## Revision History

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<th>Reason for Revisions</th>
<th>Revisions Completed By</th>
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<td>EDS Provider Relations and Publications</td>
</tr>
</tbody>
</table>
# Table of Contents

Section 1: Introduction ................................................................................... 1-1  
  Overview ..................................................................................................... 1-1  

Section 2: Service Requirements ................................................................... 2-1  
  Overview ..................................................................................................... 2-1  
  Community Mental Health Rehabilitation Option Services ......................... 2-1  
  Provider Qualifications ............................................................................. 2-2  
  Treatment Plan Requirements ..................................................................... 2-2  
  Supervision ................................................................................................ 2-3  
  Waiver Services .......................................................................................... 2-3  

Section 3: Billing Requirements .................................................................... 3-1  
  Overview ..................................................................................................... 3-1  
  Reimbursement to Midlevel Practitioners – Psychiatric Residential Treatment  
    Facility ...................................................................................................... 3-2  
  Modifiers for MRO Services ...................................................................... 3-2  
  Third-Party Liability Requirements .......................................................... 3-2  
  Third-Party Liability Billing Instructions ................................................... 3-4  
  General Billing Information ...................................................................... 3-4  
    Managed Care Considerations ................................................................ 3-4  
    Prior Authorization Status ...................................................................... 3-5  
    Prior Authorization Transition from HCE (for Non-MRO Services)....... 3-5  
    Claim Format .......................................................................................... 3-6  
    Place of Service Codes ................................................................. 3-6  
    Mailing Address for Claims ................................................................. 3-6  
    Additional Addresses and Telephone Numbers ................................... 3-6  
    Modifications to Duplicate Logic ......................................................... 3-7  

Section 4: Procedure Codes ........................................................................... 4-1  
  Overview ..................................................................................................... 4-1  
  H0004 HW – Behavioral Health Counseling and Therapy, Individual .......... 4-1  
    Definition ............................................................................................... 4-1  
    Service Standards .................................................................................. 4-2  
    Unit of Service ...................................................................................... 4-2  
    Nonbillable Activities ............................................................................ 4-2  
  H0004 HW HR – Behavioral Health Counseling and Therapy, Family with  
    Client Present and H0004 HW HS Behavioral Health Counseling and  
    Therapy, Family without Client Present .................................................. 4-2  
    Definition ............................................................................................... 4-2  
    Service Standards .................................................................................. 4-3  
    Unit of Service ...................................................................................... 4-3  
    Nonbillable Activities ............................................................................ 4-3  
  H0004 HW HQ – Behavioral Health Counseling and Therapy, in Group  
    Setting ................................................................................................. 4-3  
    Definition ............................................................................................... 4-3  
    Service Standards .................................................................................. 4-3  
    Unit of Service ...................................................................................... 4-3  
    Nonbillable Activities ............................................................................ 4-4  
  H0031 HW – Mental Health Assessment, by Nonphysician ......................... 4-4  
    Definition ............................................................................................... 4-4  
    Unit of Service ...................................................................................... 4-4
Section 1: Introduction

Overview

The instructions in this supplemental Indiana Health Coverage Programs (IHCP) provider manual are specifically for providers enrolled in the Community Mental Health Rehabilitation Services Program, generally known as the Medicaid Rehabilitation Option (MRO) or Mental Health Rehabilitation. Specific rules for the MRO program can be found in Indiana Administrative Code (IAC) 405 IAC 5-20, 5-21, 5-25, which is available online at http://www.in.gov/legislative/iac/title405.html. Details provided in the applicable IAC are not repeated in this manual except to clarify or expand on procedural issues.

The IHCP Provider Manual has detailed information about how community mental health centers (CMHCs) or other providers bill clinic services. The IHCP Provider Manual is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/manuals.htm.

Unique MRO requirements are outlined by exception in this manual. Exception discussion centers on the following topics:

- Common service standards
- Treatment plan requirements
- Supervising physician responsibilities
- Medicare and third-party liability (TPL) requirements
- Prior authorization (PA) status
- Claim format requirements
- Procedure code and narrative requirements

Note: This manual does not address MRO services performed by Children's Welfare Rehabilitation Option (CWRO) (provider type 11, specialty 118).
Section 2: Service Requirements

Overview

Medicaid Rehabilitation Option (MRO) services are designed to assist in developing the member’s optimum functional ability in daily living activities. This is accomplished through a series of assessments and counseling or psychotherapy sessions. Services may be provided in individual or group settings.

Note: Hoosier Healthwise Package C members are not eligible to receive MRO services.

Community Mental Health Rehabilitation Option Services

MRO services are clinical mental health services provided to members, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness. The Indiana Health Coverage Programs (IHCP) provides reimbursement for the following MRO outpatient mental health services:

- Assertive community treatment (ACT) intensive case management services
- Case management services
- Crisis intervention
- Diagnostic assessment or prehospitalization screening
- Family counseling or psychotherapy
- Group counseling and psychotherapy
- Individual counseling or psychotherapy
- Medication or somatic treatment
- Partial hospitalization
- Training in activities in daily living
- Group training in activities of daily living

As stated in 405 IAC 5-21, IHCP reimbursement is available to community mental health services for members with mental illness when those services are provided through a mental health center that is an enrolled IHCP provider that meets applicable federal, state, and local laws concerning the operation of community mental health centers (CMHCs). Outpatient mental health services may include clinical attention in the member’s home, workplace, mental health facility, emergency room, or wherever needed. These services must be rendered by a qualified mental health professional, as outlined in 405 IAC 5-21-1-C, or by personnel who meet appropriate federal, state, and local regulations for their respective disciplines and are under the supervision or direction of a qualified mental health professional.

