Frequently Asked Questions OHH Updated 4/19/22

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Question	Answer
How are individuals identified to participate in the OHH program?	Through the MDHHS Waiver Support Application (WSA), NMRE and Health Home Providers have access to the Beneficiary Roster Report that identifies individuals who meet criteria for the OHH program. The information is based on Medicaid claims and encounters for a beneficiary within the past 18 months.
What are the requirements to receive services in the Opioid Health Home (OHH) program?	To be enrolled and participate in the Opioid Health Home program beneficiaries must reside within the NMRE region, be enrolled and eligible for Medicaid or the Healthy Michigan Plan and have a diagnosis of an opioid use disorder. Providers can recommend individuals for enrollment within the Waiver Support Application (WSA), if they meet all of the eligibility requirements.
If client is enrolled in another benefit plan can they be enrolled in OHH program?	Clients that are in a disqualified plan outlined below will not be listed on the potential beneficiaries list in the WSA and will not be eligible for OHH/BHH services. As indicated in the Health Home handbook; disqualified plans for OHH include HHBH, Health Home MI Care Team, Integrated Care MI Health Link, Nursing Home, Hospice and/or Spend down
What are the benefits for individuals to participate in the OHH program, if they are already receiving enhanced services?	The purpose of the health home is to help support coordination of care so that individuals have the best opportunity for good outcomes. The state would like to know how many people are interested in receiving health home services, which is done through the enrollment and consent process. The three goals of the OHH program are to: 1)improve care management of beneficiaries with opioid use disorders and comorbid chronic conditions, including Medication Assisted Treatment; 2)improve care coordination between physical and behavioral health care services; and 3)improve care transitions between primary, specialty and inpatient settings of care. As part of the orientation process, OHH providers are encouraged to review the MDHHS Opioid Health Home Brochure with individuals and offer them a copy.
What documents are required to enroll an individual in the OHH program?	To enroll an individual in OHH services through NMRE, an OHH provider is required to submit the following information and recommend enrollment through the WSA; 1)MDHHS 5515 Consent to Share Behavioral Health Information for Care Coordination Purposes form 2)NMRE Opioid Health Home Program Enrollment Consent 3)Individualized Care Plan derived from an evidence-based assessment of need 4)Treatment Needs Questionnaire screening tool

	These documents can be found under the Knowledge Base section of the NMRE Help Desk labeled Opioid Health Home Enrollment Documents.
What is the MDHHS 5515 and how is the document used?	The MDHHS 5515 form is used by an individual to give or take away consent to share health care information. The form is required for beneficiaries to receive the OHH benefit. Here is some helpful information in assisting an individual in completing the form. Section 2a – List of individuals and organizations who can see and share information. Must include the OHH provider and NMRE. (If client has been enrolled at another OHH location or will be transferring to another location, include that provider so that care coordination can occur) Section 2b – Check box to share information with past, current and future providers. If an individual transfers to another OHH provider the new provider will have access to all client documents in WSA with signed release. Provider is required to fill out the exchanges within their networks in which information is shared electronically, including the Waiver Support Application. Other examples would be hospitals which have portals where health care, pharmacy, physician and physical therapy information may be stored and shared. Section 3 – Individuals can specify what type of information is shared. Section 4 – The date of consent is valid for **one** year from the signature date, unless otherwise specified. Will need to be renewed after one year. Section 5 – This section is completed **only** if an individual no longer wants to share records as listed in Section 3. The release allows for a written or verbal withdrawal of consent, which must be documented by the provider. Additional information on the 5515 form is also available online through MDHHS 5515 Resources.
Are verbal consents allowable for OHH?	NMRE is permitting the use of verbal consents in the Health Home enrollment process on a limited basis, under the guidance of MDHHS and the Substance Abuse Services and Mental Health Administration (SAMHSA). Please see Verbal Consent process under Knowledge Base Documents of the NMRE Help Desk.
What is the Opioid Home Program Enrollment Consent?	The consent form briefly describes the OHH program and grants permission to enroll client in OHH services. The date on this form is the date the client had their initial OHH visit and will be used by NMRE to establish date of enrollment.
What information needs to be included on the Care Plan?	An individualized care plan is required for each OHH client. The care plan document identifies the needs of the client and details how the OHH provider will address them. The care plan is completed by the care team and submitted as part of the enrollment packet. The care plan will be updated by OHH providers as needed. The care plan document must include verification of an Opioid Diagnosis, other chronic condition(s) or risk factors, specific goals and interventions on what the health home provider will do to assist client in managing their conditions and improving health outcomes. A sample template care plan document is located under the Knowledge Base section of the NMRE Help Desk labeled Opioid Health Home Enrollment Documents.
How do providers submit enrollment and disenrollment for OHH?	Providers can review beneficiary status and recommend enrollment through the MDHHS Waiver Support Application (WSA). Health Home Provider staff must request access to this system. Training will be provided on how to access beneficiary information, attach enrollment documents and view reports within the WSA.
What is the time frame and process for getting an	Enrollment packets are to be submitted by providers as they are completed throughout the month. Providers recommend enrollment and attach enrollment packet to the beneficiary file in WSA. NMRE reviews the recommended enrollments as they are received to verify that client meets criteria to enroll in the Health Home.

