PROVIDER BULLETIN

BT200820 APRIL 8, 2008

To: All Providers

Subject: Clarification of BT200719 – Managed Care Organization Behavioral Health Frequently Asked Questions

Overview

On August 17, 2007, provider bulletin *BT200719* was issued to all providers entitled "*MCO Behavioral Health – Frequently Asked Questions.*" Many providers asked follow-up questions about the response to question number 12, which concerned billing by community mental health centers (CMHCs) of revenue code 510. The original question and the clarified answer are presented in this bulletin.

Original Question

Note:	*Question 12 refers to the UB-92 form. Effective March 1, 2008 UB-92 was replaced by UB-04.*

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.

Clarified Response

It can be appropriate for CMHCs to bill revenue codes 500 and 510 on UB-04 claim forms. Some CMHCs are enrolled in Medicaid as psychiatric hospitals, or they are part of a larger hospital system. When billing under their hospital provider specialties, it is appropriate for the CMHC or hospital system to bill the UB-04 claim form. Some CMHCs are not enrolled as hospitals. These CMHCs should not bill the UB-04.

Other CMHCs are enrolled under more than one specialty. They may be enrolled as a hospital and also separately enrolled as a mental health provider. When services are performed at the hospital under the hospital provider number, it would be appropriate for the facility to bill the facility charges on the UB-04 and bill the professional services on the CMS-1500. However, billing the UB-04 under the mental health provider specialty would not be appropriate. The following illustrates what is and is not acceptable:

1. Facility fees may be billed for inpatient and outpatient non-medical rehabilitation option (MRO) behavioral health services that are provided to managed care organization (MCO) enrollees by facilities that are licensed as hospitals by the Indiana State Department of Health under *IC 16-21* and enrolled in Medicaid as a hospital.
2. Facility fees may be billed for inpatient and outpatient non-MRO behavioral health services that are provided to MCO enrollees by facilities that are licensed as psychiatric hospitals by the Division of Mental Health and Addiction under *IC 12-25* and enrolled in Medicaid as a psychiatric hospital.
3. No facility fees will be paid for MRO services.
4. No facility fees will be paid for non-MRO behavioral health services that are provided by CMHCs not licensed or enrolled as a hospital or psychiatric hospital.
5. A claim for a facility fee must be billed under the hospital or psychiatric hospital provider number.
6. Professional fees should be reimbursed according to *405 IAC 1-11.5-2(b)(10),* Reimbursement for services of physicians and limited liability partnerships (LLPs) shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at 80 percent of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.

This clarification may result in the need for some claims to be reconsidered for payment. The reconsideration process will be determined on an individual MCO level. Should reconsideration of claims require a resubmission of the medical bill by the provider of service, any filing limits that may be applicable will be waived to the extent necessary to accommodate resolution of these claims.

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