Healthcare and Family Services (HFS) Managed Care Billing Guidelines: Community Mental Health Center (CMHC) Services

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This guide establishes the standardized claims submission processes to be utilized across the HFS' contracted Managed Care Plans for the reimbursement of services rendered by certified and enrolled CMHCs. It is designed to provide guidance and clarification to both Managed Care Plans and CMHC certified providers. The HFS encounter claims system will accept encounter claims from the Managed Care Plans in line with the standardized claims submission requirements outlined in this guide.

Section 1 – Services Overview

HFS contracted Managed Care Plans are required to provide coverage for 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.

Section 2 – Definitions

The following common terms are used throughout this Billing Guide.

1. Clinician refers to the qualified individual within a CMHC site delivering a covered service.

2. MHP refers to an individual who meets the definition for a Mental Health Professional as described in 59 Ill. Administrative Code 132.25.

3. Provider refers to a uniquely certified CMHC site, operating under a distinct National Provider Identification (NPI) number.

4. QMHP refers to an individual who meets the definition for a Qualified Mental Health Professional as described in 59 Ill. Administrative Code 132.25.

5. 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.

6. RSA refers to an individual who meets the definition for a Rehabilitative Services Associate as described in 59 Ill. Administrative Code 132.25.

4. 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.

Section 3 – General Claims Submission Requirements

1. To be reimbursed for services provided to a recipient who receives a HFS Medical Assistance Program benefit and who is enrolled with a HFS contracted Managed Care Plan, CMHCs must be fully contracted and credentialed with that Managed Care Plan on the date of service.

2. CMHC services may only be rendered from a certified site. The NPI number providers use to bill Managed Care Plans must correspond to a certified CMHC site.

3. Providers rendering both substance abuse and mental health services from the same site shall 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 substance abuse services. Providers that do not obtain and report a unique NPI for each provider type may be subject to claims denial.

4. 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.

5. It is the responsibility of the provider to ensure compliance with all of the service requirements of a recipient's payer, including service notifications or prior authorizations, prior to providing CMHC services. Providers should reference the appropriate Managed Care Plan's Provider Handbook and their Provider Agreements for information on service requirements. A crosswalk of the prior authorization requirements of each of the HFS contracted Managed Care Plans can be found on the HFS website. Providers that do not comply with the service requirements of a recipient's payer may be subject to claims denial.

Section 4 – Rendering and Billing Provider

1. **Billing Provider:** 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.

2. **Rendering Provider:** 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 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.

Section 5 – 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 MCO's policies, procedures, and service requirements corresponding to the practitioner's provider type, including being enrolled as an active provider with HFS and the Managed Care Plan on the date of service.

Section 6 – 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. MCO claiming systems shall be set up to recognize each distinct procedure code, modifier, and place of service combination covered under the HFS Medical Assistance Programs as a unique service.

Billing Guidelines and Examples:

1. 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.

Example 1: An MHP-level staff at a CMHC provides a total of 2 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

Example 2*:* An MHP-level staff at a CMHC provides 2 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 2 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 has not been billed appropriately. Claim 1 will positively adjudicate, but Claim 2 will be denied as a duplicate claim. For CMHC services, the provider is identified at the entity level, not the clinician level. Therefore, 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

Example 3: An MHP-level staff at a CMHC provides 3 units of Mental Health Assessment in the office to a single recipient. A QMHP-level staff at the same CMHC provides 1 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.

2. 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.

   Example 4: An MHP-level staff at a CMHC provides 2 units of Crisis Intervention in the office to a single recipient. Later that same day, the same MHP-level staff provides 2 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.

   Example 5: An RSA-level staff at a CMHC provides 2 units of Community Support Individual to a single recipient at the recipient's school. Later that same day, an RSA-level staff provides 3 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 using the following coding summary:

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