Reimbursement for MRO services is restricted to providers enrolled as CMHCs (provider type 11, specialty 111) that meet the requirements for Division of Mental Health and Addiction approval under IC 12-29 in accordance with 440 IAC 4.
Provider Qualifications

A qualified mental health professional (QMHP) is defined as follows:

- A licensed psychiatrist
- A licensed physician
- A licensed psychologist or a licensed psychologist endorsed as a health service provider in psychology (HSPP)
- An individual with at least two years of clinical experience after completing a master’s or doctoral degree, under the supervision of a psychiatrist, physician, psychologist, or HSPP, working with individuals who have a mental illness

The master’s or doctoral degree must include one of the following sets of credentials:
- Psychiatric nursing, from an accredited university, and licensing as a registered nurse in Indiana
- Social work, from a university accredited by the Council on Social Work Education
- Psychology, from an accredited university, and meeting the requirements for the practice of psychology in Indiana
- Mental health counseling, from an accredited university
- Pastoral counseling, from an accredited university
- Rehabilitation counseling, from an accredited university
- Marital and family therapy, from an accredited university

- A licensed independent practicing school psychologist under the supervision of the psychiatrist, physician, psychologist, or HSPP

- An advanced practicing nurse credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center, under the supervision of a physician, psychiatrist, psychologist, or HSPP

- A mental health professional who has documented education, training, or experience comparable or equivalent to other individuals listed in this section, and who has been approved by the supervising physician or HSPP, and is under the supervision of a physician, psychiatrist, psychologist, or HSPP

- Personnel who meet appropriate federal, state, and local requirements for their respective disciplines

- Personnel under the supervision of a QMHP

Treatment Plan Requirements

A treatment plan is an individualized plan of care developed by the provider for medical or remedial services aimed at treating the disability and maintaining or improving the member’s level of function. The treatment plan is developed after completing a clinical assessment. The clinical assessment includes the following:

- Review of psychiatric symptoms and how they affect the member’s functioning
- Review of the member’s skills and the support needed for the member to function in living, working, and learning environments
- Review of the member’s strengths and needs and their documentation in the member’s permanent records
A treatment plan is developed with the individual and must reflect the individual’s desires and choices. It also must include documentation of the following:

- Outline of goals directed at the treatment of mental illness
- Individuals or teams responsible for treatment
- Specific treatments and services that will be provided to the member
- Time limitations for service
- Review at intervals not to exceed 90 days
- Document certification by the supervising physician, psychiatrist, or HSPP, consistent with the CMHC’s Clinical Plan for Professional Services or similar document defining services under policies and procedures for the facility

**Supervision**

The supervising provider is enrolled in the IHCP as a rendering provider linked to the CMHC. The supervising physician, psychiatrist, or HSPP has the following responsibilities:

- Review information submitted by the QMHP.
- Approve the initial treatment plan and certify the diagnosis within seven days.
- See the member or review the treatment plan submitted by the QMHP at intervals not to exceed 90 days. Changes made in the treatment plan during the period between reviews do not require additional physician, psychiatrist, or HSPP review.
- Be available to see the member in emergency situations and when additional consultations are requested.
- Keep all documentation in the individual’s treatment record.
- Provide clinical attention in the member’s home, workplace, provider facility, emergency room, or wherever attention is required.
- Establish procedures for the emergency provision of medication, first aid, or other medical care.

**Waiver Services**

A member can receive waiver services and other IHCP services, such as MRO services, at the same time. However, a federally approved waiver requires that waiver services not duplicate services already available. Service duplication would most likely occur in the following two areas:

- Activities of Daily Living (ADL) training
- Case management services

Waiver case managers are responsible for monitoring services to prevent duplication. The CMHC must coordinate the provision of services with the waiver case manager.
Section 3: Billing Requirements

Overview

Reimbursement procedures for accommodating the maximum fee schedule percentage differential in Indiana AIM are as follows:

- Individual Indiana Health Coverage Programs (IHCP) rendering provider numbers are assigned to physicians or health services providers in psychology (HSPPs). The rendering provider numbers are linked to the group provider number of the community mental health center (CMHC).

- Each line on the CMS-1500 claim form accommodates a rendering provider number. Multiple rendering provider numbers can be reflected on one claim to indicate the individual practitioner in the group that performed each service billed on the claim form. The rendering provider’s National Provider Identifier (NPI) and taxonomy (optional) are included in field 24J, and qualifiers (if necessary) are included in field 24I on the CMS-1500 claim form. The group’s billing provider NPI is included in field 33a, and taxonomy (optional) is included in field 33b of the claim form. The group provider number is used for billing and incorporates all the individual provider services on the group Remittance Advice (RA). Psychologists who do not have HSPP certification and providers that have a master of social work (licensed MSW) or Academy of Certified Social Workers (ACSW) certification or licensed clinical social worker (LCSW) are not assigned an individual IHCP provider number.

- Because midlevel practitioners – ACSWs, certified clinical social workers (CCSWs), LCSWs, licensed MSWs, advanced practice nurses credentialed in psychiatric or mental health nursing, licensed psychologists, licensed independent practice school psychologists, licensed marriage and family therapists, licensed mental health counselors, psychologists with basic certificates, and registered nurses with master’s degrees in nursing with majors in psychiatric and mental health nursing – that provide the service for a particular line item cannot have a rendering provider number for mental health billing purposes, per 405 IAC 5-20 and 405 IAC 5-21, the individual provider number of the supervising physician, psychiatrist, or HSPP must be entered as the rendering provider. The group provider is used for billing provider number in field 33a, and modifiers are added to the procedure code in field 24D on the individual line item.

- Each line on the CMS-1500 is individually priced at the IHCP allowed rate for the procedure billed. The IHCP allowed rate is the lower of the submitted charge or the IHCP maximum fee for that procedure. Physicians, psychiatrists, and HSPPs receive 100 percent of the IHCP allowed rate. Other Medicaid Rehabilitation Option (MRO) mental health practitioners receive 75 percent of the allowed rate with the use of modifiers.

- The signature on the claim must be the signature of the supervising practitioner.

- Services should be billed based on the credentials of the individual rendering the service and not the individual supervising the service.

- Outpatient mental health and MRO providers may bill for medically necessary services that are provided prior to the approval of the treatment plan, as long as the treatment plan is signed within seven days of intake. If the treatment plan is not signed within seven days of intake, providers may not bill for services provided after the seventh day, until the treatment plan is signed.

- For detailed, line-by-line billing instructions for the CMS-1500 (08/05), refer to IHCP Provider Manual Chapter 8.
Reimbursement to Midlevel Practitioners – Psychiatric Residential Treatment Facility

Midlevel practitioner services may be reimbursed for services provided on the same date as admission to and/or discharge from a Psychiatric Residential Treatment Facility (PRTF). Submit these claims to EDS with documentation from the midlevel practitioner or PRTF showing the services were rendered outside the PRTF setting. Documentation must include one of the following:

- Patient records that indicate services were rendered in the office or outpatient setting
- Records submitted from the PRTF showing admission and/or discharge date

Providers with previously denied claims for audit 6636 – *Mid-level services not reimbursable the same day as a paid PRTF service*, can resubmit claims for special processing only if the denials were for midlevel practitioner services on the same day as an admission to and/or discharge from a PRTF.

