

## 3 Clinic Guidelines

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## 3.1 Mental Health (MH) Clinic Service Policy

### 3.1.1 Introduction

This section covers all Medicaid services provided by mental health (MH) clinics and diagnostic screening clinics as deemed appropriate by the Idaho Department of Health and Welfare (IDHW). It addresses the following:

- Provider enrollment and credentialing.
- Psychotherapy and diagnostic screening.
- Record keeping.
- Covered services.
- Exclusions.
- Reporting requirements.
- Claims payment.
- Claim billing.

### 3.1.2 Overview

The MH Clinic Program is designed to promote overall mental wellness for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all MH clinic services must be provided at the clinic, unless provided to an eligible homeless individual per regulations. Services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid-covered MH clinic services.

#### 3.1.2.1 Provider Enrollment and Credentialing

In order to become enrolled as a Medicaid mental health clinic provider, the provider applicant must meet the requirements established through the credentialing program as identified in *IDAPA 16.03.09.712 Mental Health Clinics Services – Credentialing Responsibilities of the Department*. All existing MH clinic providers must meet the requirements of the credentialing program on a schedule established by DHW.

All locations where Medicaid MH clinic services are provided must be registered with DHW and must have a valid Provider Agreement. Mental health clinics must obtain a provider number for each location where they provide services.

#### 3.1.2.2 Physician Requirement

All MH clinics must have a contract with a medical doctor or doctor of osteopathy in which the doctor agrees to perform the following:

- See each participant at least once annually in order to establish medical necessity for clinic services. See *IDAPA 16.03.09.714.07.b Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant's Care*.
- Review and sign the treatment plan and all treatment plan updates. See *IDAPA 16.03.09.714.07c-.d Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant's Care* and *IDAPA 16.03.09.710.04 Mental Health Clinic Services – Written Individualized Treatment Plans*.
- Provide overall clinic supervision, as indicated in *IDAPA 16.03.09.714.06 Mental Health Clinic Services – Provider Agency Requirements; Physician Requirement for Clinic Supervision*, and agree to spend as much time in the clinic as is necessary to assure that all participants are receiving services in a safe and efficient manner.

### 3.1.2.3 Services

Mental health clinic services are provided by professionals who are trained to perform evaluation, diagnostic, and treatment services to participants with a variety of mental health needs. Available services for participants in the **Medicaid Basic Plan** include the following:

- Intake, Comprehensive Diagnostic, or Functional Assessments
  - Assessments must be performed prior to delivery of treatment services.
  - Assessments must be performed by qualified professionals as described in *IDAPA 16.03.09.715 Mental Health Clinic Services – Agency Staff Qualifications*.
  - Providers must ensure assessments are conducted to match program requirements.
  - See *IDAPA 16.03.09.709.03, Mental Health Clinic Services – Coverage and Limitations, Evaluation and Diagnostic Services in Mental Health Clinics*.
- Psychological or Neuropsychological Testing
  - Testing may be performed to provide additional clinical information when medically necessary.
  - Testing must be provided by qualified licensed professionals within the scope of their license.
  - See *IDAPA 16.03.09.709.03.d and e, Mental Health Clinic Services – Coverage and Limitations, Evaluation, and Diagnostic Services in Mental Health Clinics*.
- Occupational Assessment and Therapy
  - Assessment and therapy must be performed by licensed occupational therapists.
  - See *IDAPA 16.03.09.709.03.f and 16.03.09.709.11, Mental Health Clinic Services – Coverage and Limitations, Evaluation and Diagnostic Services in Mental Health Clinics and Occupational Therapy Services*.
- Individual, Group, and Family Psychotherapy
  - Psychotherapy must be provided by qualified licensed professionals within the scope of their license.
  - See *IDAPA 16.03.09.709.04 and 05, Mental Health Clinic Services – Coverage and Limitations, Psychotherapy Treatment services in Mental Health Clinics and Family Psychotherapy*.
- Emergency Psychotherapy
  - In the event of a psychiatric emergency, providers may deliver psychotherapy prior to intake or evaluation services.
  - Psychotherapy must be provided by qualified licensed professionals within the scope of their license.
  - Psychotherapy must be counted toward the allowable service limit unless the participant's contact results in hospitalization.
  - See *IDAPA 16.03.09.709.06, Mental Health Clinic Services – Coverage and Limitations, Emergency Psychotherapy Services*.
- Pharmacological Management
  - In addition to management of medication, this service includes brief psychotherapy.
  - Pharmacological management must be provided by qualified licensed professionals within the scope of their license.

