illinicare health

Behavioral Health Billing Guidelines

Questions?

- call **866-329-4701** or
- visit **IlliniCare.com**

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General Behavioral Health Billing

CLAIM SUBMISSION

Timely Filing: 180 days from the date of service for the first claim submission.

There are 3 ways to submit behavioral health claims to IlliniCare Health:

(1) On the Provider Portal at Provider.IlliniCare.com.
Participating providers can setup a user account to submit both professional and institutional services, as well as to check eligibility and the status of previously submitted claims.

(2) Through Clearinghouses.
Payer ID: 68069

For more information about clearinghouses, please contact:
IlliniCare Health c/o Centene EDI Department
800-225-2573 ext. 6075525
EDIBA@centene.com

(3) Submit Paper Claims.
IlliniCare Health
Attn: Claims
P.O. Box 4020
Farmington, MO 63640-4402

BILLING FAQS

Do I need to bill with a Medicaid number and NPI?
Yes. All providers are required to have an Illinois Medicaid number. In addition the Medicaid number, IlliniCare Health requires that all services provided be billed with an appropriate National Provider Identifier (NPI) and Taxonomy number.
• Additional NPI information can be found at: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html

Where do I find the covered billing codes?
Please refer to the reimbursement exhibit (fee schedule) in your agreement. Please follow all applicable authorization processes when billing these codes.

Does IlliniCare Health offer Electronic Funds Transfer (EFT)?
Yes. IlliniCare Health partners with PaySpan Health to provider EFTs and ERAs. To register for PaySpan, providers should visit www.payspanhealth.com or by contact Provider Services at 866-329-4701.
• For more information about this program, visit: https://www.illinicare.com/providers/resources/electronic-transactions/payspan.html

What if I disagree with how my claims was processed?
Providers can submit a request for reconsideration, corrected claim, or claim dispute within 180 days from the date of the Explanation of Payment (EOP). A detailed explanation of these processes can be found in the Provider Manual on IlliniCare.com.

Who do I contact if I have questions about billing and/or claims?
Provider Services: 866-329-4701

CLINICAL FAQS

Where can I find the IlliniCare Health clinical practice guidelines, medical necessity criteria, and outpatient treatment request forms?
Providers can find these materials on the IlliniCare Health website at IlliniCare.com. For clinical practice guidelines and medical necessity criteria, providers can also refer to the Provider Manual on the IlliniCare Health website.

Does IlliniCare Health offer provider training or CEU opportunities?
IlliniCare Health is an approved CEU provider and offers online training through E-Learning. In addition, IlliniCare Health's network and clinical teams are available to conduct provider forums, orientation, or individual trainings on topics such as: best practices, current trends, integration with physical health, forums, and IlliniCare Health policies and procedures. Call Provider Services at 866-329-4701 if you would like further information regarding training.

How can IlliniCare Health partner with providers to ensure members realize positive treatment outcomes?
Our Case Managers and Care Coordinators assist members in finding network provides that best meet their needs, coordinating appointments, and providing follow-up reminders. For member at risk for re-admission and do not have a phone, a pre-programmed cell phone is provided to keep members and providers connected. IlliniCare Health has also developed other incentive programs to ensure members follow treatment recommendations to increase the likelihood of positive outcomes.

MMP – SPECIFIC INFORMATION

For specific information about IlliniCare Health's Medicare-Medicaid Plan (MMP), visit mmp.IlliniCare.com.

Drug, Alcohol, and Substance Abuse (DASA) Residential Billing

Effective July 1, 2016, IlliniCare Health aligned our billing guidelines to follow the recent changes implemented by the Illinois Department of Alcohol & Substance Abuse (DASA) and the Illinois Department of Human & Family Services (HFS). IlliniCare Health now follows the standardized billing codes and claims submission process for reimbursement of services rendered by DASA certified providers. The HFS encounter claims system will only accept encounter claims from IlliniCare Health that meet these standardized claims submission requirements.

- All outpatient DASA services must be submitted on a CMS 1500 (837P) claim form.
- All institutional DASA services must be submitted on a CMS 1450 (837I) claim form. When billing on a CMS1450, the bill type must be outpatient 089X.

OUTPATIENT COVERED SERVICES

Outpatient DASA services must be bills on a CMS 1500 (837P) claim form.

