Fee-for-Service Behavioral Health 101

Indiana Health Coverage Programs
DXC Technology
Annual Provider Seminar – October 2020

Agenda

- Reminder
- Behavioral Health 101
- Overview
- Eligibility
- Prior Authorization
- Outpatient Services
- Inpatient Services
- Helpful Tools

Behavioral Health 101

- This Behavioral Health 101 presentation is designed for the novice biller for behavioral health providers

- Behavioral Health 201 class is structured with more in depth information on specific aspects of behavioral health and substance abuse for the experienced biller

Overview

Overview

- The Indiana Health Coverage Programs (IHCP) provides coverage for inpatient and outpatient behavioral health services, including substance abuse treatment services.
- Reimbursement is available for services provided by:
  - Licensed Physicians
  - Psychiatric hospitals
  - General hospitals
  - Psychiatric residential treatment facilities (PRTFs)
  - Other residential facilities
  - Outpatient mental health facilities
  - Health Service Providers in Psychology (HSPPs)
  - Advanced practice registered nurses (APRNs)
  - Physician Assistants (PAs)
  - Mid-level practitioners

Eligibility

Verify Eligibility

Verification options

- Interactive Voice Response (IVR) system at 1-800-457-4584
- IHCP Provider Healthcare Portal (Portal) at portal.indianamedicaid.com
- Electronic 270/271 interactive or batch transactions

Verify eligibility on every visit!

What Does Eligibility Tell Us?

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	06/29/2020	06/29/2020
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 4, Service Package 4	06/29/2020	06/29/2020
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	06/29/2020	06/29/2020

- Full Medicaid- member has full array of Medicaid benefits
- Medicaid Rehabilitation Option (MRO)- Member is receiving services through a Community Mental Health Center (CMHC)
- Qualified Medicare Beneficiary (QMB) ALSO- Claims paid by FFS for all services including MRO
- QMB ONLY- Claims paid by FFS for Medicare coinsurances, copayments and deductibles along with their Medicare Part B premiums. This excludes MRO services

Eligibility – Special Programs

These members do not have any Medicaid benefits.

The following are Medicare premium benefits only and do not require a waiver to bill member:

-Specified Low Income Medicare Beneficiary (SLMB)
-**Qualified Individual (QI)**
-**Qualified Disabled Working Individual (QDWI)**

Medical Review Team (MRT) and Pre Admission Screening and Resident Review (PASRR)- have very limited coverage
See Member Eligibility Module and Long Term Care modules

Family Planning only covers prevention or delaying of pregnancy services and requires specific diagnosis codes See Family Planning module

Managed Care Assignment

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
06/29/2020	06/29/2020	SOUTHEASTRANS, INC	

Look under this tab to determine who will pay claims

- Southeastrans - the member is Fee For Service- claims billed to DXC
- Managed Care- bill the appropriate managed care payer

Benefit Limits

- Reserved for screenshot of benefit limits

If the benefit limit for 20 therapy services has been met: - PA is needed

Remaining indicates 15 remaining, you don't need PA yet

If you get down to 2 remaining and you know the member will be continuing services, start the PA process

Members may self-refer; a referral from a member's primary medical provider (PMP) is not required.

Presumptive Eligibility

Presumptive Eligibility (PE) is a IHCP process by which individuals are deemed to be presumptively eligible for ***temporary*** coverage, until the Family and Social Services Administration (FSSA) determines official eligibility.