- See *IDAPA 16.03.09.709.08, Mental Health Clinic Services – Coverage and Limitations, Pharmacological Management.*
- Nursing Services
  - Services must be ordered and supervised by a physician.
  - Services must be provided by qualified licensed professionals within the scope of their license.
  - See *IDAPA 16.03.09.709.09, Mental Health Clinic Services – Coverage and Limitations, Nursing Services.*
- Collateral Contact
  - Collateral contact cannot be used to bill Medicaid for therapy to an ineligible person or for an individual who is a resident of a public institution or a nursing home, including an intermediate care facility for developmentally disabled/mentally retarded (CF/MR).
  - Collateral contact must result in an action or service that directly benefits the participant.
  - Medicaid does not reimburse for parent education or other parent support groups.
  - See *IDAPA 16.03.09.709.07, Mental Health Clinic Services – Coverage and Limitations, Collateral Contact.*

A total of 12 hours per calendar year of evaluative or diagnostic services are allowed. A maximum of two hours are allowed per calendar year for treatment plan development.

*Medicaid Basic Plan* participants are limited to 26 services for any combination of Mental Health Clinic services. The 12 hours of evaluative or diagnostic services count toward the 26 services limitation. See *IDAPA 16.03.09.709.10; Mental Health Clinic Services – Coverage and Limitations, Limits on Mental Health Clinic Services.*

For participants in the **Medicaid Enhanced Plan**, in addition to the services specified above, the following Mental Health Clinic benefits are available:

- Partial Care Services
  - Partial care services may only be provided when other services have failed or are not appropriate for the clinical needs of the participant.
  - These services are limited to 12 hours per week.
  - Services must be provided by qualified licensed professionals within the scope of their license.
  - See *IDAPA 16.03.10.111.18; Enhanced Outpatient Mental Health Services – Definitions, Partial Care; IDAPA 16.03.10.112.01; Enhanced Outpatient Mental Health Services – Participant Eligibility, General Participant Eligibility Criteria; and IDAPA 16.03.10.118.02; Enhanced Outpatient Mental Health Services – Descriptions – Partial Care Services.*
- Psychotherapy services
  - Psychotherapy service includes individual, group, or family psychotherapy and emergency psychotherapy services.
  - These services are limited to 45 hours annually in any combination.
  - Services must be provided by qualified licensed professionals within the scope of their license.
  - See *IDAPA 16.03.10.111.22; Enhanced Outpatient Mental Health Services – Definitions, Psychotherapy and IDAPA 16.03.10.118.01; Enhanced Outpatient Mental Health Services – Descriptions, Psychotherapy.*

**Note:** Services not approved in the treatment plan must be documented as indicated in *Section 3.1.4 Record Keeping*.

### 3.1.3 Exclusions

Mental health clinic services are not reimbursable when performed outside of the clinic; when provided in an institution; when performed by a non-qualified staff person; or when not adequately documented in the participant's record.

See *IDAPA 16.03.09.711; Mental Health Clinic Services – Excluded Services Not Reimbursable Under Medicaid*.

### 3.1.4 Record Keeping

Each mental health clinic is required to maintain medical records on all services provided to Medicaid participants. The record must contain a current treatment plan based on an individual assessment of the participant's needs and signed by a physician within 30 days of the initiation of treatment in the clinic.

