Mental Health Guidelines and Billing Practices

HP Provider Relations

July 2011

Agenda

- Session Objectives
- Outpatient Mental Health
- Medicaid Rehabilitation Option (MRO)
- Risk-Based Managed Care (RBMC)
- Eligibility Inquiry
- Web interChange and CMS-1500 Billing Guidelines
- Helpful Tools
- Questions

Objectives

At the end of this presentation, providers will understand the following:

- Outpatient coverage requirements
- MRO services
- Meaning of rolling 12-month period
- Role of the health service provider in psychology (HSPP)
- Managed care carve-in
- How to verify member eligibility
- How to submit claims via the Web interChange and the CMS-1500 claim form

Understand

Outpatient Mental Health

Mental Health

– The Indiana Health Coverage Programs (IHCP) under the direction of the Indiana Administrative Code (IAC) *405 IAC 5-20-8* reimburses for outpatient mental health services when provided by:
  - Licensed physicians
  - Psychiatric hospitals
  - Psychiatric wings of acute care hospitals
  - Outpatient mental health facilities
  - Licensed psychologists with the HSPP designation

Mental Health

– The IHCP also reimburses under *405 IAC 5-20-8* for psychiatrist or HSPP-directed outpatient mental health services when provided by mid-level practitioners:
  - Licensed clinical social worker (LCSW)
  - A person holding a masters degree in social work (MSW), marital and family therapy or mental health counseling , except that partial hospitalization services provided by such person shall not be reimbursed
  - Licensed psychologist
  - Licensed independent practice school psychologist
  - Licensed marriage and family therapist (LMFT)
  - Licensed mental health counselor (LMHC)
  - An Advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing

– Mid-level practitioners are not enrolled by the IHCP

Mental Health

Psychiatrist or HSPP responsibilities

- Must certify the diagnosis and supervise the plan of treatment as stated in *405 IAC 5-20-8 (3) (a)-(b)*
- Must see the patient or review information obtained by a mid-level practitioner within seven days of intake
- Must see the patient or review documentation to certify treatment plan and specific modalities at intervals not to exceed 90 days
- Must document and personally sign all reviews
  - No cosignatures on documentation
- Must be available for emergencies
  - An emergency is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) danger to the individual, (2) danger to others, or (3) death of the individual

Mental Health

PA requirements

- Prior authorization (PA) is required for units in excess of 20 per member, per rendering provider, per rolling 12-month period:
  - Codes below in combination are subject to 20 units per member, per provider, per rolling 12-month period:
    - 90804 through 90815
    - 90845 through 90857
    - 96151 through 96153
- Requests for PA should include a current plan of treatment and progress notes to support the effectiveness of therapy
- Reference the *IHCP Provider Manual Chapter 6* for prior authorization guidelines and instructions
  - Managed care entities (MCEs) may have different PA requirements; providers are encouraged to contact each MCE for PA processes

Mental Health

What is a rolling 12-month period?

– A rolling 12-month period is:
  - Based on the first date that services are rendered by a particular provider
  - Renewable one unit at a time beginning 365 days after the date that services are rendered by a particular provider

– It is not:
  - Based on a 12-month calendar year
  - Based on a fiscal year
  - Renewable on January 1 of each year

Mental Health

Psychiatric diagnostic interview (90801)

- One unit of psychiatric diagnostic interview (90801) is allowed per member, per provider, per rolling 12-month period per *IAC 405 IAC 5-20-8 (14)*
- Additional units require PA
- Exception: Two units are allowed without PA if separate evaluations are performed by a psychiatrist or HSPP and a mid-level practitioner

Mental Health Prior Authorization

– Mail or Fax PA requests to:

ADVANTAGE Health Solutions-FFS
P.O. Box 40789
Indianapolis, IN 46240

Fax number: 1-800-689-2759

– For questions or inquiries, call 1-800-269-5720

– For Rick based managed care (RBMC) members, contact the appropriate Managed Care Entity (MCE)

Care Select Organizations – Prior Authorization

– ADVANTAGE Health Solutions

- advantageplan.com
  P.O. Box 80068
  Indianapolis, IN 46280
  Phone: 1-800-784-3981
  Fax request: 1-800-689-2759

– MDwise

- mdwise.org
  P.O. Box 44214
  Indianapolis, IN 46244-0214
  Phone: 1-866-440-2449
  Fax request: 1-877-822-7186

Physician, HSPP Covered Services

– Medical services provided by mid-level practitioners, such as clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) are not reimbursable for the following codes:
  - 90805
  - 90807
  - 90809
  - 90811
  - 90813
  - 90815
  - 90862

Physician, HSPP Covered Services

– PA is always required for neuropsychological and psychological testing
  - 96101 – Psychological Testing
  - 96110 – Developmental Testing
  - 96111 – Developmental Testing Extended
  - 96118 – Neuropsychological Testing Battery
    - According to *405 IAC 5-2-8(7)*, a physician or HSPP must provide these services

Mental Health

Noncovered services

- Biofeedback
- Broken or missed appointments
- Day care
- Hypnosis

Mental Health

Billing overview

- Services are billed on the 837P or the CMS-1500 paper claim form
- Services are billed using the National Provider Identifier (NPI) of the facility or clinic, and the rendering NPI of the supervising psychiatrist or HSPP
- Medical records must document the services and the length of time of each therapy session
- Psychiatrists and HSPPs are reimbursed at 100 percent of the allowed amount
- Mid-level practitioners are reimbursed at 75 percent of the allowed amount
  - Services rendered by mid-level practitioners are billed using the rendering NPI of the overseeing provider

Mental Health

Billing overview

– Appropriate modifiers must be used for mid-level practitioners
  - AH – Clinical psychologist
  - AJ – Clinical social worker
  - HE and SA – Nurse practitioner or nurse specialist
  - HE – Any other mid-level practitioner as addressed in the *405 IAC 5-20-8*
  - HO – Master's degree level
  - SA – Nurse practitioner or clinical nursing specialist (CNS) in a nonmental health arena

Mental Health

Billing overview

– Mental health providers that submit claims with procedure codes and append modifier HE or HO when the member is dually eligible for Medicare and Medicaid may now utilize claim notes for billing to indicate that the provider has performed a service that is not approved to bill to Medicare

- Claims submitted using claim notes must indicate in the claim notes on the 837P the following text: “Provider not approved to bill services to Medicare”
- The use of claim notes allows the claim to suspend for review of the claim note and be adjudicated appropriately