Please submit your claim and documentation for special processing to EDS Written Correspondence (WC) at the following address:

EDS Written Correspondence  
P.O. Box 7263  
Indianapolis, Indiana 46207-7263

Modifiers for MRO Services

The following instructions must be followed for billing claims to the IHCP for MRO services:

- The CMHC’s billing group’s NPI must be entered in field 33a of the CMS-1500 claim form.
- Each line of the CMS-1500 claim form must include the rendering or supervising psychiatrist, physician, or HSPP’s NPI in field 24J.
- Rendering physicians, psychiatrists, or HSPPs should not use the midlevel practitioner modifiers AJ and AH. These providers are reimbursed at 100 percent.
- All other qualified providers (as specified in 405 IAC 5-21-1(b) and 405 IAC 5-21-2(2)) must use the following modifiers in field 24D of the CMS-1500:
  - AH – Clinical psychologist (only)
  - HE – Midlevel practitioner
  - AJ – Clinical social worker (only)
  - HE and SA – Services provided by a nurse practitioner or clinical nurse specialist
  - SA – Nurse practitioner or clinical nurse specialist (NP/CNS) in a nonmental-health arena
  - HW – MRO services
- MRO services billed for midlevel practitioners are reimbursed at 75 percent.

Third-Party Liability Requirements

To ensure that the IHCP does not pay for services covered by other insurance sources, federal regulations (42 CFR 433.139) require that the IHCP be the payer of last resort. With some exceptions, providers are required to bill all liable third parties before submitting a claim to the IHCP. This activity is commonly referred to as cost avoidance. Although other insurance carriers routinely cover some MRO services, other MRO services are so unique to the Medicaid program that no other insurance
carrier covers them. Therefore, some MRO services are exempt from cost avoidance. Third-party liability (TPL) cost avoidance requirements for all MRO services are listed by code in Table 3.1.

<table>
<thead>
<tr>
<th>Level II Code and Modifier(s)</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004 HW</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
<td>Service must be billed to Medicare Part B or private insurance before submitting a claim to the IHCP.</td>
</tr>
<tr>
<td>HR HS</td>
<td>Family/couple with client present Family/couple without client present</td>
<td></td>
</tr>
<tr>
<td>HQ H0031 HW</td>
<td>Group setting Mental health assessment, by nonphysician</td>
<td>Service must be billed to Medicare Part B or private insurance before submitting a claim to the IHCP.</td>
</tr>
<tr>
<td>H0033 HW</td>
<td>Oral medication administration, direct observation</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.</td>
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<tr>
<td>H0035 HW</td>
<td>Mental health, partial hospitalization, treatment, less than 24 hours</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to Medicare first.</td>
</tr>
<tr>
<td>H0040 HW</td>
<td>ACT services, per diem</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>H2011 HW</td>
<td>Crisis intervention service, per 15 minutes</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>H2014 HW</td>
<td>Skills training and development, per 15 minutes</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>T1016 HW TG</td>
<td>Case management</td>
<td>This code is exempt from TPL cost avoidance editing. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>Level II Code and Modifier(s)</td>
<td>Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care/home management training</td>
<td>This code is exempt from TPL cost avoidance. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
<td>Funded by state mental health agency</td>
</tr>
<tr>
<td>HW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97537</td>
<td>Community/work reintegration training (for example, shopping, transportation, money management)</td>
<td>This code is exempt from TPL cost avoidance. This code can be billed directly to the IHCP.</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
<td>Funded by state mental health agency</td>
</tr>
<tr>
<td>HW</td>
<td></td>
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</tr>
</tbody>
</table>

**Third-Party Liability Billing Instructions**

When payment from the insurance carrier has been received, the CMHC may bill the IHCP for any unpaid portion of the provider’s usual and customary charge. The IHCP reimburses the CMHC up to the IHCP allowable charge. If the insurance carrier denies payment for an MRO service, the CMHC must submit a paper claim with an attached copy of the insurance denial notice, or an 837P transaction followed by a paper attachment via mail to the IHCP for review and processing.

Partial hospitalization (PH) is exempt from TPL edits. However, if the CMHC’s PH program meets the requirements for the Medicare program, and therefore qualifies for Medicare reimbursement, the provider must bill Medicare first. The provider must have a PH program description sufficient to distinguish its program from Medicare and to substantiate why it does not qualify for Medicare reimbursement. Distinguishing features include, but are not limited to, level of intensity, staffing requirements, hours of programming, and clinical supervision requirements. Such documentation must be available for future IHCP surveillance and utilization review audits. PH is exempt from all other TPL edits.

**General Billing Information**

Insurance payment or denial information for the procedure codes must be appropriately reflected when billing the IHCP. In addition, Medicare and TPL denials must be attached to claims submitted to the IHCP or can be sent as paper attachments for electronic 837P claim transactions.

**Managed Care Considerations**

MRO services by provider type and specialty are carved out of the Hoosier Healthwise managed care program. CMHCs are reimbursed for a carved-out service only if the rendering or supervising provider is enrolled with mental health provider specialty 011, 110-117, or 339 and is linked to a CMHC billing number with the same specialty. Claims submitted for rendering or directing providers not enrolled with one of these provider specialties will be denied because primary medical provider (PMP) authorization is necessary. Claims for members of the Care Select program require PMP authorization and data for claim processing. Those claims for risk-based managed care (RBMC) members are submitted to EDS for processing. Chapter 8 of the IHCP Provider Manual provides additional information about mental health services for managed care enrollees.
**Prior Authorization Status**

Community Mental Health Rehabilitation Services as defined in the *Indiana Administrative Code* are case-managed by the CMHC and do not require prior authorization (PA). *Form 1261A* is not applicable to MRO services.

**Prior Authorization Transition from HCE (for Non-MRO Services)**

Beginning November 1, 2007, the PA function transitioned from Health Care Excel (HCE) to the entities identified in Table 3.2.

<table>
<thead>
<tr>
<th>PA Entities</th>
<th>Program</th>
<th>Contact Information</th>
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<tr>
<td>ADVANTAGE℠ Health Solutions, Inc.</td>
<td>Traditional Medicaid, Hoosier Healthwise Carve-Outs (RBMC)</td>
<td>P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720</td>
</tr>
<tr>
<td>ADVANTAGE℠ Health Solutions, Inc.</td>
<td>Care Select – Care Management Organization (CMO)</td>
<td>P.O. Box 80068 Indianapolis, IN 46280 1-800-784-3981</td>
</tr>
<tr>
<td>MDwise</td>
<td>Care Select – Care Management Organization (CMO)</td>
<td>P.O. Box 44214 Indianapolis, IN 46244-0214 1-866-440-2449</td>
</tr>
</tbody>
</table>

It is important for all providers to understand that this change affects all IHCP providers requesting PA. Providers must contact the member’s care management organization (CMO) regarding PA and restricted card services when a member is enrolled in the Care Select program. The correct CMO can be verified using one of the available Eligibility Verification Systems (EVS). If an EVS does not identify specific CMO information, the provider must determine the IHCP program with which the member is associated.