Services must be provided in accordance with the current treatment plan, and the records must contain all of the following in a legible format::

- The exact type of treatment provided.
- Who provided the treatment.
- The duration of the treatment and the start time and stop time of day delivered.
- Detailed records of exactly what occurred during the therapy session or participant contact documented by the person who delivered the service.
- The legible, dated signature, with degree credentials listed of the staff member performing the service.

Any service not adequately documented in the participant's record by the signature of the treatment professional providing the service or participant contact, the length of the session, and the date of the contact will not be reimbursed by the Department.

See *IDAPA 16.03.09.716 Mental Health Clinic Services – Record Requirements for Providers*.

### 3.1.5 Determining How to Bill Units for 15-Minute Timed Codes

Several CPT and HCPCS codes used for evaluations, therapy modalities, procedures, and collateral contact specify that one unit equals 15 minutes. Providers bill procedure codes for services delivered using these codes and the appropriate number of units of service. Providers should not bill for services performed for less than eight minutes. This time should be documented though it may not be billed for that day unless additional service time occurs on that same day for the same participant. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

For any single procedure code, providers bill one 15-minute unit for treatment greater than or equal to eight minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes and less than 38 minutes.

Time intervals for larger numbers of units are as follows:

**3 units ≥ 38 minutes to < 53 minutes**

**4 units ≥ 53 minutes to < 68 minutes**

**5 units ≥ 68 minutes to < 83 minutes**

**6 units ≥ 83 minutes to < 98 minutes**

**7 units ≥ 98 minutes to < 113 minutes**

**8 units ≥ 113 minutes to < 128 minutes**

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than eight minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with the note describing the treatment. (For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.)

### 3.1.6 Billing Procedure for Date Spanning

The dates of service billed on a single detail line must be within the Sunday through Saturday calendar week. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one detail line. When date spanning, services must have been provided for every day within that span. For example, it would be incorrect to date span the entire week when services were only performed on Thursday and Saturday. Additionally, it would be inappropriate to date span bill if services were provided on a Monday and a Friday but there were no services offered in between those days.

#### Example:

Services provided to the participant on:

- Thursday, December 11, 2008
- Saturday, December 13, 2008

Enter each date on a separate detail line.

Date(s) of Service	Procedure Code	Charges
12/11/2008 – 12/11/2008	XXXXX	\$XXX.XX
12/13/2008 – 12/13/2008	XXXXX	\$XXX.XX

### 3.1.7 Procedure Codes

Idaho Medicaid uses the following 5-digit codes for MH clinic services:

Service	CPT or HCPCS	Description
<b>Diagnosis and Evaluation</b>		
Medical report based on new exam	<b>90889</b>	Preparation of report on participant's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) <i>for other physicians, agencies, or insurance carriers</i> . Bill with the appropriate MH diagnosis. 1 Unit = 1 Report