Learn

MRO Services

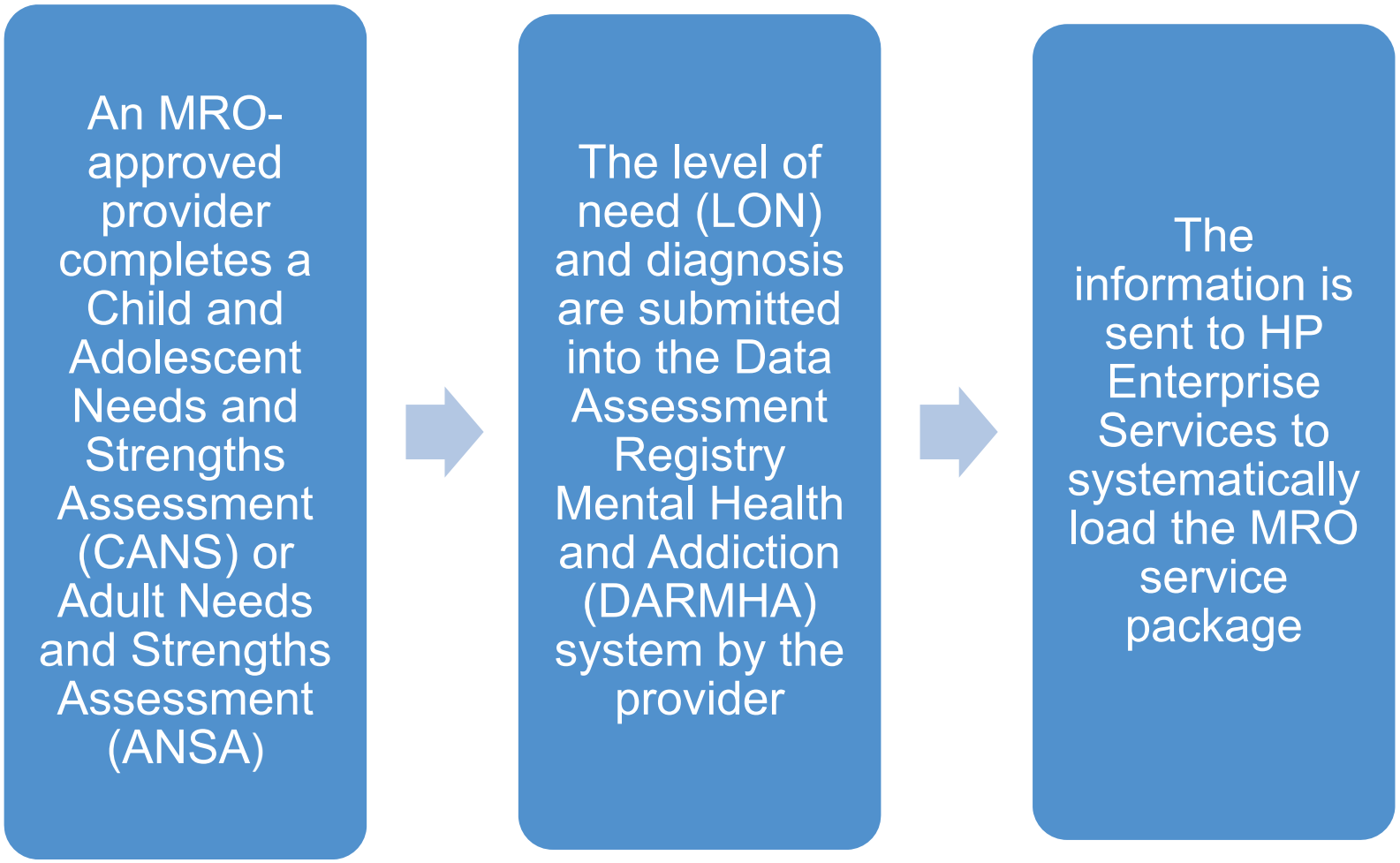
MRO (Medicaid Rehabilitation Option)

- The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Division of Mental Health and Addiction (DMHA), developed a benefit plan structure for Medicaid members receiving MRO services
- While members can continue to access MRO providers based on a self-referral, members who have a qualifying MRO diagnosis will be assigned a service package based on their individual level of need (LON)

Importance of Verifying Eligibility

- It is important that providers verify member eligibility on the date of service
- Viewing a Hoosier Health card alone does not ensure member eligibility
- If a provider fails to verify eligibility on the date of service, the provider risks claim denial
- Claim denial could result if the member was not eligible on the date of service
- If the member is not eligible for Medicaid on the date of service, the member can be billed
  - If retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member

Service Package Process



When to Submit a Prior Authorization

- If a member requires additional medically necessary services, a PA request is required
- Please note that submitting a PA request for a full service package is not permitted
- Under the following four scenarios, an MRO service provider is required to submit a PA request to the PA vendor:
  - Scenario 1: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
  - Scenario 2: A member requires a medically necessary MRO service not authorized in his or her MRO service package.
  - Scenario 3: A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
  - Scenario 4: A member is newly eligible to the Medicaid program or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive PA request is appropriate for MRO services provided during the retroactive period.

Prior Authorization

Prior authorization by telephone, fax, or mail

- **ADVANTAGE Health Solutions**
  Prior Authorization Department
  P.O. Box 40789
  Indianapolis, IN 46240

- Phone: 1-800-269-5720
  Fax: 1-800-689-2759

Medicaid Rehabilitation Option

- Medicaid Rehabilitation Option (MRO) services remain carved out of the risk-based managed care (RBMC) delivery system
- MRO services remain reimbursable only to providers enrolled as type 11 (mental health) with a specialty of 111 (community mental health center)
- Clinical mental health services are provided for individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness
- Services must be reported with an HW modifier

MRO Covered Services

- The following services are covered:
  - Behavioral Health Counseling and Therapy (Individual and Group setting)
  - Behavioral Health Level of Need Redetermination
  - Case Management
  - Psychiatric Assessment and Intervention
  - Adult Intensive Rehabilitative Services (AIRS)
  - Child and Adolescent Intensive Resiliency Service (CAIRS)
  - Intensive Outpatient Treatment (IOT)
  - Addiction Counseling (Individual and Group setting)
  - Peer Recovery Services
  - Skills Training and Development (Individual and Group setting)
  - Medication Training and Support (Individual and Group setting)
  - Crisis Intervention
- Reminder: Do not use mid-level modifiers when billing for MRO services

MRO Provider Qualifications

- Three categories of provider types can render MRO services:
  - Licensed Professional
  - Qualified Behavioral Health Professional (QBHP)
  - Other Behavioral Health Professional (OBHP)
- For a detailed list of qualified providers, please see the following resources:
  - *MRO Provider Manual* located on the indianamedicaid.com Web site under Manuals
  - The Family Social Services Administration (FSSA) public Web site at https://myshare.in.gov/FSSA/ompp/MRO/default.aspx

Define

Risk-Based Managed Care (RBMC)