Community Mental Health Centers (CMHC) are the only mental health provider type that can do Presumptive Eligibility applications

Retroactive Eligibility

- 180 days to bill claims from the date the member becomes retroactive
  - Add claim note: “Retroactive Eligible”
- Payments made by retroactively approved members should be refunded to the member and claims billed to the payer
- Member is responsible for notifying providers timely of retroactive eligibility

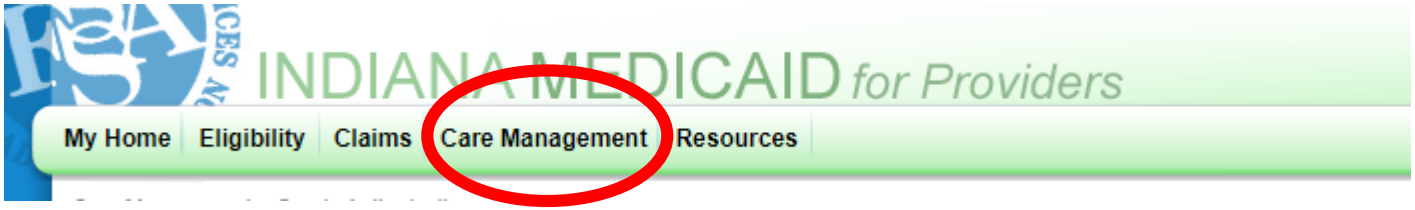
Prior Authorization

Prior Authorzation Process

During intake process, ask member if they have received any mental health services within the last year

- No- verify benefit limits on portal
- Yes- If you are not the requesting provider you can contact DXC to obtain a current prior authorization number in place

Request for Prior Authorization



Member Information

Enter Member ID, Date of Birth and at least one character of First and Last Name

*Member ID
*Birth Date
*Last Name
*First Name

Rendering Provider Information

If you wish to enter a Rendering Provider for this Authorization, you can either click the checkbox to use the Requesting Provider, select the Rendering Provider from your list of Favorites or enter ID, ID Type and Taxonomy (as needed). You will have the option of selecting a different Rendering Provider for any Service Detail below. You MUST select a Service Type for this Authorization.

Rendering Provider same as Requesting Provider
Select from Favorites
Provider ID
ID Type
Name
Add to Favorites
Taxonomy
*Service Type: MENTAL HEALTH