- Use ONLY the HCPCS codes - NO REVENUE codes
- Must bill a separate line for each date of service

SERVICE NAME	ASAM LEVEL(S)	CLAIM TYPE	REVENUE CODE	BILLING CODE	MODIFIER	UNIT	PER UNIT RATE
Admission and Discharge Assessment	All levels	837P	N/A	H0002		1/4 hour	$16.32
Psychiatric Evaluation	All levels	837P	N/A	90791		Event	$81.31
Medication Monitoring	All levels	837P	N/A	H2010		1/4 hour	$15.53
Individual -Therapy/ Counseling Substance Abuse	Level I	837P	N/A	H0004		1/4 hour	$15.53
Group -Therapy/ Counseling Substance Abuse	Level I	837P	N/A	H0005		1/4 hour	$5.87
Individual - Intensive Outpatient, Substance Abuse	Level II	837P	N/A	H0004	TF	1/4 hour	$15.53
Group - Intensive Outpatient, Substance Abuse	Level II	837P	N/A	H0005	TF	1/4 hour	$5.87

INSTITUTIONAL COVERED SERVICES

ALL institutional DASA services must be submitted on a CMS 1450 (837I) claim form. When billing on a CMS1450, the bill type MUST be outpatient 089X.

- Only one service is permitted for each date of service
- Must bill a separate line for each date of service
- Must have a State assigned rate for the specific service to receive payment
- A Value Code of 80 is required on all CMS 1450 (837I) claims for the number of covered treatment days

SERVICE NAME	ASAM LEVEL(S)	CLAIM TYPE	REVENUE CODE	BILLING CODE	MODIFIER	UNIT	PER UNIT RATE
Rehabilitation - Adult (age 21+)	Level III.5	837I	944 or 945	H0047		Per Diem	Provider Specific Global Rate
Rehabilitation - Child (age 20 or under)	Level III.5	837I	944 or 945	H0047	HA	Per Diem	Provider Specific Global Rate
Adolescent Residential	Level III.5	837I	944 or 945	H2036		Per Diem	Provider Specific Global Rate
Detoxification	Level III.7D	837I	944 or 945	H0010		Per Diem	Provider Specific Global Rate

MEDICAL NECESSITY CRITERIA

American Society of Addiction Medicine (ASAM) criteria are applied to all chemical dependency cases. IlliniCare Health focuses on collaborating with providers to ensure the best care and outcomes possible. The medical necessity criteria materials can be found on IlliniCare.com.

Community Mental Health Centers (CMHC) Billing

CMHC DEFINITIONS

Clinician: The qualified individual within a CMHC site delivering a covered service.

Provider: A uniquely certified CMHC site, operating under a distinct NPI number.

Rolled Up: How a provider may bill for numerous incidents of the same service provision during a day, done by adding separate units of the service provided together onto one service line on a claim for the purposes of billing. Please see the Billing Examples section for additional details.

Same Service: A specific service delivered at a specific level of care and at a specific location, represented on a claim by a distinct procedure code, modifier, and place of service combination.

CMHC COVERED SERVICES (RULE 132 SERVICES)

Managed care organizations, such as IlliniCare Health, are required to provide coverage for the mental health services covered under the HFS Medical Assistance Program, as detailed in the Service Definition and Reimbursement Guide (SDRG), or its successor Provider Handbook.

- The SDRG can be found at: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/CMHP.aspx

SERVICE DESCRIPTION	BILLABLE PROVIDER TYPE(S)	AUTHORIZATION REQUIRED
Medication Monitoring Limited to 4 units (1 hour) per day 15 min = 1 unit	CMHC	No
Case Management – LOCUS Member must be 18 or older Limited to 1 per day	CMHC	No
Individual Therapy 15 min = 1 unit	CMHC	No
Group Therapy 15 min = 1 unit	CMHC	No
Family Therapy 15 min = 1 unit	CMHC	No
Mental Health Assessment/ Psych Evaluation 15 min = 1 unit	CMHC	No
Treatment Plan Development 15 min = 1 unit	CMHC	No
Medication Training 15 min = 1 unit	CMHC	No
Assertive Community Treatment (ACT) Member must be 18 or older 15 min = 1 unit	CMHC	Yes
Crisis Intervention 15 min = 1 unit	CMHC	No auth required for first 12 units (3 hours) per day.
Crisis Intervention – Multiple Staff 15 min = 1 unit	CMHC	

