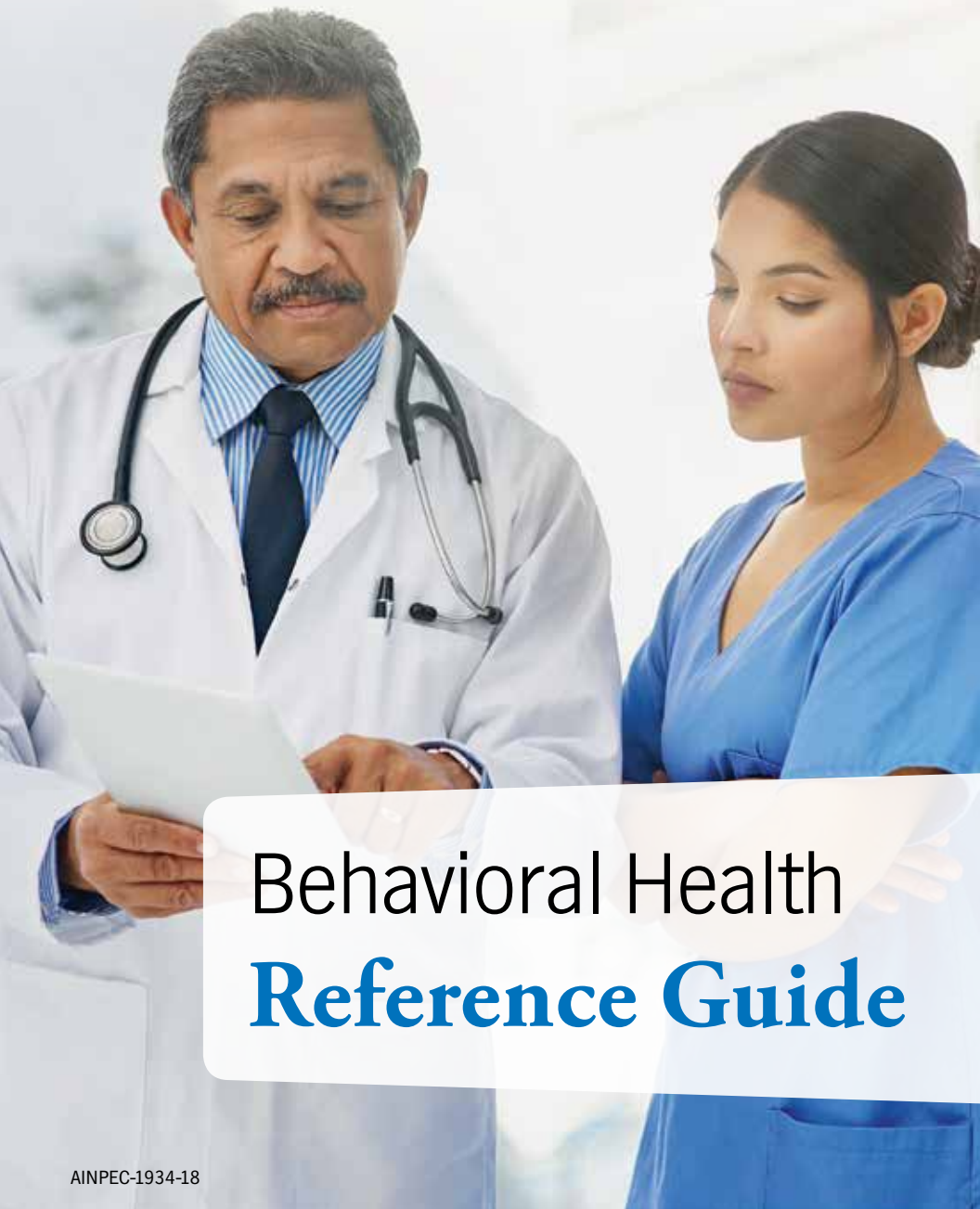
Anthem®

Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect



Behavioral Health Reference Guide

AINPEC-1934-18

Thank you

for providing great service to Anthem Blue Cross and Blue Shield (Anthem) members enrolled in Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect!