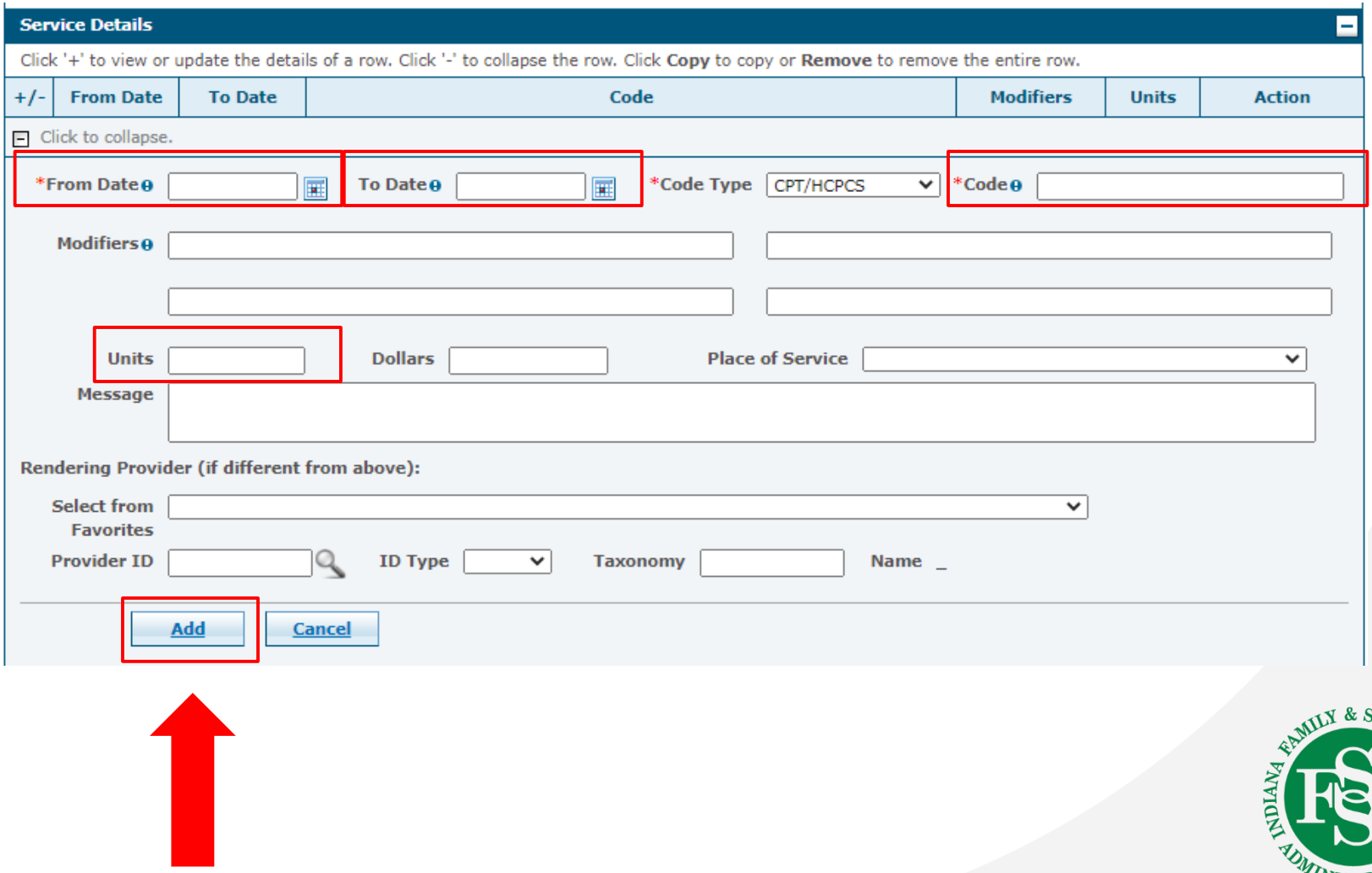
Message Information

Enter any additional information concerning this Authorization request.

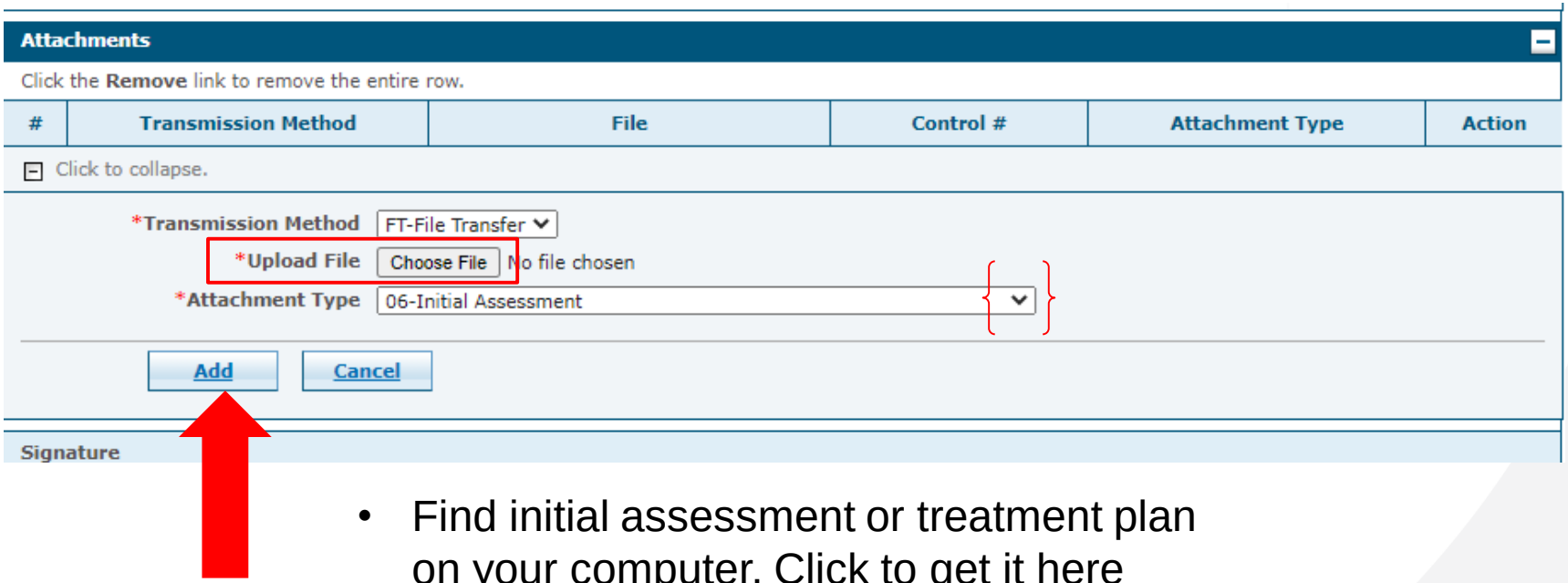
Message: Requesting 10 units of 90834 for 1 session every two week through February 5, 2021 and 15 units of 90853 for 1 session through May 31, 2021. Treatment plan attached

