



Questions and Answers on Medicaid Cost Containment Strategies in FY 2012-13 Budget Part II October 4, 2011

Below is a list of additional questions that the Ohio Department of Mental Health has received or that were asked during one of the ODMH regional training sessions on the mental health benefits. This supplements the first version of the FAQ released May 19, 2011. Additional questions may be directed to the ODMH Office of Health Integration at Medicaid@mh.ohio.gov.

A number of documents related to cost containment for mental health Medicaid are available on the ODMH website: <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/index.shtml>

Section 1: Mental Health Benefits, Covered Services and Limitations

1. When does ODMH anticipate the benefit limits for all services and prior authorization requirements will become effective?

Benefit limits for Medicaid mental health services and prior authorization for CPST and partial hospitalization will begin November 1, 2011. The benefit year will run July 1 – June 30. The full annual benefit will be available to Medicaid consumers for the period of November 1, 2011, through June 30, 2012. Please use the following link to access more information in the September 30, 2011, memo from Ohio Department of Mental Health Director Tracy J.Plouck related to the implementation status of the cost containment initiatives:

<http://mentalhealth.ohio.gov/assets/medicaid/20110930-service-limits-plouck-memo.pdf>

2. When will the Ohio Department of Job and Family Services (ODJFS) emergency file rules and what rules will be emergency filed?

Rule 5101:3-27-05 was emergency filed and effective July 1, 2011. This rule, entitled “Reimbursement for community mental health Medicaid services,” made changes to the reimbursement for CPST. The permanent version of that same rule has gone through the complete JCARR public filing process. It became effective September 29, 2011.

Rule 5101:3-27-02 – “Coverage and limitations of Medicaid community health services” – will be emergency filed in October so as to make it effective November 1, 2011. The permanent

version of the same rule will be filed shortly thereafter and be promulgated via the regular JCARR public rulemaking process.

3. Has ODJFS submitted a state plan amendment (SPA) to CMS? Has the SPA been approved? Can ODJFS and ODMH implement the benefit limits and prior authorization for CPST and Partial Hospitalization (PH) without an approved SPA?

A state plan amendment has been submitted to CMS requesting approval of the tiered pricing of the CPST service. It has been submitted for a retroactive July 1, 2011, effective date. The state plan amendment requesting annual benefit limits and prior authorization was submitted to CMS on September 30, 2011 for a November 1, 2011, effective date.

4. When were Medicaid consumers and/or parents/legal guardians of Medicaid consumers notified of the changes in their mental health benefits? Will you give providers and boards a copy of the notice?

The Ohio Department of Job and Family Services (ODJFS), as the single state agency for Medicaid, is sending notices to all 1.3 million Medicaid assistance groups no later than October 15, 2011, meeting the federal and state guidelines requiring notice at least 15 days prior to the effective date of a Medicaid benefit change. Stakeholder groups including advocates and representatives of providers and ADAMHS/CMH boards have received a copy of this notice and it is also available on the ODMH website.

<http://mentalhealth.ohio.gov/assets/medicaid/20110923-consumer-notice-mh-dadas-benefit-limits.pdf>

5. When will ODMH provide additional written information for consumers that describes the benefit limits and prior authorization process?

The Ohio Department of Mental Health will work with providers and other stakeholders to develop additional information about benefit limits to share with consumers. ODJFS will also arrange for information to be conveyed to callers to the Medicaid Consumer Hotline.

6. Will Medicaid consumers and/or parents/legal guardian of Medicaid covered children be able to access information about their mental health benefit limits, including how much service he or she has used during the benefit year? If so, how will this work and how will consumers be notified of how they can access information about their benefits?

Ohio Department of Mental Health staff members are working with the Ohio Department of Job and Family Services to develop an option for Medicaid consumers to access their benefit information through the existing Medicaid consumer hotline.

7. Will Medicaid consumers receive an explanation of benefits (EOB) describing their service use so they can participate in managing their service utilization?

Medicaid consumers can obtain this information through their providers. In addition, Ohio Department of Mental Health is working with the Ohio Department of Job and Family Services to develop an option for consumers to access their benefit information through the existing Medicaid consumer hotline.

8. If all Medicaid services must be medically necessary and supported by clinical evidence that supports medical necessity currently, why is prior authorization for CPST and PH even necessary?