Risk-Based Managed Care

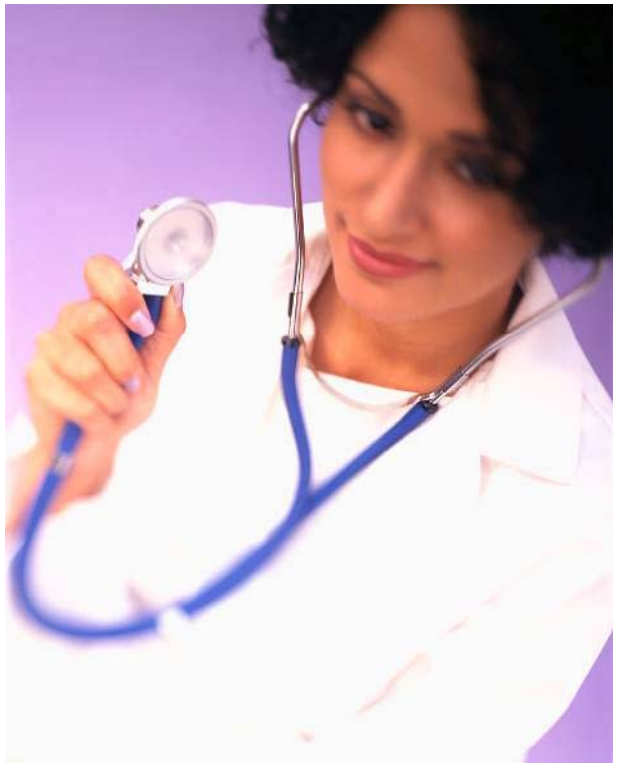
– Services that are the responsibility of the MCEs:

  • Office visits with a mental health diagnosis

  • Services ordered by a provider enrolled in a mental health specialty, but provided by a nonmental health specialty, such as a laboratory and radiology

  • Mental health services provided in an acute care hospital

  • Inpatient stays in an acute care hospital or freestanding psychiatric facility for treatment of substance abuse or chemical dependency



Risk-Based Managed Care

– Services provided to RBMC members by the following specialty types are the responsibility of the MCEs:
  - Freestanding Psychiatric Hospital (011)
  - Outpatient Mental Health Clinic (110)
  - Community Mental Health Center (111)
  - Psychologist (112)
  - Certified Psychologist (113)
  - HSPP (114)
  - Certified Clinical Social Worker (115)
  - Certified Social Worker (116)
  - Psychiatric Nurse (117)
  - Psychiatrist (339)

Risk-Based Managed Care

- MCEs
  - Anthem anthem.com
  - Managed Health Services (MHS) managedhealthservices.com
  - MDwise mdwise.org
- Behavioral Health Organizations (BHO)
  - Anthem anthem.com
  - Cenpatico (MHS) cenpatico.com
  - MDwise mdwise.org

Understand

Eligibility Verification System

Importance of Verifying Eligibility

- It is important that providers verify member eligibility on the date of service
- Viewing a Hoosier Health card alone does not ensure member eligibility
- If a provider fails to verify eligibility on the date of service, the provider risks claim denial
- Claim denial could result if the member was not eligible on the date of service
- If the member is not eligible on the date of service, the member can be billed for services
  - However, it is important to remember that if retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member

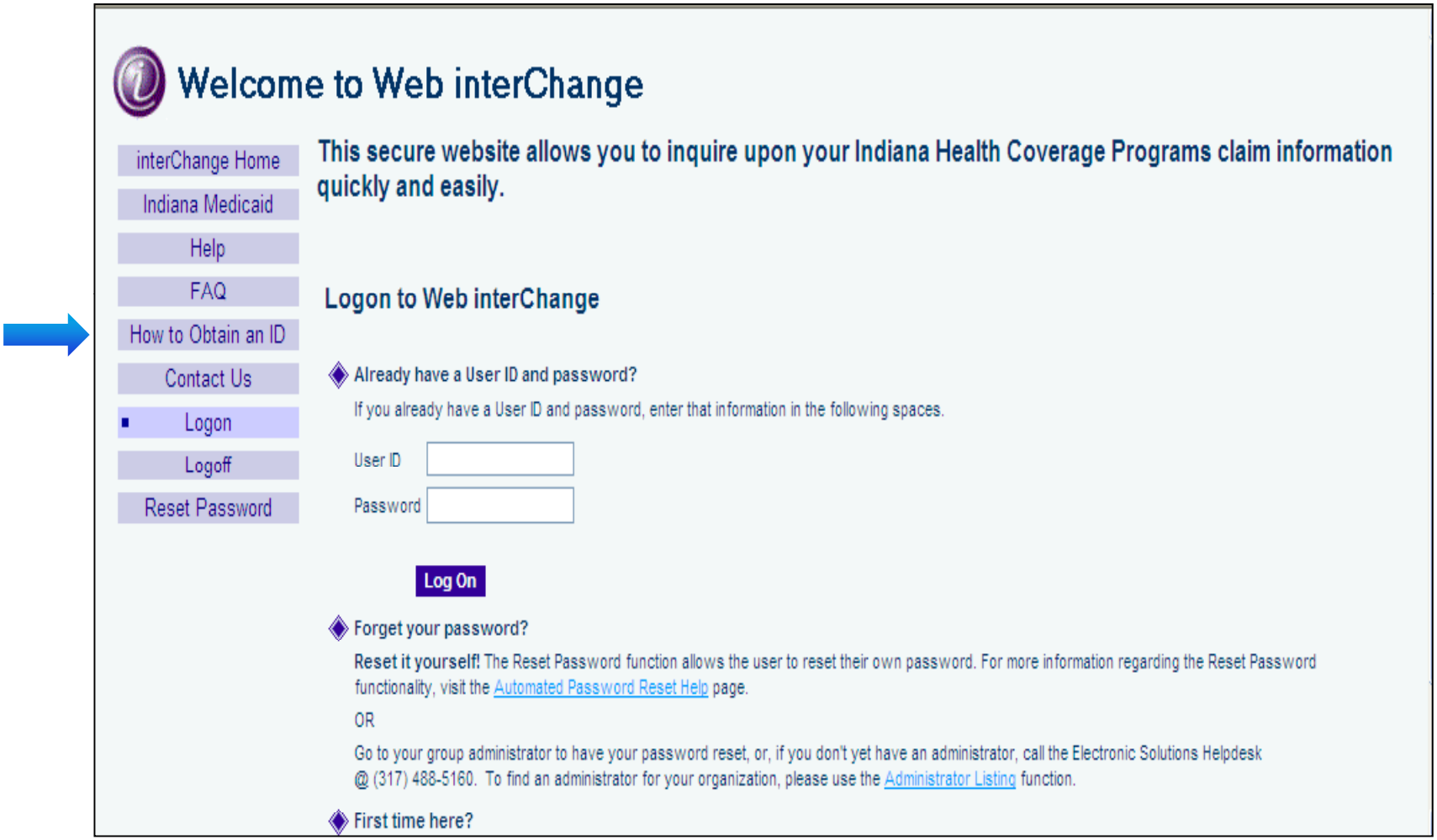
Methods to Verify Eligibility

- Providers can verify eligibility by using one of the following eligibility verification methods:
  - Web interChange
    - https://interchange.indianamedicaid.com
  - Omni swipe card device
    - Requires upgrade for benefit limit information (refer to IHCP Provider Bulletin *BT200711*)
    - Omni instructions are in Chapter 3 of the *IHCP Provider Manual*
  - Automated Voice Response (AVR)
    - Contact AVR at (317) 692-0819 in the Indianapolis local area or 1-800-738-6770
    - AVR instructions are in Chapter 3 of the *IHCP Provider Manual*