Provide request of services required, including frequency and duration

Provide Details



Prior Authorization Attachments



- Find initial assessment or treatment plan on your computer. Click to get it here
- Tell what kind of attachment it is
- Click ADD
- Signature and Submit
- Keep track of tracking number given

Outpatient Services

Psychiatric Diagnostic Interview Examinations

- One unit per member per provider per rolling 12-month period; no PA required
  - 90791, 90792
- Additional units require PA; exception:
  - Two units allowed when member is separately evaluated by physician/HSPP/APRN, and mid-level practitioner

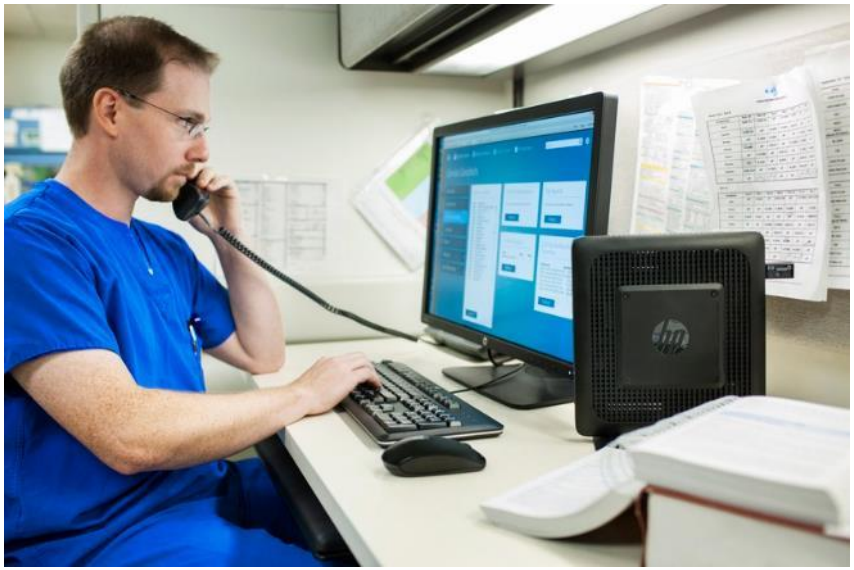
Outpatient Services

- PA is required for certain services that exceed 20 units per member, per provider, per rolling 12-month period.
- Procedure codes subject to 20 units per rolling year:
  - 90832-90834
  - 90836-90840
  - 90845-90853
  - 90899
- Physician/HSPP/APRN-directed services for group, family, and individual psychotherapy may be provided by mid-level practitioners who are not separately enrolled

Mid-level Practitioners

- Licensed psychologist
- Licensed independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addiction counselor (LCAC)
- A person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing, from an accredited school of nursing

Mid-level Services



- Mid-level services are billed using the supervising practitioner's NPI.
- An appropriate modifier should be used; reimbursed at 75% of allowable fee.
- APRNs who bill for services for members on their primary care panel must use their own NPIs.