Service	CPT or HCPCS	Description
Medical report on past record, rather than new exam	<b>90885</b>	Psychiatric evaluation of hospital records or other psychiatric reports and tests <i>for medical diagnostic purposes</i> . Must use the appropriate MH diagnosis. 1 Unit = 1 Report
Intake assessment	<b>T1028</b>	Initial intake work done by a new agency for basic services only. This service may also be performed when a participant transfers to a new agency. Includes time with the participant and informants, and preparing the report. 1 Unit = 15 Minutes
Comprehensive diagnostic assessment	<b>90801</b> <b>U1</b> Modifier is required when provided by physician	Primary diagnostic assessment. Includes time with the participant and informants, and preparing the report.  1 Unit = 15 Minutes
Interactive comprehensive diagnostic assessment	<b>90802</b> <b>U1</b> Modifier is required when provided by physician	Interactive primary diagnostic assessment using play equipment, physical devices, language interpreter, or other mechanisms of communication. Includes time with the participant and informants, and preparing the report.  1 Unit = 15 Minutes
Functional assessment <i>Available to Medicaid Enhanced Plan Participants only</i>	<b>H0031</b>	Assessment used to determine the need for partial care services. Only used when a participant's comprehensive diagnostic assessment indicates the need for skill training. Includes time with the participant and informants, and preparing the report.  1 Unit = 15 Minutes
Psychological testing	<b>96101</b>	Psychological testing per hour. Includes face-to-face time with the participant, time interpreting test results, and preparing the report. 1 Unit = 1 Hour
Psychological testing, by technician	<b>96102</b>	Psychological testing with qualified health care professional interpretation and reporting, administered by a technician, per hour of technician time, face-to-face. 1 Unit = 1 Hour.
Psychological testing, by computer	<b>96103</b>	Psychological testing administered by computer with qualified health care professional interpretation and reporting. 1 Unit = 1 Test
Neuropsychological testing	<b>96118</b>	Neuropsychological testing Includes face-to-face time administering tests to the participant, interpreting the test results, and preparing the report. 1 Unit = 1 Hour
Neuropsychological testing, by technician	<b>96119</b>	Neuropsychological testing With qualified health care professional interpretation and reporting, administered by a technician face-to-face, per hour of technician time.  1 Unit = 1 Hour

Neuropsychological testing, by computer	<b>96120</b>	Neuropsychological testing Administered by computer.  1 Unit = 1 Test
<b>Individual and Group Psychotherapy</b>		
Individual psychotherapy	<b>90804</b> <b>90806</b> <b>90808</b> <b>UA</b> Modifier is required when provided by physician	Individual psychotherapy, approximately 20-30 minutes face-to-face with the patient ( <b>90804</b> ). The codes are based on length of time spent with the participant. Providers should select the code that is closest to the duration of the session and bill the code as 1 unit. <b>90804</b> = 20-30 Minutes; <b>90806</b> = 45-50 Minutes; <b>90808</b> = 75-80 Minutes.
Group psychotherapy	<b>90853</b> <b>U1</b> Modifier is required when provided by physician	Group psychotherapy, with two or more participants. Must be face-to-face.  1 Unit = 15 Minutes
Family psychotherapy	<b>90847</b> <b>U1</b> Modifier is required when provided by physician	Family psychotherapy (with patient present) Must be face-to-face.  1 Unit = 15 Minutes
Family psychotherapy without participant present	<b>90846</b> <b>U1</b> Modifier is required when provided by physician	Family psychotherapy (without patient present). Must be face-to-face with at least one family member present. The participant must be the focus of the services.  1 Unit = 15 Minutes
Interactive individual psychotherapy	<b>90810</b> <b>90812</b> <b>90814</b> <b>UA</b> Modifier is required when provided by physician	Individual psychotherapy that is interactive; e.g., using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication. Approximately 20-30 minutes face-to-face with the patient ( <b>90810</b> ). The codes are based on length of time spent with the participant. Providers should select the code that is closest to the duration of the session and bill the code as 1 unit. <b>90810</b> = 20-30 Minutes; <b>90812</b> = 45-50 Minutes; <b>90814</b> = 75-80 Minutes.