**Note:** Based on the above table, ADVANTAGE Health Solutions plays multiple roles in the PA process. The organization processes PA for Care Select members who are assigned to a PMP contracted with their organization and will also process PA requests for members who are assigned to Traditional Medicaid, and Hoosier Healthwise carve-out services (RBMC) when the member is not in Care Select. (Care Select does not have carve-out services.) Because ADVANTAGE Health Solutions is processing PAs in two different capacities, they have designated two separate P.O. Boxes for submitting PA requests. It is important for providers to ensure that PA requests are mailed to the correct P.O. Box for the applicable program.

HCE accepted new and updated PA requests through October 31, 2007. After that date, HCE’s PA telephone and fax numbers were disconnected. HCE can be contacted at (317) 347-4500 for information about PAs that were submitted to HCE. Providers must submit all PA requests to the appropriate PA vendor.
Claim Format

MRO claims can be billed using the CMS-1500 paper claim format or Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic 837P claim format. Additional procedures for billing with the CMS-1500 claim form are provided in Chapter 8 of the IHCP Provider Manual.

MRO services may be billed with other IHCP-covered services on the same claim. Each IHCP provider number identifies all the programs for which a provider is qualified to deliver services and that were elected during the enrollment process. In addition, IndianaAIM adjudicates claims line by line, which allows a mixed-program claim as long as the claim is billed under the same provider number. However, mixing program billings on the same claim significantly complicates the Remittance Advice (RA) claim reconciliation, and it is easier to reconcile RA claim transactions if MRO billing is separate from IHCP clinical billing, especially if different departments are responsible for those functions.

Place of Service Codes

MRO services can be rendered in the following locations with the place of service code listed:

- 11 – Office
- 12 – Home
- 23 – Emergency room – hospital
- 31 – Nursing facility
- 53 – Community mental health center (such as therapy)
- 99 – Other unlisted facility (such as employment or a community place)

**Note:** The CMHC must ensure that the service provided is not already included in the nursing home per diem rate.

Mailing Address for Claims

MRO claims are sent to the standard medical claim address:

**EDS CMS-1500 Claims**
P. O. Box 7269
Indianapolis, IN 46207-7269

Additional Addresses and Telephone Numbers

Providers should direct questions about filing claims to Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278. The addresses and telephone numbers are also available on the Indiana Health Coverage Programs Quick Reference on the IHCP Web site at [http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf](http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf) or as an attachment to each IHCP Provider Monthly Newsletter.
**Modifications to Duplicate Logic**

For claims and replacements received on or after September 27, 2007, IndianaAIM duplicate logic was modified for Medical, Medical Crossover Part B, Outpatient, Outpatient Crossover C, and Home Health claim types. Dental claims are excluded from this change. Instead of reading only the first three characters of the procedure code billed, IndianaAIM was enhanced to read all five characters of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT)\(^1\) code, in addition to an HCPCS/CPT code that includes modifiers as part of the procedure, such as 99600 TD-Home Health visit, RN.

For example, before August 1, 2007, if a claim was billed with procedure code 82550 and procedure code 82552 for the same date of service, the second detail would have suspended for *Edit 5000 – Possible duplicate* because the first three characters of the procedure code were the same as the first three characters of the procedure code submitted on the first detail. Enhancements allow IndianaAIM to read all five characters billed without suspending the second detail of the claim for *Edit 5000 – Possible duplicate*.

HCPCS codes with the same beginning alpha or numeric characters, for the same member, on the same date of service, and rendered by the same provider required special handling due to claim denials for the exact duplicate edits. As a result of the above modification to duplicate logic in IndianaAIM, claims submitted with the above criteria do not require special handling by the EDS provider field consultant staff or the Written Correspondence Unit. Providers submit claims through their normal business process.

Section 4: Procedure Codes

Overview

The structure of the Indiana Health Coverage Programs (IHCP) Community Mental Health Rehabilitation Service local Healthcare Common Procedure Coding System (HCPCS) procedure codes is described in this section.

Table 4.1 – HCPCS Codes

<table>
<thead>
<tr>
<th>New Level II Code</th>
<th>New Modifier(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
<td>HW</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td></td>
<td>HR</td>
<td>Family/couple w/client</td>
</tr>
<tr>
<td></td>
<td>HS</td>
<td>Family/couple w/o client</td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>Group setting</td>
</tr>
<tr>
<td>H0031</td>
<td>HW</td>
<td>Mental health assessment, by nonphysician; one unit equals 15 minutes</td>
</tr>
<tr>
<td>H0033</td>
<td>HW</td>
<td>Oral medication administration, direct observation</td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>Group setting</td>
</tr>
<tr>
<td>H0035</td>
<td>HW</td>
<td>Mental health, partial hospitalization, treatment, less than 24 hours</td>
</tr>
<tr>
<td>H0040</td>
<td>HW</td>
<td>Assertive Community Treatment (ACT) services</td>
</tr>
<tr>
<td>H2011</td>
<td>HW</td>
<td>Crisis intervention; one unit of service equals 15 minutes</td>
</tr>
<tr>
<td>H2014</td>
<td>HW</td>
<td>Skills training and development; one unit equals 15 minutes</td>
</tr>
<tr>
<td>T1016</td>
<td>HW</td>
<td>Case management, each 15 minutes</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>Complex/high-tech level of care</td>
</tr>
<tr>
<td>97535</td>
<td>HW</td>
<td>Self-care/home management training</td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>Group setting</td>
</tr>
<tr>
<td>97537</td>
<td>HW</td>
<td>Community/work reintegration training</td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>Group setting</td>
</tr>
</tbody>
</table>

H0004 HW – Behavioral Health Counseling and Therapy, Individual

Definition

The Healthcare Common Procedure Coding System (HCPCS) manual defines psychotherapy as:

- “Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.”
Individualized treatment consists of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized treatment plan. The face-to-face interaction may also be with family members or other significant individuals when the patient is a child or adolescent, has a severe and persistent mental illness (SPMI), or is chronically addicted; and the goal of treatment is improved functioning.

Individualized counseling or psychotherapy must be billed using HCPCS Level II Code H0004 – Behavioral health counseling and therapy, per 15 minutes, and modifier HW – Funded by state mental health agency.

**Service Standards**

At least one enrolled member is the focus of the treatment; documentation must support how the service relates to the enrolled member.

