INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER BULLETIN

BT200719 (TR678) AUGUST 17, 2007

To: All Indiana Health Coverage Programs Providers

Subject: MCO Behavioral Health – Frequently Asked Questions

Overview

Effective January 1, 2007, the MCO behavioral health carve-out was significantly changed. Most of the behavioral health services that previously had been carved-out are now included in the managed care organization (MCO) responsibility. Medicaid Rehabilitation Option (MRO) services and Psychiatric Residential Treatment Facility (PRTF) services remain carved-out.

This bulletin provides answers to frequently asked questions (FAQ) regarding the recent changes to Hoosier Healthwise Behavioral Health. The questions throughout this bulletin are taken directly from provider submissions and may not accurately reflect current Indiana Health Coverage Programs (IHCP) policy. If applicable, the answers within this bulletin provide clarification of any inaccurate statements in the question asked.

Frequently Asked Questions

1. **Can a freestanding psychiatric hospital receive reimbursement from Medicaid?**

   If the facility in question is licensed as a psychiatric hospital and has more than 16 beds, Medicaid cannot reimburse for inpatient services provided to individuals between the ages of 22 and 65. Medicaid can reimburse for inpatient services provided to individuals under age 22, and 65 years of age and older.

   If the facility is licensed as a psychiatric hospital and has less than 17 beds, Medicaid can reimburse for inpatient services provided to individuals of any age. There are also no age restrictions on inpatient mental health services provided in a psychiatric wing of a general acute care hospital. (*405 IAC 5-20-1*) See Appendix A.1 for further detail of federal regulations.

2. **The regulations state that freestanding psychiatric facilities with more than 16 beds cannot be utilized for Medicaid services. Is there a waiver in place, or would a waiver be considered to provide better access?**

   There is no waiver in place, nor is one being considered. Refer to the answer for Question 1.

3. **Can Hoosier Healthwise Package C members receive inpatient mental health services in freestanding psychiatric facilities (not just acute care hospitals)?**

   Yes, Package C members can receive inpatient psychiatric services in a freestanding facility that has fewer than 17 beds.

4. **Can Community Mental Health Centers (CMHCs) receive reimbursement from the managed care organizations (MCOs) for CPT-4 Evaluation and Management procedure codes (for example, 99201-99205, 99211, and 99242-99244) when provided externally to the CMHC, such as the emergency department?**

   Further information regarding what types of providers would be rendering these services is necessary for response. It would be important to ensure that services are only rendered and billed within each provider's scope of practice. Because CPT codes 99201-99205 and 99242-99244 can *only* be provided by a physician or nurse practitioner, the Office of Medicaid Policy and Planning (OMPP) would like clarification regarding what providers the CMHC would have rendering the services.

5. **Can the OMPP issue a position paper on coverage of medically necessary procedures that have been traditionally covered through the Hoosier Healthwise Program?**

   Clarification of the current policy, as of January 1, 2007, was published in the *April 2007 Provider Newsletter* (http://www.indianamedicaid.com/ihcp/Newsletters/NL200704.pdf). Further clarification is provided in this bulletin, and to the extent that there is any conflict between the April newsletter article and this bulletin, this bulletin will supersede the newsletter article.

6. **CPT-4 Evaluation and Management (E&M) procedure codes (99201-99205 and 99211) have been covered when medically appropriate in Hoosier Healthwise. Will the MCOs be required to list the codes on their reimbursement schedule without any changes/alterations to those codes?**

   The OMPP needs additional and more specific information to provide an answer to this question.

7. **What is or is not included under Medicaid Rehabilitation Option (MRO)?**

   MRO services can only be provided by CMHCs. Appendix B provides a list of the procedure codes and descriptions that are included in the MRO carve-out. See also the *MRO Provider Manual* available on the Indiana Health Coverage Programs (IHCP) Web site and the *April 2007 Provider Newsletter* (http://www.indianamedicaid.com/ihcp/Newsletters/NL200704.pdf)

8. **What are HAP services and how are they related to the MRO match?**

   The Hoosier Assurance Plan (HAP) is not a fee-for-service program. It does not pay for specific services for registered individuals. HAP rates were set factoring in that some individuals served would also have Medicaid or other insurance. In other words, it was never intended to fund those services covered by Medicaid, but to offset those that were not Medicaid-funded yet are required for the continuum of care through a certified CMHC. Paying the match for MRO services is the responsibility of the CMHC providing those services.

