Direct Billing of Community Mental Health Services to HFS

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General Overview

Legislative Mandate

- In accordance with Public Act 096-1405, HFS is preparing to receive the direct billing of services by community mental health (CMH) providers beginning with claims submitted on or after July 1, 2011.

Benefits of Change

- In response to this legislation, HFS is working with DHS to unify and simplify mental health billing.
  - Establish a single flow of bills to HFS.
  - Unify the Illinois Mental Health Service Coding System.
  - Establish dedicated training and support for the transition.

Remaining Constant

- Interface with DHS for Registration and Prior Authorization
- DHS Reporting Requirements.
  - Met by utilizing the 2300 and 2400 loops/notes fields of the 837p.

Overview of HFS Billing Procedures

Important Changes

- Full compliance with HFS requirements:
  - Enrollment
  - NPI – Provider ID and Payee
  - Bill Submission
    - Electronic
    - MEDI Batch
    - MEDI DDE
  - Remittance (Paper and 835)
  - Notices and Handbooks
  - CMH Provider Coding

Provider Participation Unit (PPU)

- Updates to Provider File
- Link: http://www.hfs.illinois.gov/enrollment/
- Phone: 217-782-0538
- Address:
  - Illinois Department of Healthcare and Family Services
    Provider Participation Unit
    P.O. Box 19114
    Springfield, IL 62794-9114

National Provider ID (NPI)

- Each Provider site must have a one-to-one relationship with an NPI
- Each Payee ID must be linked to an NPI
- To register NPIs with HFS - contact Provider Enrollment at 217-782-0538
- National Enrollment:
  - https://nppes.cms.hhs.gov

12 Month Filing Limit

- Initial and resubmitted claims must be received within 12 months of date of service.

- Review claim, refer to error code explanation, correct error, and rebill within 12 months of the date of service.

Other Insurances

- HFS is the payer of last resort
- Bill all other insurances including Medicare prior to HFS

Claim Edits

- Validity of information on the claim
- Prior authorization verification
  - Client Eligibility
  - Is the DOS within the PA date range?
  - Can the provider bill the service and is the provider on the authorization file?
  - Procedure code/service package/service class

837P – Electronic Claim

When billing through a vendor or clearinghouse

- Current requirements for the Collaborative:
  - Loop 2300 is utilized to identify the staff's qualification level
- New requirements for HFS:
  - Move the level of staff information (17 bytes) to the last 17 bytes of the loop 2400, NTE segment.

837P Payee Information

- Loop 2010AA, Billing Provider
  - Enter NPI that is connected to Payee; this is where HFS will send Remittance Advice and Payments.
- Loop 2310B, Rendering Provider
  - Enter NPI that is connected to specific site
  - Not required if the Rendering is the same as the Billing Provider, Loop 2010AA

Medical Electronic Data Interchange (MEDI)

- www.myhfs.illinois.gov
- Verify claim status (individual claim or batch)
- Verify client eligibility
- Submit claims directly to HFS through direct data entry (DDE)
- Electronic Remittance Advice (ERA)
  - Reason/remark codes
    - http://www.wpc-edi.com/codes

MEDI Help

- CMS Help Desk: 800-366-8768, option 1, option 3
  - Registration assistance
  - Digital Certificate/Password Reset
  - Administration/biller authorization
- EDI Help Desk: 217-524-3814
  - Authentication error (non-password)
  - Upload batch
  - 824 and 997 assistance
- Billing Consultants: 877-782-5565, option 0, ask for a Community Mental Health Support Consultant.
  - Entering claim data

Error Codes

- Remittance Advices mailed to Payee address on Provider Information Sheet.
- Chapter 100, Appendix 5
  - Error Codes & Explanations
  - http://www.hfs.illinois.gov/assets/100app5.pdf
- ERA (835P) – Reason/Remark Codes
  - http://www.wpc-edi.com/codes

Provider Notices

- Sign up to receive electronic notification of new releases online at the following:
  - http://www.hfs.illinois.gov/provrel/
- Provider notices posted at the following:
  - http://hfs.illinois.gov/releases/