individual registered in the OHH program?	
How is a provider notified when an enrollment has been processed?	Providers will receive email notification on the status of an OHH enrollment thru the WSA system. The PIHP has the option to approve, deny or send back an enrollment. Comments will indicate the reason that an enrollment is sent back or denied. After an enrollment is approved in the WSA, NMRE will create the authorization and admission in our PCE system. After the email notification is received from WSA, providers should check comments in the beneficiary file and review condition counts in the WSA. All questions regarding OHH services, enrollments and billing should be submitted via the NMRE help desk https://support.nmre.org
What services are considered as an OHH encounter?	OHH services are listed in the OHH handbook under section **1.3 OHH Services**. The services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of their comorbid physical and behavioral health conditions. The OHH services must completed by health home staff (as indicated in the handbook section 2.6),be tied to one of the six categories described in the handbook and payments are intended to cover the allowable costs of the OHH services that are not otherwise covered by other funding sources or other Medicaid reimbursement mechanisms. If a service can billed elsewhere, then it should not be submitted or billed as an OHH encounter. Questions on specific services can be addressed to NMRE.
How do providers enter encounters to the RECON system?	Training and access to the RECON system will be provided by NMRE. The Help Menu in RECON also contains resources and step by step information to view, enter and change information in the RECON system. Encounters for all OHH services should be entered directly into the RECON system or submitted through an 837 file. See OHH Billing Instructions for 837 files. Encounters must be tied to an OHH service category as identified in the OHH handbook under **Section 1.3 OHH services**. All OHH services that a client receives, which can not be reimbursed elsewhere, should be added into the system for billing. Only the first service that is provided within the month is eligible for reimbursement. All claims must include the OHH reimbursable amount and the RECON system will determine which claims can be paid.
OHH Care Management Encounters	Health Home Partners must provide at least one OHH service (as defined in OHH Handbook under Covered Services) within the service month. The S0280 code is to be billed for the initial service and all subsequent OHH services. Encounters should be submitted for all OHH services provided within the month, however the rate will only be paid once per month, regardless of the number of encounters submitted.
What modifiers and Z codes are used with OHH services?	The specific code requirements for OHH billings are described in the OHH handbook under **Section 4.4 OHH Service Encounter Codes.** The HG modifier must be used for all encounters. TS Modifier must be used to document non-face-to-face encounters (when client is not physically present in the room). Z codes are a special group of ICD 10 CM codes for reporting factors influencing health status and contact with health services. The following z codes groups are recommended for Health Home services, but any z code can be entered to an encounter. Z55 - Z65 (Socio-Economic Conditions) Z77 - Z99 (Environmental Conditions) Z80 – Z99 (Persons with potential health hazards related to family and personal history and certain conditions influencing health status) Z code descriptions and resources are available in the Knowledge Base of the Help Desk at https://support.nmre.org/helpdesk/KB/View/26237326-use-of-icd---z-codes
What is the time frame for entering encounters?	OHH encounters can be submitted at any time following the delivery of services, once the enrollment has been processed and NMRE enters the authorization in RECON. Valid OHH encounters must be submitted within **90 days** of providing the service to ensure timely service verification and payment. Providers must submit an encounter code reflecting an OHH service to be paid within a given month. See OHH handbook **Section IV: OHH Payment** for more details.

What is the process for reviewing monthly eligibility for a beneficiary?	Providers are responsible for running monthly Medicaid Eligibility Checks for all clients through RECON or CHAMPS. When reviewing eligibility please review subscriber address and county of residence and work with client to update with MDHHS through Mi Bridges system as needed. This is important as re-enrollment paperwork will be sent to the address that MDHHS has on file. If paperwork is not received by a beneficiary this could result in lapse of their eligibility and coverage. Clients who lose Medicaid/HMP benefits for a particular month are not eligible for OHH services and must be disenrolled until benefits can be re-established. Health Home Partners should also review monthly eligibility by running the Potential Disenrollment report within the WSA. The report will identify beneficiaries with potential disenrollment and the reason. Please work with beneficiary to confirm status and submit disenrollment requests as appropriate.
Is there a way to determine when a beneficiary's benefits are up for renewal?	In RECON there is a report under the Reports and Downloads menu called **Medicaid Redetermination Dates for SUD Consumers**. This report will identify the redetermination date for beneficiaries active at your location. Please work with beneficiaries to review that they have received paperwork from MDHHS to renew benefits, answer questions and connect with DHHS as needed. Working with clients to explain or renew benefits or assist them in changing an address with MDHHS is considered an OHH service and can be billed to NMRE.
What conditions would exclude a beneficiary from participating in Health Home Services?	The potential disenrollment report in the WSA will identify beneficiaries ***who may be subject for disenrollment in WSA.*** Reasons for potential disenrollment may include the following; 1 – Beneficiary is not enrolled in a full coverage benefit plan 2 – Beneficiary has spend down 3 – Beneficiary has moved to a county not served by PIHP Region 2 4 – Beneficiary is deceased 5 – Beneficiary has transitioned to a nursing home or hospice facility (they now have NH or Hospice Benefit plan assigned to them.) The disenrollment date for Health Home services is always the last date of the month. See OHH handbook **Section 3.3 Beneficiary Disenrollment** for more details.
If an individual is discharged from services at an OHH provider or loses their Medicaid, what is the effective date of their OHH disenrollment?	Beneficiaries can choose to disenroll from OHH program at any time. A provider will submit disenrollment requests through the WSA and dis-enrollments will be processed by the NMRE. Disenrollment date should be the end of the month which client last received an OHH service. In WSA comments please enter last OHH service date. NMRE will review the disenrollment request and approve in the WSA. NMRE will also create the disenrollment for OHH services in RECON. WSA disenrollment date defaults to the current month, if client was discharged from service in previous month, please update disenrollment date in WSA. The disenrollment date for OHH is always the end of the month of their last service, whether a beneficiary is auto disenrolled or disenrolled by NMRE. The RECON discharge will reflect same date as the WSA. Disenrollment Reasons include: • Administrative Dismissal (to be used when client is discharged from OHH provider)