   Hoosier Healthwise members should not be denied services with the assumption their care should be covered by HAP, nor should requested prior authorization (PA) be denied with a recommendation to bill MRO instead, as these services are a complement to the Clinic Option services.

9. **Is it a federal or state requirement to have a form 1261A for inpatient psych services from the admitting facility?**

   Federal regulations require certification of the need for psychiatric admission *(42 CFR 441.151)*. Indiana meets the federal certification requirement with the *State Form 1261A (405 IAC 5-20-5)*.

10. **Can an MCO authorize more than a two-day inpatient psych stay if medically necessary?**

    The MCOs may authorize more than two days at each review if medical necessity is supported by the clinical information provided.

11. **What is the grievance process?**

    Generally, the grievance process starts with the member notifying the MCO of his or her dissatisfaction with something. If the member exhausts the steps at the MCO level and is still not satisfied, he or she may then file an appeal with the FSSA Hearings and Appeals Office. For providers, there is a separate claims dispute process.

More specific information about the processes can be found as follows:

- The grievance and appeal process is outlined in *Banner 200707*, published February 13, 2007, "Filing Grievances and Appeals for MCO Members." A summary table can also be found at http://www.indianamedicaid.com/ihcp/index.asp under the Managed Care menu.
- Contracted MCO providers: The grievance and appeal process and claims dispute process are in the contract with the MCO.
- Out-of-network providers: For claims disputes with MCOs, the claims dispute process is outlined in the February 13, 2007, banner at http://www.indianamedicaid.com/ihcp/Banners/BR200707.pdf under "Claims Disputes and Resubmissions with MCOs."
- For non-MCO-related issues, providers should consult the *IHCP Provider Manual*, Chapter 10, Section 6.
- If a provider or member does not receive a timely response to a grievance or appeal using the processes described above, an e-mail can be sent to the OMPP Managed Care Unit at ManagedCare@fssa.in.gov.

12. Is it appropriate for CMHCs to bill for both revenue code 500 or 510, in addition to CPT codes in the series 90800-801 and continuing (also 99200-201 and continuing)? This billing has been standard practice in facilities that are hospital-based and is allowed by Medicare. Hospital-based CMHCs have outpatient clinics as defined in *42 CFR 413.65*. These facilities are billing and receiving reimbursement from EDS, for revenue codes 500 & 510 on UB-92 claim forms for facility charges. They also bill professional fees on the CMS-1500 and receive payment for the same outpatient encounters. We have been informed by the MCOs that the facility charges will not be covered. Do the MCOs have the authority to deny these services that have historically been reimbursed by the Medicaid program? If it is not appropriate, please explain why and let us know if there are exceptions.

Even though a CMHC (defined at *IC 12-7-2-38*) can be owned or operated by a hospital, it is excluded from the definition of a hospital (*IC 16-18-2-179*), because they are specifically designed to provide services to persons with mental illness. Effective 45 days from the date of this bulletin, the OMPP will not support the CMHC billing of revenue code 510 or the use of the UB-92 claim form.

13. Will there be partial hospitalization (PH) or intensive outpatient program (IOP) benefits and who will be authorizing and paying for these services?

In accordance with current Medicaid rules (*405 IAC 5-21*), only CMHCs can offer IOP and PH. There are no variations or exceptions to this rule. These services are part of the MRO carve-out. It is not the responsibility of the MCOs to prior authorize these services or pay these claims. EDS will adjudicate claims for these services. Claims submitted for these services by any provider other than a CMHC will be denied by EDS.

14. Will there be an electroconvulsive therapy (ECT) benefit for inpatient and outpatient?

CPT 90870, electroconvulsive therapy, including necessary monitoring, is a covered service payable by the MCOs.

15. Is the current outpatient fee schedule paid differently by discipline?

Yes. Mid-level practitioners rendering services that can also be rendered by a physician or health service provider in psychology (HSPP) must bill with the appropriate modifier and will be paid a lesser amount than the physician or HSPP. These mid-level practitioners may not be enrolled separately as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. The IHCP reimburses for covered services rendered. The employer or supervising psychiatrist bills for the services.

16. Can HSPP-supervised mid-level practitioners be used?

The use of these practitioners is permissible under the Indiana Medicaid managed care program and only within the respective mid-level practitioner's scope of practice. Rule *405 IAC 5-20-8* allows service provision by these mid-level practitioners under the supervision of physician or HSPP psychologist with prior authorization.