Recently Released Notices

11/15/10:

National Provider Identifier (NPI) Reporting

11/10/10

Phasing Out Mailing of Paper Notices and Bulletins – Phase IV

Handbooks:

http://www.hfs.illinois.gov/handbooks/

- HFS Chapter 100: Handbook for Providers
- HFS Chapter 200: Specific to Provider Type
- HFS Chapter 300: Handbook for Electronic Processing
- Service Definition and Reimbursement Guide
  - http://www.hfs.illinois.gov/reimbursement/cmhp.html
- Value Options:
  - http://www.illinoismentalhealthcollaborative.com/

Billing Assistance

- 877-782-5565, option “0”
  - Ask for a Community Mental Health Support Representative once you reach an operator

Updates to the Community Mental Health Service Definition and Reimbursement Guide

Updated Service Definition Reimbursement Guide (SDRG)

- HFS to release an Enhanced SDRG.
  - Enhanced SDRG is “Handbook Like” and will be transitioned into a formal provider handbook with billing details.
- Updated format that is standardized and streamlined for easier usage.
- Unified Mental Health Coding Structure for Medicaid and Non-Medicaid.

Service Definition:

An evidence-based model of treatment/services that provides an inclusive array of community-based mental health and supportive services for adults (18 years of age and older) with serious and persistent mental illness or co-occurring mental health and medical or alcohol/substance abuse disorders. It requires an intensive integrated package of services, provided by a multi-disciplinary team of professionals over an extended period of time.

Notes:

- Individual must be 18 years of age or older.
- Provider must be in compliance with the assertive community treatment (ACT) paradigm of the Department of Human Services. Other services listed in this document may be provided only to facilitate transition into and out of ACT services in accordance with an ITP or while a client is receiving residential services to stabilize a crisis.
- "ACT team" should be identified as "responsible staff" on ITP.
- Services to the family on behalf of the client will be reimbursed as services to the individual client, either on-site or off-site.
- Group billing limited to curriculum-based skills training offered only to ACT members—not more than 8 participants per group, a client to staff ratio of no more than 4:1 and no more than two hours per week per client.

Applicable Populations:

☒ Adult (21+)	☒ Adult (18 to 21)	☐ Child (0 to 18)
☐ Specialized substitute care	☒ SASS	

Acceptable Delivery Mode(s):

☒ On Site	☒ Home	☒ Off Site
☒ Face-to-face	☒ Video	☒ Phone
☒ Individual	☒ Group	☐ Multi-staff (HT)

Service Requirements:

☒ Medical Necessity	☒ Mental Health Assessment
☒ Treatment Plan	☒ Prior Authorization – DMH
☐ Registration – DMH	☐ Prior Authorization – CARES

Minimum Staff Requirements:

☐ RSA	☐ MHP	☐ QMHP	☐ LPHA
☐ Master's Level Psychologist (MCP)			
☐ Licensed Clinical Psychologist (LCP)			
☐ LPN w/ RN Supervision	☒ RN	☒ Team	
☐ APN	☐ Physician (Doc)	☐ Other	

Staffing Note(s):

- Each ACT Team shall consist of at least six FTE staff including a licensed clinician as team leader and at least on RN. The tem must be supported by a psychiatrist and program/administrative assistant. At least one team member must have training or certification in substance abuse treatment, one in rehabilitative counseling and one person in recovery.

Example Activities:

- Symptom assessment and management including ongoing assessment, psycho-education, and symptom management efforts.
- Supportive counseling and psychotherapy on planned and as-needed basis.
- Medication prescription, administration, monitoring and documentation.
- Dual-diagnosis substance abuse services including assessment and intervention.
- Support of activities of daily living.
- Assist client with social/interpersonal relationship and leisure time skill building.
- Encourage engagement with peer support services.
- Services offered to families and/or other major natural supports (with the client's permission).
- Development of discharge or transition goals and related planning.

