Mental Health

HP Provider Relations/October 2014
Agenda

- Objectives
- Outpatient Mental Health
- Inpatient Mental Health
- Eligibility and Aid Categories
- Prior Authorization
- Medicaid Rehabilitation Option (MRO)
- 1915 (i) Programs
- Psychiatric Residential Treatment Facilities (PRTF)
- Partial Hospitalization
- Risk-Based Managed Care (RBMC)
- Top-10 Denials for Mental Health
- Helpful Tools and Q&A
Objectives

At the end of this session, providers should:

• Have a thorough understanding of who can provide mental health services, what services are covered, and how they should be billed

• Understand the responsibilities of physicians, health service providers in psychology (HSPPs), and midlevel practitioners

• Have a basic understanding of MRO, 1915(i), PRTF, and Partial Hospitalization programs

• Understand prior authorization requirements

• Know the top-10 claim denial codes for mental health providers

• Understand risk-based managed care implications
Outpatient Mental Health
Outpatient Mental Health

Providers

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

Physician/HSPP-directed services

- The IHCP also reimburses under 405 IAC 5-20-8 for physician or HSPP-directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one of the following midlevel practitioners:
  - Licensed independent practice school psychologist
  - Licensed clinical social worker (LCSW)
  - Licensed marital and family therapist (LMFT)
  - Licensed mental health counselor (LMHC)
  - A person holding a master's degree in social work, marital and family therapy, or mental health counseling
  - Advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing
Outpatient Mental Health

Midlevel practitioners

• Midlevel practitioners may not be separately enrolled as individual providers to receive direct reimbursement
• Midlevel practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP
• Covered services rendered by midlevel practitioners must be billed using the rendering National Provider Identifier (NPI) of the supervising practitioner and the billing NPI of the outpatient mental health clinic or facility
Outpatient Mental Health

Physician/HSPP responsibilities

• Must certify the diagnosis and supervise the plan of treatment as stated in 405 IAC 5-20-8 (3) (A) (B)

• Must see the patient or review information obtained by a midlevel practitioner within seven days of the initial assessment

• Must see the patient or review documentation to certify treatment plan and specific modalities at intervals not to exceed 90 days

• Must document and personally sign all reviews
  - No cosignatures on documentation

• Must be available for emergencies
  - An emergency is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) danger to the individual, (2) danger to others, or (3) death of the individual
Outpatient Mental Health

Covered services

• One unit of psychiatric diagnostic evaluation (90791 and 90792) is allowed per member, per provider, per rolling 12-month period per 405 IAC 5-20-8 (14)
  - Additional units require prior authorization
  - Exception: Two units are allowed without prior authorization (PA) if separate evaluations are performed by a psychiatrist or HSPP and a midlevel practitioner

• Neuropsychological and psychological testing
  - 96101, 96110, 96111, 96118
    ➢ A physician or HSPP must provide these services
    ➢ Always require prior authorization
  - 96102, 96119
    ➢ May be rendered by a midlevel practitioner under supervision of physician/HSPP
    ➢ Always require prior authorization
Outpatient Mental Health

Services

• The following codes, in any combination, are subject to 20 units per member, per provider, per rolling 12-month period:
  - 90785, 90791, 90792, 90801-90815, 90832, 90833, 90834, 90837, 90838, 90839, 90840, 90846-90857, 90899, 96151, 96152, 96153, 96154, 96155, 96567

• Additional units will require prior authorization
  - Once a PA is required for services, it will continue to be required until at least one year from the last date of service has passed and the member is considered a new patient
Outpatient Mental Health

What is a rolling 12-month period?

• A rolling 12-month period is:
  – Based on the first date that services are rendered by a particular provider
  – Renewable one unit at a time beginning 365 days after the first date of service
  – If a prior authorization is used for additional units, a new rolling 12-month period will begin 365 days after the last date of service is rendered by a particular provider

• A 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
Outpatient Mental Health

Billing overview

• Clinic services are billed on the 837P or the CMS-1500 paper claim form
• Services are billed using:
  – NPI of the facility or clinic
  – Rendering NPI of the supervising psychiatrist or HSPP
• Medical records must document the services and the length of time of each therapy session
• Physicians and HSPPs are reimbursed at 100% of the allowed amount
• Midlevel practitioners are reimbursed at 75% of the allowed amount
  – Services rendered by midlevel practitioners are billed using the rendering NPI of the HSPP or physician
Outpatient Mental Health
Billing overview