SERVICE DESCRIPTION	BILLABLE PROVIDER TYPE(S)	AUTHORIZATION REQUIRED
Community Support – Individual 15 min = 1 unit	CMHC	No auth required for first 200 units (50 hours) per member per provider.
Community Support – Group 15 min = 1 unit	CMHC	
Community Support – Team 15 min = 1 unit	CMHC	
Community Support – Residential Individual 15 min = 1 unit	CMHC	
Community Support – Residential Group 15 min = 1 unit	CMHC	
Psychosocial Rehab – Individual Member must be 18 or older 15 min = 1 unit	CMHC	No auth required for first 800 units (200 hours) per member per provider.
Psychosocial Rehab – Group Member must be 18 or older 15 min = 1 unit	CMHC	
Mental Health Intensive Outpatient 1 hour = 1 unit	CMHC	Yes
Case Management – Mental Health 15 min = 1 unit	CMHC	No auth required for first 200 units (50 hours) per member per provider.
Case Management – Transition Linkage and Aftercare 15 min = 1 unit	CMHC	
Case Management – Mandated Follow-Up 15 min = 1 unit	CMHC	
Case Management – Client Consult 15 min = 1 unit	CMHC	
Program Intake Assessment Limited to 1 per day	CMHC	No Covered for FHP and ACA only
Program Intake Assessment Limited to 1 per day	CMHC	No Covered for FHP and ACA only
Medication Administration Limited to 1 per day	CMHC	No

MEDICAL NECESSITY CRITERIA

Interqual criteria are applied to all behavioral health outpatient services. Community-Based Services medical necessity criteria is applied to all community-based services. IlliniCare Health focuses on collaborating with providers to ensure the best care and outcomes possible. The medical necessity criteria materials can be found on IlliniCare.com.

CMHC CLAIMS SUBMISSION REQUIREMENTS

In order to provide services to a member who is enrolled with IlliniCare Health, CMHCs must be fully contracted and credentialed with IlliniCare health on the date of service in order to successfully submit a claim for payment.

CMHC services may only be rendered from a State certified site. Additionally, the National Provider Identification (NPI) number used to bill IlliniCare Health must correspond to the CMHC State certified site where services are rendered.

Providers offering both substance abuse and mental health services from the same site must have unique NPI numbers for billing substance abuse and mental health services. Providers with multiple certified sites must obtain a unique NPI number for each CMHC site. Providers that do not obtain and report a unique NPI for each provider type or CMHC site may be subject to claims denial.

- If you need to add a new provider type or CMHC site please visit IlliniCare.com and select "Join Our Network".

Billing Provider. The billing provider represents the payee on an individual claim. The NPI corresponding to the payee ID that a provider wants remittance advice and payments sent to should be reported in loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form.

Rendering Provider. The rendering provider represents the specific CMHC site that delivered the services on the claim. For CMHCs, Rendering Provider is captured at the entity level, not the individual clinician level. The Rendering Provider is reported in loop 2310B on 837P submissions or Box 24J on a CMS 1500 form.

MD & APRN Services. Qualified practitioners (i.e., physicians, Psychiatric Advanced Practice Nurses) may deliver psychiatric services in a CMHC and list the CMHC as the Billing Provider (loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form) on the claim. These claims must list the NPI for the practitioner delivering services in the Rendering Provider field (loop 2310B on 837P submissions or Box 24J on a CMS 1500 form) and report an allowable procedure code from the appropriate practitioner fee schedule.

CMHC Add-On Payments. The State has increased reimbursement rates for specific psychiatric and behavioral health services rendered by a physician, advanced practice nurse or a licensed community mental health center. The rate change is for services provided between July 1, 2016 and June 30, 2017. Services qualifying for the enhanced payment are identified in the Community Mental Health Services Fee Schedule posted on the HFS website.

- In order to receive the Psychiatric add-on payments, claims must be submitted with the applicable procedure code (CPT), UB modifier, and designate the rendering practitioner as the billing provider/payee (box 24J).
- HCPCs do not require a UB Modifier.

Duplicate Claims. CMHCs may provide multiple units of the same service to the same recipient on the same day, provided that claims are submitted pursuant to the following policies.

- Providers may only be reimbursed once for delivering the same service to the same recipient on the same day. Multiple units of the same service provided to the same recipient on the same day by the same provider must be "rolled up" onto one service line on a single claim in order to avoid a rejection for a duplicate claim.
- Providers delivering the same service to the same client, but from two different places of services, under a single CMHC's NPI, on the same day must submit the services on two different service lines, using the appropriate place of service codes to distinguish the two services from one another.