IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201425 JUNE 24, 2014

Clarification of billing requirements for mental health therapy services in outpatient facilities

The Indiana Health Coverage Programs (IHCP) is issuing clarification of billing requirements for mental health therapy services rendered in outpatient facilities and billed on the *UB-04* claim form under the fee-for-service (FFS) delivery system. Accordingly, the IHCP reminds providers of the following:

- Outpatient claims for the mental health therapy services must be billed using revenue code (RC) 513 – *Clinic/ Psychiatric*. For ease of reference, the outpatient mental health therapy procedure codes linked to RC 513 are listed in Table 1 on the next page. When billing RC 513, a procedure code must be billed.
  - If the claim detail is billed with revenue code 513 and the corresponding procedure code is not one listed in Table 1, the detail will deny for edit 0520 – *Invalid revenue code/procedure code combination*.
  - If the claim detail is billed with revenue code 513 and no corresponding procedure code is present on the claim, the detail will deny for edit 0389 – *Revenue code requires a corresponding HCPCS/CPT 4 code*.
- Individual therapy codes will be reimbursed the lesser of the billed amount (for facilities not eligible for Hospital Assessment Fee [HAF]) or a statewide flat fee of $40.80 per member, per session. Family and group therapy codes

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will be reimbursed the lesser of the billed amount (for facilities not eligible for HAF) or a statewide flat fee of $20.40 per member, per session. The 3% reduction will be applied to the statewide flat fee amounts for dates of service on or after January 1, 2014.

- Modifiers should be used on outpatient claims as appropriate.
- Providers will be reimbursed up to two individual sessions and one group session on the same day of service. The second individual session must be billed with an appropriate modifier to indicate that the service was separate and distinct from the first individual session. Modifiers are used to identify the level of service rendered, not to affect pricing.

Please see *Chapter 8* of the *IHCP Provider Manual* for more details and general billing guidance.

Table 1 – Outpatient mental health therapy procedure codes linked with RC 513

Procedure Code	Description
90791 (Individual)	Psychiatric diagnostic evaluation
90792 (Individual)	Psychiatric diagnostic evaluation with medical services
90832 (Individual)	Psychotherapy, 30 minutes with patient and/or family member
90833 (Individual)	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)
90834 (Individual)	Psychotherapy, 45 minutes with patient and/or family member
90836 (Individual)	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)
90837 (Individual)	Psychotherapy, 60 minutes with patient and/or family member
90838 (Individual)	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)
90845 (Individual)	Medical psychoanalysis
90846 (Group)	Family psychotherapy (without the patient present)
90847 (Group)	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849 (Group)	Multi-family group psychotherapy
90853 (Group)	Group psychotherapy (other than of a multi-family group)
90857 (Group)	Interactive group psychotherapy

Age range on D1206 expanded

Effective August 1, 2014, the Indiana Health Coverage Programs (IHCP) will expand the age range for Healthcare Common Procedure Coding System (HCPCS) code D1206 – *Topical application of fluoride varnish*. Currently, this treatment is restricted to members ages 1 through 4. The new age range for code D1206 will include members ages 1 through 20. This change applies to all IHCP programs that cover dental services for dates of service (DOS) on or after August 1, 2014.

Prior authorization policy for compounded prescriptions revised

The Indiana Health Coverage Programs (IHCP) announces a change in the prior authorization requirements for compounded prescriptions ("compound claims"). Effective August 1, 2014, all compound claims with submitted charges equal to or greater than $500 will require prior authorization (PA).

The purpose of the PA requirement is to confirm the accuracy of the claim and determine the medical necessity of the prescribed compound. Beginning August 1, 2014, compound claims with charges equal to or greater than $500 that are submitted via point of sale (POS) without PA will reject with a message stating, "Compound claims >/= $500 require prior authorization." Prescribers requesting PA should complete a *Compound Claim Prior Authorization Form* and fax it to the Catamaran Call Center at 1-855-577-6384. A Catamaran clinical pharmacist will review the request and approve or deny it within 24 hours.

Pharmacy PA criteria and PA forms are available under the Pharmacy Services link at indianamedicaid.com. Please direct PA requests or questions about the Preferred Drug List (PDL), the Over-the-Counter (OTC) Drug Formulary, or this bulletin to the Catamaran Clinical and Technical Help Desk by calling toll-free at 1-855-577-6317.

QUESTIONS?

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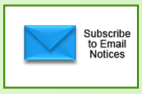

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