This reference guide is designed to help you effectively and accurately provide service to our members in Indiana. You are a valued partner, and we are happy to provide this information to you.

If you have questions, call Provider Services:

Hoosier Healthwise: 1-866-408-6132
Healthy Indiana Plan: 1-844-533-1995
Hoosier Care Connect: 1-844-284-1798

Table of contents

Outpatient treatment services

Services must be billed under the NPI of the medical doctor or health service provider in psychology (HSPP). The allowable mid-level modifiers are the following:

- AH: clinical psychologist — not licensed HSPP
- AJ: clinical social worker
- SA: nurse practitioner/clinical nurse specialist
- HE: services provided by any other mid-level practitioner as addressed in the 405 IAC 5-20-8 (10)

Note: Anthem does not recognize the HO modifier.

Providers seeing a member for an initial appointment should complete and submit the *Behavioral Health Treatment Data Sharing Form* within five business days of the initial visit, per state requirements. Once Anthem receives the form, it will be forwarded to the member's PMP, and an authorization will be entered into the system for an initial diagnostic review. **Please fax the form to 1-866-877-5229.**

Same-day services

Anthem follows the National Correct Coding Initiative (NCCI) for multiple behavioral health (BH) services on the same day. Anthem's system recognizes the XE modifier for procedure-to-procedure (PTP) edit indicators.

For participating providers, prior authorization requirements for the services listed below have been removed. However, providers are still required to submit a *Behavioral Health Treatment Data Sharing Form* or a copy of the PMP notification letter within five business days of the initial diagnostic interview.

Procedure code:	Service:
90785	*Interactive complexity add-on code*
90791	*Psychiatric diagnostic evaluation*
90792	*Psychiatric diagnostic evaluation, with medical service*
90832	*Individual psychotherapy (20 to 30 minutes)*
90833	*30-minute psychotherapy add-on*
90834	*Individual psychotherapy (45 to 50 minutes)*
90836	*45-minute psychotherapy add-on*
90837	*Psychotherapy (60 minutes), with patient and/or family member*
90838	*60-minute psychotherapy add-on*
90839	*Crisis intervention*
90840	*Crisis intervention — each additional 30 minutes*
90846	*Family therapy, without patient*
90847	*Family therapy, with patient*
90849	*Medical psychotherapy, multi-family group*
90853	*Group therapy*
99406	*Behavior change — smoking (3 to 10 minutes)*
99407	*Behavior change — smoking (more than 10 minutes)*
99408	*Alcohol and/or substance abuse structured screening*
99409	*Alcohol and/or substance abuse structured screening*
96150	*Assessment health/behavior — initial**
96151	*Assessment health/behavior — subsequent**
96152	*Intervention health/behavior — individual**
96153	*Intervention health/behavior — group**
96154	*Intervention health/behavior — family, with patient**
96155	*Intervention health/behavior — family, without patient**
99201-99205 & 99211-99215	*Pharmacological management (for evaluation and management E&M visits)*

**ABA modifiers required (see page 8).*

For 90791 and 90792, reimbursement is available without prior authorization for one unit per member, per provider, per rolling 12-month period. All additional units require prior authorization with the exception that two units are allowed per rolling 12-month period without prior authorization when the member is separately evaluated by **both** the physician or HSPP **and** a mid-level practitioner (one unit must be provided by the physician or HSPP and one unit must be provided by the mid-level practitioner).

Psychological and neuropsychological testing

Psychological and neuropsychological testing requires prior authorization. Prior authorization can be obtained by submitting the following documentation by fax to **1-866-877-5229:**

- A completed psychological testing form that includes:
  - Reason for request, with clear and specific statement regarding the diagnostic or treatment questions to be answered
  - The total number of hours needed for testing
  - A list of tests that will be conducted and duration for each
  - Approved hours, including administration scoring and interpretation (writing of the report is not covered)
- Intake assessment
- Recent progress notes
- Any screenings conducted

Note: It is expected that screening and/or treatment has been attempted before a referral for testing is made.