	• Beneficiary is unresponsive • Change in Health Home Setting (please work with client and NMRE to transfer client to another HPP as appropriate) • Deceased (please include date of death if known) • Hospice • Moved (to be used when client moved to another area and will not be served by current provider or moved out of NMRE region) • No Medicaid Eligibility • Voluntary Disenrollment (to be used when client chooses to opt-out of OHH services but will continue in treatment) Please submit disenrollment requests timely.
Disenrolling Beneficiaries who are unresponsive	Please see section **3.3 Beneficiary Disenrollment** for steps on disenrollment process for Beneficiaries who are unresponsive for reasons other than moving or death. The HHP must make at least three unsuccessful beneficiary contact attempts within at least three month, while the beneficiary remains enrolled in the WSA. Disenrollment request can occur after attempts are completed and documented in WSA. More information on OHH disenrollments is available in the Health Home Disenrollment Process.
What is the process for re-enrolling a client to the OHH program if they regain Medicaid eligibility?	If an individual is enrolled in the OHH program and then becomes disenrolled due to losing Medicaid benefits, they can re-enroll in the program once benefits are re-established. If eligibility occurs within 6 months of disenrollment and the beneficiary remains in treatment, then new OHH enrollment paperwork is not required. If client regains eligibility more than 6 months after disenrollment from OHH, new enrollment paperwork will be required. After the provider verifies that the individual is Medicaid/HMP eligible, OHH providers will recommend enrollment through the WSA. NMRE will verify eligibility, complete the enrollment in the WSA and enter a new admission in RECON. Providers are encouraged to work with individuals and identify redetermination dates and to proactively assist clients with benefit renewal. To better assist clients in understanding and their Medicaid benefits, providers can become Mi Bridges Navigators or Partners. See https://www.michigan.gov/mdhhs/0,5885,7-339-71551_82637_82640---,00.html for more information If an individual leaves treatment at an OHH provider and then re-enters treatment with that same provider, they can re-enroll in OHH services, if they meet eligibility requirements. Since this is a new treatment episode, new enrollment paperwork is required.
How to view current list of OHH clients at my location?	In WSA filter by Enrolled and Health Home Provider site to obtain full list of beneficiaries enrolled in OHH. List can be exported. In RECON select Reports and Downloads and PCE Standard Reports. Choose FFS Admissions Detail report, select report criteria and date range. This report includes information such as admission and discharge date, last service date and current funding.
How to view OHH billings for my location?	In RECON select Reports and Downloads and AP Claim Detail Report. Specify report criteria. This report includes all OHH billings and payments by client for date range specified.
What happens if the beneficiary wants to move to another OHH provider?	Beneficiaries have the option of transferring to another OHH service provider. Health Home Partners should work with the NMRE Access Center at 800-834-3393 to discuss client needs and coordinate the transfer of services. See OHH handbook **Section 3.4 Beneficiary Changing Health Home Partner Sites** for details on coordinating services for the beneficiary. In order for providers to share information on client care and for NMRE to share care plans, the beneficiary must give consent via the MDHHS 5515. Transfers can be recommended within WSA for another provider within NMRE region or if client moves to another PIHP region.

How do providers obtain more OHH brochures and posters?	Providers can request brochures and posters through https://support.nmre.org with quantities needed and mailing address. Health Home Coordinator will coordinate the delivery or mailing of the materials to provider sites.
Additional OHH trainings have been discussed. How will providers receive notice when trainings are scheduled?	MDHHS will communicate the training information to NMRE for distribution to provider contacts. Providers are also encouraged to visit the MI Improving Practices website https://aenow.com/explore/improving-mi-practices, which is an online training site for behavioral health professionals.
What to do if there are questions about OHH enrollments, services, billing or roster list that are not addressed here?	Please submit all OHH related questions to the NMRE ticket system at https://support.nmre.org and include "OHH" in the subject line. This will ensure that the ticket is directed to the appropriate NMRE staff member and that a response can be given in the most timely manner.