17. Hoosier Healthwise Package C:

- **The current CHIP rule for Package C members' outpatient visits states, "no PA for first 30 visits on a rolling 12-month basis, with maximum of 50 visits". Are the MCOs required to honor this rule?**
- **Could an MCO exceed the annual 50-visit limit for outpatient visits for Package C members?**

In regard to prior authorization, please refer to the response in #29 below. The MCO may provide more benefits than the 50-visit maximum, but is not required to do so.

18. Is there an issue with Fairbanks providing outpatient services so long as the MCO authorizes units above 20 rolling per year for Medicaid patients?

There is no issue with Fairbanks providing outpatient services.

19. Is Fairbanks carved-in for Hoosier Healthwise, as they do the substance abuse treatment component of behavioral health services?

Effective January 1, 2007, the substance abuse treatment component of behavioral health services is no longer carved-out of the MCO's responsibility.

20. We have MCO members seeking services from CMHCs that are not in their Behavioral Health Managed Care Network. When the CMHC requests a PA, the request is denied due to the out-of-network status. Some of these members are choosing to stay with the out-of-network CMHC and pay for their services out of their own funds. Under these circumstances, can the CMHC bill these patients, provided they have a statement in writing to this agreement to pay?

When a provider intends to bill a member, he or she must be in compliance with the *IHCP Provider Manual* in Chapter 4, Section 5. The member must sign a written statement prior to receiving the services acknowledging that they understand that they could receive the same services free of charge from an appropriate provider within their health plan's network of providers. However, the member waiver process does not relieve the provider of the duty to verify eligibility or seek MCO prior authorization as needed, and waivers cannot include conditional statements such as "if the service is not covered by IHCP, or not authorized by the member's MCO, then the member is responsible for payment."

21. What is and is not included in the Psychiatric Residential Treatment Facility (PRTF) per diem? Does it depend on the code or the provider type rendering the services? CPT code 90817 services can be provided by either a physician or a mid-level practitioner.

Please note the CPT definition of 90817 is – *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services*. This service can only be provided by a provider, such as an MD or nurse practitioner, whose scope allows such services.

The PRTF rule *(405 IAC 1-21-3)* states the following regarding physician (psychiatrist) services:

"(3) The per diem rate determined in subdivision (1) shall exclude those costs incurred for the following:

(B) Physician services. Medicaid reimbursement for costs incurred for physician services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in *405 IAC 5-25*."

The above rule also excludes pharmacy supplies and services from the PRTF per diem. Therefore, because pharmacy and physician services are the only exclusions of PRTF services permitted under the PRTF rule, all remaining PRTF services are included in the PRTF per diem. In reference to your example, CPT code 90817, this service can be billed separately and reimbursed apart from the PRTF per diem *only* if provided by a physician, such as a psychiatrist, or HSPP – not mid-level practitioners.

In addition to the above exclusions, the rule also allows for separate reimbursement outside the per diem when the service is unrelated to the patient's psychiatric condition and is performed outside the PRTF because the service is not available at the PRTF.

Therefore, separate reimbursement does depend on what services are provided, who provides them (physician vs. mid-level practitioner), and where they are provided (on-site or off-site).

> *Note: Originally, only the PRTF per diem was carved-out of the MCO responsibility. OMPP has subsequently decided to also carve-out the psychiatrist services provided to members residing in a PRTF. In the near future, providers impacted by this decision will be allowed to submit their claims to EDS for payment.*

22. Where should the providers bill their professional fees and facility charges?

Except for the Medicaid Rehab Option (MRO) and PRTF carve-outs, behavioral health providers should send their claims to the behavioral health organizations (BHOs). For example, if a behavioral health provider submitted claims for an MCO member to EDS for payment prior to January 1, 2007, that provider should now be submitting its claims to the BHO.

23. Are injections billed to the MCO or BHO? Both the administration and drug fee are on the same claim.

The administration and drug fee should be billed to MCO on the same CMS-1500 claim form.

24. Have the National Provider Identifier (NPI) numbers been crosswalked with the center's Medicaid provider number as well as the physician's Medicaid provider number?

