Mental Health Updates
Presented by
EDS Provider Field Consultants
Agenda

- Session Objectives
- Outpatient Mental Health
- Medicaid Rehabilitation Option (MRO)
- Somatic Treatment
- Assertive Community Treatment (ACT)
- Psychiatric Residential Treatment Facilities (PRTF)
- Risk-Based Managed Care
- Helpful Tools
- Questions
Objectives

At the end of this session, providers will:

- Understand outpatient coverage requirements
- Understand the meaning of rolling 12-month period
- Understand the role of the health service provider in psychology (HSPP)
- Understand services covered under:
  - Medicaid Rehabilitation Option
  - Assertive Community Treatment
  - Psychiatric Residential Treatment Facility
- Understand the impact of the managed care carve-in
Outpatient Mental Health

- The Indiana Health Coverage Programs (IHCP) reimburses for outpatient mental health services provided by:
  - Licensed physicians
  - Psychiatric hospitals
  - Psychiatric wings of acute care hospitals
  - Outpatient mental health facilities
  - Licensed psychologists with the HSPP designation
Outpatient Mental Health

• The IHCP also reimburses for psychiatrist or HSPP-directed outpatient mental health services when provided by mid-level practitioners:
  – ACSW, CCSW, LCSW, MSW
  – Advanced practice nurses, credentialed in psychiatric or mental health nursing
  – Licensed psychologist
  – Licensed independent practice school psychologist
  – Licensed marriage and family therapist
  – Licensed mental health counselor
  – Psychologist with basic certificate
  – Registered nurse (RN) with master’s degree in nursing with major in psychiatric and mental health nursing

• **Mid-level practitioners are not enrolled by the IHCP**
Outpatient Mental Health
Psychiatrist or HSPP Requirements

- Psychiatrist or HSPP responsibilities:
  - Must certify the diagnosis and supervise the plan of treatment
  - Must see the patient or review information obtained by mid-level 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
  - 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 expect to result in (1) danger to the individual, (2) danger to others, or (3) death of the individual
Outpatient Mental Health
Rolling 12-Month Period

• **Is not:**
  – Based on a 12-month calendar year
  – Based on a fiscal year
  – Renewable on January 1 of each year

• **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
Outpatient Mental Health
PA Requirements

• Prior authorization (PA) is required for units in excess of 20 per member, per provider, per rolling 12-month period:
  – Codes subject to limitation
    • 90801 through 90802
    • 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
  – Managed care organizations may have different PA requirements
Outpatient Mental Health
PA Requirements

• Package C members are allowed 30 units per member, per rolling 12-month period. The IHCP may cover an additional 20 units with PA, for a maximum of 50 units per year.

• PA is always required for neuropsychological and psychological testing
  – 96101 – Psychological Testing
  – 96110 – Developmental Testing
  – 96111 – Developmental Testing – Extended
  – 96118 – Neuropsychological Testing Battery

These services must always be performed by a psychiatrist or HSPP.
Outpatient Mental Health
PA Requirements

- One unit of psychiatric diagnostic interview (90801) is allowed per member, per provider, per rolling 12-month period
- Additional units require PA
- Exception: Two units are allowed without PA if a separate evaluation is performed by both a psychiatrist or HSPP and a mid-level practitioner
Outpatient Mental Health-Prior Authorization

• **Through October 31, 2007**, mail PA requests to:
  Health Care Excel Prior Authorization Department
  P. O. Box 531520
  Indianapolis, IN  46253-1520

• Obtain emergency PA by calling the HCE Prior Authorization Department at (317)347-4511 or (800) 457-4518.

• **On and after 11-1-07**, mail PA requests to:
  ADVANTAGE Health Plan-FFS
  P.O. Box 40789
  Indianapolis, Indiana 46240

• Or call 1-800-269-5720

• For RBMC members, contact the appropriate MCO
Outpatient Mental Health
Non-Covered Services

- The IHCP does not cover
  - Biofeedback
  - Broken or missed appointments
  - Day care
  - Hypnosis
  - Partial hospitalization (except as set forth in 405 IAC 5-21)
  - **Medical** services by mid-level practitioners
    - 90805
    - 90807
    - 90809
    - 90811
    - 90813
    - 90815
    - 90862
Outpatient Mental Health
Billing Overview

• Services are billed on the CMS-1500 (08/05) claim form
• Services are billed using the Legacy Provider Identifier (LPI) and/or National Provider Identifier (NPI) of the facility or clinic, and the rendering LPI and/or 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 allowed amount
Outpatient 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 and RN – Masters degree in nursing with major in psychiatric and mental health nursing
  – HE – Any other mid-level practitioner
  – SA – Nurse practitioner or clinical nursing specialist (CNS) in a non-mental health arena

• Refer to IHCP provider bulletin BT200603 for recommended internal audit guidelines
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 community mental health centers (CMHCs)
- 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 may include attention in member’s home, workplace, mental health facility, or wherever needed
- Services must be rendered by a qualified mental health professional (QMHP)
- MRO is not covered for Package C members
- Services must be reported with an HW modifier
  - Also report modifiers to identify specialty of the mid-level practitioner
Medicaid Rehabilitation Option

• Covered MRO procedure codes:
  – 97535   Self Care/Home Management Training
  – 97537   Community Work Reintegration
  – H0002   Behavioral Health Screening
  – H0004   Behavioral Health Counseling
  – H0031   Mental Health Assessment (non-physician)
  – H0033   Oral Medication Administration
  – H0035   Partial Hospitalization
  – H0040   ACT Program
  – H2011   Crisis Intervention
  – H2014   Skills Training Development
  – T1016   Case Management