Psychotherapy, Evaluation/Management on Same Day

- Psychotherapy performed by a mid-level practitioner, and E/M (Evaluation/Management) performed by a psychiatrist/physician, may be done on the same day
- Procedure codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are *medical* services, and therefore cannot be billed by a mid-level (except APRN's)
- In these circumstances, it is appropriate to bill the stand-alone psychotherapy service codes with the mid-level modifier, and for the supervising practitioner to bill the E/M service
- The mid-level modifier will override the applicable NCCI PTP (National Correct Coding Initiative Procedure-to-Procedure) edit.
- Refer to Service Limitations in Mental Health and Addictions module

Physician/HSPP/APRN Supervision Requirements

- Responsible for certifying the diagnosis and supervising the plan of treatment
- Must be available for emergencies
- Must see the patient or review the information obtained by the mid-level practitioner within seven days of the intake process
- Must see the patient again or review the documentation to certify the treatment plan and specific treatment modalities at intervals not to exceed 90 days
- All reviews must be documented in writing; a co-signature is not sufficient

Psychological Testing

- All neuropsychology and psychological testing requires PA
- PA must be provided by physician/HSPP/APRN:
  - 96101 PSYCHO TESTING BY PSYCH/PHYS
  - 96110 DEVELOPMENTAL SCREEN W/SCORE
  - 96111 DEVELOPMENTAL TEST EXTEND
  - 96118 NEUROPSYCH TEST BY PSYCH/PHYS
- May be provided by mid-level under supervision:
  - 96102 PSYCHO TESTING BY TECHNICIAN
  - 96119 NEUROPSYCH TESTING BY TEC

Annual Depression Screening

- The IHCP covers procedure code G0444 – *Annual depression screening, 15 minutes.*
- Service is limited to one unit per member, per provider, per rolling 12-month period.
- PA is not required.
- Providers are expected to use validated, standardized tests for the screening.

Outpatient Mental Health Hospital Services

- Hospitals bill for “facility use” associated with outpatient mental health hospital services.
- Billed on a *UB-04* form, Provider Healthcare Portal institutional claim, 837I electronic transaction
- Individual, group, and family counseling procedure codes should be used with:
  - Revenue codes 900, 907, 914, 915, 916, 918
- Reimbursement is based on statewide flat fee amount.

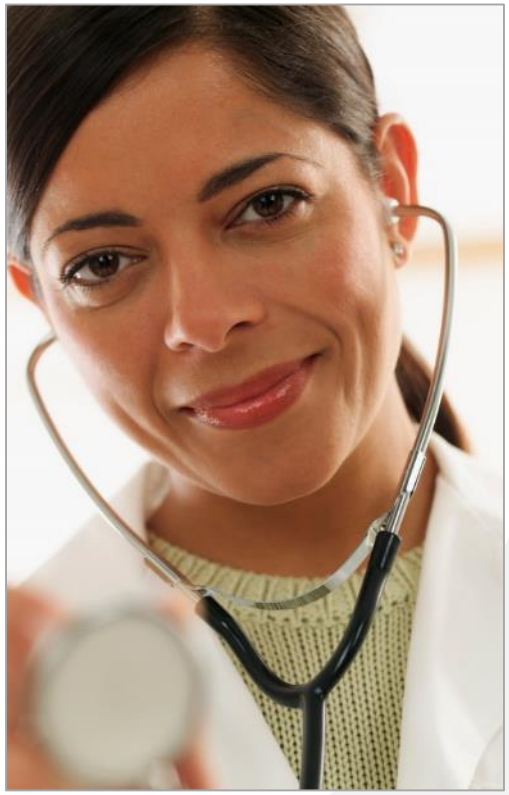
Inpatient Services

Inpatient Services

- Available in freestanding psychiatric hospitals or psychiatric units of acute care hospitals with 16 beds or less; no age restrictions
- Available in freestanding psychiatric hospitals or psychiatric units of acute care hospitals with 17 beds or more (including institutions of mental disease) only for individuals under 21 or over 64, UNLESS the individual has a primary SUD diagnosis.
  - IHCP authorized to pay for Hoosiers 21-64, suffering from serious mental disease who require inpatient stays in institutions for mental disease with more than 16 beds. See BT202003
- All admissions require PA.

