Community Mental Health Center (CMHC) Services – Billing Guidelines

Behavioral Health

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A WellCare Company

CMHC Training Objective

- CMHC Provider Type
- Claim Submission Format
- Claim Submission Requirements and Duplicate Claiming
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- CMHC Services
- CMHC Fee Schedule
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CMHC Providers

- Providers rendering and billing CMHC services are required to enroll with IL HFS under Provider Type 36

Provider	Provider Type Code	Taxonomy
CMHC	036	261QM0801X- MENTAL HEALTH CLINIC/CENTER

Claim Submission Formats

MeridianHealth (Meridian) will accept the following claim types for CMHC:

- HIPAA 5010-Health Care Claim: Professional (837P)
  - https://www.illinois.gov/hfs/SiteCollectionDocuments/837p.pdf
- National Uniform Claim Committee (NUCC) CMS-1500
  - http://www.nucc.org/
- Direct claim entry in Meridian's Provider Claims Portal

Claim Submission

Electronic Claim Submission	Direct Data Entry Portal Claim Submission	Paper Claim Submission
CMHC providers can submit claims using Meridian Payer ID 13189 with any of the following clearinghouse vendors:	Register and enter claims in the Meridian claims portal at our website: https://corp.mhplan.com/en/provider	MeridianHealth 1 Campus Martius, Suite 700 Detroit, MI 48226 Attn: Claims Department

Availity
Customer Support: 800-282-4548
http://www.availity.com

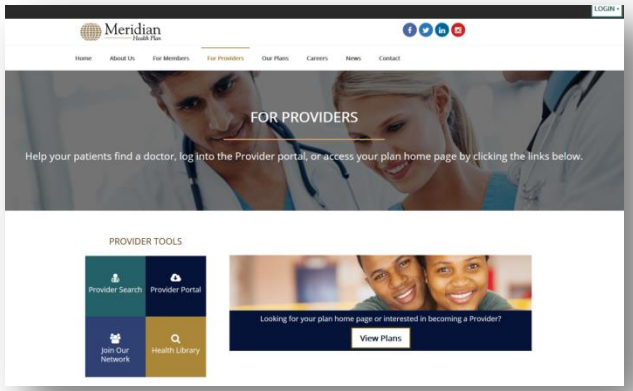
Emdeon
Customer Support: 800-845-6592
http://www.emdeon.com/claims/

Netwerkes
Customer Support: 262-523-3600
http://www.netwerkes.com

PayerPath
Customer Support: 877-623-5706
http://www.payerpath.com

RelayHealth
Customer Support: 866-735-2963
http://www.relayhealth.com

The SSI Group
Customer Support: 800-880-3032
http://www.thessigroup.com



Definitions

- Clinician refers to the qualified individual within a CMHC site delivering a covered service
- MHP refers to an individual who meets the definition for a Mental Health Professional as described in 59 Ill. Administrative Code 132.25
- Provider refers to a uniquely certified CMHC site, operating under a distinct National Provider Identification (NPI) number
- QMHP refers to an individual who meets the definition for a Qualified Mental Health Professional as described in 59 Ill. Administrative Code 132.25.
- Rolled Up is a term used to describe how a provider may bill for numerous incidents of the same service provision during a day, done by totaling the number of separate units of the service provided onto one service line on a claim for the purposes of billing. Please see the Billing Examples section for additional details
- RSA refers to an individual who meets the definition for a Rehabilitative Services Associate as described in 59 Ill. Administrative Code 132.25
- Same Service refers to 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

Claim Submission Requirements

- To be reimbursed for services provided to a recipient who receives HFS Medical Assistance Program benefit and who is enrolled with an HFS contracted Managed Care Plan, CMHC's must be fully contracted and credentialed with that Managed Care Plan on the date of service
- CMHC services may only be rendered from a certified site. The NPI providers use to bill Meridian must correspond to a certified CMHC site
- Providers offering both substance abuse services and mental health services from the same site may not utilize the same NPI number for billing substance abuse and mental health services. Mental health services must be billed under a separate NPI number from the substance abuse services. Providers that do not obtain and report a unique NPI for each provider type may be subject to a claims denial
- 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 site may be subject to claims denial
- It is the responsibility of the provider to ensure compliance with all of the service requirements by Meridian including any notifications or prior authorizations, prior to rendering CMHC services, otherwise the claims are subject to denial. Providers can reference the Provider Handbook on the Meridian website