**Unit of Service**

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

**Nonbillable Activities**

Individualized treatment in excess of two hours, or eight units, at a time is not billable as individualized counseling or psychotherapy. Linkages to partial hospitalization or other services must be sought.

**H0004 HW HR – Behavioral Health Counseling and Therapy, Family with Client Present and H0004 HW HS Behavioral Health Counseling and Therapy, Family without Client Present**

**Definition**

The HCPCS manual defines psychotherapy as:

- “Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.”

Family treatment consists of a series of time-limited, structured, face-to-face sessions that work toward attaining defined goals identified in the individualized treatment plan. The face-to-face interaction may also be with family members or other significant individuals when the patient is a child, adolescent, SPMI, or is chronically addicted; the goal of treatment is improved functioning; and the face-to-face sessions are part of the treatment plan.

Family counseling or psychotherapy must be billed using HCPCS Level II Code H0004 – Behavioral health counseling and therapy, per 15 minutes, and modifiers HW – Funded by state mental health agency and HR – Family/couple with client present or HS – Family/couple without client present.
Service Standards

At least one enrolled member is the focus of the treatment.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

Nonbillable Activities

Family treatment in excess of two hours, or eight units, at a time is not billable as family counseling or psychotherapy. Linkages to partial hospitalization or other services should be sought.

H0004 HW HQ – Behavioral Health Counseling and Therapy, in Group Setting

Definition

The HCPCS manual defines psychotherapy as:

- “Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.”

Group treatment consists of a series of time-limited, structured, face-to-face sessions that work toward attaining defined goals identified in the individualized treatment plan. Interventions are provided in a group setting. The face-to-face interaction may also be with family members or other significant individuals when the patient served is a child or adolescent, has SPMI, or is chronically addicted; the goal of treatment is improved functioning; and the face-to-face sessions are part of the treatment plan.

Group counseling or psychotherapy must be billed using HCPCS Level II Code H0004 – Behavioral health counseling and therapy, per 15 minutes, and modifiers HQ – Group setting and HW – Funded by state mental health agency.

Service Standards

At least one enrolled member is the focus of the treatment; however, documentation must support how the service relates to the enrolled member. Med/Somatic and partial hospitalization may be billed for the same day, when appropriate. Documentation should support that the group activities are not duplications of partial hospitalization activities. If activities of daily living (ADL) activity occur during partial hospitalization day, services must be subtracted from the partial hospitalization day.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.
Nonbillable Activities

Group treatment in excess of two hours, or eight units, at a time is not billable as group counseling or psychotherapy. Linkages to partial hospitalization or other services should be sought.

H0031 HW – Mental Health Assessment, by Nonphysician

Definition

The diagnostic and prehospitalization assessment examines the skills and supports needed for a member to function in his or her living, working, and learning environments and how the psychiatric symptoms affect these areas. The assessment includes face-to-face contact with the member and face-to-face collateral contacts with family members or other significant individuals. The assessment should be sensitive and responsive to the needs of members with disabilities, and varied ethnic and cultural backgrounds.

Outpatient diagnostic assessment and prehospitalization screening must be billed using HCPCS Level II Code H0031 – Mental health assessment, by non-physician, and modifier HW – Funded by State Mental Health Agency.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

Billable Activities

• Cognitive and behavioral functioning at the time of admission
• Completed assessment for members who do not require a treatment plan
• Diagnostic impressions
• Drug and alcohol abuse history
• Family health history
• Health behaviors
• Health history
• Major body systems review
• Mental status
• Physical abuse history
• Physical or developmental disabilities
• Pregnancy history
• Prehospitalization screening available 24 hours a day
• Psychiatric symptomatology
• Psychometric test administration, interpretation, and report writing
• Recommendations
Social history
- Sociodemographic information identification
- Face-to-face or collateral contacts with family members or other significant individuals

Nonbillable Activities
- Telephone contact with the patient
- Documentation

H0033 HW – Oral Medication Administration, Direct Observation, with Individual and H0033 HW HQ – Oral Medication Administration, Direct Observation, with a Group in a Group Setting

Definition
Medication and somatic treatment includes responding to a physician’s orders, dispensing or administering prescribed medications, monitoring medication side effects, and conducting medication groups or classes.

Medication and somatic treatment must be billed using HCPCS Level II Code H0033 – Oral medication administration, direct observation and modifier HW – Funded by state mental health agency.

Service Standards
Face-to-face contact with a licensed physician is required before the initial prescription of medication. However, at the 90-day review, face-to-face contact may be made with the physician or an advanced practice nurse with prescription authority who is acting within the appropriate scope of authority. Face-to-face contact with the physician is not necessarily required for other allowed medication and somatic activities. However, the agency must have a physician designated as the medical director to supervise this service.

Unit of Service
One unit equals one-quarter hour (15 minutes). For IHCP billing purposes, it is permissible to document the amount of time spent with each client over a 24-hour period and round up to the nearest one-quarter hour. When services are provided in group settings, it is appropriate to bill for each individual in the group for the time spent in the group.
**Billable Activities**

- Face-to-face contact, either individually or in a group setting, for the purpose of monitoring medication compliance, assessing the functional level of the patient, and monitoring medication side effects
- Medication and somatic treatment, which may include the following:
  - Responding to a physician’s or advanced practice nurse’s orders, including filling prescription orders and filling medical boxes
  - Checking blood pressure before administering injectable medication
  - Dispensing, administering, or monitoring self-administration of prescribed medications
  - Monitoring side effects
  - Conducting medication groups or classes
  - Ensuring that laboratory work is obtained pursuant to physician order
  - Conducting specialized dietetic services that are physician directed
  - Consulting with the attending physician or advanced practice nurse
  - Assisting the patient to access other treatment resources

When medication and somatic treatment occurs during the same one-quarter hour as case management and consumes less than half the time interval, providers must bill one-quarter hour of case management.

Coaching and instruction of medication procedures can instead be billed as ADL, as delineated in the CMHC’s *Clinical Plan for Professional Services* or similar document.

**Nonbillable Activities**

Medication and somatic treatment activities billed by the physician under clinic option services or another Medicaid Rehabilitation Option (MRO) service such as individual counseling or psychotherapy are not reimbursable under medication or somatic treatment.

**H0035 HW – Mental Health, Partial Hospitalization, Treatment, Less than 24 Hours**

**Definition**

Partial hospitalization refers to a structured group-activity program with scheduled components of two or more but less than 24 hours a day. The actual time per day (rounded up to the closest one-quarter hour) may be billed. The number of days per week required is determined by what is medically necessary and indicated in the individualized treatment plan. This service is provided for individuals who require less than full-time hospitalization, but more extensive or structured treatment than intermittent, hourly outpatient mental health services. Partial hospitalization includes services such as psychosocial rehabilitation, intensive outpatient treatment, clubhouse services, or day programs. Through goals and interventions identified in individualized treatment plans, these services stabilize level of function and crisis situations for members experiencing psychiatric conditions.

