BlueCross BlueShield of Illinois

CMHC Services Billing Guideline, Effective May 1, 2017

In accordance with instructions from the Illinois Department of Health and Family Services (HFS), this document sets forth the established standardized claims submission processes which all certified Community Mental Health Centers (CMHCs) providers that are contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) must follow in order to be eligible for reimbursement of covered services rendered to eligible Blue Cross Community Options℠ members.

Services Overview

The required mental health services covered by BCBSIL under the Blue Cross Community Options program are detailed in the Service Definition and Reimbursement Guide (SDRG) established by HFS, or its successor Provider Handbook. The SDRG can be found at **https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/CMHP.aspx.**

Definitions

The following are common terms used throughout this Billing Guide:

1. **Clinician** refers to the qualified individual within a CMHC site delivering a covered service.
2. **Provider** refers to a uniquely certified CMHC site, operating under a distinct National Provider Identifier (NPI) number.
3. **Rolled Up** refers to how a provider may bill for numerous incidents of the same service provision during a day, done by adding separate units of the service provided together onto one service line on a claim for the purposes of billing (please see the Billing Examples section for additional details).
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.

General Claims Submission Requirements

1. CMHC services are categorized as professional by Illinois Department of Human Services (IDHS) and must be billed as an electronic professional claim (837P transaction), or on the CMS-1500 claim form if submitting paper.
2. CMHC services may only be rendered from an IDHS certified site.
3. Providers with multiple certified sites offering both substance abuse (DASA) and mental health services (CMHC) from the same site must obtain and report a unique NPI for each service type (i.e., one for DASA services and another for CMHC).
4. BCBSIL has edits in place to ensure that only compliant claims are accepted in order to ensure successful encounter submission to HFS. Claims that are submitted that are not compliant will be rejected and not processed. To ensure this edit rule does not impact claim submissions, a provider must:
   - Ensure the **NPI** used to file claims is registered with HFS via Impact.
   - Ensure the associated **Provider Type** and **Categories of Service** (COS) on file are appropriate for the services billed.
   - For electronic claims, except for Availity™ and Experian Health, the Payer ID is MCDIL. For all other clearinghouses, providers should confirm the correct Payer ID; the Payer ID should tie to BCBSIL-Blue Cross Community Options Program (IL Medicaid).
   - Ensure that the **Taxonomy Code** is appropriate for services delivered, and is included on the claim. **261QM0801X** is the current assignment for Mental Health Clinic/Center, as published in the HFS Handbook for Electronic Processing, Chapter 300 – Requirements for Electronic Processing in the Category of Service/Taxonomy Default Table for 837P at **https://www.illinois.gov/hfs/SiteCollectionDocuments/060607_app5.pdf**.

Place of Service (POS) Codes

The following place of service codes must be utilized for CMHC billing:

- **11 – Office**
- **12 – Home**
- **99 – Other Place of Service**

POS Codes using HT Modifier

When billing Crisis Intervention (H2011-HT) or Crisis Intervention Pre-hospitalization screening (T1023-HT), the following POS codes must be used if the service is performed with multiple staff:

- **03 – School**
- **04 – Homeless Shelter**
- **12 – Home**
- **13 – Assisted Living Facility**
- **14 – Group Home**
- **31 – Skilled Nursing Facility**
- **32 – Nursing Facility**
- **33 – Custodial Care Facility**
- **49 – Independent Clinic**
- **50 – Federally Qualified Health Center**
- **71 – State or Local Public Health Clinic**
- **72 – Rural Health Clinic**
- **99 – Other Place of Service**

Benefit Preauthorization Requirements

The following CMHC Services require benefit preauthorization:

SERVICE TYPE	CPT CODE	MODIFIER
Assertive Community Treatment	H0039	none
Community Support Team	H2015	HT
Community Support Residential	H2015	HE, HM
Community Support Residential	H2015	HE, HN
Community Support Residential	H2015	HE, HO
Community Support Residential	H2015	HE, HM, HQ
Community Support Residential	H2015	HE, HN, HQ
Community Support Residential	H2015	HE, HO, HQ
Intensive Outpatient Treatment	S9840	none
Psychosocial Rehabilitation	H2017	none

Credentialing Requirements

1. CMHC certified sites must be participating with IL Medicaid and must be credentialed with BCBSIL in order to provide services to eligible members.

Rendering and Billing Provider

1. **Billing Provider:** Billing Provider represents the payee on an individual claim. The NPI corresponding to the payee ID that a provider wants the remittance advice and payments sent to 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.

CMHC as the Payee

It is permissible 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 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.

Duplicate Claiming

CMHCs may provide multiple units of the same service to the same recipient on the same day, provided claims are submitted following the appropriate guidelines: distinct procedure code, modifier and place of service combination.

CMHC 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 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 using the following coding summary:*

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 service lines on a single claim using the following coding summary:*

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. Service Line 1 will positively adjudicate, but Service Line 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 using the following coding summary:

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:*

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, 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 service lines using the following coding summary:*

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 distinct service lines 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 service lines using the following coding summary:*

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

This claim has not been billed appropriately. Service Line 1 will positively adjudicate, but Service Line 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).

Therefore, 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 using the following coding summary:

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