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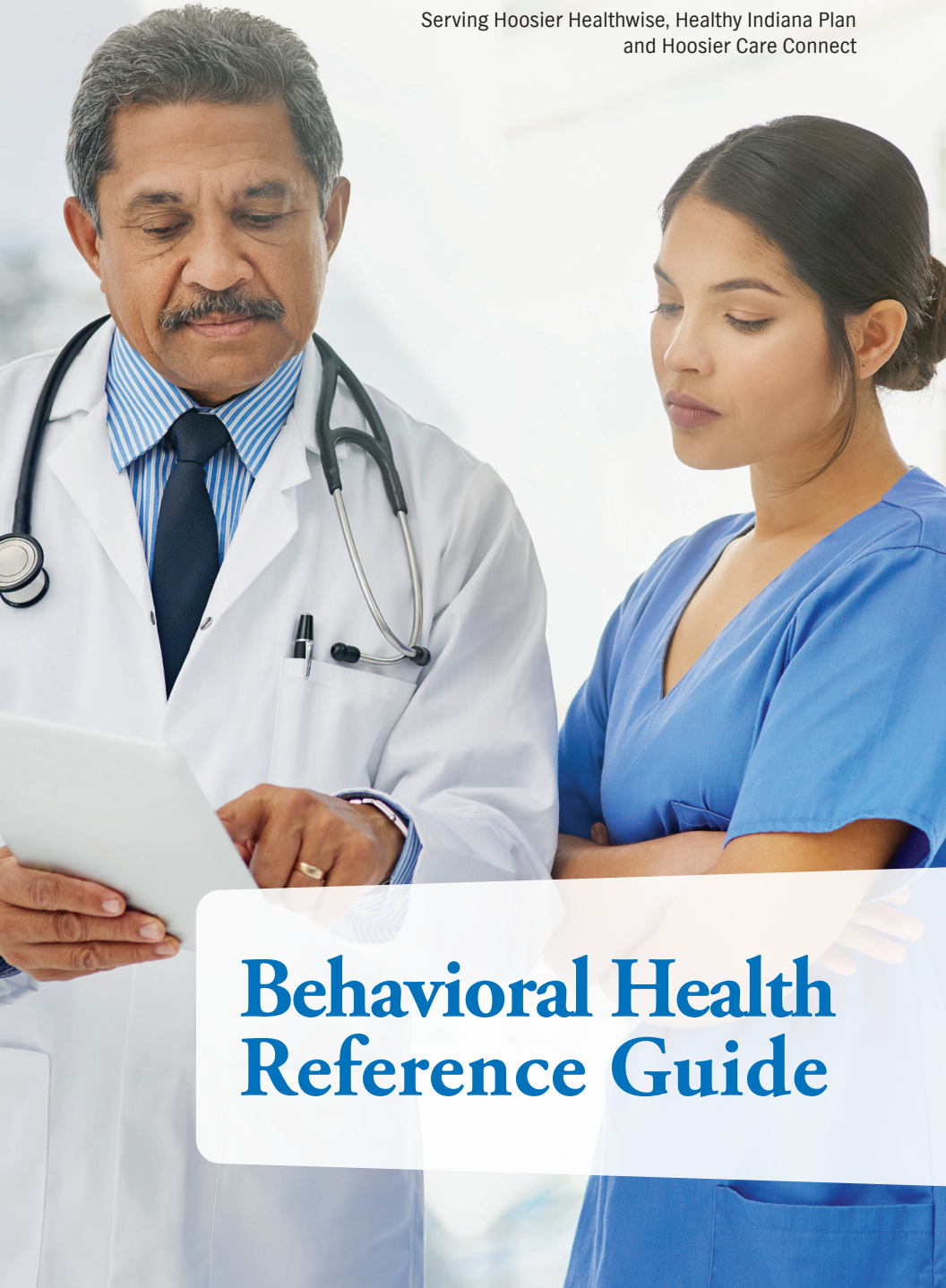
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect



Behavioral Health Reference Guide

Thank you

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

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Outpatient treatment services

Modifiers to use when a mid-level practitioner who is not enrolled in Indiana Medicaid under their own NPI is providing the service:

Behavioral health (BH) services provided by mid-level practitioners must be billed under the NPI of the supervising medical doctor or health service provider in psychology (HSPP) unless they have enrolled in Indiana Medicaid with their own NPI number. The procedure code must be accompanied by the applicable modifier to denote the level of the practitioner rendering the service.

The allowable mid-level modifiers are the following:

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

Effective November 1, 2020, Anthem follows Indiana Health Coverage Programs (IHCP) bulletins BT2020108 and BT2020122 that outline criteria required for mid-levels to enroll in Indiana Medicaid (under provider type 11: Behavioral Health Provider) and the specialties eligible outlined in BT2020122 listed in table 1.

- Providers enrolled under the new Indiana Medicaid type and specialty for mid-levels (BT2020108) and (BT2020122) do not bill with a modifier.
- Mid-level providers are able to continue to bill under a HSPP/physician using the appropriate mid-level modifiers if they choose not to enroll under the new provider type/specialty.