Partial hospitalization services must be billed using HCPCS Level II Code *H0035 – Mental Health, partial hospitalization, treatment less than 24 hours.*
Service Standards

• The service standard is met when the clinical supervisor is on-site at least twice weekly. The clinical supervisor of a partial hospitalization service must monitor services sufficiently to ensure familiarity with the population served and the population’s capabilities, the roles and abilities of the staff, and the characteristics of the services provided. The clinical supervisor oversees the clinical program and is not responsible for billing face-to-face services.

• The agency must provide an available on-call supervisor when the supervisor is off site.

• The service addresses diagnostic impressions requiring direct observation of function and interactions to develop an individualized treatment plan. Staff documents the need for individualized treatment in a goal-oriented structure designed to facilitate return to, or continuation of, family, community, education, or employment activities.

• Individualized treatment plans for members in partial hospitalization services include provisions for coordination of all services in the plan.

• The partial hospitalization staff records daily participation in the service. An attendance record is not sufficient to meet this requirement.

• A weekly review and update of progress occurs and is documented in the member’s medical record. Documentation includes dates of service, type of service, duration or length of session, and significant occurrences.

• The agency ensures availability of qualified staff to maintain adequate staff-to-member ratios, as outlined in the CMHC’s Clinical Plan for Professional Services or similar document.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

If a partial hospitalization day is interrupted by MRO services, such as special groups, these services are billed separately, and the time is subtracted from the partial hospitalization day.

Billable Activities

• Face-to-face contact in a group setting

• Partial hospitalization services integrated in treatment interventions that may include, but are not limited to, the following:
  – Group psychotherapy
  – Individual, group, or family counseling
  – Occupational therapy
  – Activity therapies
  – Clubhouse activities
  – ADL skills
  – Goal-oriented interventions
  – Creative expression therapies directed toward eliminating psychosocial barriers
H0040 HW – Assertive Community Treatment (ACT) Services

Definition

Assertive community treatment (ACT) means that a multidisciplinary team is responsible for the direct provision of community-based psychiatric treatment, assertive outreach, rehabilitation, and support services to an adult population with serious mental illness. This population served by ACT also has co-occurring problems or multiple hospitalizations and meets the criteria outlined in the Indiana Administrative Code (IAC). (Division of Mental Health and Addiction; 440 IAC 5.2-1-4; filed Sep 30, 2003, 9:50 a.m.: 27 IR 492)

Service Standards

Development of individual treatment plans is required. This includes administering and monitoring medication; monitoring self medication; crisis assessment and intervention; assessing and managing symptoms; individual supportive therapy; substance abuse training and counseling; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; and case management, consultation, and psycho-educational support for individuals and their families provided on behalf of the ACT consumer.

Services must be available 24 hours a day, seven days a week, with emergency response coverage, including availability of a psychiatrist. Consumers receiving ACT services must not attend traditional partial hospitalization programs.

To meet the service standard, the ACT team must meet daily during the work week and discuss services rendered, scheduled services, and progress of ACT consumers. ACT teams should have procedures in place to track daily team meeting attendance and client tracking (for example, cardex system, minutes, and so forth).

Billing and Reimbursement

Providers may submit claims for ACT services using the CMS-1500 paper claim or Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic 837P claim. Providers may bill the IHCP for one unit of ACT service daily per approved consumer, provided that the ACT team meets the ACT service standard. ACT services must be billed using Healthcare Common Procedure Coding System (HCPCS) level II code H0040 – ACT services, per diem.

One unit of ACT service equals one 24-hour day. The current reimbursement rate for H0040 is $70.30. The ACT team psychiatrist or a health services provider in psychology (HSPP) who is an ACT team member must be present at the daily team meeting for the service code to be reimbursed at 100 percent. Follow the billing and modifier guidelines described in IHCP Provider Manual Chapter 8, including billing at 75 percent of the allowed rate with the use of modifiers when the ACT team psychiatrist or HSPP is not in attendance at the daily team meeting.
H2011 HW – Crisis Intervention

**Definition**

Crisis intervention is delivered either face-to-face or by telephone, and helps members acquire services to stabilize a crisis. This may include collateral contacts with the family and other significant individuals to coordinate community service systems. This service must be available 24 hours a day, seven days a week.

Crisis intervention must be billed using HCPCS Level II Code H2011 – Crisis intervention service, per 15 minutes and modifier HW – Funded by state mental health agency.

**Service Standards**

This service is available to members for whom crisis intervention is an appropriate response. This service is provided consistent with the CMHC’s Clinical Plan for Professional Services or similar document. The consulting psychiatrist, physician, or HSPP must be available 24 hours a day, seven days a week. This service ensures that backup support for staff is always available during an intervention.

If the crisis intervention is because of a preexisting problem that has been addressed in the treatment plan, a physician, psychiatrist, or HSPP review is not required on the crisis intervention documentation. However, if the crisis intervention is for a new issue, a physician, psychiatrist, or HSPP review and revision of the treatment plan are required.

**Unit of Service**

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

Group therapy and partial hospitalization may be billed for the same day, when appropriate. Documentation should support that group therapy activities do not duplicate partial hospitalization activities. If activity occurs, the services must be subtracted from the partial hospitalization.

**Billable Activities**

- Coordinate community emergency service systems, such as hospital, fire, police, and ambulance
- Function as part of an integrated, comprehensive system of health, mental health, or other human services
- Provide assistance in acquiring all services necessary to stabilize the crisis, including obtaining consultation, locating other services and resources, and providing written and oral information to assist the patient with follow-up services
- Provide priority access to case management and prehospitalization screening
H2014 HW – Skills Training and Development, Individual
(Activities of Daily Living)

Definition

Individual training in ADL includes the development of skills, such as self-care, daily life management, or problem solving, that are directed toward eliminating psychosocial barriers. Development of these skills is provided through structured interventions for attaining goals identified in the individualized treatment plan.

Training in activities of daily living must be billed using HCPCS Level II Code H2014 – Skills training and development, per 15 minutes and modifier HW – Funded by state mental health agency.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

Billable Activities

• Individual face-to-face contact

Nonbillable Activities

• Skill-building activities not specifically related to the treatment plan
• Solely recreational or social activities

T1016 HW – Case Management

Definition

Case management services are goal-oriented activities that help members locate, coordinate, and monitor necessary care and services. The major components of service are essential to reducing disabilities resulting from the impairment of the person served. Backup support for this service should be available 24 hours a day, seven days a week. Services are provided on behalf of the client.