Psychological and neuropsychological testing is not covered if:

- Testing is primarily for educational or vocational purposes.
- Testing is primarily for legal purposes.
- Testing is primarily for cognitive rehabilitation.
- The tests requested are experimental or have no documented validity.
- The time requested to administer the testing exceeds established time parameters.
- Testing is routine for entrance into a treatment program.

Note: Anthem does not authorize services retrospectively.

Inpatient and partial hospitalization and intensive outpatient services

Inpatient services

- All inpatient services require prior authorization, which can be received by calling the appropriate intake department 24/7.
- Anthem **does not** accept the *Universal Prior Authorization (UPA)* form for inpatient services.

Bridge appointments

- Anthem recommends that members being discharged from an acute psychiatric facility be scheduled for a bridge appointment.
- Licensed mental health practitioners should conduct this therapy session **after** discharge but **before** the member actually leaves the facility.
- The bridge appointment should be billed on form *UB-04,* using HCPCS code T1015 and revenue code 0513.

Partial hospitalization services

- All partial hospitalization services require prior authorization, which can be received by calling the appropriate intake department 24/7.
- Anthem **does not** accept the *UPA* form for partial hospitalization services.
- Partial hospitalization should be billed on the *UB-04* with CPT code H0035 with revenue codes 912 or 913.

Intensive outpatient services (IOP)

- Effective February 1, 2017, IOP covers Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members.
- Authorization for IOP services is required and can be obtained by calling **the appropriate intake department.** IOP services **cannot** be authorized via the *Outpatient Treatment Request (OTR) Form.*
- Providers serving members that have both managed care benefits and Medicaid rehabilitation option (MRO) benefits must bill IOP services through the MRO benefit package under the FFS delivery system.
- IOP services for a facility should be billed on a *UB-04* claim form with CPT code 90899 with revenue codes 905 for psychiatric and 906 for chemical dependency.
- IOP services for professional billing should be billed on a *CMS-1500* claim form with CPT codes S9480 for psychiatric and H0015 for chemical dependency.

Case management (CM)

- Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members who are discharged from inpatient stays are provided CM support for a minimum of 90 days postdischarge.
- Phone number: 1-866-902-1690

Applied behavioral analysis (ABA)

Effective February 6, 2016, ABA therapy is covered for the treatment of autism spectrum disorder (ASD). Specifically, ABA therapy is available to members from the time of initial diagnosis through 20 years of age when it is medically necessary for the treatment of autism. These services require prior authorization, subject to the criteria outlined in *Indiana Administrative Code 405 IAC 5-3* for members age 20 and younger. **(For more information, see Indiana Health Coverage Programs (IHCP) bulletins BT201606 and BT201774.)**

Provider requirements

For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician
- Licensed pediatrician
- Licensed HSPP
- Licensed psychiatrist
- Other BH specialist with training and experience in the diagnosis and treatment of ASD

ABA therapy services must be delivered by an appropriate provider. For the purposes of ABA therapy, appropriate providers include:

- HSPP.
- Licensed or board-certified behavior analyst, including bachelor-level (BCaBA), master-level (BCBA) and doctoral-level (BCBA-D) behavior analysts.
- Credentialed registered behavior technicians (RBT).

Note: Services performed by a BCaBA or RBT must be under the direct supervision of a BCBA, BCBA-D or an HSPP. Services performed by a BCaBA or RBT under the supervision of a BCBA or BCBA-D will be reimbursed at 75% of the rate on file. ABA services rendered by a BCaBA or RBT must be billed under the NPI of an IHCP-enrolled BCBA-D or BCBA. As of March 1, 2018, IHCP enrolls BCBA-D and BCBA under provider type 11 and provider specialty 615.

Providers must bill using the appropriate modifier (U1, U2 or U3) to indicate which practitioner rendered the services. Services rendered by a nonapproved provider will not be reimbursed.

Opioid treatment services

On September 1, 2017, IHCP began covering the rendering and reimbursement of opioid treatment services. Refer to bulletin BT201755 for billing guidance and program details.