- MHS/Cenpatico – Providers can send both numbers.
- MDwise/CompCare – This has been an ongoing educational effort to get providers to supply MDwise/CompCare with both their Medicaid ID number and their respective NPI number, so that MDwise/CompCare can match this information in its systems. CompCare does not have a way to do that without notification from the provider. This information is then being housed in CompCare's computer systems. There has been a delay by the Centers for Medicare & Medicaid Services (CMS) in implementing the NPI numbers.
- Anthem/Magellan – Magellan has crosswalked all providers who have submitted their Medicaid ID numbers to Magellan.

25. As of April 1, 2007, will the new CMS-1500 paper claim form or electronic claim with both the legacy Medicaid provider number and the NPI number be accepted?

- MHS/Cenpatico – At this time, providers can use either.
- MDwise/CompCare – CompCare can accept both types and MDwise/CompCare is currently receiving both.
- Anthem/Magellan – Magellan is currently accepting both numbers on paper and electronic data interchange (EDI) claims. Magellan is accepting both the new and old CMS-1500. Magellan is able to accept the Medicaid ID and NPI number on paper claims as well as EDI claims at this time.

26. As of May 23, providers will only bill with an NPI. Will each MCO be able to accept and pay?

The MCOs are following EDS regarding the NPI deadlines. The deadline for Phase II has been extended until further notice.

27. An Anthem question only: Anthem is transitioning mental health from Magellan to Anthem. What impact, if any, will this have with our ongoing relationship with Magellan for Medicaid MCO services?

Anthem will continue to subcontract with Magellan for Hoosier Healthwise members under the Anthem MCO plan.

28. Is the confusion over provider numbers versus facility provider numbers now resolved?

- MHS/Cenpatico – Yes.
- MDwise/CompCare – CompCare must have both the rendering provider's and the billing provider's (facility's) IHCP number on the claim, because this is required per EDS' shadow claims reporting standards.
- Anthem/Magellan – Magellan requires:
  - CMS-1500: TIN number of the pay-to organization / Name of pay-to organization in Box 33 / Name and credentials of supervising provider in Box 31/ HIPAA modifier designating level of treating provider in Box 24D
  - UB-92 / UB-04: TIN number of the pay-to organization / Name of pay-to organization in Box 1 / Name and credentials of supervising provider in Box 44 / HIPAA modifier designating level of treating provider in Box 44

29. What are the rules for prior authorization (PA)?

Providers that are not contracted with a particular member's MCO must obtain prior authorization from the MCO before providing services to that member. MCOs are not required to allow members to receive services from out-of-network providers unless the service is not available within the network or unless it is a self-referral service, such as psychiatrist services.

Providers that are contracted with an MCO should follow the prior authorization procedures in their contract. If the contract is silent on the issue, then the fee-for-service rules would apply.

Rules regarding prior authorization for behavioral health services include, but may not be limited to, the following:

- *405 IAC 5-3-13(18), psychiatric inpatient admissions, including admissions for substance abuse, require prior authorization.*
- *405 IAC 5-20-8(5), neuropsychological and psychological testing provided by a physician or an HSPP requires prior authorization.*
- *405 IAC 5-20-8(6), services provided in an outpatient or office setting that exceed 20 visits per provider in a rolling 12-month period require PA.*
- *405 IAC 5-20-8(2), outpatient mental health services provided by mid-level practitioners under the supervision of a physician or HSPP require PA.*
- *405 IAC 5-20-8(7)(E)*, partial hospitalization services can only be provided, as set out in *405 IAC 5-21*, by CMHCs in the context of MRO services, and are therefore carved-out of the MCO responsibility.

30. Can PA request be e-mailed instead of being mailed, faxed, or phoned in?

- OMPP – Transmitting personal health information via unsecured e-mail creates a Health Insurance Portability and Accountability Act (HIPAA) concern. Therefore, all PA requests must be submitted by secure processes or processes not governed by HIPAA.
- MHS/Cenpatico – Cenpatico receives outpatient treatment request (OTRs) only by mail or fax at this time.
- MDwise/CompCare – CompCare regrets that it cannot currently accept e-mails for PA requests, due to HIPAA restrictions that only allow e-mail when a secure e-mail mechanism is in place.

- Anthem/Magellan – Magellan provides two primary mechanisms by which a provider may obtain authorization for services – electronically via the Web and facsimile of the treatment request form (TRF).