  • Add the appropriate modifier(s): HW, HQ, HR, HS, and TG
Somatic Treatment

- CMHCs report procedure code H0033 with the HW modifier for somatic treatment
- Report additional modifiers for mid-level practitioners
Assertive Community Treatment

• Assertive Community Treatment (ACT) services are coordinated by an interdisciplinary team (ACT Team) responsible for the direct provision of:
  – Community-based psychiatric treatment
  – Assertive outreach
  – Rehabilitation
  – Support services

• Intensive mental health services for consumers with serious mental illness with co-occurring problems or multiple hospitalizations

• Member’s level of functioning must be low or moderate as defined by the Division of Mental Health and Addiction

• PA is established by the team psychiatrist/HSPP

• Services must be available 24 hours a day, seven days a week, with emergency response coverage
Assertive Community Treatment

- Reimbursement is based on a per diem for procedure code H0040 HW
- Reimbursement is at 75 percent if the ACT team psychiatrist or HSPP is not in attendance at daily team meeting (see IHCP banner page BR200420 for more information)
- Billing on CMS-1500 (08/05)
- ACT remains carved-out of RBMC
Psychiatric Residential Treatment Facilities

• What is a psychiatric residential treatment facility (PRTF)?
  – A facility licensed as a private secure care institution under 470 IAC 3-13
  – A facility accredited by one of the following:
    • The Joint Commission on Accreditation of Healthcare Organizations
    • The Council on Accreditation of Services for Families and Children
Psychiatric Residential Treatment Facilities

- The IHCP reimburses for services provided to children younger than 21 years of age
- All PRTF services require PA
- PRTF services remain carved-out of RBMC
  - The MCO retains responsibility for services outside the PRTF, including transportation, pharmacy, and other related healthcare services
- PRTF services are not covered for Hoosier Healthwise Package C members
Psychiatric Residential Treatment Facilities

- PRTF services are billed on the CMS-1500 (08/05) claim form using the following procedure codes:
  - T2048 – Per Diem
  - T2048 U1 – Medical Leave
  - T2048 U2 – Therapeutic Leave
- One unit equals a 24-hour day of care (midnight to midnight)
- PRTF services are reimbursed on a per diem, which includes:
  - All IHCP-covered psychiatric services performed in a PRTF
  - All IHCP-covered services not related to the psychiatric condition that are performed at the PRTF
Psychiatric Residential Treatment Facilities

- The PRTF per diem **does not** include:
  - Pharmaceutical supplies
  - Non-psychiatric physician services **not** available at the PRTF and performed at another location

- Medical leave days ordered by a physician are reimbursed at 50 percent, for as many as four days per admission, unless the occupancy rate is less than 90 percent

- Therapeutic leave days ordered by a physician are reimbursed at 50 percent, for as many as 14 days per calendar year, unless the occupancy rate is less than 90 percent
Risk-Based Managed Care

- Effective January 1, 2007, outpatient mental health services are carved-in to the RBMC delivery system
Risk-Based Managed Care

• Services provided to RBMC members by the following specialty types are the responsibility of the MCOs, effective January 1, 2007:
  – 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

- Services that are the MCO’s responsibility:
  - Office visits with a mental health diagnosis
  - Services ordered by a provider enrolled in a mental health specialty, but provided by a non-mental 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

- **MCOs**
  - Anthem [www.anthem.com](http://www.anthem.com)
  - Managed Health Services (MHS) [www.managedhealthservices.com](http://www.managedhealthservices.com)
  - MDwise [www.mdwise.org](http://www.mdwise.org)

- **Behavioral Health Organizations (BHO)**
  - Magellan (Anthem) [www.magellanhealth.com](http://www.magellanhealth.com)
  - Cenpatico (MHS) [www.cenpatico.com](http://www.cenpatico.com)
  - Comp Care (MDwise) [www.compcare.com](http://www.compcare.com)
Risk-Based Managed Care

• The MCO or BHO may have different rules for PA, timely filing limits, claims processing, and so forth

• MCO or BHO and EDS must honor PAs approved by the original payor for a period of 30 days following a change from the originating entity to the receiving entity

• Providers should verify eligibility before providing service
Modifications to Duplicate Logic

• IndianaAIM now reads all five digits of the procedure code and all modifiers

• Applicable to claims and replacement claims received on or after September 27, 2007

• Applicable to the following claim types:
  – Medical
  – Medical Crossover Part B
  – Outpatient
  – Outpatient Crossover C
  – Home Health

• Effective August 1, 2007:
  – Crossover claims billed on a CMS-1500 claim form no longer deny with edits 5007 (exact duplicate, header), or 5008 (suspect duplicate, header)
  – These claims now emulate the possible, and exact duplicate logic applied to medical claims, which apply the 5000 (possible duplicate), and 5001 (exact duplicate) edits
Modifications to Duplicate Logic

Example 1:

10/25/07   H0033 HW AH
10/25/07   H0033 HW HE

Example 2:

10/26/07   H0044 HW HQ AH
10/26/07   H0044 HW HQ HE

The second detail line will no longer deny as a duplicate to the first detail line
Helpful Tools
Avenues of Resolution

- IHCP Web site at www.indianamedicaid.com
- IHCP Provider Manual (Web, CD-ROM, or paper)
- MRO Provider Manual
- Customer Assistance
- Written Correspondence
- Provider Field Consultant
Questions