Questions and Answers from the 2021 IHCP Roadshow Panel Discussion: Seasoned Behavioral Health Professionals

The Indiana Health Coverage Programs (IHCP) hosted a panel discussion on Friday, April 30, 2021, for seasoned behavioral health professionals as part of the 2021 IHCP Roadshow. This document provides a summary of the questions and answers discussed during the panel.

How do the IHCP and managed care entities determine which behavioral health services require prior authorization?

The IHCP and its managed care entities (MCEs) use nationally recognized criteria to determine medical necessity and appropriateness of all services and admissions. Sources of criteria includes but are not limited to:

- State and federal legislation
- Medicare and other Centers for Medicare & Medicaid Services (CMS) policies
- Nationally recognized guidelines as assessed by Milliman Care Guidelines and InterQual
- Professional standards and association recommendations from entities such as the American College of Obstetricians and Gynecologists (ACOG) and American Dental Association (ADA)
- Food and Drug Administration (FDA) recommendations
- Other state Medicaid programs
- Journal articles and research studies

Will the MCEs still recognize the midlevel modifiers on claims submitted under a supervising physician?

Yes. Claims will require the use of the supervising physician's National Provider Identifier (NPI) and a midlevel modifier if the practitioner does not enroll with the IHCP. If a practitioner enrolls with the IHCP, a midlevel modifier is not needed to bill for services. For detailed information about newly enrolled behavioral health professionals, please refer to *IHCP Bulletin* *BT2020122* and *IHCP Banner Pages* *BR202119* and *BR202123*.

Will there be any claim-processing issues if a CMHC chooses not to enroll or credential midlevel providers?

No. There should be no claim-processing issues if community mental health centers (CMHCs) or any provider group chooses not to enroll or credential a midlevel practitioner. If you experience denials, please reach out to your provider consultant at Gainwell Technologies or the MCEs to alert them of the situation.

What are your recommendations to providers verifying benefit limits?

To verify benefit limits, the provider must check the appropriate provider portal.

For fee-for-service(FFS) claims, providers can check the remaining units on a prior authorization on the IHCP Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers. This number will only reflect services that have been submitted and paid. There may be outstanding claims that could reduce the available number.

To check benefit limits at each health plan, please refer to the following methods:

- **Anthem** – The Anthem provider portal is available at mediprovider.anthem.com. There is no benefit limit on outpatient behavioral health.
- **CareSource** – The CareSource Indiana provider portal is available at providerportal.caresource.com/IN. Outpatient mental health services do not have a limitation, but prior authorization is required after 24 visits.
- **MDwise** – Providers with questions can call the MDwise Provider Customer Service Unit at 833-654-9192. There is no benefit limit on therapy services.
- **Managed Health Services (MHS)** – The MHS provider portal is available from mhsindiana.com/providers. The Behavioral Health Outpatient Therapy (BHOP) limitations for Hoosier Care Connect, Healthy Indiana Plan and Hoosier Healthwise (Non-Package C) is 20 units per member, per practitioner, per rolling 12-month period. The benefit limit for Hoosier Healthwise Package C members is 30 units per member, per practitioner, per rolling 12-month period.
- **UnitedHealthcare** – Providers with questions can call UnitedHealthcare Provider Services at 877-610-9785. Currently, outpatient behavioral health visits do not require prior authorization for in-network providers. There is no benefit limit on outpatient behavioral health.

What are the billing requirements when behavioral health services and medical services are provided on the same day?

For FFS claims, behavioral health providers can bill medical services and therapy services for the same day with the appropriate behavioral health codes and diagnosis.

If a member visits an office twice on the same day with two different diagnoses, a second claim can be submitted for the second visit, using a separate claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a single visit with multiple diagnoses by separating the diagnoses on different claims.

When two valid practitioners, such as a medical provider and a mental health provider, see the same patient on the same day, the principal diagnoses should not be the same.

Anthem: Modifier 25 should be used on the Physical Health claim. The Anthem Blue Cross and Blue Shield (Anthem) Modifier 25 reimbursement policy provides the criteria for reimbursement for a significant, separately identifiable evaluation and management (E/M) service performed by the same provider on the same day of the original service or procedure. See the Anthem Provider Communication *Reimbursement Policy Update: Modifier 25* (Feb. 1, 2019).

For additional billing guidance specific to a particular MCE, please refer to individual reimbursement policy updates.