For certain services, ODJFS or its designee reserves the right to examine the clinical evidence and determine medical necessity pursuant to OAC 5101:3-1-01. Examples of Medicaid services requiring prior authorization include certain durable medical equipment and certain surgical procedures. Medicaid CPST and Partial Hospitalization services are being added to the list of Medicaid services which must be prior authorized when a consumer has reached his or her annual benefit limit.

9. What options does a Medicaid consumer or parent/legal guardian have when the consumer's individual service plan recommends services in excess of the consumer's annual benefit limits?

The consumer or the consumer's parent/legal guardian can request that the provider seek prior authorization for additional CPST and partial hospitalization services and provide documentation explaining why they are thought to be medically necessary. If a child needs services in excess of the annual benefit limits, the provider can use the "SC" modifier for services such as mental health assessment, counseling and pharmacological management. An adult who believes that the annual benefit limit has been inappropriately applied to them may also file for a Medicaid appeals hearing.

10. Will a Medicaid consumer be notified when he or she has reached or exceeded the annual benefit limit in any given service? If so, how will notification occur?

Providers of Medicaid mental health services have access to the ODMH web portal and can notify consumers of their benefit limit as well as units received. In addition, staff members at the Ohio Department of Mental Health and the Ohio Department of Job and Family Services are developing an option for Medicaid consumers to access their benefit information through the existing Medicaid consumer hotline.

11. If a Medicaid consumer exhausts his/her annual service benefit in a particular service and continues to need medically necessary services, is it possible for the client to receive approval for additional units of services until the beginning of the next benefit year using the ODJFS appeals process in OAC 5101:6-1?

Please refer to the response to Question 9 above.

12. How long does an ODJFS consumer appeals process take?

Hearing decisions are required to be issued within 90 days of the request date.

13. Can a provider file an appeal with ODJFS on behalf of a client?

Only an authorized representative appointed by the individual may assist the consumer in the Medicaid hearings process. As required by OAC, 5101:6-3-02, a form appointing an authorized representative must be signed by the individual and must accompany all hearing requests made by an authorized representative. Medicaid does not pay for the services of an authorized representative.

14. Will a provider be allowed to bill CPST services for assisting the consumer with the ODJFS appeals process if the individual's mental illness impairs the client's ability to advocate for him/herself and navigate the system? Would CPST services be approved through prior authorization for a client in this circumstance if necessary?

All CPST services are individualized and must meet the definition of medical necessity. If CPST is to be billed, the documentation must state how the client's mental illness prevents him or her from advocating/navigating the process to file an appeal. In addition, note that Medicaid will not pay for the services of an authorized representative.

15. At what age will a young person be considered an "adult" for purposes of the mental health Medicaid benefit?

Ohio Medicaid and Healthchek (Ohio's Early Periodic Screening Diagnosis and Treatment, or EPSDT benefit) consider enrollees to be children until they reach their 21st birthday. At that time enrollees are considered "adults."

16. What is the rationale for setting the limit for partial hospitalization at the 65th percentile? Is ODMH looking at eliminating this service from the continuum of care?

The rationale for setting this limit is that, as the most clinically intense service, partial hospitalization should be closely monitored and managed. The Ohio Department of Mental Health is not planning to eliminate partial hospitalization from the continuum of care.

- 17. Clarification requested: Is the limit for partial hospitalization based on calendar days or units? For example, if a child receives two units of PH in a day, does that still count as one day toward the benefit limit? Does the PH limit imply services must be provided on consecutive calendar days?**

The limit for partial hospitalization is based on calendar days. If a child receives two units of this service in a day, it will still be counted as one day and two units of partial hospitalization (PH) may be billed per day. For adults, one unit of PH may be billed per day. The days do not need to be consecutive. The limit is set at 60 days.

- 18. Clarification requested: The psychiatric diagnostic interview (CPT code 90801) is a physician service code that may be used by an advanced practice nurse (APN) who is performing the psychiatric assessment. Is ODMH saying an APN is not permitted to bill the same service (90801) for performing the same psychiatric diagnostic interview as the psychiatrist even though this service is reimbursed using the same blended rate that is paid for both the psychiatric diagnostic interview and pharmacological management regardless of whether the individual provider was a physician or nurse?**

The ODMH Medicaid service of psychiatric diagnostic interview (CPT code 90801) may only be performed by a physician.