Claims Submission Requirements

- Billing Provider
  - Represents the payee on an individual claim. The NPI corresponding to the payee ID where a provider wants remittance advice and payments sent should be reported in loop 2010AA on 837P submissions or Box 33 on a CMS 1500 form. If the billing NPI also corresponds to the rendering provider site, no rendering provider NPI is required on the claim
- Rendering Provider
  - Represents the specific CMHC site that delivered the services on the claim. For CMHC's, rendering provider is captured at he entity level, not the individual clinician level. The NPI for the rendering provider must be reported if the Billing Provider NPI corresponds only to a payee ID or to a different provider site location. The rendering provider is reported in loop 2310B on 837P submissions or Box 24J on a CMS 1500 form

Claims Submission Requirements

CMHC as the Payee

- It is allowable for qualified practitioners (i.e., physicians, Psychiatric Advanced Practice Nurses) to 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. For these claims to adjudicate appropriately as a practitioner service rather than a CMHC service, the claim 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
- The rendering provider must comply with the Meridian's policies, procedures, and service requirements corresponding to the practitioner's provider type, including being enrolled as an active provider with HFS and Meridian on the date of service

Claims Submission – Duplicate Claiming

- 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

Claims Submission – Examples

- Example 1: An MHP-level staff at a CMHC provides a total of two units of Case Management – Mental Health in the office to a single recipient, but at separate times of the day (not back to back). The service (same code/modifier/place of service combination), the provider NPI, the recipient, the date of service, and place of service all remain the same. The provider correctly bills Case Management – Mental Health on one service line on a single claim using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	T1016	TF	11	2

Claims Submission – Examples

- Example 2: An MHP-level staff at a CMHC provides two units of Crisis Intervention in the office to a single recipient. Later that same day, the same recipient returns to the same CMHC and a different MHP-level staff provides two additional units of Crisis Intervention to the recipient. The provider bills Crisis Intervention on two separate claims using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	2
2	H2011		11	2

- This claim above has not been billed appropriately. Claim/service line two will be denied as duplicate because the recipient, the service (procedure code/modifier/place of service combination), the provider NPI, and the date of service all remained the same; the provider should roll up the services and bill Crisis Intervention on one service line on a single claim using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	4

Claims Submission – Examples

- Example 3: An MHP-level staff at a CMHC provides three units of Mental Health Assessment in the office to a single recipient. A QMHP-level staff at the same CMHC provides one additional unit of Mental Health Assessment, also in the office, to the same recipient on the same day. The provider correctly bills Mental Health Assessment on two separate service lines using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H0031	HN	11	3
2	H0031	HO	11	1

- The provider correctly separated the services provided onto two distinct service lines using appropriate modifiers to account for the change in the clinician qualification level

Claims Submission – Examples

- Example 4: An MHP-level staff at a CMHC provides two units of Crisis Intervention in the office to a single recipient. Later that same day, the same MHP-level staff provides two more units of Crisis Intervention to the same recipient, but this time at the recipient's home. The provider correctly bills Crisis Intervention on two separate claims using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2011		11	2
2	H2011		12	2

- The provider correctly separated the services provided onto two claims using appropriate Place of Service codes to account for the change in location
- 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, or on two separate claims, using the appropriate place of service codes to distinguish the two services from one another

Claims Submission – Examples

- Example 5: An RSA-level staff at a CMHC provides two units of Community Support Individual to a single recipient at the recipient's school. Later that same day, an RSA-level staff provides three more units of Community Support Individual to the same recipient, but this time at a local community center. The provider bills Community Support Individual on two separate claims using the following coding summary:

Claim/ Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	HM	99	2
2	H2015	HM	99	3

- These services have not been billed appropriately. Claim 1 will positively adjudicate, but Claim 2 will be denied as a duplicate claim. Although the physical location from which services were delivered changed from a school setting to a community center, the place of service code did not change
- Consistent with the SDRG, the only place of service codes available for CMHC services are: office (11), home (12), and other place of service (99). Because the recipient, the service (procedure code/modifier/place of service combination), the provider's NPI, and the date of service all remained the same, the provider should roll up the services and bill Community Support Individual on one service line on a single claim

Claims Submission – Examples

Example 5: (cont'd)

- Consistent with the SDRG, the only place of service codes available for CMHC services are: office (11), home (12), and other place of service (99). Because the recipient, the service (procedure code/modifier/place of service combination), the provider's NPI, and the date of service all remained the same, the provider should roll up the services and bill Community Support Individual on one service line on a single claim using the following coding summary:

Service Line	Procedure Code	Modifier(s)	Place of Service	Units
1	H2015	HM	99	5

Taxonomy Codes

- Beginning 01/01/17, all claims submitted to Meridian will require a taxonomy on the claim
- Taxonomy codes are designed to categorize the type, classification, and/or specialization of healthcare providers
- The taxonomy code included on the claim must also match the taxonomy code Meridian has on file for the rendering and/or billing provider
- Claims received on or after 01/01/17 that do not contain the rendering provider's taxonomy code will be rejected

CMHC Services

- Meridian reimburses and follows the HFS guidelines in accordance to Rule 132, Group A and B services only
- CMHC services categorized under Group A and B include the following services:

Group A	Group B
• Mental Health Assessment • Psychological Evaluation • Treatment Plan Development, Review and Modification	• Assertive Community Treatment • Case Management—Client-Centered Consultation • Case Management—Mental Health • Case Management—LOCUS Assessment • Case Management—Transition Linkage and Aftercare • Community Support (Individual, Group) • Community Support (Residential) • Community Support—Team • Crisis Intervention • Crisis Intervention— State Ops • Mental Health Intensive Outpatient • Psychosocial Rehabilitation • Psychotropic Medication Administration • Psychotropic Medication Monitoring • Psychotropic Medication Training • Therapy/Counseling

NPI Enrollment and Registration Requirements

NOTE: CMHC providers are required by IL HFS and Meridian to acquire an NPI (National Provider Identification) number with NPPES (National Plan and Provider Enumeration System)

- The corresponding taxonomy per provider type must be registered with NPPES
- The NPI used to submit claims must also be registered with IL Medicaid IMPACT system and Meridian

CMHC Fee Schedule – Group A and Group B

HCPC Code	Modifiers/Activity Code			State Maximum			Add-On (Effective 7/1/16 - 6/30/17)			Total State Max with Add-On		
	1	2	3	On Site (11)	Home (12)	Off Site (99)	On Site (11)	Home (12)	Off Site (99)	On Site (11)	Home (12)	Off Site (99)
GROUP A SERVICES												
H0031	HN			$16.65	$19.31	$19.31	$5.00	$5.00	$5.00	$21.65	$24.31	$24.31
H0031	HO			$18.02	$20.90	$20.90	$5.00	$5.00	$5.00	$23.02	$25.90	$25.90
H0031	TG			$24.12	$27.98	$27.98	$5.00	$5.00	$5.00	$29.12	$32.98	$32.98
H0031				$18.02	$20.90	$20.90	$5.00	$5.00	$5.00	$23.02	$25.90	$25.90
H0032	HN			$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
H0032				$18.02	$20.90	$20.90	$0.00	$0.00	$0.00	$18.02	$20.90	$20.90
GROUP B SERVICES												
H0039				$26.46	$30.70	$30.70	$12.00	$12.00	$12.00	$38.46	$42.70	$42.70
H0039	HQ			$8.82	$10.23	$10.23	$0.00	$0.00	$0.00	$8.82	$10.23	$10.23
T1016	TG			$13.68	$15.87	$15.87	$0.00	$0.00	$0.00	$13.68	$15.87	$15.87
T1016	HN	TG		$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
T1016				$13.68	$15.87	$15.87	$0.00	$0.00	$0.00	$13.68	$15.87	$15.87
T1016	TF			$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
H0002	HE			$41.04	$47.61	$47.61	$0.00	$0.00	$0.00	$41.04	$47.61	$47.61
T1016	HN			$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
T1016	HO			$18.02	$20.90	$20.90	$0.00	$0.00	$0.00	$18.02	$20.90	$20.90
T1016	HN	HK		$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
T1016	HO	HK		$18.02	$20.90	$20.90	$0.00	$0.00	$0.00	$18.02	$20.90	$20.90
H2015	HM			$13.68	$15.87	$15.87	$0.00	$0.00	$0.00	$13.68	$15.87	$15.87
H2015	HN			$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
H2015	HO			$18.02	$20.90	$20.90	$0.00	$0.00	$0.00	$18.02	$20.90	$20.90
H2015	HM	HQ		$3.42	$3.97	$3.97	$0.00	$0.00	$0.00	$3.42	$3.97	$3.97
H2015	HN	HQ		$4.16	$4.83	$4.83	$0.00	$0.00	$0.00	$4.16	$4.83	$4.83
H2015	HO	HQ		$6.01	$6.97	$6.97	$0.00	$0.00	$0.00	$6.01	$6.97	$6.97
H2015	HE	HM		$13.68	N/A	N/A	$0.00	N/A	N/A	$13.68	N/A	N/A
H2015	HE	HN		$16.65	N/A	N/A	$5.00	N/A	N/A	$21.65	N/A	N/A
H2015	HE	HO		$18.02	N/A	N/A	$0.00	N/A	N/A	$18.02	N/A	N/A
H2015	HE	HM	HQ	$3.42	N/A	N/A	$0.00	N/A	N/A	$3.42	N/A	N/A
H2015	HE	HN	HQ	$4.16	N/A	N/A	$0.00	N/A	N/A	$4.16	N/A	N/A
H2015	HE	HO	HQ	$6.01	N/A	N/A	$0.00	N/A	N/A	$6.01	N/A	N/A
H2015	HT			$18.02	$20.90	$20.90	$9.00	$9.00	$9.00	$27.02	$29.90	$29.90

