Opiate Treatment Program (OTP)
Health Home (HH)
Provider Billing Manual

June 28, 2016

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1. Overview

This provider billing manual (Billing Manual) is designed to be a reference document for providers, Rhode Island Medicaid Managed Care Organizations (MCOs), patients, family members, primary care providers, other behavioral health care providers, hospitals and other social service providers who are involved in the Opioid Treatment Program Health Home (OTP HH). *This manual does not apply to providers billing for Integrated Health Home Services in Community Mental Health Organizations (CMHO's).*

This manual has been developed by the Rhode Island Executive Office of Health and Human Services (EOHHS), including Medicaid and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), to foster a smooth transfer of program administration to the MCOs, for MCO members on July 1, 2016 and for continued program implementation of this service.

This Billing Manual represents a new way of billing for OTP Health Home. Beginning July 1, 2016, all OTP Health Home services will be billed to either the member's MCO or to EOHHS if a member is not enrolled in an MCO but is covered by Medicaid and is "Out of Plan."

2. Definitions

Opioid Treatment Program Health Home (OTP HH) – The OTP Health Home is built upon the evidence-based practices of the patient-centered medical home (PCMH) model. OTP Health Home coordinates care for persons with opioid dependence who have or are at risk of another chronic condition and builds linkages with and among behavioral healthcare providers, primary care, specialty medical providers, and other community and social supports, and enhances coordination of medical and behavioral healthcare. The goal of the OTP Health Home is to address more effectively the complex needs of the OTP Health Home members. The OTP Health Home program is a service provided to community-based members and collateral providers by a team of professional and paraprofessional staff who are experienced in addiction in accordance with an approved treatment plan for the purpose of ensuring the member's stability, improved medical outcomes and less reliance on more restrictive services, such as the emergency department, inpatient medical-surgical, and/or inpatient psychiatric care. The desired outcome is increased community stability, recovery from opioid dependence, improved health outcomes for the member's other chronic conditions, or reduced risk of those chronic conditions. OTP Health Home teams coordinate care and ensure that medically necessary interventions are provided to help the member manage symptoms of their illness. The OTP Health Home also helps the members, their providers, and their natural community supports to address the social determinants affecting the member's well-being with the goal of improving the member's overall life situations. Members receive assistance in accessing needed medical, social, educational, vocational, and other services necessary to meeting basic human needs.

Required Services – OTP Health Home providers will be approved by BHDDH. OTP Health Homes are required to provide all of the following services: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, and chronic condition management and population management. These services may be coordinated through health information technology or other mechanisms (i.e. CurrentCare, etc.) to facilitate coordination of care with primary care providers and other behavioral healthcare providers.

Team-based Approach - OTP Health Home uses a team-based approach to care coordination, opioid dependence and chronic condition management, health promotion and peer/family support. Each team member's unique background and expertise provide a valuable resource for optimizing the care coordination activities that can benefit the members they serve.

Eligible OTP Health Home Providers – Only OTP's certified by BHDDH to provide OTP Health Home services, may bill for OTP Health Home.

Service Delivery - OTP Health Home services are based on a team approach for each member, driven by a person-centered, recovery-oriented, strength-based care plan. Service intensity and service mix among the six required services is likely to vary from month-to-month. A member of the team will maintain contact with the member, the member's family, with the member's signed release of information, and/or the members' collateral providers and supports to ensure that the treatment plan is being implemented and to address any barriers to care and support that are identified.

Note: The descriptions of OTP Health Home provided in this billing manual are only a high-level description of the programs. Please refer to the OTP Health Home Provider Manual for full details and descriptions of services and requirements included in the OTP Health Home program.

Members will qualify for OTP Health Home based on the completion of the OTP Health Home Eligibility and Follow-up Checklist contained at the back of the OTP Health Home Program Manual.

3. Other Behavioral Health Services Available to Members Receiving OTP Health Home

OTP Health Home: The menu of OTP Health Home services has been designed to complement the direct services that members receive for their behavioral health and chronic medical conditions such as, medication management, intensive outpatient therapy, and/or primary care/specialty care visits with their primary care or specialty medical care provider. The role of the OTP Health Home team is to ensure coordination among all providers and to address members' unique needs, especially in times of crisis or high acuity and to facilitate smooth transitions of care for the member, the member's family, with the member's signed release of information and the members' other supports.

4. Initial Enrollment – July 1, 2016

OTP Health Home providers should continue to enter member enrollment information into the portal. Effective July 1, 2016, DXC Technology (DXC) will provide information to the Managed Care Organizations (MCO's) submitted by OTP Health Home provider. OTP Health Home providers should ensure the accuracies of their July 1, 2016 enrollment into the portal, no later than June 1, 2016. The BHDDH portal will continue to be the entry point for OTP Health Home providers to enroll new members and to update information on existing members.