• Appropriate modifiers must be used for midlevel practitioners
  - AH – Clinical psychologist
  - AJ – Clinical social worker
  - HE and SA – Nurse practitioner or nurse specialist
  - HE – Any other midlevel practitioner as addressed in the 405 IAC 5-20-8, including master's degree
Outpatient Mental Health
Billing overview

• Procedure codes billed with midlevel modifier HE for dually eligible Medicare/Medicaid members may use “claim notes” to indicate the provider has performed a service that is not approved to bill to Medicare
• This option is not available for other commercial insurance plans
  – Claims submitted using claim notes on each detail line must indicate in the claim notes on the 837P the following text: “Provider not approved to bill services to Medicare”
  – The use of claim notes allows the claim to suspend for review of the claim note and be adjudicated appropriately
Outpatient Mental Health – Claim Notes

Professional Claim

Billing Information
- NPI
- Legacy Provider ID
- Member ID
- Last Name
- First Name
- Rendering Provider
- Rendering NPI
- Referring Provider
- Referring NPI
- Signature Indicator
- Medical Record #

Service Information
- Claim Type
- Place of Service

Claim Note Information

Header Notes
Note Reference Code
Note Text
ADD

https://interchange.indianamedicaid.com/Claims/Supplemental.aspx?SuppType=Claim N
Outpatient Mental Health – Revenue Code 513

• Billing requirements for therapy services rendered in an **outpatient facility** and billed on the *UB-04* claim form (facility use)

• Individual, group, and family therapy counseling procedure codes should be billed using Revenue Code 513 – *Clinic Psychiatric*

• Outpatient claims for individual, group, or family therapy cannot be billed with revenue codes 500, 510, 90X, 91X, and 96X

• Providers must bill all professional services associated with outpatient mental health services on the *CMS-1500* claim form
Outpatient Mental Health – Revenue Code 513

• The IHCP clarified billing requirements for mental health therapy services rendered in outpatient facilities and billed on the UB-04 claim form under the fee-for-service delivery system

• Outpatient claims for mental health therapy must be billed using revenue code 513

• Individual therapy codes will be reimbursed at the lesser of the billed amount or a statewide flat fee of $40.80 per member, per session

• Family and group therapy codes will be reimbursed the lesser of the billed amount or a statewide flat fee of $20.40 per member, per session

• Providers will be reimbursed up to two individual sessions and one group session on the same date of service
### Revenue Code 513 – Acceptable Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791 (Individual)</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792 (Individual)</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832 (Individual)</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90833 (Individual)</td>
<td>Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90834 (Individual)</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90836 (Individual)</td>
<td>Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837 (Individual)</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90838 (Individual)</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90845 (Individual)</td>
<td>Medical psychoanalysis</td>
</tr>
<tr>
<td>90846 (Group)</td>
<td>Family psychotherapy (without the patient present)</td>
</tr>
<tr>
<td>90847 (Group)</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
</tr>
<tr>
<td>90849 (Group)</td>
<td>Multi-family group psychotherapy</td>
</tr>
<tr>
<td>90853 (Group)</td>
<td>Group psychotherapy (other than of a multi-family group)</td>
</tr>
<tr>
<td>90857 (Group)</td>
<td>Interactive group psychotherapy</td>
</tr>
</tbody>
</table>
Outpatient Mental Health – Pricing Change

• Effective for dates of service July 1, 2014, and thereafter, the IHCP adopted relative value units (RVUs) for the following CPT codes:
  – 90839 – *Psychotherapy for crisis; first 60 minutes* ($102.59)
  – 90840 – *Psychotherapy for crisis; each additional 30 minutes* ($49.16)

• Prior to July 1, 2014, these codes were manually priced at 90% of the provider’s charge
Inpatient Mental Health
Inpatient Mental Health

- Prior authorization is required for all inpatient psychiatric admissions, including substance abuse admissions – 405 IAC-50-20-1(d)
- The IHCP reimburses inpatient psychiatric services for recipients between 22 and 65 years old only in certified psychiatric hospitals with 16 beds or less
- Inpatient psychiatric services may be provided by freestanding psychiatric facilities or distinct parts of acute care facilities
- Reimbursement is at an all-inclusive statewide Level of Care (LOC) per diem, which includes routine and ancillary costs
  - In addition to the LOC per diem, there is reimbursement for capital cost (and medical education and outliers, if applicable)
- Direct care physician services are excluded from the LOC per diem and are billable separately on a CMS-1500 claim form
Inpatient Mental Health