For the CMHC fee schedule and updates:
CMHC Fee Schedule Link

CMHC Fee Schedule – Group A and Group B (cont.)

H2011				$29.97	$34.77	$34.77	$7.00	$7.00	$7.00	$36.97	$41.77	$41.77
H2011	HT			N/A	$47.77	$47.77	N/A	$0.00	$0.00	N/A	$47.77	$47.77
H2011	HK			$29.97	$34.77	$34.77	$0.00	$0.00	$0.00	$29.97	$34.77	$34.77
S9480	HO			$16.02	N/A	$16.02	$0.00	N/A	$0.00	$16.02	N/A	$16.02
S9480	HO	HA		$32.04	N/A	$32.04	$0.00	N/A	$0.00	$32.04	N/A	$32.04
H2017	HM			$13.68	N/A	N/A	$0.00	N/A	N/A	$13.68	N/A	N/A
H2017	HN			$16.65	N/A	N/A	$0.00	N/A	N/A	$16.65	N/A	N/A
H2017	HO			$18.02	N/A	N/A	$0.00	N/A	N/A	$18.02	N/A	N/A
H2017	HM	HQ		$3.42	N/A	N/A	$0.00	N/A	N/A	$3.42	N/A	N/A
H2017	HN	HQ		$4.16	N/A	N/A	$0.00	N/A	N/A	$4.16	N/A	N/A
H2017	HO	HQ		$6.01	N/A	N/A	$0.00	N/A	N/A	$6.01	N/A	N/A
T1502				$10.21	$11.84	$11.84	$0.00	$0.00	$0.00	$10.21	$11.84	$11.84
T1502	SA			$12.30	$14.27	$14.27	$0.00	$0.00	$0.00	$12.30	$14.27	$14.27
H2010	52			$20.02	$20.02	$20.02	$0.00	$0.00	$0.00	$20.02	$20.02	$20.02
H2010	SA			$24.12	$24.12	$24.12	$0.00	$0.00	$0.00	$24.12	$24.12	$24.12
H2010				$24.44	$24.44	$24.44	$10.00	$10.00	$10.00	$34.44	$34.44	$34.44
H0034				$16.65	$19.31	$19.31	$5.00	$5.00	$5.00	$21.65	$24.31	$24.31
H0034	SA			$24.12	$27.98	$27.98	$0.00	$0.00	$0.00	$24.12	$27.98	$27.98
H0034	HQ			$5.55	$6.44	$6.44	$0.00	$0.00	$0.00	$5.55	$6.44	$6.44
H0034	HQ	SA		$8.04	$9.33	$9.33	$0.00	$0.00	$0.00	$8.04	$9.33	$9.33
H0004				$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
H0004	HR			$16.65	$19.31	$19.31	$0.00	$0.00	$0.00	$16.65	$19.31	$19.31
H0004	HQ			$4.16	$4.83	$4.83	$0.00	$0.00	$0.00	$4.16	$4.83	$4.83
H0004	HO			$18.02	$20.90	$20.90	$5.00	$5.00	$5.00	$23.02	$25.90	$25.90
H0004	HO	HR		$18.02	$20.90	$20.90	$0.00	$0.00	$0.00	$18.02	$20.90	$20.90
H0004	HO	HQ		$6.01	$6.97	$6.97	$0.00	$0.00	$0.00	$6.01	$6.97	$6.97

CMHC Fee Schedule (Psychiatrist)

*The following psychiatric add-ons apply to participating physicians rendering psychiatric services to Medicaid participants in partnership with participating Community Mental Health Centers.

*Psychiatric add-ons apply to the CPT codes listed below for services rendered on dates of service 07/01/2016 - 06/30/2017.

*In order to receive the Psychiatric add-on payments claims must be submitted with the applicable procedure code, UB modifier, and designate the Community Mental Health Center as the billing provider/payee.