31. Are PA numbers needed on claims and if so, how are they shown?

- MHS/Cenpatico – A provider is not required to provide a prior authorization number on a claim submission. The number is a reference for you but is not required by Cenpatico to process a claim because it is already populated in our claim system awaiting your claim. Cenpatico can adjudicate your claim without your providing the prior auth number on the claim.
- MDwise/CompCare – CompCare does not require prior authorization numbers on claims.
- Anthem/Magellan – Magellan does not require prior authorization numbers to be submitted on the claim forms.

32. A CompCare question only: We have and/or had a 180-day file limit from the date of service, but CompCare only has a 60-day file. Will CompCare have to increase its file limit?

Most contracted MDwise/CompCare providers have 180 days to submit claims – an issue that would have been discussed in contract negotiations. Confusion is caused by the language on CompCare's Authorization Mailer stating that providers have 60 days to file claims (the terms for CompCare commercial contracts). This wording is being modified, and will state, "Filing limit is based on your provider contract."

33. How will Health Care Excel interface with the new MCOs – with special interest in recommending and/or developing medical policy and Surveillance and Utilization Review (SUR) activities?

OMPP will include the MCOs in regularly scheduled meetings to discuss coverage and medical management issues, and coordinate program integrity activities.

34. Per the Request For Services (RFS), we have implemented the *Coordination of Care Communication* form with our primary medical providers (PMPs). We have been sending one to the MCOs when a significant change has occurred but we've been told to send one each time we update the treatment plan and sooner if there is a medication update – even though the changes may be very small. We'd like to have a better idea of what situations warrant the use of this form. When is this form required?

- OMPP – Information about MRO services is included in the OMPP/MCO contract requirement to share information with CMHCs and PMPs. The MCOs should work toward consistency in their implementation of this requirement. Because the OMPP/MCO contract requires the MCO to give the PMP a quarterly behavioral health profile of their members, it is reasonable to require communication from the CMHC not more often than at the following milestones: initial evaluation, the end of each calendar quarter, significant changes in the treatment plan, and termination of treatment.
- MHS/Cenpatico – Cenpatico expects behavioral health providers to notify the PMP within five days from the start of mental health treatment. Cenpatico requires communication from the behavioral health provider to the PMP when changes are made in a member's treatment plan and/or medication(s). Cenpatico allows providers to use either the Cenpatico *Coordination of Care* form or any other method/procedure that would ensure communication and documentation with the PMP.
- MDwise/CompCare – MDwise and CompCare's mutual goal is to remain in compliance with the RFS, but to operationalize this in a way that has minimal burden on the provider. CompCare requests that providers notify the PMP each time there is a significant change in the treatment plan or medication, but no less than once per quarter.
- Anthem/Magellan – Magellan's guidelines for PMP communication is clearly articulated in the provider handbook, downloadable from the Magellan Web site. The guidelines noted in the

handbook are: After securing appropriate release of information, communication with the PMP should occur, at a minimum, at the following points in treatment:

- Initial evaluation
- Significant changes in treatment, medication, or clinical status
- Termination of treatment

35. We thought there was legislation (HEA 1325) that basically states there will be no disruption of current/pre-carve-in medication regimes. Medication regimes are being interrupted. What are the MCOs doing to solve this problem?

- OMPP – The legislation created the Mental Health Quality Advisory Committee (MHQAC) to provide advice as to its implementation. The purpose of the committee is to develop guidelines and programs to allow open and appropriate access to mental health medications, provide educational materials to prescribers, and promote appropriate use of mental health medications. All recommendations made by the MHQAC must be reviewed and approved by the Indiana Medicaid Drug Utilization Review (DUR) Board prior to implementation.

  Prescribers need to work with the MCO if you are encountering problems. Specific concerns and issues pertaining to a particular member's access to mental health medication should be directed to OMPP at managedcare@fssa.in.gov only after attempts have been made to resolve the issue with the MCO.
- MHS/Cenpatico – No pharmacy costs are covered by Cenpatico and should be sent to the MCO. MHS is compliant with state rules and laws on medications. Some medications may require prior authorization and providers should call 1-877-MHS-4U4U and select the pharmacy prompt for more information. MHS also has a 72-hour emergency supply policy where the pharmacist can issue and get paid for giving the member a 72-hour supply while a PA is processed so there is no disruption. A second 72-hour supply can be given when the PA is taking longer to process, if for example, additional medical information is requested.
- MDwise/CompCare – For behavioral health drugs, per *HEA 1325*, all of the health plans cover the same behavioral health medications. There are however, new prescribing guidelines for behavioral health drugs that have been developed by the state DUR board and edits have been built into the MDwise Preferred Drug List (PDL) and the other health plans' PDLs accordingly. If a medication denies that was previously approved for a member, it may be due to these edits. Our PDL is located on our Web site at http://www.mdwise.org/. There is a quick reference list of the more-common medications, a searchable directory, and a download for PDAs. For questions, please contact one of the MDwise pharmacy directors at 1-800-356-1204.
- Anthem/Magellan – Anthem reimburses pharmacy costs while Magellan reimburses for the injection procedure.