- Freestanding psychiatric facilities are eligible for the Hospital Assessment Fee (HAF) payments
  - The HAF adjustment factor is 2.2 (multiplied by the LOC per diem)
- Diagnosis-related groups (DRGs) 424 through 432 are considered psychiatric and, therefore, are reimbursed on the LOC per diem
  - DRG 429 excludes diagnosis codes 317XX to 319XX
- All mental health admissions, including substance abuse and chemical dependency, require a Certificate of Need, Form 1261A
- See IHCP Provider Manual, Chapter 6, Section 4 for detailed prior authorization requirements
Eligibility and Aid Categories
2014 Medicaid Eligibility Changes

• Effective June 1, 2014, Indiana made significant changes in eligibility requirements
• Changes affect current beneficiaries and future applicants for Indiana Medicaid in the aged, blind, and disabled categories
• Indiana changed from a “209(b)” to a “1634” state
• 1634 transition results:
  – Significant net savings to Indiana
  – Eliminated spend-down program
  – More members receive more comprehensive coverage
• For detailed information, see the FSSA website
  – https://secure.in.gov/fssa/4859.htm
Verifying Eligibility

• The 1634 transition makes it even more critically important to verify eligibility each time you provide service
  – Call the Automated Voice Response (AVR) system at 1-800-577-1278, Option 4
  – Web interChange
  – Omni system has been discontinued
• Be sure to know which aid categories cover mental health services
Web interChange - Eligibility Inquiry

Eligibility Inquiry

Query Information

Search For: NPI ☐ Legacy Provider ID

NPI Taxonomy Code Postal Code

Search Criteria: By Member ID

Member ID

From Date 04/01/2014 To Date 04/01/2014

Eligibility Information

Member is Eligible from 04/01/2014 to 04/01/2014 for PACKAGE A STANDARD PLAN

Inquiry completed at 2:42:00 PM on 7/1/2014

Member Name

Address

Date of Birth 09/03/2011

Spendingdown/HCBS Waiver Liability No

Medicare No

Nursing Home Resident No

Restricted No

QMB No

Other Private Insurance No

Spendingdown/HCBS Waiver Liability

Managed Care Information

None

None

Medicare Number

Patient Liability
Aid Categories Covering Mental Health Services

• Package A Standard Plan
  – Former Foster Children
  – Pregnancy
  – Parent Caretaker
  – Hospital Presumptive Eligibility (HPE) Infant
  – HPE Children
  – HPE Parent Caretaker
  – HPE Former Foster Children
  – Supplemental Security Income
• Package C – Children’s Health Insurance Plan (CHIP)
• Package H – Healthy Indiana Plan
• QMB-Also
Aid Categories Not Covering Mental Health Services

• Package E – Emergency Services (mental health would be covered if it is an emergency)

• Package P – Pregnancy
  – PEPW – Presumptive Eligibility for Pregnant Women
  – HPE – Hospital Presumptive Eligibility Pregnant Women

• Family Planning
  – HPE Family Planning

• Medicare Coinsurance Deductible Only (QMB-Only); will only cover coinsurance and deductible on services covered by Medicare
Mental Health – Prior Authorization
Outpatient Mental Health

Prior Authorization

• Requests for PA should include a current plan of treatment and progress notes to support the effectiveness of therapy

• The universal *IHCP Prior Authorization Request Form* should be submitted for fee-for-service requests
  – Write “Behavioral Health” at the top of the request
  – Available on the [Forms](#) page at indianamedicaid.com

• See *IHCP Provider Manual Chapter 6* for prior authorization guidelines and instructions
  – Managed care entities (MCEs) and Healthy Indiana Plan (HIP) have different PA requirements and forms; providers are encouraged to contact each MCE for PA processes
Outpatient Mental Health

Prior Authorization

- Members can change between Traditional Medicaid fee-for-service, Hoosier Healthwise, and Care Select
- The receiving organization must honor PAs approved by the prior organization for the first 30 days following the reassignment or for the remainder of the PA dates of service, whichever comes first
### Indiana Health Coverage Programs

