FDRA. The Act requires entities to establish written policies detailing information about the entities policies and procedures for detecting and preventing waste, fraud, and abuse. If there is an employee handbook, it should include a specific discussion of the written policies, the rights of employees to be protected as whistleblowers and the entity's policies and procedures for detecting and preventing fraud waste, and abuse. These requirements will be incorporated into each provider enrollment agreement.