IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201313 APRIL 2, 2013

Reminder: The IHCP requires PA for outpatient mental health services exceeding established limits

In BT201253, dated December 18, 2012, the Indiana Health Coverage Programs (IHCP) outlined billing policies and guidelines for reimbursement of outpatient mental health services. Providers may also reference Chapter 8 of the *IHCP Provider Manual* for this information.

IHCP requires prior authorization (PA) for mental health services provided in an outpatient or office setting in excess of 20 units per member, per provider, per rolling 12-month period. Providers must submit a current plan of treatment and progress notes explaining the necessity and effectiveness of therapy with the PA request, and make the plan available for audit purposes, according to *405 IAC 5-20-8(4)*.

Providers that submitted claims for mental health services rendered from January 1, 2013, through January 31, 2013, which denied for explanation of benefits (EOB) 6900 – *Psychiatric services in excess of 20 per rolling calendar year require an approved prior authorization,* and who have an existing **approved** PA on file for those dates of service, may resubmit their claims for payment consideration.

BT201253 also outlined new mental health service codes that can be billed together with Evaluation and Management (E/M) service codes. When rendering outpatient mental health services in combination with E/M services, it is important to understand the PA requirements for **each** must be met.

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As outlined previously, for mental health services, PA is required for services in excess of 20 units per member, per provider, per rolling 12-month period. For E/M services, PA is required for services in excess of 30 visits per member, per provider, per rolling 12-month period (per *405 IAC 5-9-1*). The E/M Current Procedural Terminology (CPT®[1]) codes listed in Table 1 are subject to these limitations and PA requirements and are included here for ease of reference.

Table 1 – E/M CPT codes subject to mental health services limitations and PA requirements

CPT Code	Description
99201-99205	Office or Other Outpatient Visit for the E/M of a New Patient
99211-99215	Office or Other Outpatient Visit for the E/M of an Established Patient
99241-99245	Office Consultation for a New or Established Patient
99381-99387	Initial Comprehensive Preventive Medicine – New Patient
99391-99397	Initial Comprehensive Preventive Medicine – Established Patient

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New coverage and reimbursement for S4993

Effective May 1, 2013, the Indiana Health Coverage Programs (IHCP) will provide coverage for *S4993 – Contraceptive pills for birth control* retroactively for dates of service on or after January 1, 2013.

S4993 will be manually priced, with maximum reimbursement rates consistent with the IHCP physician-administered drug pricing methodology as detailed in BT201010. Providers are reminded that for manually-priced physician-administered drug codes, the National Drug Code (NDC) qualifier, the NDC of the product administered or dispensed, the NDC unit of measure, and the number of units administered or dispensed must be included on the claim. Only NDCs that are rebatable are IHCP-reimbursable.

Providers that received denials for S4993 for dates of service on after January 1, 2013, due to error code *4021 – Procedure is not covered for dates of service for the program billed* may resubmit those claims.

The provider Code Sets and Fee Schedule will be updated on indianamedicaid.com to reflect this coverage and reimbursement information.

QUESTIONS?

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