#### Prior Authorization Request Form

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantedge</td>
<td>800-269-5726</td>
</tr>
<tr>
<td>Anthem Hoosier</td>
<td>866-406-7167</td>
</tr>
<tr>
<td>Hoosier Healthwise</td>
<td>800-291-4140</td>
</tr>
<tr>
<td>MDwise Hoosier</td>
<td>See <a href="http://www.mdwise.org">www.mdwise.org</a></td>
</tr>
<tr>
<td>MHS Hoosier</td>
<td>877-647-4548</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Healthy Indiana Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Anthem HIP</td>
<td>866-395-1922</td>
</tr>
<tr>
<td>MDwise HIP</td>
<td>See <a href="http://www.mdwise.org">www.mdwise.org</a></td>
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<td>MHS HIP</td>
<td>877-647-4548</td>
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<table>
<thead>
<tr>
<th>Care Select</th>
<th>Care Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantedge and MDwise</td>
<td>800-784-3981</td>
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</table>

#### Please complete all appropriate fields.

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Requesting Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID/RID #:</td>
<td>Requesting Provider NPI #:</td>
</tr>
<tr>
<td>DOB:</td>
<td>Tax ID #:</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>Service Location Code:</td>
</tr>
<tr>
<td>Address:</td>
<td>Provider Name:</td>
</tr>
<tr>
<td>City/State/ZIP Code:</td>
<td>Rendering Provider Information</td>
</tr>
<tr>
<td>Patient/Guardian Phone:</td>
<td>Rendering Provider NPI #:</td>
</tr>
<tr>
<td>PNP Name:</td>
<td>Tax ID #:</td>
</tr>
<tr>
<td>PNP NPI:</td>
<td>Name:</td>
</tr>
<tr>
<td>PNP Phone:</td>
<td>Address:</td>
</tr>
</tbody>
</table>
Prior Authorization Form
Outpatient Mental Health Prior Authorization

• Mail or fax PA requests to:
  - ADVANTAGE Health Solutions<sup>SM</sup>-FFS
    ATTN: Prior Authorization Dept.
    P.O. Box 40789
    Indianapolis, IN 46240
  - Fax number: 1-800-689-2759

• For questions or inquiries, call 1-800-269-5720
• For RBMC members, contact the appropriate MCE
PA for “Brand Medically Necessary” Mental Health Drug Prescriptions

• PA is required for a prescriber’s specification of “brand medically necessary” for a mental health drug
  – Mental health drugs consist of antidepressants, antipsychotics, anxiolytics, and cross-indicated drugs as defined in Indiana statute
  – Pharmacy claims cannot be paid without the required prior authorization

• Pharmacy benefit PA can be obtained by contacting Catamaran
  – 1-855-577-6317 toll-free telephone number
  – 1-855-577-6384 fax number
PA for “Brand Medically Necessary” Mental Health Drug Prescriptions

• Pharmacy Benefit PA forms are located under the Pharmacy Services quick link at indianamedicaid.com

• Pharmacy providers should follow the “emergency supply” procedures for instances in which a PA cannot be immediately obtained
  - See Indiana Health Coverage Program Provider Manual, Chapter 9, Section 7
Community Mental Health Rehabilitation Services Program: Medicaid Rehabilitation Option - MRO
Medicaid Rehabilitation Option (MRO)

- The Family and Social Services Administration’s (FSSA) Division of Mental Health and Addiction (DMHA) developed a benefit plan structure for Medicaid members receiving MRO services.
- MRO services are designed to assist in the rehabilitation of the member’s optimum functional ability in daily living activities.
- Rehabilitation of optimum functional ability is accomplished by assessing the consumer’s needs and strengths and developing an individualized plan of care.
- MRO services can only be provided by DMHA approved community mental health centers (CMHCs).
MRO Provider Qualifications

• Three predominant categories of providers may provide MRO services
  – Licensed professional
  – Qualified behavioral health professional (QBHP)
  – Other behavioral health professional (OBHP)
MRO Diagnosis and Level of Need

- All Medicaid consumers who have a behavioral health need are eligible for “Clinic Option” services
- Only consumers with a qualifying diagnosis and level of need (LON) are eligible for a MRO service package
- The qualifying LON, is determined by DMHA-approved assessment tools
  - Child and Adolescent Needs and Strengths (CANS)
    - LON of 2 or higher eligible for MRO service package
  - Adult Needs and Strengths Assessment (ANSA)
    - LON of 3 or higher eligible for MRO service package
MRO Covered Services