Case management services must be billed using HCPCS Level II Code T-1016 – Case Management and modifier HW – Funded by state mental health agency.

Service Standards

• Detailed case management service criteria for adults and children are provided in 405 IAC 5-20-8, 5-21-1, 5-25, 5-26-2 (1), 5-26-5 (1).
• The member is seriously mentally ill and seriously emotionally disturbed, or has a substance-related diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition rev., and subsequent revisions (DSM-IV). The diagnosis does not have to be primary. If the client was dually diagnosed, one axis would have a mental illness diagnosis, whether primary or
secondary. Case management services are reimbursable to dually diagnosed mentally retarded/developmentally disabled (MR/DD) and mentally ill (MI) clients.

- The CMHC’s Clinical Plan for Professional Services or similar clinical policy covers the provision and description of case management services.

- The individualized treatment plan addresses the provision of case management services. Centers may choose to have separate case management treatment plans or to include case management in members’ individualized master treatment plans. All treatment plans must adhere to the standards outlined in Section 2: Service Requirements.

- Composition and training of case management staff are sensitive to the cultural needs and characteristics of the local service area.

- Service may be provided either face-to-face or by telephone contact with the member or with a collateral contact person; however, the service must be provided on behalf of the member.

- Case management services are designed according to the needs of the person served.

- The provision of case management services cannot restrict a member’s free choice of providers. There are no restrictions on the freedom of a member’s choice of a provider, and there are no targeted case management restrictions on the member’s free choice of a provider for other IHCP services.

- Services are accessible to seriously mentally ill (SMI) adults, seriously emotionally disturbed (SED) youth, individuals with substance-related disorders, other significant members, and their families in their homes, schools, workplace, or wherever services are needed.

**Unit of Service**

One unit equals one-quarter hour (15 minutes). Because case management services often include tasks that require less than 15 minutes, for IHCP billing purposes, it is permissible to document the amount of time spent on each client during a 24-hour period and round up to the one-quarter hour.

**Billable Activities**

- Identification and outreach that integrate activities to ensure that the member is linked with the appropriate services and supports in the service system. Outreach activities may assist current IHCP members identified by the targeted case management program to access needed medical, social, and other services.

- Individual assessment after admission includes a comprehensive appraisal of basic needs, such as food, shelter, clothing, and entitlements. The comprehensive assessment also includes a review of specialized needs for treatment services, such as individual psychotherapy, medical consultation, rehabilitation, and other social services. In addition, the assessment identifies integrative service needs to determine the appropriate level of service intervention to meet such needs. The case manager coordinates the assessment and the results.

- Service planning activities ensure that the member’s service needs are translated from what is identified in the assessment to a plan of action for the member. An individual treatment plan identifies the skills and supports needed for the member to successfully participate in medical treatment and rehabilitative services. The case manager should encourage the member to participate in the development of the treatment plan. The case manager also coordinates treatment planning for the member.

- Implementation encompasses accessing, coordinating, and obtaining commitments for multiple services – for example, basic supports such as medical and health care, social services, community services, food stamps, energy assistance, legal services, psychosocial, recreational, crisis
intervention, and other services – to ensure the success of the individual treatment plan. The case manager helps members achieve their objectives and maximize their independence and productivity by providing training and making it easy for members to use community resources to attain treatment plan goals.

- Monitoring includes reviewing service delivery and member use through ongoing contact with members and providers. This ensures that services identified in the member’s treatment plan are delivered as specified. The case manager ensures that the member follows through on referrals, and agencies and providers follow through on plans and commitments to ensure that the member is not denied access to services. The member is allowed to evaluate the plan of care and progress made, and to modify the plan to ensure his or her success, as well as appropriate and efficient use of services.

- In reassessment, the case manager makes scheduled evaluations of the member’s situation and modifies the service plan based on the member’s continuing or changing needs. This includes continuation, alteration, or termination of the service plan.

- The case manager provides other services, within the definition of case management, to relieve the client’s symptoms and improve the client’s functioning.

- The case manager maintains relevant documentation and notes progress relevant to the member’s treatment plan. Documentation time is included in the billable time and is part of the unit of service.

- Case management services can be provided when IHCP membership is pending and, if approved, can be billed retroactively.

**Nonbillable Activities**

- Targeted case management cannot be used to restrict access to other services available under the plan.

- Case management services cannot be provided as a means for enrollment in the IHCP.

- Case management services cannot be reimbursed for vocational or job-skill activities, such as job coaching or job development.

- Case management services cannot be reimbursed for activities that are purely recreational or social.

- Interpreter service is not billable.

**T1016 HW TG – Case Management, Second Case Manager**

**Definition**

When an MRO case manager prepares to make a face-to-face client or collateral contact and feels that an unstable situation requires an additional case manager to attend, the primary case manager or backup must contact the supervising qualified mental health professional (QMHP) to receive authorization for an additional case manager.

MRO case management – second case manager must be billed using HCPCS Level II Code T1016 – Case management and modifiers HW – Funded by state mental health agency and TG – Complex/high-tech level of care.
Service Standards

If the supervising QMHP is not available, another QMHP employed by the community mental health center (CMHC) can be contacted for authorization to provide services. If the primary case manager is a QMHP, authorization is not required. In an emergency situation, the QMHP can provide authorization after the contact is made. In either case, the QMHP must document the authorization on the progress note.

Unit of Service

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

On approval from the supervising QMHP, the CMHC may bill IHCP for the second case manager at one-half of the full case manager rate.

The primary case manager units must be billed with code T1016 and modifiers HW and TG, as usual. The progress note must include a brief narrative outlining the second case manager’s attendance and assistance. The primary and secondary case manager services are exempt from Medicare Part B and all other TPL edits.

Billable Activities

A second case manager is billable only at the request of the primary case manager and with the approval of the QMHP.

97535 HW HQ – Self-Care/Home Management Training, in Group Setting and 97357 HW HQ – Community/Work Reintegration Training (Activities of Daily Living)

Definition

Group training in ADL includes the development of skills, such as self-care, daily life management, and problem solving, which are directed toward eliminating psychosocial barriers. Development of these skills is provided through structured interventions for attaining goals identified in the individualized treatment plan.

Reminder  The guidelines regarding vocational rehabilitation have not changed and should not be billed to the MRO Program.