Providers using any of these systems may verify member eligibility seven days a week, 24 hours a day

Web interChange Access

https://interchange.indianamedicaid.com

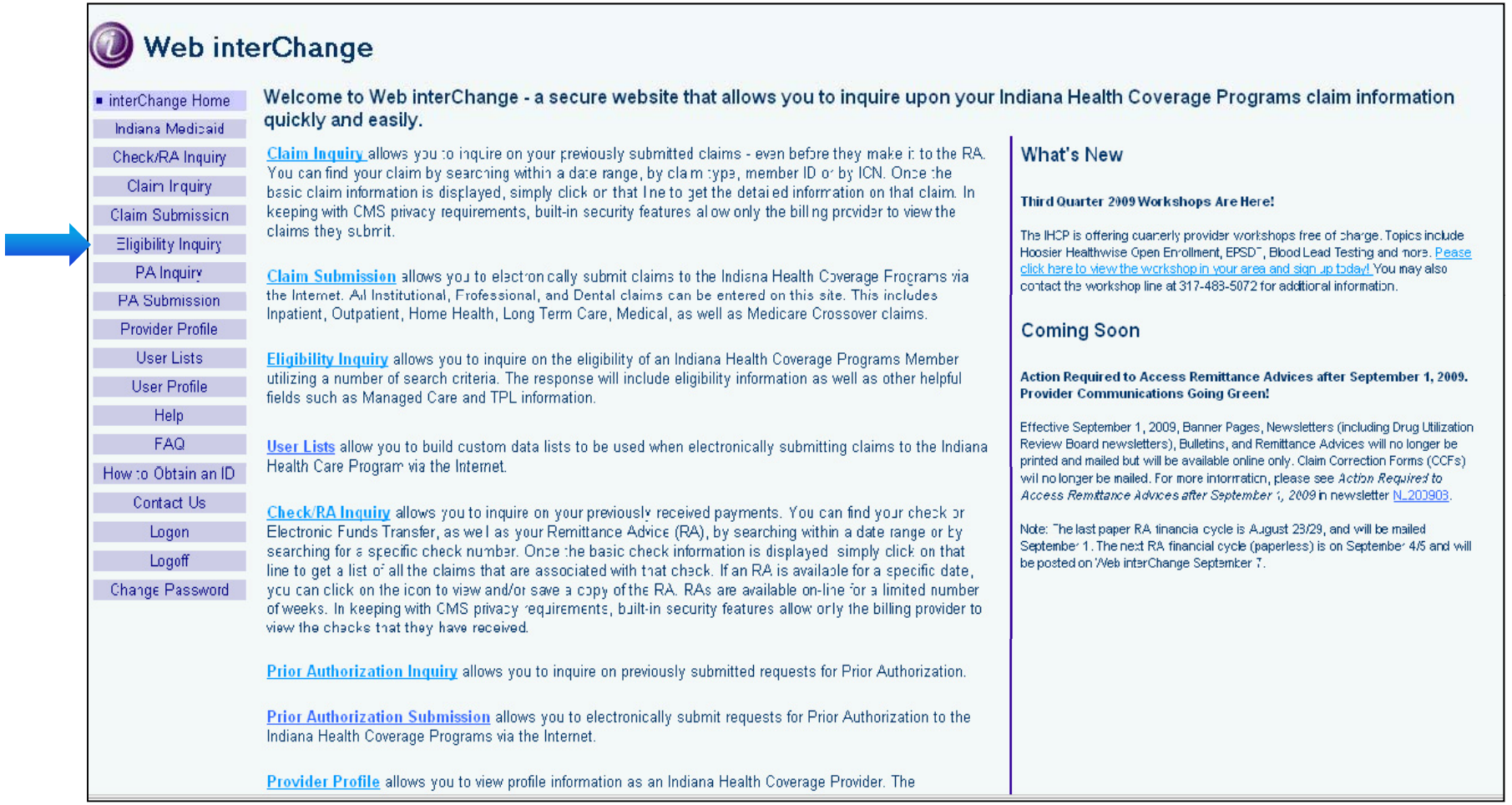


Administrator Request Form

- Complete and mail the Administrator Request Form and owner letter to:
  - Electronic Solutions Help Desk
    950 N. Meridian Street
    Suite 1150
    Indianapolis, IN 46204-4288
- Request form and owner letter may be faxed to (317) 488-5185
- The owner letter indicates you are approved as a Web interChange administrator for your organization
- Each provider should assign a Web interChange administrator to oversee the daily functions of the individual practice or group