Service	CPT or HCPCS	Description
Interactive group psychotherapy	<b>90857</b> <b>U1</b> Modifier is required when provided by physician	Interactive group psychotherapy; e.g., using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication.  Must be face-to-face.  1 Unit = 15 Minutes
Collateral contact	<b>90887</b>	Coordination of care communication that is initiated by a medical or qualified treatment professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. This communication is limited to interpreting or explaining the results of psychiatric or other medical examinations and procedures, or other accumulated data, to family or responsible persons, or advising them how to assist the participant. Can be face-to-face or by telephone if that is the most expeditious and effective way to exchange information. Specify person contacted and relationship to the participant. 1 Unit = 15 Minutes
Partial care  <i>Available to Medicaid Enhanced Plan Participants only</i>	<b>H2014</b>	Skills training and development. Partial care services are structured group programs of therapeutic interventions. This service must be provided at the clinic.  1 Unit = 15 Minutes
Pharmacologic management	<b>90862</b>	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.  1 Unit = 1 Visit
Nursing service	<b>T1001</b>	Nursing assessment: Evaluation also includes review of lab results, face-to-face physician and/or participant consultation to discuss the participant's condition, or face-to-face physician contact to obtain prescription refills.  1 Unit = 15 Minutes
Blood drawing fee	<b>36415</b>	Routine venipuncture for collection of specimen(s).  1 Unit = 1 Visit
Medication injection	<b>96372</b>	Therapeutic, prophylactic, diagnostic (specify material injected), subcutaneous, or intramuscular injection. Includes nurse time and administration.  1 Unit = 1 Injection
Medication supply	<b>J3490</b>	Unclassified drugs. Specify medication and dosage. Use of this code requires submission of the National Drug Code (NDC); note the drug code in the comments field of the claim.

Occupational therapy (individual)	<b>97535</b>	For purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health in individuals who are limited by the symptoms of their mental illness. Direct one-on-one contact by provider.  1 Unit = 15 Minutes
Interpretive services	<b>8296A</b>	Interpretive services, performed by non-certified, partially certified, and certified personnel.  1 Unit = 1 hour
Sign language interpretive services	<b>T1013</b>	Sign language interpretive services, performed by non-certified, partially certified, and certified personnel.  1 Unit = 15 minutes

### 3.1.7.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS codes must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each medication. This requirement applies to claims submitted electronically and on the paper CMS-1500 claim form.

The HCPCS medications that require NDC information are listed in the current *Healthcare Common Procedure Coding System (HCPCS) Manual; Appendix 3*, alphabetically by both generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with *EOB 628, NDC required*.

The collection of the NDC information allows Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program. This requirement is mandated by the Center for Medicare and Medicaid Services (CMS), which requires all states to develop systems to claim drug rebates when Medicaid pays any portion of a drug claim. See State Medicaid Director Letter #06-016 at: <http://www.cms.hhs.gov/smdl/downloads/SMD071106.pdf>

**Electronic Claims:** For professional providers that use the PES billing software (provided by EDS at no cost), a HIPAA compliant field to report the NDC information is included. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information at:

**(208) 383-4310 in the Boise calling area**

**(800) 685-3757 (toll free)**

To enter NDC data in the PES software, complete the Service and RX Tab fields using the following guidelines:

**Service Tabs:**

- Step 1 Complete Service Tabs 1 and 2 as appropriate.
- Step 2 Select Service Tab 3 and complete the appropriate fields.
- Step 3 Enter Y in the RX Ind field to open the RX Tab.

**RX Tab:** Complete the following fields:

- NDC: Enter the 11-digit NDC number.
- Prescription Number: Not required.
- Units: Enter the units dispensed. Refer to the *Healthcare Common Procedure Coding System (HCPCS) Manual; Appendix 3*, for brief directions regarding the, Amount (Unit) column.
- Basis of Measurement: Enter IU (International Units); GR (Grams); ML (Milliliters); or UN for (Unit).
- Unit Price: Enter the price for the HCPCS medication dispensed.

See the *Provider Electronic Solutions (PES) Handbook; Section 9 (837 Professional Forms)*, for more information on completing the Rx fields.

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

**Paper Claims:** Submission of an NDC Detail Attachment is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the NDC Detail Attachment is available in *Appendix D; Forms*, and can be used as a master copy.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

### 3.1.8 Mental Health (MH) Clinic Modifiers

Some procedure codes may require a modifier. Refer to the procedure code table listed for the specific modifiers needed.