Provider requirements

A qualified provider must:

- Be enrolled with IHCP with an addiction services provider type and a specialty of opioid treatment program (OTP).
- Maintain a Drug Enforcement Administration (DEA) license.
- Maintain certification from the state's Division of Mental Health and Addiction (DMHA).
- Enroll with Anthem by submitting an online *Provider Maintenance Form (PMF);* in the comments section, *indicate opioid treatment program provider for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.*

Substance use disorder (SUD) treatment

Effective March 1, 2018, IHCP expanded coverage of substance use treatment to include residential treatment. Refer to bulletins BT201801 and BT201821 for billing guidance and program details.

Provider requirements

A qualified provider must:

- Have designation by the DMHA as offering American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.5 and/or 3.1.
- Enroll with IHCP with provider type 35 and specialty 836.
- Refer to their Anthem contract manager to decide if a contract amendment or *PMF* submission is required.

Benefit overview

Self-referral services

Members may self-refer (they do not need a PMP referral) to any BH provider in Anthem's network or to an IHCP psychiatrist. It is the provider's responsibility to contact Anthem for authorization for these services.

Covered benefits

Hoosier Healthwise (packages A and C), Healthy Indiana Plan (including Healthy Indiana Plan Maternity) and Hoosier Care Connect covered benefits:

- Inpatient services
  - Except inpatient services provided in a state psychiatric hospital or psychiatric residential treatment facility (PRTF)
- Residential SUD treatment
- OTP
- Partial hospitalization services
- Outpatient services, including psychological testing
- Applied behavioral therapy
- Smoking cessation services
- Telemedicine
- IOP

Note: MRO and 1915(i) services are not covered by Anthem but are covered under state benefits and can be coordinated with community mental health centers.

Copays for Healthy Indiana Plan Basic services (see bulletin BT201707):

- Nonemergent use of the ER: $8
- Outpatient services: $4
- Inpatient services: $75
- Pharmacy: $4 for preferred and $8 for nonpreferred

Copays for Hoosier Care Connect services (see bulletin BT201579):

- Nonemergent use of the ER: $3 per nonemergent visit
- Pharmacy: $3 per prescription
- Transportation: $1 each one-way trip

Some members are excluded from copay requirements. These members include:

- Those who are pregnant.
- Those under the age of 18.
- American Indian or Alaska Natives.
- Those receiving Supplemental Security Income (SSI).

Note: Services related to family planning or pregnancy are also excluded from copay requirements.

Provider enrollment

Anthem credentials BH practitioners, including psychiatrists and physicians, who are:

- Certified or trained in addiction, child and adolescent, and geriatric psychiatry.
- State-licensed doctoral and clinical psychologists.
- State-licensed master-level clinical social workers, mental health counselors, and marriage and family therapists.
- Nationally and state-certified, state-licensed master-level clinical nurse specialists or psychiatric nurse practitioners.
- Other behavioral care specialists, such as licensed, board-certified or state-registered for independent practice behavior analysts, including bachelor-level (BCaBA), master-level (BCBA) and doctoral-level (BCBA-D) behavior analysts.

To join the Anthem network or make demographic changes to an existing contract, an online PMF must be submitted. Links to the forms can be found at **www.anthem.com/inmedicaiddoc.**

Access standards and access to care

Prior authorization: timeliness of decisions

- Urgent pre-service requests: within 72 hours of request
- Urgent concurrent requests: within 24 hours of request
- Routine, nonurgent requests: seven days
- Retrospective review requests: within 30 days of request

Access to care standards

- Emergent: immediately
- Emergent, nonlife-threatening/crisis stabilization: within six hours of request
- Urgent: within 24 hours of referral/request
- BH examination: within 14 days of request
- Routine BH visit: within 10 business days of request
- Outpatient following discharge from an inpatient hospital stay: within seven days of discharge

Authorization adverse decisions

Expedited appeal

When a provider feels that pursuing the standard appeals process could seriously jeopardize the member's life; health; or ability to attain, maintain or regain maximum function, they can request an expedited appeal. For BH appeals, members must still be in the inpatient facility at the time of the request. Appeals should be faxed to **1-855-516-1083.**