Initial Billing and Verification of Member Eligibility

Providers are responsible for verifying the member's Medicaid eligibility and OTP Health Home enrollment at the close of the month before submitting the bill for the monthly bundled payment.

5. Enrollment of New Members into OTP Health Home

After July 1, OTP Health Home providers will enroll OTP Health Home members in the same manner as is currently practiced.

All enrollments should be prospective. It is suggested, but not required, that the provider should submit the updated roster to the portal between the 20-25th of a month, for prospective enrollment the first of the following month. This will allow time for data transfer and to ensure that data can be passed successfully to the MCOs and that the OTP Health Home provider can bill for the member on a timely basis. Questions on data entry into the portal should be directed to DXC.

For all members enrolled after July 1, 2016 the provider must complete the OTP Health Home Eligibility and Follow-up Checklist form before enrollment is entered into the portal.

6. Billing for OTP Health Home Encounter Data Requirements

Billing for OTP Health Home

The OTP Health Home providers should submit bills for OTP Health Home services using a bundled payment methodology that equals the daily rate times the number of days that the provider is billing for the enrolled member: weekly, bi-weekly or monthly.

Providers bill for Member Out-of-Plan member using **H0037**. ***This code replaces H0046, with modifier U1.*** For Out-of-Plan Members, the rate for this service is $7.64 per day or $229.20 for a 30-day month.

Providers bill United Health Plan (UHP), Neighborhood Health Plan of RI (NHP), and Tufts Health Plan (THP) for the Members enrolled in their MCO as a covered service beginning on July 1, 2016. Providers will bill at a rate of $7.64/day, $53.50 per week or $229.20 per 30-day month. Below is a table for the codes for OTP Health Home and detail line billing for each plan and for members out of plan.

Shadow Billing in the Detail Lines of a Claim

As part of the delivery of OTP Health Home service the provider must document OTP Health Home activities that the client received during the billing period, no less frequently than one (1) month. These activities will be included in the detail billing lines that will be required. The provider must include at least one (1) shadow level activity on the claims at the provider's usual and customary charge, in order to get paid for the OTP Health Home bundled payment in the time span billed. The code for members who are out of plan is **H0036** for Direct Service to the members, and **H0006** for indirect collateral or telephone contact relating to care coordination activities of the member for whom OTP HH is being billed. The Plans will issue their own codes and include them in their contract with the providers.

Below is a table of the codes by payer:

OTP HH	Out of Plan	NHPRI	UHC	THP
Billing Code	H0037	H0037	H0047	H0037
Detail/Shadow-Direct	H0036	H0036	H0006	H0036
Detail/Shadow-Indirect	H0006	H0006	H0006 - U1	H0006

Requirements for Billing for Less than 30 days in a Monthly Cycle

EOHHS recognizes that from time to time, a member's Medicaid eligibility may switch from a MCO to Out of Plan, or that the member may be disenrolled from Medicaid entirely during a month. Under these circumstances, the provider may submit per diem bills to the MCO and/or EOHHS (BHDDH) for the dates that the member was enrolled, using the same methodology of one service or event for the billing period. The provider may bill per diem when a member's enrollment changes during the course of the month, and the provider may bill EOHHS for members not in a plan, or another plan when the members switches mid-month. Per diem billing is allowed for members not enrolled for the full calendar month.

7. Continuing Authorization

Once enrolled into the OTP Health Home, the OTP's will continue to bill OTP Health Home no less frequently than a monthly basis. However, the provider is accountable for having an active treatment plan. Service authorizations are valid for up to six (6) months.

EOHHS, BHDDH and the MCOs reserve the right to conduct joint case reviews.

8. Discharge from OTP Health Home

OTP Health Home is a voluntary service; a member may disenroll from the OTP Health Home at any time. A member's disenrollment from OTP Health Home does not impact their Medicaid eligibility. Members who stop their active participation may also be disenrolled from OTP Health Home. However, providers are expected to make ongoing efforts to reach out to and engage the member before disenrolling the member.
The provider must maintain active management of their OTP Health Home census and determine a member's continuing participation in the OTP Health Home program each month. A member's participation may be suspended or the member may be discharged based on the OTP Health Home team's assessment of the member's status.

9. Duplication of OTP Health Home Services

OTP Health Home Activities When Members are Admitted to Acute Inpatient Care

As was stated in the description of the program model, OTP Health Home is a service designed to complement and enhance care coordination in attaining behavioral health and primary care direct services, such as outpatient therapy, and chronic care services. There is no inherent conflict or potential for duplication of OTP Health Home services with other covered services of a MCO or unbundled Fee-for-Service medical and outpatient behavioral health services.