36. We have been asked to provide information outside the scope of payment responsibility of the MCOs. Are we obligated to provide other data, such as records of all the MRO services provided during the last year?

- MHS/Cenpatico – Cenpatico will not inquire about MRO services.
- MDwise/CompCare – Early on, CompCare staff did request information on MRO services from providers, but discontinued that practice following concerns expressed by the provider community. That being said, CompCare's experience has been that providers have been willing to provide needed information in support of care coordination without a specific request about MRO services by CompCare.
- Anthem/Magellan – Magellan has not requested any such records from its facilities.

37. We are getting conflicting/confusing information from the MCO workshops – specifically concerning PA, PMP, and case manager communications. Workshop presenters have even said "...don't worry about [some contract provisions] they were only put in because it was required of Medicaid." How do we know what the correct information is?

The OMPP will begin to require that provider notices regarding any changes in MCO policies or procedures be reviewed and approved by OMPP, and then published by OMPP using the current mechanisms in place for fee-for-service, such as newsletters and bulletins, to eliminate the confusion and the need for providers to search for information in various locations. However, information related to each MCO is also available as noted below.

A. MHS/Cenpatico – Providers would benefit from reviewing the Cenpatico provider manual, document who stated the discrepancies and contact Cenpatico's NetWork Manager Tammy Grubbs, when such incidents occur.

B. MDwise/CompCare – The CompCare contract provisions are all accurate. Prior authorization and communication with the PMP are both State-required contract terms, which the provider must follow as specified in the contract. If providers have questions about their contract, MDwise/CompCare urges them to call MDwise at 1-800-356-1204 and select the option for behavioral health to speak with a Provider Relations representative. They can also call Jackie Marsalis, CompCare Provider Relations, directly at 317-829-8243.

C. Anthem/Magellan – Magellan's provider contracts require them to communicate key data elements to Magellan within five days of the initial session. Magellan asks and encourages its providers to share treatment information with other treating providers, including the PMP, when required authorization is obtained from the member. As part of the quality improvement process, Magellan randomly monitors high-volume providers through the treatment record review process. A key component monitored is PMP communication.

38. Will the provider workshops have mental health representatives from each of the MCOs?

- MHS/Cenpatico – Cenpatico will have representatives at the EDS workshops as well as ongoing provider orientations, which all network and non-network providers are encouraged to attend. Look for invitations in the mail. In the meantime, call if you have questions.
- MDwise/CompCare – CompCare will be attending all upcoming provider workshops with MDwise to assist with questions and concerns. In addition, providers are welcome to schedule an individual meeting at their location by calling MDwise at 1-800-356-1204 and selecting the option for behavioral health to speak with a Provider Relations representative. They can also call Jackie Marsalis, CompCare Provider Relations, directly at 317-829-8243.
- Anthem/Magellan – Magellan will have a representative available and presenting at each of the upcoming scheduled EDS workshops.

Appendix A – Further Information

1. Inpatient Mental Health Services

The CMS policy on inpatient mental health services is as follows:

- An Institution for Mental Diseases (IMD) is defined as "… a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." *42 CFR 435.1009*. The IMD definition is not restricted by licensure category to ensure states remain financially responsible for the cost of providing inpatient psychiatric services to individuals between the ages of 22 and 65. Federal financial participation (FFP) is available for inpatient psychiatric care provided in a psychiatric wing of general acute care hospital for this same age group, so long as the acute care hospital is not an IMD.
- Inpatient mental health services rendered in an IMD are limited to individuals 65 years of age or older or individuals under age 21 (services can continue until the individual reaches age 22 if receiving inpatient mental health services before reaching age 21). CMS prohibits Medicaid agencies from claiming FFP for inpatient mental health services rendered to individuals between the ages of 22 to 65 when provided in an IMD. *42 CFR 435.1008(a)(2)*. This prohibition of Medicaid reimbursement is referred to as the "IMD exclusion."
- A facility with less than 17 beds that is part of a larger entity must meet certain conditions to be deemed a separate provider. For example, if multiple components of a larger entity share a common owner, chief executive officer (CEO), or chief financial officer (CFO); or have integrated medical staff, the separate 16-bed facility would likely not qualify for the 16-bed IMD exemption.
- Inpatient mental health services can be provided in a freestanding psychiatric facility with less than 17 beds or a psychiatric wing of a general acute care hospital, with NO age restrictions.