- 19. If a Medicaid covered client experiences a psychiatric crisis and is stabilized in a crisis stabilization unit where that stabilization exhausts the client's pharmacologic management benefit, what options does the provider and consumer have in accessing additional pharmacologic management services at a stepped down level of care?**

It is incumbent upon all service providers to assess clinical need and deliver services based on the service package. While benefit limits are new to mental health Medicaid, they are used throughout health care and Medicaid in general. Providers are expected to manage these limits in a similar manner as they do other payer requirements and limits.

- 20. If a client has exhausted his/her psychiatric assessment benefit of two hours annually, does ODMH expect a psychiatrist new to the case to initiate treatment and prescribe medications without first completing a psychiatric diagnostic assessment?**

The service limit for psychiatric evaluation is two hours annually. It is incumbent upon all service providers to assess clinical need and deliver services based on the service package. While benefit limits are new to mental health Medicaid, they are used throughout health care and Medicaid in general. Providers are expected to manage these limits in a similar manner as they do other payer requirements and limits.

21. Did and/or would ODMH consider counting CPST groups differently than individual CPST given the reimbursement rate and service model (i.e. 2 hrs group = 1 hr individual) toward the annual limit?

The Ohio Department of Mental Health did consider this approach, but decided to combine group and individual services for the benefit package taking into account overall feedback from the field on the benefit package.

22. Does ODMH still support the use of evidenced based practices (EBP) such as IDDT, ACT and DBT that are proven to achieve good outcomes? If so, will an adult client receiving one of these EBPs be able to receive additional medically necessary services, such as pharmacologic management and counseling, if needed above the limits consistent with fidelity to the EBP?

The Ohio Department of Mental Health continues to value and finance several evidence based practices. Future work for SFY 13 could include the incorporation of some of these practices as Medicaid services. Pharmacologic management and counseling services are not subject to prior approval and will be offered within annual benefit limits.

23. If an adult Medicaid client has exhausted the annual diagnostic assessment benefit and seeks treatment at a new agency and OAC 5122-29-04 requires an assessment be completed prior to delivery of any service (except crisis intervention or pharmacologic management when they are the least restrictive option), does this mean a provider would be prevented from providing all care to this client?

Within the certification standard for mental health assessment is the caveat that mental health service providers may accept mental health assessments from prior evaluations (see (B)(2)). The clinical record shall reflect that such assessments have been reviewed and updated, when appropriate, prior to the initiation of any mental health services.

24. If a client, adult or child needs psychological testing that will require more time than the client's annual benefit, what options do the client and provider have to receive services? What if the psychological testing for an adult is as the result of the client being on conditional release?

For children, if medically necessary, the "SC" modifier can be used to document medically necessary mental health assessments and/or psychiatric diagnostic interview services beyond the annual benefit limit. For adults, an annual benefit limit will apply to both mental health assessments and psychiatric diagnostic interview services.

25. If a client has exceeded the annual limit for PH services and enters treatment with a new agency where it is determined PH is the appropriate, medically necessary service, will the client need to wait for a prior authorization to be approved before PH services may be provided?

A provider may provide services before prior authorization is received. However, in so doing the provider is taking a risk of the prior authorization being denied and, therefore, not getting payment. If the prior authorization is approved, it will be effective on the original date of the request. ODMH's vendor contract for prior authorization requires that PA requests for partial hospitalization must be turned around within 24 hours from the date of submission.

26. Will ODMH be identifying and tracking clients that exhaust their Medicaid mental health benefits and analyzing the outcomes when a client continues to need medically necessary services beyond the limits?

The Ohio Department of Mental Health removed its outcomes requirements at the request of the Ohio Council of Behavioral Health & Family Services Providers. Information on clients who exceed limits and providers who have significant numbers of clients exceeding the limits may be gathered for several different purposes.

27. Can a provider deny admission to service(s) if a Medicaid client seeking services has used up his or her annual benefit?

Most Medicaid providers are not required to accept clients who do not have a payer. However, Federally Qualified Health Centers and Rural Health Centers must follow the federal requirements which govern their provider responsibility.

28. Can a provider limit services only to those mental health services for which a client has hours remaining in his or her annual benefit? (e.g. a client has used up counseling hours, but still has some pharmacologic management hours remaining.)

Services should be based on clinical need and not on what services are remaining. However, providers are not required to accept clients who do not have a payer source. Also, while benefit limits are new to mental health Medicaid, they are used throughout health care and Medicaid in general and many providers have learned to manage them appropriately.