Similarly, if the member is hospitalized for an acute medical-surgical or behavioral health condition, the OTP Health Home team will assign the Hospital Liaison and/or other OTP Health Home team member to be responsible for coordinating the discharge planning with the hospital staff to effect a smooth transition of care back to the community. The liaison and/or other OTP Health Home team member will also be responsible for ensuring timely follow up to outpatient behavioral health services, primary care and medical-surgical services, and will be responsible for establishing a prevention plan in collaboration with the member and MCO to prevent or minimize any subsequent readmissions for medical-surgical and behavioral health problems.

When an OTP Health Home member is admitted to an acute medical-surgical or acute inpatient psychiatric hospital unit or detoxification program, the OTP Health Home provider may continue to bill the MCO or the State for OTP Health Home.

Crisis stabilization and residential treatment are considered community services; members in those programs may also receive OTP Health Home services.

Duplication of OTP Health Home Members in Other Institutional Care Settings

Admission to state-operated facilities including Eleanor Slater, Taveras, or Zambrano Hospitals, or an out of State facility will result in the member being disenrolled from the Medicaid health plan. EOHHS and DXC will institute and edit to prevent billing for OTP Health Home when a member is admitted to these facilities. Billing for OTP Health Home members under these circumstances will be considered duplicative billing and the claims will be denied by the MCOs and EOHHS. OTP Health Home billing will be allowed when an OTP Health Home member is admitted for an acute inpatient psychiatric hospitalization to an out of state hospital that is in the MCO provider network or contracted with EOHHS for inpatient psychiatric services.

OTP Health Home providers cannot bill for a person that is incarcerated unless they are still enrolled and/or Medicaid eligible, before they are placed in a Medicaid-restricted benefit status.

Duplication When Member Enrolled in other Health Home Service

When a new member is assessed by an OTP Health Home provider, the provider must check the DXC portal to see if the member is already attributed to another Health Home provider for OTP Health Home, Integrated Health Home (IHH) or Assertive Community Treatment Program (ACT) services (the latter two provided by a CMHO). The current OTP Health Home, IHH or ACT provider must disenroll the member at the end of the current month in order for the new OTP Health Home provider to enroll the same member at the beginning of the next month using the BHDDH Transfer Form when there is a disagreement about OTP Health Home assignment. Questions regarding the process of the transfer of members from one OTP Health Home to another should be directed to BHDDH, following the usual coordination of care transfers. Any disputes on transition should be referred to BHDDH.

11. Notice Process and Appeals

1. Upon enrollment in OTP Health Home, providers must complete an enrollment form that ensures that a provider has discussed the OTP Health Home program with the member and that the member has consented to participate. This is a voluntary program. Providers must attest that they have completed this action as documented in the patient's file before entering an enrollment segment.

2. Upon enrollment or a part of the initial intake process, members are to be given a written copy of the BHDDH and EOHHS process to file a complaint, appeal a decision or request a hearing. The process to file a complaint with BHDDH is written in the Rule and Regulations for the Licensing of Behavioral Healthcare Organizations, Section 19, Concern and Complaint Resolution Procedure. The Appeal Process is written under the Executive Office of Health and Human Services, Medicaid Code of Administrative Rules, Section 0110 Complaints and Hearings.

3. The providers shall provide written notification to the member when the member is discharged from the program or agency or when the member's enrollment in this program has been terminated; and when the member has successfully transitioned to another OTP Health Home provider or another appropriate level of care.

4. Members may appeal their discharge or termination as part of the EOHHS Fair Hearing process for enrollment disputes. The OTP Health Home provider must notify members of this right. Members enrolled in MCOs may also appeal through the MCO's complaint, grievance and appeal process. Providers are responsible for interpreting their certification requirements around incident reporting and following MCO contract requirements on grievances and appeals.

5. If consent is not properly captured and attested to in the member's record, and the provider enrolls and then bills for a member for OTP Health Home, the State reserves the right to recoup any funds paid for the service.

6. Per BHDDH and EOHHS regulations, the provider must maintain all records for any follow up auditing upon the request of the State.

12. Program Integrity

Both the State and the MCOs will engage in periodic audits to review the OTP Health Home Eligibility and Follow-up Checklist on a sample of members from each provider. The audit may be based on a random sample of members or on a targeted sample of members if there are anomalies in service mix, metrics, staffing or other programmatic characteristics. The State and/or the MCO may outreach to a provider to submit additional information on the OTP Health Home Eligibility and Follow-up Checklist. If the State or the MCO deny a level of care or seek a modification, and the provider disagrees with this assessment, the provider may appeal to the State for out of plan members or the MCOs for MCO members.