Standard appeal

A standard appeal allows members or providers acting on the member's behalf 33 days from the date of action notice to request an appeal. When a provider submits a grievance or appeal on behalf of a member for a pre-service, the file must contain signed and dated written consent from the member giving the provider permission to file the grievance or appeal on the member's behalf. Appeals should be done in writing and mailed to:

Anthem Blue Cross and Blue Shield
Member Appeals and Grievances
P.O. Box 62429
Virginia Beach, VA 23466

Claim Information

Electronic payer identification:
Professional: 00630 Institutional: 00130

CMS-1500 tips:

- Even though the member is the patient, both sides (left/right) of the *CMS-1500* form need to be completed.
- Box 31 needs to contain the name of the IHCP supervising provider.
- Box 24D should include the modifiers noted below.
- Box 24J should be populated with the supervising provider's NPI (the person noted in box 31).
- Box 25 should be populated with the pay to TIN.
- Box 33 should be populated with the service location address and 9-digit ZIP code on file with IHCP.
- Box 33a should be populated with the group's NPI number.
- Box 33b should be populated with the group's taxonomy number and qualifier if required.
- Box 32 is not required.
- Payment is remitted to the address on file with IHCP, not to the location indicated in box 33.

UB-04 claim tips:

- **Do not** file professional services on a *UB-04* form.
- Field 1 requires the address and 9-digit ZIP code that is on file with IHCP.
- Field 56 should be populated with the facility NPI.
- Field 81CCa should be populated with B3 qualifier and taxonomy code.
- Field 76 should be populated with the attending NPI. Attending physicians do not have to be contracted with Anthem but must be IHCP-enrolled.
- Present on admission (POA) for all nonexempt diagnoses is required on all claims submitted with bill types 11X and 12X, unless the organization is exempt. Organizations that are exempt from POA should include their taxonomy code in box 81.

Telemedicine:

BH telemedicine services are reimbursed. Services can be filed on a *CMS-1500* form, utilizing the procedure code Q3014 with the GT modifier and 02 place of service or on a *UB-04* with revenue code 780. A separate authorization for Q3014 is not required. See BT201807 for more information.

Claims questions/disputes

Customer Service should be the first form of contact for questions and concerns. Obtain a reference number for any further assistance that may be needed:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-866-408-6132
- Hoosier Care Connect: 1-844-284-1798

Disputes can filed within 60 days from the date of the *EOB:*

- Via the Availity portal.
- Verbally, via phone call to Customer Service.
- Via the mail using the dispute form.

Behavioral Health contact information

Contact your assigned BH Network Education representative or anthembehavioral@anthem.com.

Department staff

Dr. Lynn Bradford, Program Director of Behavioral Health
Julie Kirby, Manager Behavioral Health Case Management
La-Risha Ratliff, Manager Behavioral Health Utilization Management

Important phone numbers

Behavioral Health Case Management referrals/Right Choices Program:

1-866-902-1690

Prior authorizations — BH:

Hoosier Healthwise
Phone: **1-866-408-6132**
Fax — inpatient: **1-877-434-7578**
Fax — outpatient: **1-866-877-5229**

Healthy Indiana Plan
Phone: **1-844-533-1995**
Fax — inpatient: **1-877-434-7578**
Fax — outpatient: **1-866-877-5229**

Hoosier Care Connect
Phone: **1-844-533-1995**
Fax — inpatient: **1-877-434-7578**
Fax — outpatient: **1-866-877-5229**

Provider Services:

Hoosier Healthwise: **1-866-408-6132**
Healthy Indiana Plan: **1-844-533-1995**
Hoosier Care Connect: **1-844-284-1798**

Member Services and 24/7 NurseLine (for members):

Hoosier Healthwise and Healthy Indiana Plan :
1-866-408-6131 (TTY: 711)
Hoosier Care Connect: **1-844-284-1797 (TTY: 711)**

Transportation for members to covered services:

Anthem provides non-emergent transportation to Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members via LogistiCare. **At least two business days' advance notice is required** for routine transportation scheduling. Hoosier Care Connect members only pay $1 for each one-way trip.
Phone: **1-844-772-6632 (TTY: 1-866-288-3133)**
Website: **http://www.logisticare.com**

www.anthem.com/inmedicaiddoc

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.