• The following services are covered:
  - Behavioral Health Counseling and Therapy (Individual and Group setting)
  - Behavioral Health Level of Need Redetermination
  - Case Management
  - Psychiatric Assessment and Intervention
  - Adult Intensive Rehabilitative Services (AIRS)
  - Child and Adolescent Intensive Resiliency Services (CAIRS)
  - Intensive Outpatient Treatment (IOT)
  - Addiction Counseling (Individual and Group setting)
  - Peer Recovery Services
  - Skills Training and Development (Individual and Group setting)
  - Medication Training and Support (Individual and Group setting)
  - Crisis Intervention
MRO Service Packages

- The MRO service package comprises units of MRO services that match the needs of a majority of MRO consumers

  Example – Adult LON 3
  - Individual Counseling and Therapy  32 units
  - Group Counseling and Therapy  48 units
  - Medication Training and Support  60 units
  - Skills Training and Development  600 units
  - Peer Recovery Services  104 units
  - Addiction counseling  32 hours

- If no qualifying diagnosis or LON, but has a significant behavioral health need that requires medically necessary MRO services, a prior authorization may be submitted for MRO services

- MRO service package needs additional units of service or a service not included in the package, prior authorization may be submitted
MRO Inquiry

- Providers can view past and present MRO service packages on the *MRO Inquiry* window
- MRO service packages are not assigned to the provider that requested the package
- The services belong to the member, which allows a member to seek treatment from more than one CMHC at any time
- More information is available in the *Medicaid Rehabilitation Option (MRO) Provider Manual*, available at indianamedicaid.com
1915(i) Home and Community-Based Service Programs (HCBS)
Adult Mental Health Habilitation (AMHH)

• Home and Community-Based Service Program offered under the 1915(i) state plan amendment to allow the provision of intensive home and community-based services to eligible adults age 35 and older

• AMHH Services include:
  – Adult Day Services
  – Respite Care
  – Therapy and Behavioral Supports
  – Peer Support Services
  – Supported Community Engagement Services
  – Care Coordination
  – Medication Training and Support
  – Home and Community-Based Habilitation and Support

• AMHH services can only be provided by DMHA approved CMHCs
• For additional information: [http://www.in.gov/fssa/dmha/2876.htm](http://www.in.gov/fssa/dmha/2876.htm)
Child Mental Health Wraparound (CMHW)

• New HCBS program under the 1915(i) state plan amendment providing home and community-based services to youth with serious emotional disturbances (SED)

• Allows provision of intensive home and community-based wraparound services to eligible youth ages 6 to 17

• CMHW services, based on the youth’s approved individualized plan of care, include
  – Wraparound Facilitation
  – Habilitation
  – Respite
  – Family Support and Training

• CMHW services can be provided by DMHA approved providers only

• For additional information: [http://www.in.gov/fssa/dmha/2766.htm](http://www.in.gov/fssa/dmha/2766.htm)
Behavioral & Primary Healthcare Coordination (BPHC)

• Program *coordinates* physical and behavioral healthcare services for individuals with mental illness residing in a home or community-based setting

• BPHC is designed to assist individuals with serious mental illnesses (SMI) who do not otherwise qualify for Medicaid and do not have other third party insurance that provides coverage for the level of services needed to function safely in the community

• Eligible individuals include those who are 19 years of age or older, have been diagnosed with mental health conditions, and have had difficulty managing their behavioral and physical health
  – Includes those who previously qualified for Medicaid with a spend-down, who may have lost coverage due to eligibility changes implemented in June 2014

• Services can only be provided by DMHA approved CMHC’s

• For additional information:  [http://www.in.gov/fssa/dmha/2883.htm](http://www.in.gov/fssa/dmha/2883.htm)
Psychiatric Residential Treatment Facilities
Psychiatric Residential Treatment Facilities
What is a psychiatric residential treatment facility (PRTF)?