Inpatient Reimbursement

- Inpatient psychiatric services reimbursed on an all-inclusive per diem level of care (LOC).
  - If DRG 740, 750-760
- Substance abuse and chemical dependency admissions reimbursed on diagnosis-related group (DRG).
- Services excluded from LOC per diem and DRG, and billed separately on a *CMS-1500* professional claim form:
  - Direct-care services of physicians, including psychiatric evaluations
  - E/M rounding



Change in Coverage During Stay

- Coverage can change during the stay – for example, from FFS to managed care, or from one MCE to another.
  - If LOC reimbursement, each plan is responsible for its own days
  - If DRG reimbursement, the plan in effect on the day of admission is responsible for all days

Third Party Liability (TPL)

Third Party Liability Guidelines

Blanket Denials:

If TPL denies a mental health claim for not a covered service, that denial can be used as a blanket denial for all claims the remainder of the calendar year

- Submit claim to DXC as primary with EOB attached
  - -EOB must have “Blanket denial” written across top and date circled
  - -Procedure code must be the same code you are billing
  - -Must get a new denial at beginning of following year

90 Day Provision:

If no response from TPL after 90 days, can bill to DXC as primary

- -Provider must document efforts to collect from primary
- -Submit claim to DXC as primary with documentation
- - See TPL module for documentation requirements

Third Party Liability Guidelines

Provider Out of Network for TPL:

Refer member to in network provider. If member is seen by primary out of network provider, member is responsible **IF** member was made aware prior to service rendered. If member was not made aware, provider is liable. Claims are not paid by the IHCP for out of network denials from primary payers

TPL reimburses member:

- Contact primary payer and advise payment made to member in error
- Request correction and payment made to the provider
- If unsuccessful, document attempts and submit under the 90 day provision rule

Helpful Tools

Self Training

Behavioral Health & ABA documentation guidelines

- Recommend mandating all service rendering providers to review

IHCP Provider Portal Training

- Recommended for billers who are new to billing the IHCP

Tips & Reminders

- March 2019 Workshop Presentation- Good information on timely filing, Presumptive Eligibility, and charging members

Mental Health & Addictions IHCP Provider Reference Module

- Detailed outline of billing processes for mental health and addiction

CMHC providers-Obtaining treatment plan signatures

- Avoiding signature errors- video presented by OMPP

Helpful Tools

Provider Relations Consultants

Region	Field Consultant	Email	Telephone	Counties Served
1	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Amber Keegan & Emily Redman (interim)	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne

Virtual Business Cards

Indiana Medicaid- Region1
Jean Downs
317.488.5071
inxixregion1@dxc.com
DXC Technology

Indiana Medicaid- Region 2
Shari Galbreath
317.488.5080
inxixregion2@dxc.com
DXC Technology

Indiana Medicaid-Region3
Crystal Woodson
317.488.5324
inxixregion3@dxc.com
DXC Technology

Indiana Medicaid- Region 4

317.488.5153
inxixregion4@dxc.com
DXC Technology

Indiana Medicaid- Region 5
Virginia Hudson
317.488.5186
inxixregion5@dxc.com
DXC Technology

Helpful Tools

IHCP website at in.gov/medicaid/providers:

- *IHCP Provider Reference Modules*
- *Medical Policy Manual*
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal

  *(After logging in to the Portal, click the **Secure Correspondence** link to submit a request)*

Thank you for attending