13. Other References

The provider and MCOs may refer to the BHDDH OTP Health Home Program Manual for more specific requirements for OTP Health Home program. This Billing Manual is designed to complement the BHDDH Program manual and certification requirements for OTP's.

This manual also complements existing billing codes for OTP Health Home, outpatient and other event codes currently in place for OTP Health Home. (See Appendix I for List of New Billing and Procedures Codes)

Appendix I

List of Billing and Procedure Codes

(**Updated** from the previous version of the OTP Health Home Program Manual [05.25.16 (v3.0)] - Page 18):

HEALTH HOME BILLING AND CODING

1. Standard conventions utilized for Medicaid billing should be followed. For Medicaid FFS members that are not receiving OTP Health Home Services, EOHHS will issue a new code to replace the current code, H0020 for Methadone Maintenance Treatment.

2. For all Health Home, Out of Plan Medicaid recipients, a new methadone treatment code will replace the current code: H0020 with a U1 modifier.

3. For all Medicaid Members enrolled in a managed care plan, existing contracts, codes and rates for methadone treatment apply. A new billing code from the Health Plans will replace the current billing code for Health Home H0046, with modifiers U8 and U1. The Health plans will establish their own codes in their contract with OTP HH providers or use the same code. (See Table on page 5.)

4. For all Health Home patients who are Out of Plan, EOHHS and DXC will issues a new OTP Health Home code that replaces the current code: H0046 with a U8 modifier.

5. Health Home events should be recorded in **FIFTEEN (15) MINUTE** units. The first unit must last a **FULL**15-minutes; additional units during the same encounter should be rounded up/down as appropriate.

6. Health Home telephone contacts may be recorded in FIVE (5) MINUTE units. The first unit must last a **FULL 5-MINUTES**; additional units during the same encounter should be rounded up/down as appropriate.

Updated from the previous version of the OTP Program Manual [05.25.16 (v3.0)] - Page 19:

	Program code	New Procedure code as of 7/1/2016	Modifier	Effective Date*	Rate	Unit Basis
1	MSA010	H0037		7/01/2016	$7.64	Daily
2	MBO020	NHP-H0037 UHC – H0047 THP – H0037		7/1/2016	$7.64	Daily, can be billed daily, weekly, bi-weekly or monthly
3	MSA010	H0020	U1	7/1/2016	$85.00	Weekly
4	MSA010 MBO020 MBO020	Out of Plan - H0036 NHP – H0036 UHC – H0006 THP - H0036		7/1/2016	N/A	15-Minute direct care coordination
5	MSA010 MBO020 MBO020	Out of Plan - H0006 NHP – H0036 UHC – H0006 THP – H0006	U1(UHC)	7/1/2016	N/A	5-Minute indirect care coordination

These codes will be replaced by new codes issued by the Health Plans, EOHHS/DXC..

1 – Out of Plan Health Home Code/Rate
2 – MCO Health Home Code/Rate
3 – Out of Plan Methadone Maintenance Rate
4 – Detail Line billing for Direct (face-to-face) Care Coordination
5 – Detail Line Billing for Indirect (telephone) Care Coordination

Appendix II

BHDDH Requirements for Minimum OTP Health Home Participation and Disenrollment

Discharge Criteria (OTP Health Home)

Discharge from the OTP Health home will occur when a patient and program staff mutually agree to the termination of services or transfer to a different level of care. This shall occur when patients:

- Have successfully reached individually established goals for discharge, and when the patient and program staff mutually agree to the termination of services;
- Follow-up assessments (i.e., bio-psycho-social, treatment plan, toxicology screen, etc.) indicate a need for higher or lower level of care;
- Move outside the geographic area of the OTP. In such cases, the OTP Health Home team shall arrange for transfer of medication assisted treatment and Health Home services to another OTP provider wherever the patient is moving or an Integrated Health Home program. The OTP Health Home team shall maintain contact with the patient until the transfer is completed;
- Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the patient;
- Do not consistently participate in any services for a 90 day period, despite demonstrated engagement and outreach efforts by provider. This shall be documented in the patient's file. Re-enrollment options are always available for initial or subsequent patients who decline HH services; and/or
- No longer meet eligibility criteria to participate in the Health Home program; No longer meet eligibility criteria for medication assisted treatment as outlined in the State of Rhode Island's Rules and Regulations for the Licensing of Behavioral Healthcare Organizations [Section 28.0].