29. Given that Medicaid is the payer of last resort, if a Medicaid covered client exhausts his/her benefit and needs additional medically necessary services and a Board chooses to pay for those services, is a Board prohibited from paying for those Medicaid eligible services because Medicaid has in essence denied payment and is the payer of last resort?

Consumers who exhaust their annual coverage limit for specific Medicaid services become non-covered for units of service beyond the benefit limit. ADAMHS boards may pay for services that are not reimbursable under Ohio Medicaid. However, they are not required to do so.

30. Does ODMH expect Boards to use non-Medicaid funds to pay for additional services to a Medicaid covered individual, particularly an adult, if he or she needs additional medically necessary services that have exceeded the annual benefit limit?

See the answer to question #29.

31. Will ODMH be conducting a cost-benefit analysis to determine whether the cost of implementing service limits and prior authorization achieved any true cost saving to the system and did not shift costs to non-Medicaid or inpatient services?

ODMH will be tracking the impact of service limits and prior authorization.

32. If this cost containment methodology doesn't achieve projected cost savings, does ODMH have a back-up plan and if so, what would that look like?

ODMH expects cost savings measures to be effective and will closely monitor and track Medicaid expenditures. The department has a number of options to ensure that budget goals are met and will continue to communicate with all stakeholders involved.

Section 2: Web Portal and Claims Payment

1. When will the web portal be "live"? When will the MACSIS claims processing specs and updated information on the prior authorization, claims loops, benefit rules, and modifiers be shared with the field? Will this be posted on the MACSIS website?

The web portal will go "live" at the same time service limits and prior authorization requirements are implemented on November 1, 2011. Information concerning prior authorization, claim loops, benefit rules, modifiers, etc. will be shared with the field prior to implementation and during the training scheduled for late October and early November. The information will also be posted on the MACSIS website. Training on prior authorization will be conducted in conjunction with Health Care Excel, Inc., the vendor ODMH has hired to conduct the process. Information related to this training can be found at:

<http://mentalhealth.ohio.gov/assets/medicaid/20110929-health-care-excel-memo.pdf>

- 2. Will providers be able to look up a client in the web portal prior to conducting an intake and without a UCI number to determine whether a client has any MH services available?**

Yes. When the web portal goes “live,” providers will have the ability to do a primary or secondary look up. The primary look up is based on a client’s UCI number or Medicaid number. The secondary look up is based on date of birth, social security number and either last name or first name.

- 3. Will the web portal provide information on the client’s Medicaid eligibility?**

The Ohio Department of Mental Health web portal does not provide information about client Medicaid eligibility. Medicaid eligibility information can be accessed using the Ohio Department of Job and Family Services Medicaid web portal.

- 4. Will the ODMH web portal be able to interact with a provider’s electronic medical record?**

No. The ODMH web portal will not interact with provider electronic medical records.

- 5. With implementation of the EDI module, when does ODMH anticipate providers and boards will be able to process claims daily?**

The Ohio Department of Mental Health implemented the first-in, first-out processing as of July 22, 2011. First-in will be determined based on the date and time the claim file was received by ODMH. For more information, please see the MACSIS helpdesk communications from July 15, 2011 and July 20, 2011. These documents can be found at:

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/index.shtml>

- 6. Will ODMH establish standards and timelines for Board claims processing and hold boards accountable for promptly submitting provider claims to MACSIS given the critical role of payable claims in the web portal for calculating the service benefit limits?**

As stated in the July 15, 2011, and the July 20, 2011, MACSIS helpdesk communications, boards should submit files daily into their board directory. Multiple daily submissions of claims are accepted. Smaller and more frequent file submissions are encouraged because they permit faster processing. ODMH, providers and boards will maintain regular communication to ensure any problems are mitigated in a timely manner.

- 7. Is there a limit on how long a Board can hold a provider’s claims file before submitting it to MACSIS?**

Boards may not hold provider claims files before submitting them to MACSIS.

8. Will providers have a process to expedite claims submission if a Board is holding claims files?

Boards may not hold provider claims files before submitting them to MACSIS. Claims will be processed in the order received by MACSIS in the single processing directory. Claim files will be processed in order, oldest to newest. For more information, see the July 15, 2011, and the July 20, 2011, MACSIS helpdesk communications.

9. When is a claim considered “payable” in MACSIS so that it is counted by the accumulator and applied toward the annual service limit?