References:

Rule – *59 Ill. Admin. Code* 132.150(j)
HIPAA – Assertive Community Treatment

SDRG Service Detail Updates

- Several detail sections have been standardized, such as:
  - Minimum Staffing Level
  - Applicable Population
  - Delivery Mode
  - Service Requirements

- Check boxes are used to simplify interpretation of the document along with required narratives.

SDRG Rate Schedule

- All Coding Changes are highlighted in the SDRG with two asterisks on each side of the code. This indicator suggests that there may have been a change in the code depending upon funder and the coding should be verified before submission of a bill to HFS.

- Example:

** H0031 **

SDRG Rate Schedule

Example – HCPCS / MOD / POS Combo

HCPCS Code	Modifier(s) (1)	(2)	(3)	(4)	Practice Level	Mode	Unit of Service	Place of Service On Site (11)	Home (12)	Off Site (99)
H0031	HN				MHP	Individual	¼ hr.	$16.65	$19.31	$19.31
** H0031 **	HO				QMHP	Individual	¼ hr.	$18.02	$20.90	$20.90

** Service Procedures highlighted with asterisks indicate a change or update. Providers should verify coding prior to claim submission.

SDRG Rate Schedule

Example – HCPCS / Activity Code / POS Combo

HCPCS Code	Activity Code	Practice Level	Mode	Unit of Service	Place of Service		
					On Site (11)	Home (12)	Off Site (99)
S9986	W009C	RSA	Individual	¼ hr.	$26.46	N/A	$30.70
S9986	W009D	RSA	Group	¼ hr.	$8.82	N/A	$10.23

Note: Please note the presence of a “W” Code which is required to be reported during claiming. See Topic 203.4.3 above.

SDRG Rate Schedule

Example – HCPCS / Activity Code Encounter

HCPCS Code	Activity Code	Unique Service	Mode	Unit of Service	Place of Service		
					On Site (11)	Home (12)	Off Site (99)
S9986	W00J1	Rent, Utilities	N/A	N/A	N/A	N/A	N/A
S9986	W00J2	Recreational Activities	N/A	N/A	N/A	N/A	N/A
S9986	W00J3	Educational Activities	N/A	N/A	N/A	N/A	N/A
S9986	W00J4	Household Expenses	N/A	N/A	N/A	N/A	N/A

Note: Please note the presence of a “W” Code which is required to be reported during claiming. See Topic 203.4.3 above.

Specific SDRG Coding Changes

SDRG Coding Changes

- Actual SDRG coding changes are minimal.
- Providers with systems set to code services using the Value Options Coding Matrix will have to convert their systems back to the SDRG.
- The following changes are represented in the updated SDRG and may not reflect a change to the guide as much as a change for the provider.

Specific Codes

- H0031 – Mental Health Assessment and Psychological Evaluation
  - Replaced DMH modifier “AH” with “TG” to match HFS system.
  - Removed “HO” from HFS code for Psychological Evaluation. The code is not represented in DMH code set.
  - Added “HO” code for Mental Health Assessment (QMHP) to match DHS system.

Specific Codes

- The following HCPCS Codes dropped the following DHS modifiers as the HFS code defaults to the level of service in question:
  - H0032: “HO”
  - 90862: “UA”
  - H0004: “HN”
  - H0034: “HN”
  - H0039: “HT”

Specific Codes

- H2011 - Crisis Intervention
  - Added “HK” modifier for Crisis Intervention – State Ops.

Specific Codes

- T1016 - Case Management
  - Dropped the “HM” modifier from the DHS code.
  - Added T1016/“HN”/“HK” for Case Management – Mandated Follow Up (MHP).
  - Added T1013/“HO”/“HK” for Case Management – Mandated Follow Up (QMHP).

Specific Codes

- H0024 - Stakeholder Education
  - Dropped the “HM” modifier from the DHS code.
  - Several code/modifier combinations were added.

- S9986
  - Replaced with W-Code/Activity Code to differentiate non-Medicaid services.

Questions and Answers

- Official answers will be those posted to the HFS Web site in the official Question and Answer (QA) Document:

http://hfs.illinois.gov/cmhc/

- Thank you for your participation. Please remember to check the HFS Web site for frequent updates and additional materials.