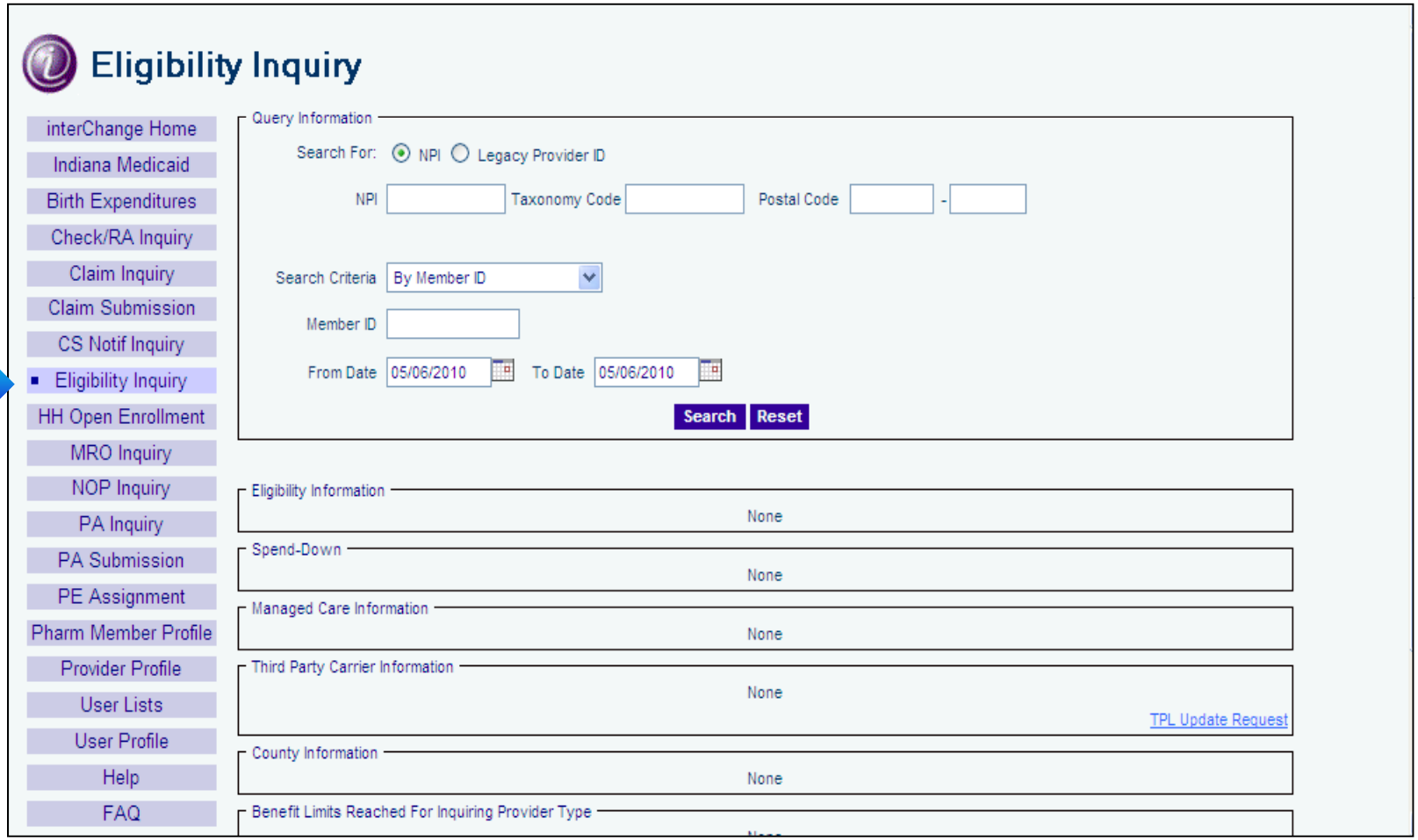
Web interChange Menu

Web interChange home page

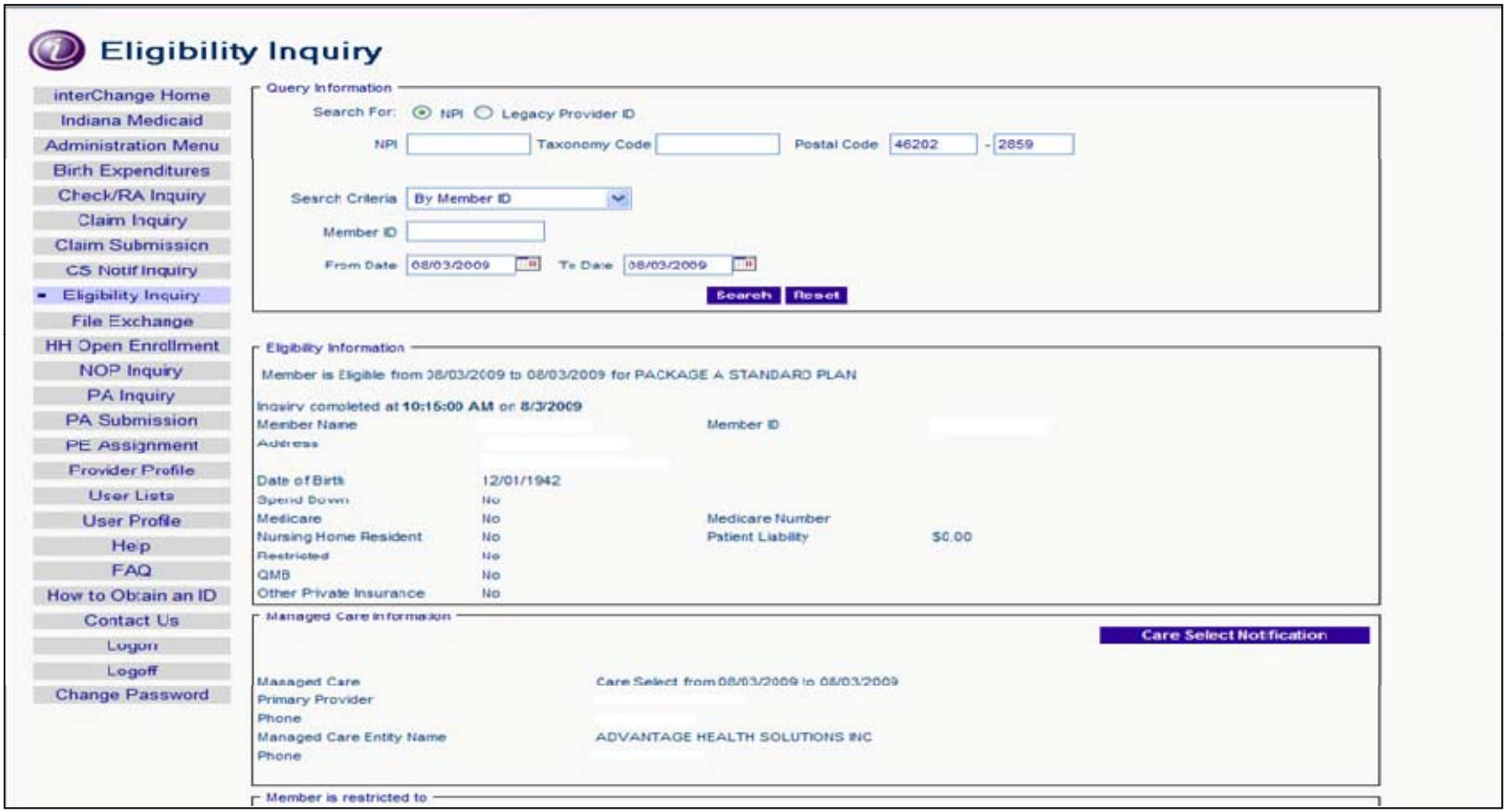


Verifying Member Eligibility

Eligibility Inquiry window



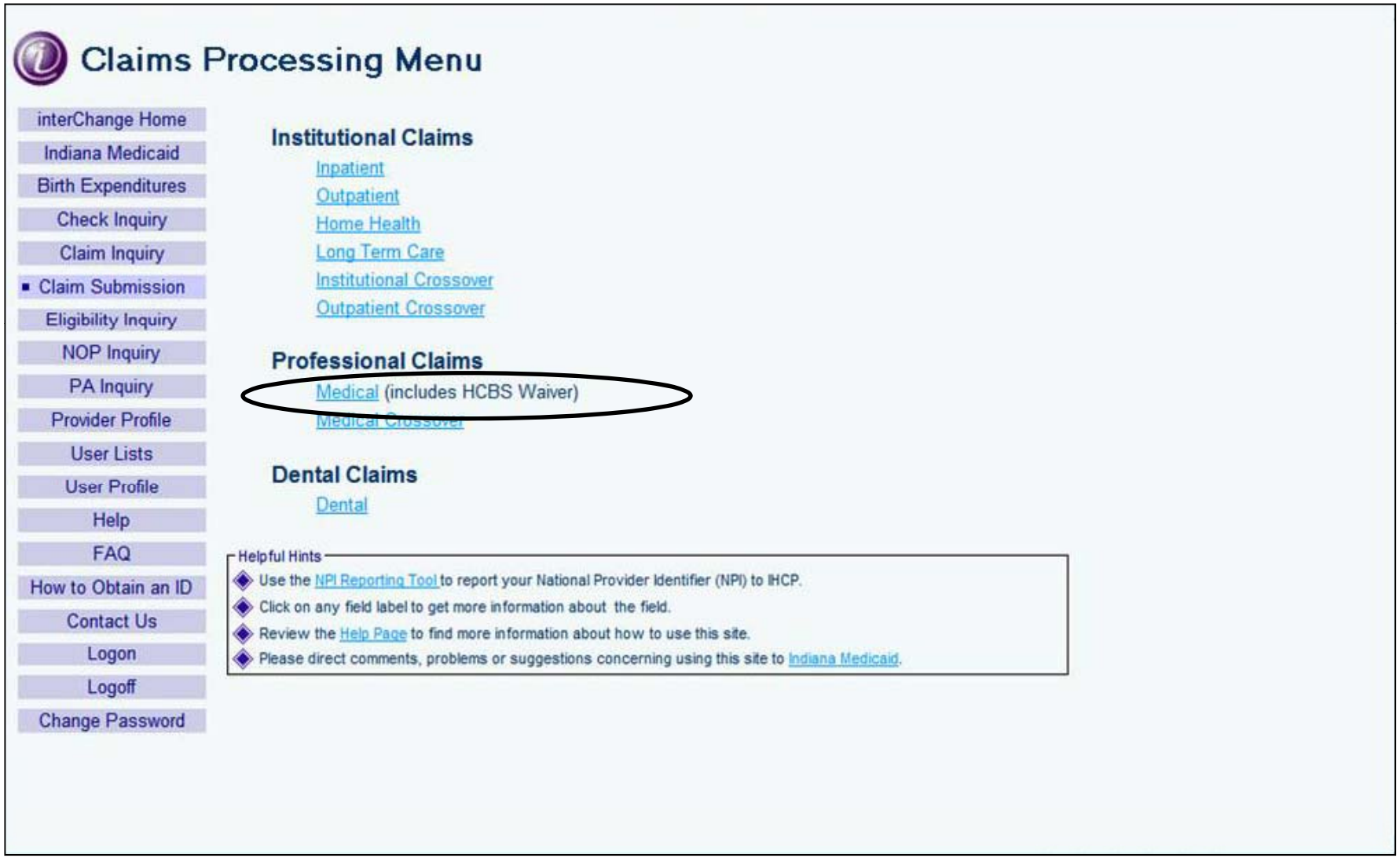
Eligibility Inquiry Window



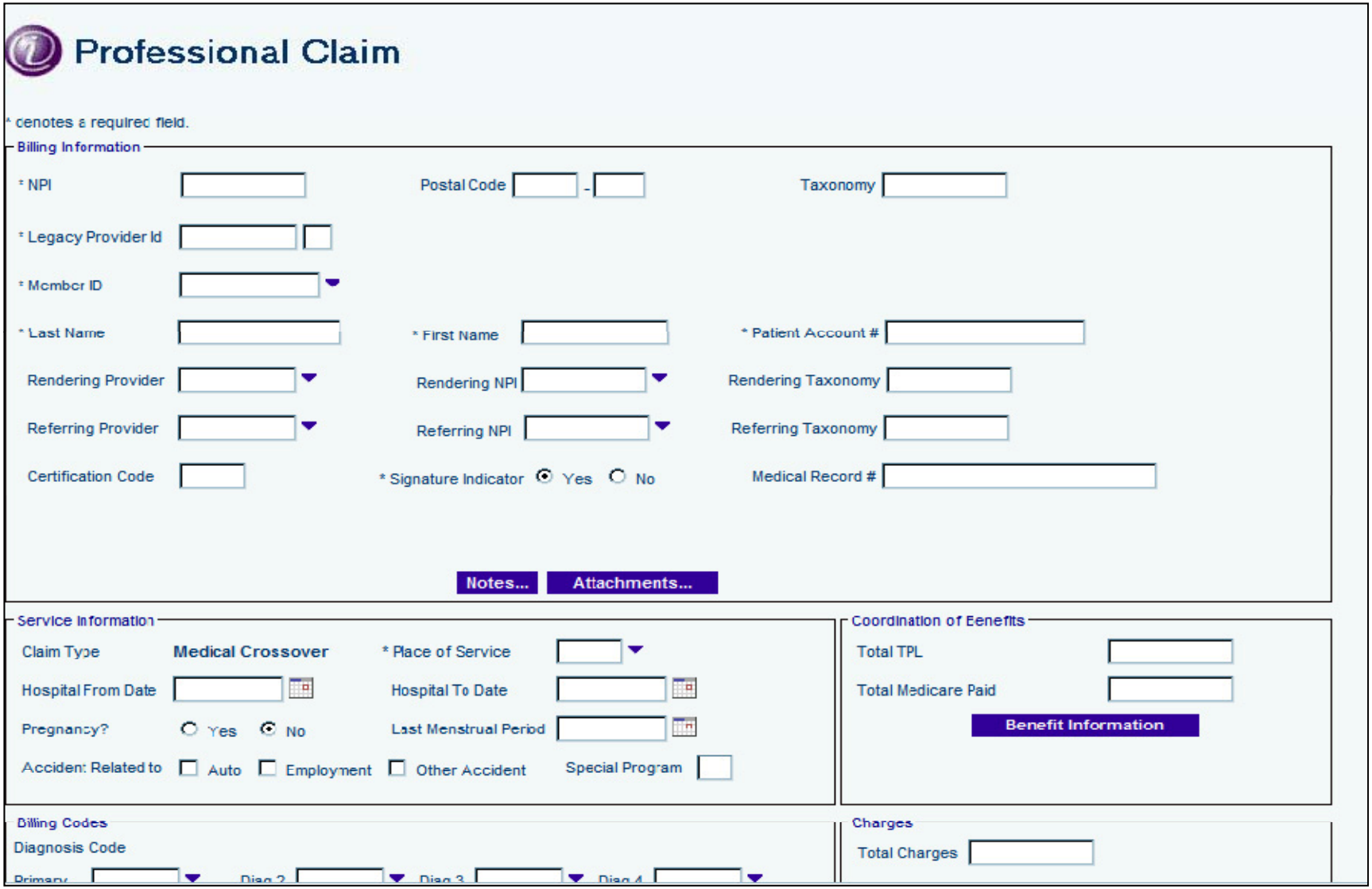
Learn

Web interChange and CMS-1500 Billing Guidelines

Claims Processing Menu



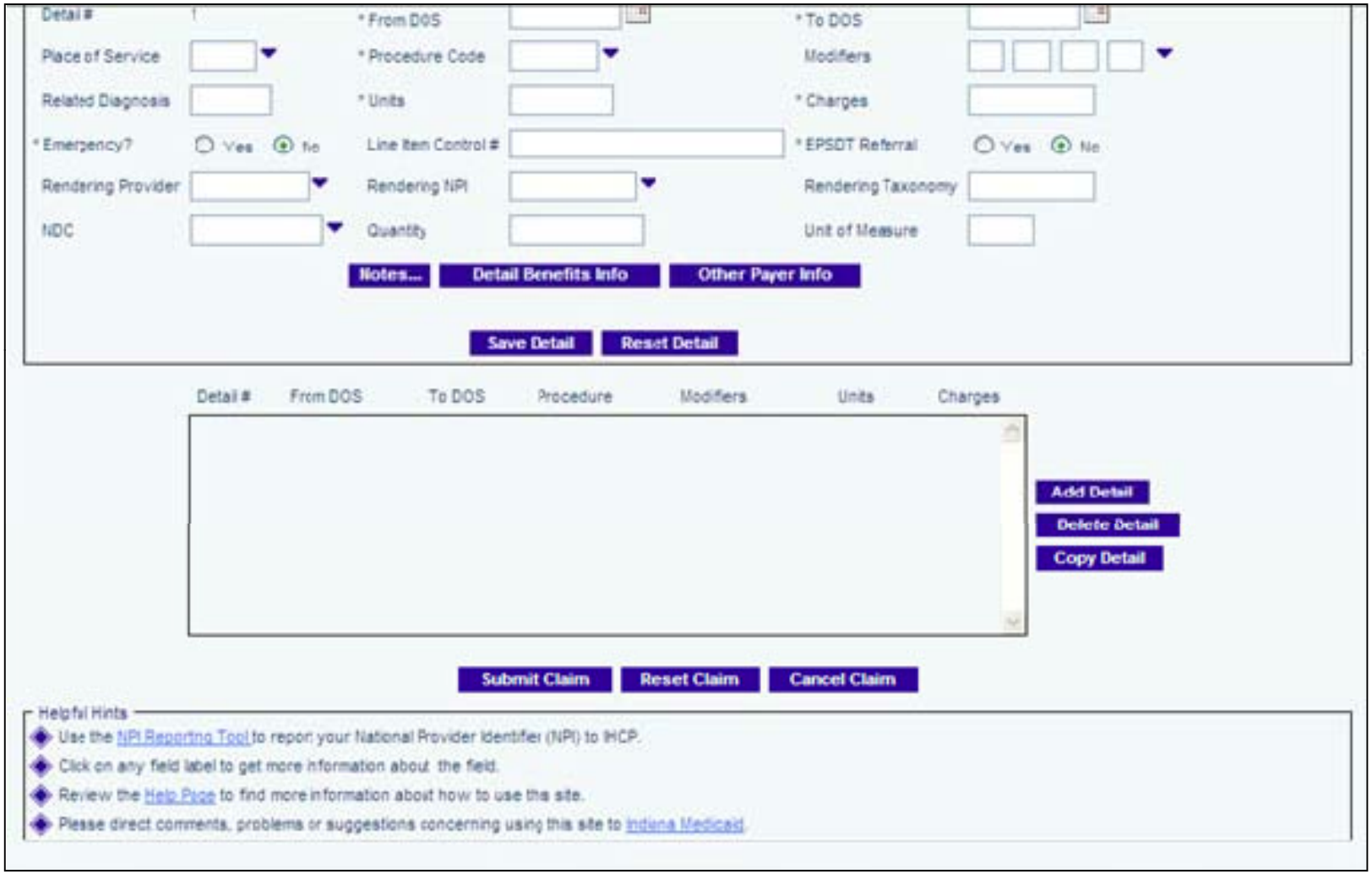
Professional Claim



Web interChange Claim Submission