A claim is counted by the benefit accumulator as soon as it is processed in MACSIS and is assigned a claim number. Held claims and denied claims are not counted. Claims with critical errors are not entered into MACSIS, do not receive a claim number and are not counted by the benefit accumulators.

10. Will Boards have access to the MACSIS web portal?

Boards will not have access to the MACSIS web portal because they already have access to this information through the MACSIS keyword **DSPBN**.

11. Will consumers and/or parents/legal guardians have access to the MACSIS web portal?

No. See the answer to question 6 in the Mental Health Benefits, Covered Services, and Limitations section on page 2.

12. Will the web portal provide information on both Medicaid and non-Medicaid claims?

The ODMH web portal will provide information regarding Medicaid claims.

13. Can a provider add the “SC” modifier to all claims assessment, pharmacological management and BH counseling for children to ensure those services are paid regardless of whether the client is close to or has exceeded the benefit limit?

The “SC” modifier indicates that the consumer has exceeded his or her annual benefit and that the provider has determined that service in excess of that limit is medically necessary. It does not ensure payment.

14. Does use of the “SC” modifier increase the likelihood a provider will be subject to a retrospective post-payment review by either or both ODMH and ODJFS SURS?

All services, regardless of whether they are processed with the “SC” modifier or other utilization management tools, are subject to post-payment review.

15. Does use of the “SC” modifier increase the risk of an audit by ODMH or ODJFS?

Please refer to the response in the previous question.

16. If a provider uses the “SC” modifier on a non-Medicaid claim, will that claim be denied?

Yes. The “SC” modifier can only be used on Medicaid claims. The “SC” modifier is restricted to Assessment (90801 & H0031), Pharmacologic Management (90862) and Individual/Group Counseling (H0004) services to children.

17. Will the providers be able to run a “batch” report for all clients scheduled for a specific day or by clinician caseload to manage service utilization and monitor need for prior authorization?

At this time, providers are not able to run batch reports.

18. If a client has a Medicaid spenddown, will services provided during the spend-down period count toward the annual service limit?

No. Services provided during the spenddown period will not count toward the annual service limit.

19. What happens and how is the annual benefit impacted when a client receives retroactive Medicaid eligibility? Will a provider be able to request retroactive prior authorization for CPST and/or PH? What happens to the client if, as a result of the retroactive Medicaid eligibility, the client has exhausted the annual benefit for a service that has a hard limit, such as pharmacological management or counseling?

Claims that had previously been paid as non-Medicaid, when re-processed as Medicaid, will count toward the annual benefit. Providers will be able to request retroactive prior authorization for CPST and/or partial hospitalization. Services with a “hard limit” are considered exhausted whether or not retroactive Medicaid eligibility was involved.

20. Will services provided through the Recovery to Work program be applied toward the client’s annual benefit limit?

Services provided through Recovery to Work will not count toward the annual limit.

21. Will claims billed to Medicare advantage plans where Medicaid is the secondary payer, be counted toward the annual benefit limit since these are billed in MACSIS as a third-party payment?

Claims billed to Medicare advantage plans with Medicaid as the secondary payer should not be paid through MACSIS Medicaid as a third party payment. All claims for dually eligible clients must be paid through Ohio Department of Job and Family Services, not MACSIS.

Section 3: Prior Authorization

1. When does ODMH anticipate being able to implement prior authorization for CPST and PH services?

Service limits and prior authorization requirements will be implemented on November 1, 2011. Information concerning prior authorization, claim loops, benefit rules, modifiers, etc. will be shared with the field prior to implementation and during the training scheduled for late October and early November. The information will also be posted on the MACSIS website. Training on prior authorization will be conducted in conjunction with Health Care Excel, Inc., the vendor ODMH has hired to conduct the process. Information related to this training can be found at:

<http://mentalhealth.ohio.gov/assets/medicaid/20110929-health-care-excel-memo.pdf>

2. Will services provided prior to the effective/implementation date of prior authorization be counted toward the annual benefit limit? For example: If prior authorization is implemented 8/1/11, will PH or CPST services provided between 7/1/11 and 7/31/11 accumulate toward the 60-day or 104-hour benefit limit leaving fewer days to request PA if additional services will be medically necessary beyond the limit?