Procedure Code	Modifier	State Max	Base Add-On Child or Adult	Psych Add-On Child or Adult
90791	UB	70.00	52.11	30.00
90792	UB	72.33	52.11	30.00
90832	UB	29.48	N/A	12.00
90833	UB	24.62	N/A	10.00
90834	UB	44.20	N/A	15.00
90836	UB	40.24	N/A	15.00
90837	UB	66.71	N/A	25.00
90838	UB	64.64	N/A	25.00
90839	UB	66.71	N/A	12.00
90847	UB	61.20	N/A	15.00

CMHC Service Definition and Reimbursement Guideline

The CMHC Service Definition and Reimbursement Guide provides the following information for each service type:

Service Type: Mental Health Intensive Outpatient	**Group B:** Medicaid Reimbursed Service
Service Definition	**Minimum Staff Requirements**
Scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week for clients at risk of, or with a history of, psychiatric hospitalization.	☐ RSA ☐ MHP ☒ QMHP ☐ LPHA ☐ Master's Level Psychologist (MCP) ☐ Licensed Clinical Psychologist (LCP) ☐ LPN w/ RN Supervision ☐ RN ☐ Team ☐ APN ☐ Physician (Doc) ☐ Other
Service Notes	**Staffing Notes**
• Intensive outpatient services are intended for clients at risk of or with a history of psychiatric hospitalization. • The client's ITP must include objectives related to reducing or eliminating symptoms that, in the past, have led to the need for hospitalization. **Group Mode Ratios:** • Children 4:1 Ratio • Adult 8:1 Ratio	
Applicable Populations	**Example Activities**
☒ Adult (21+) ☒ Adult (18 to 21) ☒ Child (0 to 18) ☐ Specialized substitute care ☒ SASS	• The focus of the sessions must be to reduce or eliminate symptoms that, in the past, have led to the need for hospitalization.
Acceptable Delivery Modes	**Reference**
☒ On Site ☐ Home ☒ Off Site ☒ Face-to-face ☒ Video ☐ Phone ☐ Individual ☒ Group ☐ Multi-staff (HT)	**Rule:** 59 Ill. Adm. Code 132.150(j) **HIPAA:** Intensive outpatient **Medicaid Eligible Service**
Service Requirements	
☒ Medical Necessity ☒ Mental Health Assessment ☒ Treatment Plan ☐ Prior Authorization – DMH ☐ SASS Enrollment	

Coding Summary

HCPCS Code	Modifier(s) (1)	(2)	(3)	(4)	Practice Level	Mode	Unit of Service
S9480	HO				QMHP	Group - Adult	1 hr.
S9480	HO	HA			QMHP	Group - Child	1 hr.

For the CMHC full service definition and reimbursement guideline: CMHC Service Definition and Guideline Link

Behavioral Health

Meridian Requires a Notification

- Inpatient Mental Health, Substance Abuse and Detox – *Notify Meridian within 24 hours of admission. Initial review completed within 24 hours of notification*
- SASS services

Services that DO require a prior authorization

- Substance Abuse Residential Level of Care
- PHP (Partial Hospitalization Program)
- IOP (Intensive Outpatient Program)
- All services provided by an out-of-network provider

Business Hours: Phone - 866-796-1167

Afterhours UM Phone - 313-324-9043

Fax - 312-508-7200

Check our website often for up-to-date prior authorization requirements:

http://corp.mhplan.com/en/provider/illinois/meridianhealthplan/benefits-resources/tools-resources/documents-forms/

Additional Sources of Information

EFT (Electronic Funds Transfer):

https://corp.mhplan.com/en/provider/illinois/meridianhealthplan/benefits-resources/tools-resources/documents-forms/

Fee Schedule Updates:

https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/CMHP.aspx

Reimbursement Guidelines:

https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/CMHP.aspx

Meridian Provider Bulletins:

https://corp.mhplan.com/en/provider/illinois/meridianhealthplan/news/bulletins-newsletters/bulletins/

Top Reasons for Claim Denials

1. Invalid member ID
2. Procedure code not authorized
3. Invalid NPI submitted
4. Missing or Invalid CPT-4 or HCPCS codes
5. CPT or HCPCS code billed on the incorrect form
6. Duplicate denials – billing multiple units for the same procedure code, same date of service, same place of service, and not rolling up into one service line
7. Replacement claims not being submitted with the appropriate resubmission code of “7” when values on the original claim have changed (i.e., units, etc.)
8. Incorrect taxonomy on the claim or taxonomy not located in the correct field