- Under the Professional heading, click the Medical link
- Your Billing National Provider Identifier (NPI) will automatically populate in the NPI field
- Complete the fields:
  - Member's ID
  - Last Name, First Name
  - Patient Acct #, Rendering NPI
  - Place of Service
  - Diagnosis Code(s)

Professional Claim



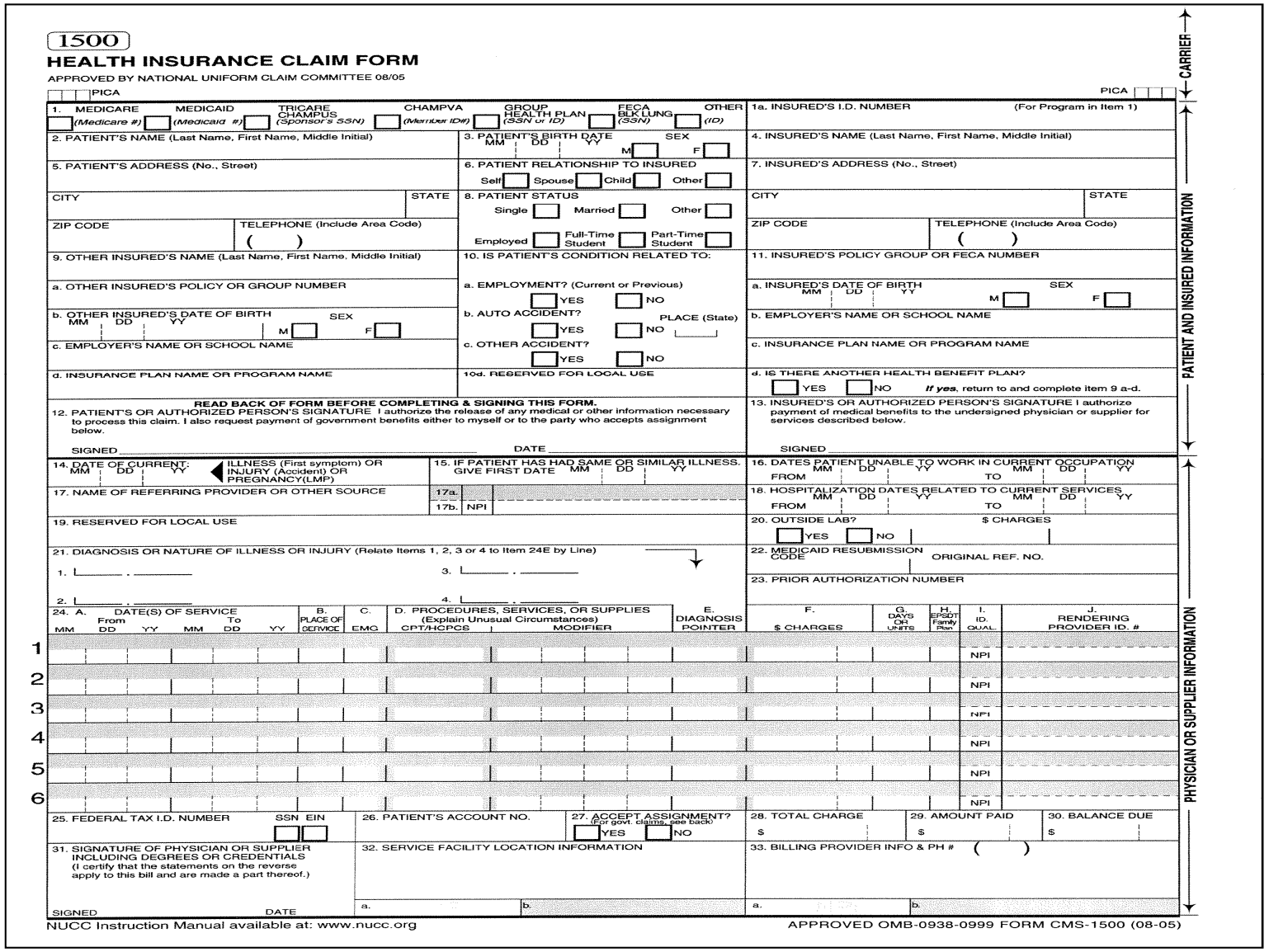
Web interChange Claim Submission

Detail Information

- From DOS, To DOS
- Procedure Code, Modifiers
- Related Diagnosis (if needed)
- Units
- Charges
- Click **Save Detail** and a summary of the detail information displays in the box at the bottom of the screen to confirm that the information saved
- Click **Submit Claim** on the bottom of the screen
- When the confirmation pop-up window appears with the claim's internal control number (ICN), confirm the information, and click **OK** to complete the process and send the claim to HP

Note: Users who are running pop-up blockers will not see the confirmation window. Please disable all pop-up blockers when using Web interChange.