Service limits will not be pro-rated; service provided prior to the effective date for the benefit limits will not count toward the annual limit. FOR EXAMPLE: Partial hospitalization and CPST services provided between 7/1/11 and 10/31/11 will not accumulate toward the limits when benefit limits and prior authorization are implemented 11/1/11. Consumers will have 60 days of PH and 104 hours of CPST available to them between 11/1/11 and 6/30/12.

3. How long will the vendor have to make a determination on a prior authorization request?

The vendor will have 24 hours from the time of submission of all necessary and accurate documentation to make a determination on prior authorization requests for partial hospitalization and 72 hours from the time of submission of all necessary and accurate documentation to make a determination on prior authorization requests for CPST.

4. What paperwork will a provider need to submit to the vendor when requesting prior authorization of services? Will the PA process be electronic, paper or both?

Training on prior authorization will be conducted in conjunction with Health Care Excel, Inc., the vendor ODMH has hired to conduct the process. Information related to this training can be found at:

<http://mentalhealth.ohio.gov/assets/medicaid/20110929-health-care-excel-memo.pdf>

Training materials will also be available on the ODMH website.

5. When and where will ODMH and the vendor provide clear written information that defines the criteria that will be used to operationalize medical necessity?

Medical necessity parameters will be shared as part of prior authorization training and information will be readily accessible by providers. Training on prior authorization will be conducted in conjunction with Health Care Excel, Inc., the vendor ODMH has hired to conduct the process. Information related to this training can be found at:

<http://mentalhealth.ohio.gov/assets/medicaid/20110929-health-care-excel-memo.pdf>

Training materials will also be available on the ODMH website.

6. Will there be different criteria for operationalizing medical necessity for residential and out-patient levels of care?

Residential level of care is not considered to be inpatient service, so level of care is the same as outpatient.

7. Will ODMH and the vendor share a copy of any medical necessity tool or checklist used by the vendor to determine medical necessity?

Yes. Medical necessity parameters will be shared as part of prior authorization training and information will be readily accessible by providers.

8. How will ODMH define the “generally accepted standards of medical practice” for purposes of medical necessity?

Training on prior authorization will be conducted in conjunction with Health Care Excel, Inc., the vendor ODMH has hired to conduct the process. Information related to this training can be found at:

<http://mentalhealth.ohio.gov/assets/medicaid/20110929-health-care-excel-memo.pdf>

Training materials will also be available on the ODMH website.

9. How does ODMH define palliative mental health care in terms of medical necessity for individuals with long term, chronic psychiatric symptoms?

Mental health services provided under palliative circumstances must be clinically specific to the needs of the individual and meet the same definition of medical necessity as all other mental health services.

10. For children and youth, particularly with EPSDT, how will ODMH operationalize and define medical necessity within the constraints of the rehabilitation option and take into consideration developmental and age appropriateness issues?

The Ohio Department of Mental Health will apply medical necessity as defined by ODJFS and will comply with ODJFS Healthchek rules. Please see the following citations for more information:

Ohio Administrative Code Rule 5101:3-1-1 and Chapter 5101:3-14.
Federal Social Security Act Section 1905

11. With children, particularly young children, how will ODMH define or determine whether a child has the cognitive ability to benefit from services?

Providers are responsible to document whether they believe the child has the cognitive ability to benefit from the delivered service. If reviewed, ODMH or the reviewing entity will look at that documentation, in combination with the age of the child and the services being provided, and determine whether medical necessity is being met.

12. Will there be a process to expedite prior authorization for children for CPST and/or PH when a child is transitioning from residential to out-patient care when those services must be in place in order for the transition to occur?

The vendor will have 24 hours to make a determination on prior authorization requests for partial hospitalization and 72 hours to make a determination on prior authorization requests for CPST.

13. Will a provider be able to obtain a retroactive prior authorization when the client received services believing they had not exhausted their annual limit only to learn additional services had been rendered elsewhere in the system? How would a retroactive PA process work?

Providers may seek retroactive prior authorization. The process for retroactive prior authorization is the same as the regular prior authorization process.

Section 4: Mental Health Service Provided to Residents in Nursing Facilities

As stated in Director Tracy Plouck's June 30, 2011, memo to the field, ODMH will not be filing emergency rules related to services provided to long-term residents of nursing facilities as originally proposed in the April 26, 2011, communication. Changes related to nursing facility reimbursement are included in the biennial budget and this will have an impact on providers billing the community mental health benefit for nursing home residents. ODMH will be working with ODJFS as this language is implemented, and additional information and guidance will be provided as it becomes available.