2. Hoosier Assurance Plan Funding (from the 2004 Assessment of Indiana Health Funding)

There are multiple federal and state sources for funding for inpatient and outpatient mental health services in Indiana. Most of the funding is administered by the Division of Mental Health and Addiction (DMHA) Services. Community Mental Health Services funding is funded by the HAP funding system. The HAP is the primary comprehensive funding system for mental health and addiction services for adults, children, and adolescents; persons with drug or alcohol addiction; and persons with gambling addiction. It includes funding from a variety of federal sources, as well as from state appropriations administered by DMHA. The HAP ***is not*** an entitlement program. Managed care providers certified by DMHA receive a payment for each enrollee up to the limit of available funding. Providers are in turn responsible for providing an array of services, for the population for which they are certified, that include the following:

- Individualized treatment planning
- 24-hour crisis intervention
- Case management, including assertive case management
- Outpatient services
- Acute stabilization
- Residential services
- Day treatment

- Family support services
- Medication evaluation and monitoring
- Other services to prevent unnecessary, inappropriate treatment hospitalization and deprivation of one's liberty

Individuals at or below 200 percent of the federal poverty level who are uninsured or underinsured for mental health or addiction services, who are eligible based on diagnosis and functional status under each of the population categories above, are eligible for HAP funding, up to the limit of ***available*** funding.

3. Contact Information

MCO/MBHO Contacts

- **MHS** – Margaret Gray Mayer, Director of Compliance and Quality Improvement
  (317) 684-9478 ext 20240 or mamayer@centene.com
- **Cenpatico** – Bart Marshall, Clinical Provider Trainer
  (877) 647-4848 ext 20196 or bmarshall@centene.com
- **Cenpatico** – Cindy Smith, Provider Network Specialist
  (877) 647-4848 ext 20268 or csmith@centene.com
- **MDwise** – Jennifer Layden, Behavior Health Manager
  (317) 630-2822 or jlayden@mdwise.org
- **CompCare** – Jackie Marsalis, Indiana Provider Relations Manager
  (317) 829-8243 or jmarsalis@compcare.com
- **Anthem** – Lisa Kellum, Director, Ethics & Compliance
  (317) 287-2501 or lisa.kellum@anthem.com
- **Magellan** – Tina Hurt, Senior Account Executive
  (317) 582-3445 or cphurt@magellanhealth.com

State Contact – OMPP, Managed Care Unit

- OMPP Managed Care Unit
  (317) 233-8800 or managedcare@fssa.in.gov

Appendix B – Tables

Hoosier Healthwise Behavioral Health Benefits – Effective January 2007

Category of Service (Provider Type/Specialty)	Reimbursed by MCO[1]	Package A Standard Plan[2,3]	Package C Children's Health Plan[4]
Inpatient (Acute Care Hospital)	YES	Prior authorization (PA) required *(405 IAC 5-20-1(d); 405 IAC 5-17-5))*	Covered; PA required *(407 IAC 3-7-1)*
Inpatient (Freestanding Psychiatric Hospital, 16 beds or less)	YES	Covered. *(405 IAC 5-20-1(c); 405 IAC 5-17-5)* PA required *(405 IAC 5-20-1(d))*	Covered; PA required *(407 IAC 3-7-1)*
Inpatient (Freestanding Psychiatric Hospital, more than 16 beds, such as institution for mental diseases)	YES	Covered for members under 21 years of age, or under 22 and begun inpatient psychiatric services immediately before his/her 21st birthday. *(405 IAC 5-20-1(b))* PA required. *(405 IAC 5-20-1(d))*	Not covered (*407 IAC 3-7-1(b), 407 IAC 3-13-1(12))*
Inpatient (Intermediate Care Facilities for the Mentally Retarded (ICF/MR))	NO; EXCLUDED	Member must be disenrolled from Hoosier Healthwise for the benefit to begin. *(405 IAC 5-13-2)*	Not covered *(407 IAC 3-13-1(3))*
Inpatient (Psychiatric Residential Treatment Facility (PRTF))	NO	Covered for children younger than 21 years old and for individuals younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. *(405 IAC 5-20-3.1)* Prior authorization required through Heath Care Excel (HCE). HCE will notify the MCO when an MCO's member is admitted to a PRTF.	Not covered *(407 IAC 3-13-1(13))*