CMS-1500 Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Billing Guidelines

- 1a INSURED'S I.D. NUMBER
- 2 PATIENT'S NAME
- 21.1 to 21.4. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
- 23 PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended to assist in tracking services that require PA
- 24A DATE OF SERVICE
- 24B PLACE OF SERVICE – Use the POS code for the facility where services were rendered
- 24D HCPCS and MODIFIER – Use the appropriate procedure code for the service rendered
- 24E DIAGNOSIS POINTER
- 24F CHARGES
- 24G DAYS OR UNITS

CMS-1500 Billing Guidelines

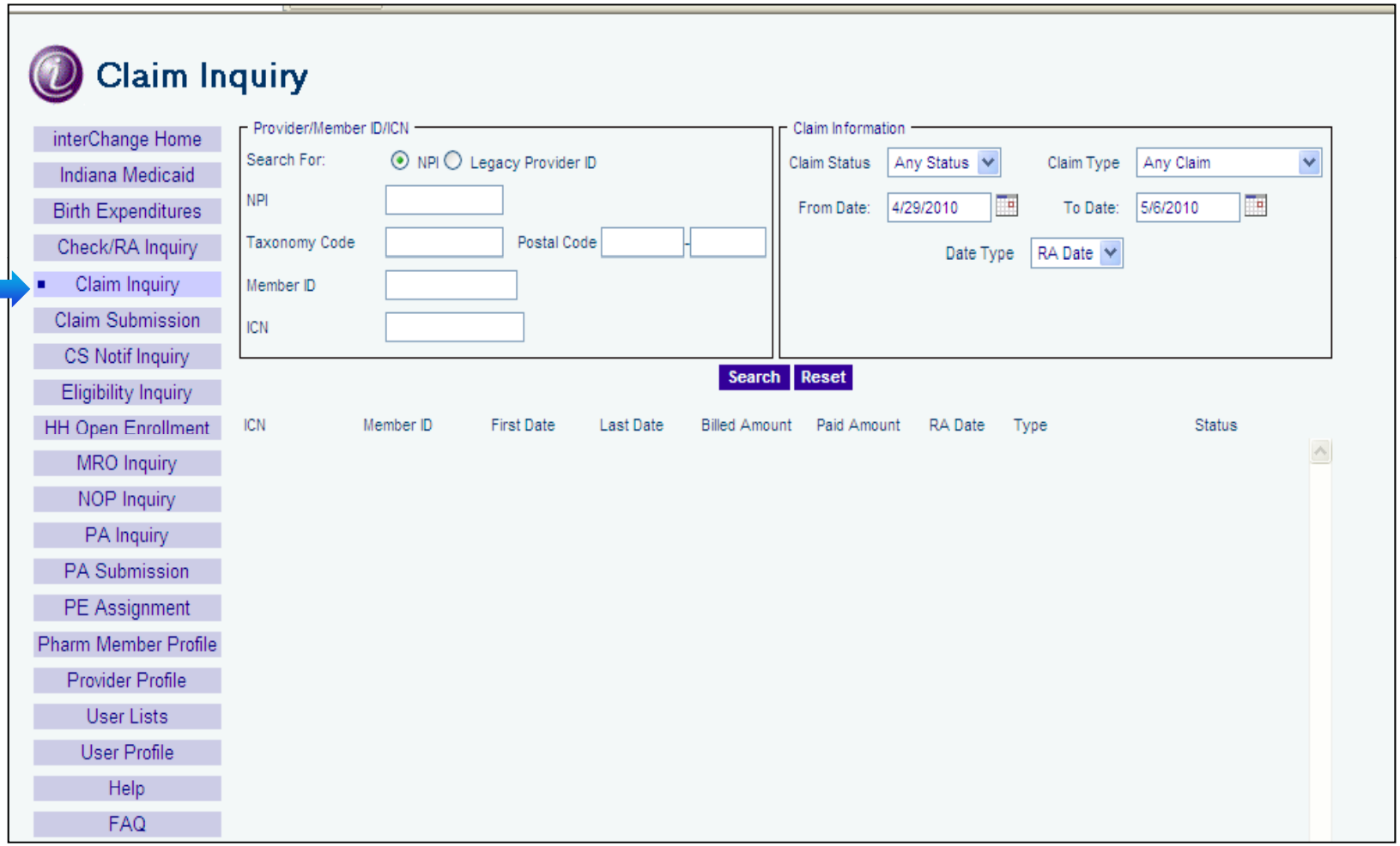
- 24 J Bottom Half RENDERING PROVIDER ID# NPI – Enter the NPI of the rendering provider.
- 28 TOTAL CHARGE
- 30 BALANCE DUE
- 31 SIGNATURE OF PHYSICIAN – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. Providers who have signed the *Signature on File* certification form will have their claims processed when a signature is omitted from this field. The form is available on the *Provider Services* page on indianamedicaid.com
- 32 SERVICE FACILITY LOCATION INFORMATION – Enter the provider's name and address where the services were rendered, if other than home or office. This field is optional, but it helps HP contact the provider, if necessary.
- 33 BILLING PROVIDER INFO – Enter the billing provider service location name, address, and the expanded ZIP Code + 4 format. Required.

Additional Billing Resources

- Paper billing resources
  - *IHCP Provider Manual* on the indianamedicaid.com *Manuals* Page – Chapter 8, Section 4
- Web interChange resources
  - Quick Reference for billing medical claims

Claim Inquiry

To view claim status on submitted claims



Find Help

Resources Available

Helpful Tools

- IHCP Web site at indianamedicaid.com
- IHCP Provider Manual
- MRO Provider Manual
  - 405 IAC 5-20 (Mental Health Services)
  - 405 IAC 5-21 (Community Mental Health Rehabilitation Services)
  - 405 IAC 5-21.5 (Medicaid Rehabilitation Option Services)
- Customer Assistance
  - 1-800-577-1278 toll-free
  - (317) 655-3240 in the Indianapolis local area
- HP Written Correspondence at the following address:

  HP Written Correspondence
  P.O. Box 7263
  Indianapolis, IN 46207-7263
- Provider Relations field consultants

Q&A