### 3.1.9 Place-of-Service (POS) Codes

Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

- 11 Office
- 99 Other - Community (used only when clinic services have been provided to an eligible homeless individual)

### 3.1.10 Specialized Services to Nursing Facility Participants

Psychotherapy may be provided to a participant residing in a nursing facility if the following criteria are met:

- The participant has been identified through the initial Pre-Admission Screening/Annual Resident Review (PASARR) process as being mentally ill.
- The participant has been identified through the PASARR level II screening process as requiring psychotherapy, as a specialized service.
- The participant, when informed of their options for service delivery, chooses a MH clinic to provide that service.
- The service is provided outside the nursing facility at a Mental Health Clinic.

Psychotherapy is:

- Supported by the independent evaluations completed and approved by DHW.
- Incorporated into the participant's medical care plan.
- Directed toward the achievement of specific, measurable objectives that include target dates for completion.

Regional Medicaid Services (RMS) offices are responsible for assuring the participant is identified as needing specialized services and for assigning prior authorization (PA) numbers for clinic services. The PA number must be included on the claim submitted for payment or the claim will be denied.

#### 3.1.10.1 Procedure Codes for Psychotherapy

All claim forms for psychotherapy participants who reside in Nursing Facilities must include the listed modifier with one of the following procedure codes.

Service	HCPCS or CPT Code	Description
Individual psychotherapy For participants who reside at nursing facilities	<b>H0004</b> <b>U4</b> Modifier required <b>U1</b> Modifier is required when provided by physician	Individual psychotherapy. Must be conducted at the clinic and be face-to-face.  1 Unit = 15 Minutes

Service	CPT or HCPCS	Description
Individual interactive psychotherapy For participants who reside at nursing facilities	<b>90899</b> <b>U4</b> Modifier required <b>U1</b> Modifier is required when provided by physician	Individual interactive psychotherapy; e.g., using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication. Must be conducted at the clinic and be face-to-face.  1 Unit = 15 Minutes
Group psychotherapy For participants who reside at nursing facilities	<b>90853</b> <b>U4</b> Modifier required <b>U1</b> Modifier is required when provided by physician	Group psychotherapy, two or more individuals. Must be conducted at the clinic and be face-to-face.  1 Unit = 15 Minutes
Group interactive psychotherapy For participants who reside at nursing facilities	<b>90857</b> <b>U4</b> Modifier required <b>U1</b> Modifier is also required when provided by physician	Interactive group psychotherapy; e.g., using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication. Group includes two or more individuals. Must be conducted at the clinic and be face-to-face.  1 Unit = 15 Minutes
Family psychotherapy For participants who reside at nursing facilities	<b>90847</b> <b>U4</b> Modifier required <b>U1</b> Modifier is also required when provided by physician	Family psychotherapy, with participant present. Must be conducted at the clinic and be face-to face.  1 Unit = 15 Minutes
Family psychotherapy without participant present For participants who reside at nursing facilities	<b>90846</b> <b>U4</b> Modifier is required <b>U1</b> Modifier is also required when provided by physician	Family psychotherapy without participant present. Must be face-to-face with at least one family member present. The participant must be the focus of services. Must be conducted at the clinic.  1 Unit = 15 Minutes.

## 3.2 Diagnostic Screening Clinic Service Policy

### 3.2.1 Overview

Diagnostic screening clinics coordinate the treatment between physicians and other medical professionals for Medicaid participants diagnosed with Cerebral Palsy, Myelomeningitis, or other neurological diseases and injuries with comparable outcomes. The clinic must be established as a separate and distinct entity from the hospital, physician, or other provider practices.

### 3.2.2 Multidisciplinary Assessment and Consultation

The clinic must perform an on-site multidisciplinary assessment and consultation with each participant and responsible parent or guardian. Diagnostic and consultation services related to the diagnosis and treatment of the participant are provided by board-certified physicians who are specialists in physical medicine, neurology, and orthopedics.