• A facility licensed as a private, secure facility under 465 IAC 2-11
  - Private secure facility – A locked living unit of an institution for gravely disabled children with chronic behavior that harms themselves or others

• 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

Covered services

- The IHCP reimburses for services provided to children younger than 21 years of age
- The IHCP requires PA for admission to a PRTF
  - Patient must show need for long-term treatment modalities
  - See IHCP Provider Manual Chapter 6 for details
- Medical leave days ordered by a physician are reimbursed at 50% for as many as four days per admission, unless the occupancy rate is less than 90%
- Therapeutic leave days ordered by a physician are reimbursed at 50%, for as many as 14 days per calendar year, unless the occupancy rate is less than 90%
Psychiatric Residential Treatment Facilities
Noncovered services

• PRTF services remain carved out of RBMC
  – The MCE retains responsibility for services outside the PRTF including transportation and other related healthcare services
    ➢ Claims for services outside the PRTF should be filed to the appropriate managed care entity
• The PRTF *per diem* does not include:
  – Pharmaceutical supplies
  – Nonpsychiatric physician services not available at the PRTF
  – Physician and HSPP services provided at the PRTF
Psychiatric Residential Treatment Facilities
Billing

• PRTF services are billed on the CMS-1500 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* basis, 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
Partial Hospitalization
Partial Hospitalization

• Partial hospital (PH) programs are highly intensive, time-limited medical services intended to either provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, substitute for an inpatient admission, per 405 IAC 5-20-8(4)

• Admission criteria for a PH program are essentially the same as for the inpatient level of care, with the exception that the patient does not require 24-hour nursing supervision
  - Patients must have the ability to reliably control themselves for safety
  - Patients with clear intent to seriously harm self or others are not candidates for PH

• The program is highly individualized with treatment goals that are measureable, functional, time framed, medically necessary, and directly related to the reason for admission
Partial Hospitalization

• Providers must contact the health plan at the time of admission to a partial hospital program to provide notification of admission
  - Services will be authorized for up to five days, depending on the patient’s condition
  - Reauthorization criteria will be applied to stays that exceed five days

• Healthcare Common Procedure Coding System (HCPCS) code H0035 – *Mental health, partial hospitalization, treatment, less than 24 hours, per diem*, must be used (H0035 replaced S0201 effective with DOS beginning 9/1/13)

• Services must be offered at least four to six hours each day for at least four days a week

• Partial hospitalization is not an MRO service

• The IHCP requires that third-party insurance, including commercial carriers and Medicare, be billed prior to submission of the claim to Medicaid
Partial Hospitalization

Limitations and restrictions

• Prior authorization is required for H0035
• Providers will be subject to postpayment review to ensure they are offering an average of four to six hours per day for H0035
• One unit is allowed per date of service
• Inpatient and MRO services are not reimbursable on the same date as H0035
• Physician services and prescription drugs are reimbursed separately from H0035
• Service must be offered at least four days per week
• For more information, see the IHCP Provider Manual, Chapter 8, Section 4
Risk-Based Managed Care
Risk-Based Managed Care

• The following mental health services remain carved out of the RBMC program and are paid by HP on the fee-for-service methodology:
  - PRTF services rendered by a provider specialty 034 – *Psychiatric Residential Treatment Facility*
    - The MCEs retain responsibility for services outside the PRTF, such as transportation and other healthcare-related services
    - The MCEs are responsible for care coordination
  - MRO services rendered by provider specialty 111 – *Community Mental Health Center*
  - Services in an intermediate care facility for individuals with intellectual disability (ICF/IID)
  - Inpatient services in a state psychiatric hospital that are not Medicaid services, but provided under the state’s 590 program
Risk-Based Managed Care

• MCEs
  - Anthem - anthem.com
  - Managed Health Services (MHS) - managedhealthservices.com
  - MDwise - mdwise.org

• Behavioral Health Organizations (BHO)
  - Anthem - anthem.com
  - Cenpatico (MHS) - cenpatico.com
  - MDwise - mdwise.org
Top-10 Denials for Mental Health

January to June 2014
# Specialty 110 - Outpatient Mental Health Clinic

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
<th># Claims</th>
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<td>Benefits not eligible for MRO dates of service</td>
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<tr>
<td>1130</td>
<td>Ordering provider not enrolled in IHCP</td>
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<tr>
<td>2502</td>
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# Specialty 111 – Community Mental Health Center (CMHC)

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## Specialty 114 - HSPP

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## Specialty 339 - Psychiatrist

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<td>Recipient covered by private insurance</td>
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</tbody>
</table>
Find Help
Helpful Tools

• IHCP website at indianamedicaid.com
• *IHCP Provider Manual*
• *MRO Provider Manual*
• Indiana Administrative Code: 405 IAC 5-20, 5-21
• Customer Assistance
  – 1-800-577-1278 toll-free
• Provider Relations field consultants
• HP Written Correspondence at the following address:
  – HP Written Correspondence
    P.O. Box 7263
    Indianapolis, IN 46207-7263
Q&A