For training in activities of daily living, groups must be billed using HCPCS Level II Code 97535 – Self care/home management training and modifiers HQ – Group setting and HW – Funded by state mental health agency, or code 97537 – Community/work reintegration training (e.g. shopping, transportation, money management) and modifiers HQ – Group setting and HW – Funded by state mental health agency.
**Unit of Service**

One unit equals one-quarter hour (15 minutes). Units of service do not have to be consecutive to be billed. Actual time per day should be totaled and then may be rounded up to the quarter-hour.

Group ADL and partial hospitalization may be billed for the same day, when appropriate. Documentation should support that the group activities do not duplicate partial hospitalization activities. If ADL occurs, these services must be subtracted from the partial hospitalization.

**Billable Activities**

- Face-to-face contact in a group setting

**Nonbillable Activities**

- Skill-building activities not specifically related to the treatment plan
- Solely recreational or social activities
Index

9

97535 ......................................................... 4-13
97537 ......................................................... 4-13

A

ACT Services .............................................. 4-8
Addresses and telephone numbers............... 3-6
Mailing .................................................... 3-6
Assertive Community Treatment (ACT)
Services ................................................... 4-8

B

Behavioral Health Counseling and Therapy,
Family with Client Present and H0004 HW
HS Behavioral Health Counseling and
Therapy, Family without Client Present.. 4-2
Definition ................................................ 4-2
Nonbillable activities............................... 4-3
Service standards..................................... 4-3
Unit of service ......................................... 4-3
Behavioral Health Counseling and Therapy, in
Group Setting .......................................... 4-3
Definition ................................................ 4-3
Nonbillable activities............................... 4-4
Service standards..................................... 4-3
Unit of service ......................................... 4-3
Behavioral Health Counseling and Therapy,
Individual ................................................ 4-1
Definition ................................................ 4-1
Nonbillable activities............................... 4-2
Service standards..................................... 4-2
Unit of service ......................................... 4-2
Behavioral health counseling and therapy, per
15 minutes ............................................. 4-2, 4-3
Billing requirements ................................. 3-1

C

Case management........................................ 4-12
Case Management Services ......................... 4-10
Billable activities..................................... 4-11
Definition ................................................ 4-10
Nonbillable activities............................... 4-12
Service standards..................................... 4-10
Unit of service ......................................... 4-11
Claim format ............................................ 3-6
CMS-1500 ................................................... 3-1
Community Mental Health Rehabilitation
Option Services ......................................... 2-1
Community Mental Health Rehabilitation
Services Program................................. 1-1

Community/work reintegration training (e.g.
shopping, transportation, money
management) .............................................. 4-13
cost avoidance .......................................... 3-2
Crisis Intervention........................................ 4-9
Billable activities..................................... 4-9
Definition ................................................ 4-9
Service standards..................................... 4-9
Unit of service ......................................... 4-9
Crisis intervention service, per 15 minutes 4-9

G

General billing information ......................... 3-4

H

H0004 ................................................... 4-2, 4-3
H0031 .......................................................... 4-4
H0033 .......................................................... 4-5
H0035 ........................................................ 4-10
H0035 .......................................................... 4-6
H2011 .......................................................... 4-9
H2014 ........................................................ 4-10
Hoosier Healthwise Package C ................... 2-1

I

Introduction ................................................. 1-1

M

Managed care considerations......................... 3-4
Medicaid Rehabilitation Option (MRO) .... 1-1
Mental Health Assessment, by Nonphysician
Nonbillable activities .............................. 4-5
Mental Health Assessment, by Non-Physician
Billable activities ..................................... 4-4
Definition ................................................ 4-4
Unit of service ......................................... 4-4
Mental Health Rehabilitation ....................... 1-1
Mental Health, partial hospitalization,
treatment less than 24 hours .................... 4-10
Mental Health, partial hospitalization,
treatment less than 24 hours .................... 4-6
Mental Health, Partial Hospitalization,
Treatment, Less than 24 Hours ............... 4-6
Mental Health, Partial Hospitalization,
Treatment, Less Than 24 Hours
Billable activities..................................... 4-7
Definition ................................................ 4-6
Service standards..................................... 4-7
Unit of service ......................................... 4-7
Modifiers ..................................................... 3-2
MRO Case Management – Second Case
   Manager.................................................4-12
   Billable activities...................................4-13
   Definition ..........................................4-12
   Service standards..................................4-13
   Unit of service ......................................4-13
MRO Exceptions.........................................1-1
MRO place of service code options.............3-6
MRO requirements......................................1-1
MRO Services performed by CWROs............1-1

O
   Oral medication administration, direct
      observation ........................................4-5
   Oral Medication Administration, Direct
      Observation, with Individual and H0033
      HW HQ – Oral Medication Administration,
      Direct Observation, with a Group in a
      Group Setting .....................................4-5
   Oral Medication Administration, Direct
      Observation, with Individual and H0033
      HW HQ – Oral Medication Administration,
      Direct Observation, with a Group In a
      Group Setting .....................................4-5
   Billable activities..................................4-6
   Definition ..........................................4-5
   Nonbillable activities ............................4-6
   Service standards..................................4-5
   Unit of service ......................................4-5
Outpatient mental health services
   Reimbursement.......................................2-1

P
   Partial hospitalization..............................3-4
   Physician .............................................2-2
   Place of service codes..............................3-6
   Prior authorization status..........................3-5
   Procedure codes.....................................4-1
   Provider qualifications .............................2-2
   Psychiatrist .........................................2-2
   Psychologist ........................................2-2

Q
   Qualified mental health professional ...........2-2

R
   Reimbursement for MRO services..............2-1
   Reimbursement procedures ......................3-1
   Reimbursement to Midlevel Practitioners –
      Psychiatric Residential Treatment Facility3-2

S
   Self care/home management training ..........4-13
   Service requirements .............................2-1
   Skills training and development, per 15
      minutes ..........................................4-10
   Supervising physician ............................2-3
   Supervision ........................................2-3

T
   T1016 ...................................................4-12
   Third-Party Liability
      Requirements .....................................3-2
   TPL billing instructions ...........................3-4
   TPL Cost Avoidance Requirements by Code3-3
   Training in Activities of Daily Living, Group
      ....................................................4-13
      Billable activities ................................4-14
      Definition .......................................4-13
      Nonbillable activities ...........................4-14
      Unit of service ...................................4-14
   Training in Activities of Daily Living,
      Individual .........................................4-10
      Billable activities ................................4-10
      Definition .......................................4-10
      Nonbillable activities ...........................4-10
      Unit of service ...................................4-10
   Treatment plan .....................................2-2

W
   Waiver services .....................................2-3