### 3.2.3 Service Limitations

As part of a diagnostic assessment, a medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of the participant. The clinic may bill no more than five hours of medical social services, per participant, during each state fiscal year (July 1-June 30).

**Note:** Diagnostic screening clinic services are a covered benefit for Medicaid Enhanced Plan participants.

## 3.3 Claim Billing

### 3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

**Note:** All claims must be received within 12 months (365 days) of the date of service.

### 3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claim Submission, General Billing Information*, for more information.

#### 3.3.2.1 Guidelines for Electronic Claims

**Provider Number:** In compliance with HIPAA and the National Provider Identifier (NPI) initiative, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

**Detail Lines:** Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

**Referral Number:** A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a Healthy Connections (HC) participant. For HC participants, enter the provider's 9-digit HC referral number.

**Prior Authorization (PA) Numbers:** Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

**Modifiers:** Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

**Diagnosis Codes:** Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

**National Drug Code (NDC) Information with HCPCS and CPT Codes:** A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.1.8.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes*, for more information.

**Electronic Crossovers:** Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

### 3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

**Example:** July 4, 2006 is entered as 07042006.



Field	Field Name	Use	Directions
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Required, if applicable	Required, if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	OTHER INSURED'S DATE OF BIRTH/SEX	Required, if applicable	Required, if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	EMPLOYER'S NAME OR SCHOOL NAME	Required, if applicable	Required, if field 11d is marked yes.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required, if applicable	Required, if field 11d is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	IS PATIENT'S CONDITION RELATED TO EMPLOYMENT?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	IS PATIENT'S CONDITION RELATED TO AUTO ACCIDENT?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items 9a - 9d.
14	DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	BLANK FIELD	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier 1D followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier 1D followed by the 9-digit HC referral number. <b>Note:</b> The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit National Provider Identifier (NPI). <b>Note:</b> The NPI number, sent on paper claims, will not be used for claims processing.

Field	Field Name	Use	Directions
19	RESERVED FOR LOCAL USE	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the Internal Control Number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the appropriate ICD-9-CM code up to four, for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	PRIOR AUTHORIZATION NUMBER	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	DATE(S) OF SERVICE FROM/TO	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003, becomes 11242003 with no spaces and no slashes.
24B	PLACE OF SERVICE	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	PROCEDURES, SERVICES, OR SUPPLIES; CPT/HCPCS	Required	Enter the appropriate 5-character CPT/HCPCS procedure code to identify the service provided.
24D 2	PROCEDURES, SERVICES, OR SUPPLIES; MODIFIER	Desired	If applicable, add the appropriate CPT/HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	DIAGNOSIS POINTER	Required	Use the number of the subfield 1 - 4 for the diagnosis code entered in field 21.
24F	\$ CHARGES	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	DAYS OR UNITS	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT FAMILY PLAN	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening Diagnosis and Treatment (EPSDT) Program screen, see <i>Section 1.6 Child Wellness</i> for more information.
24I	ID. QUAL.	Required, if applicable	Enter qualifier 1D followed by the 9-digit Idaho Medicaid provider number in 24J.
24J	RENDERING PROVIDER ID. #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the 1D qualifier was entered in 24I. <b>Note:</b> If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID. # field. <b>Note:</b> Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	TOTAL CHARGE	Required	The total charge entered should be equal to all of the charges for each detail line.



3.3.3.4 Sample Paper Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX MM DD YY M F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? 10d. RESERVED FOR LOCAL USE									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F										a. INSURED'S DATE OF BIRTH SEX MM DD YY M F									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)										20. OUTSIDE LAB? \$ CHARGES YES NO									
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
1. 2. 3. 4.										23. PRIOR AUTHORIZATION NUMBER									
F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO									
SIGNED DATE										28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$									
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH. # ( ) a. NPI b.									

NUCC Instruction Manual available at: www.nucc.org

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