[1] For services rendered to MCO members by mental health providers, claims should be submitted to the appropriate MCO's Behavioral Health Organization. Services not reimbursed by the MCO are available for Hoosier Healthwise members, but are reimbursed by EDS, such as "carved out services," unless noted otherwise. To receive some services, members must be disenrolled from the MCO before the benefit can begin, such as "excluded" services.
[2] Medicaid covered services and limitations are cited in *Title 405, Article 5 of the Indiana Administrative Code*. *Indiana Administrative Code* can be found on the State's Web site: http://www.state.in.us/legislative/iac.
[3] Package B coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy, or urgent care services, and are subject to the same limitations for those services as in Package A.
[4] Package C covered services and limitations are cited in *Title 407, Article 3 of the Indiana Administrative Code*.

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Category of Service (Provider Type/Specialty)	Reimbursed by MCO[1]	Package A Standard Plan[2,3]	Package C Children's Health Plan[4]
Inpatient (State Psychiatric Hospital)	NO; EXCLUDED	Covered for individuals under age 21 if in certified wing.	Not covered
Outpatient (Physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, community mental health clinics and psychologists endorsed as HSPPs)	YES	Evaluation and group, family, and individual psychotherapy provided by HSPP *(405 IAC 5-20-8(4)).* PA required for services in outpatient or office setting that exceed 20 units per rolling 12 months *(405 IAC 5-20-8(6)).* PA required for neuropsychological and psychological testing *(405 IAC 5-20-8(5)).* PA required for services provided by mid-level practitioners supervised by physician or HSPP *(405 IAC 5-20-8(2)).*	Covered; maximum of 30 visits per a rolling 12 months per member without PA to a maximum of 50 visits per rolling year. *(407 IAC 3-2, 3-7-1(d))*
Medicaid Rehabilitation Option (MRO) (Community Mental Health Centers (CMHC))	NO	Services include outpatient mental health services, partial hospitalization, case management and assertive community treatment (ACT) intensive case management. For members who are seriously mentally ill, seriously emotionally disturbed, or have a substance-related disorder and meet the criteria in *405 IAC 5-21-5. (405 IAC 5-21)* See attached table for list of procedure codes. Also refer to MRO Manual on IHCP Web site.	Not covered. *(407 IAC 3-7-1(f))*

MRO Carve-Out – Procedure Group 50

Procedure/PIC Code	Code Description	Effective Date
97535 HQ HW	Self-care/home management training, direct contact by provider, each 15 minutes, in group setting, funded by state mental health	1/1/2004
97537 HQ HW	Community/work reintegration training (for example, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment) direct one on one, group setting, funded by state mental health	1/1/2004
H0002	Behavioral health screening to determine eligibility for admission to treatment program	1/1/2004
H0004 HQ HW	Behavioral health counseling and therapy, per 15 minutes, group setting, funded by state mental health	1/1/2004
H0004 HW	Behavioral health counseling and therapy, per 15 minutes, funded by state mental health	1/1/2004
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes, funded by state mental health, family/couple with client	1/1/2004
H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes, funded by state mental health, family/couple without client	1/1/2004
H0031 HW	Mental health assessment, by non-physician, funded by state mental health	1/1/2004
H0033 HW	Oral medication administration, direct observation, funded by state mental health	1/1/2004
H0035 HW	Mental health partial hospitalization, treatment, less than 24 hours, funded by state mental health	1/1/2004
H0040 HW	Assertive community treatment program, per diem, funded by state mental health	11/1/2003
H2011 HW	Crisis intervention service, per 15 minutes, funded by state mental health	1/1/2004
H2014 HW	Skills training and development, per 15 minutes, funded by state mental health	1/1/2004
T1016 HW	Case management, each 15 minutes, funded by state mental health	1/1/2004
T1016 HW TG	Case management, each 15 minutes, funded by state mental health, complex/high tech LOC	1/1/2004

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