Notes:

- Per IHCP bulletin BT2020122, same day service NCCI edits may apply.
- 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. Please fax the form to **1-844-456-2698**. Providers should ensure they are coordinating care with the member's primary medical provider (PMP).

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 midlevel practitioner modifiers, and XE and XP modifiers, to identify different providers or different encounters for procedure-to-procedure (PTP) edit indicators.

Additionally, Anthem follows the state's Outpatient Fee Schedule payment methodology for treatment rooms and flat rate revenue codes that are limited to one per day.

For participating providers, prior authorization (PA) is not required for the services listed below. 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. Clinical documentation should be completed and maintained in accordance with the Indiana Administrative Code (IAC) and is subject to audit verification.

Procedure code:	Service:
90785	Interactive complexity add-on code
90791[1]	Psychiatric diagnostic evaluation
90792[1]	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	Psychotherapy for crisis
90840	Psychotherapy for crisis, each additional 15 minutes
90845	Psychoanalysis
90846	Family therapy, without patient
90847	Family therapy, with patient
90849	Medical psychotherapy, multi-family group
90853	Group therapy
99407	Behavior change – smoking (more than 10 minutes)
99408	SBI – alcohol and/or substance abuse structured screening
99409	SBI – alcohol and/or substance abuse structured screening
99201-99205, 99211-99215	Pharmacological management (for evaluation and management [E&M] visits)

1 For 90791 and 90792, reimbursement is available without PA for one unit per member, per provider, per rolling 12-month period. All additional units require PA with the exception that two units are allowed per rolling 12-month period without PA 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).

Some codes include add-on codes to designate complex interactions. When an add-on code is used, the code for the primary procedure must also be billed on the same claim to ensure correct claim adjudication.

This is not an all-inclusive list of covered BH services, only those services which do not require PA. Providers can verify the coverage and PA status of a procedure code using the Provider Look-up Tool at **www.anthem.com/inmedicaiddoc**.

Psychological and neuropsychological testing

Psychological and neuropsychological testing requires PA. PA can be obtained via the Availity* Portal or by submitting the following documentation by fax to **1-844-456-2698:**

- 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 PA, which can be obtained by using the Availity Portal.
- All PA requests should be submitted within 48 business hours of the admission (excludes weekends and holidays).
- For inpatient detox admissions, the state's *Substance Use Disorder (SUD)* form is required and must be included.

Seven-day Follow-Up After Hospitalization for Mental Illness (FUH) for inpatient or ER visit

- Anthem recommends that members being discharged from an acute psychiatric facility be scheduled for a seven-day follow-up appointment with a provider with the appropriate credentials.

Partial hospitalization services

- All partial hospitalization services require PA, which can be obtained via the Availity Portal.
- Partial hospitalization should be billed on the *UB-04* with CPT® code H0035 with revenue codes 912 or 913.

Intensive outpatient services (IOP)

- Effective July 1, 2019, we cover intensive outpatient services (IOP) for Hoosier Healthwise, HIP and Hoosier Care Connect members.
- Authorization for IOP services is required and can be obtained via the Availity Portal.
- IOP services for a facility should be billed on a *UB-04* claim form 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.
- See BT201929 for detailed information regarding coverage and limitations.

Crisis intervention and peer recovery

- Effective July 1, 2019, Anthem covers Hoosier Healthwise, HIP and Hoosier Care Connect members for crisis intervention (H2011) and peer recovery services (H0038).
- Authorization is not required for crisis intervention.
- Peer recovery services are available without PA up to 365 hours (1,460 units) per rolling calendar year.
- See *Indiana Health Coverage Programs (IHCP) Bulletin BT201929* for detailed information regarding coverage and limitations.

Case management (CM)

- Hoosier Healthwise, HIP and Hoosier Care Connect members who are discharged from inpatient stays are provided case management (CM) support for a minimum of 90 days post discharge.
- Phone number: **1-866-902-1690**
- Fax number: **1-855-417-1289**

Applied behavioral analysis (ABA)

Applied behavioral analysis (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 PA, subject to the criteria outlined in *Indiana Administrative Code 405 IAC 5-3* for members age 20 and younger. **(For more information, see the *IHCP Bulletin BT201867* and the Anthem bulletin dated April 2019.)**

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 Board Certified Assistant Behavior Analyst (BCaBA) or RBT must be under the direct supervision of a BCBA, BCBA-D or an HSPP. IHCP enrolls BCBA-D and BCBA under provider type 11 and provider specialty 615.

Opioid treatment services

IHCP covers the rendering and reimbursement of opioid treatment services. Refer to the *IHCP Bulletin BT201755* for billing guidance and program details.

Provider requirements

A qualified provider must:

- Be enrolled with IHCP with a Behavioral Health 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*. Current participating providers with Anthem wanting to offer OTP services will need to complete the *PMF Form*.

Substance use disorder (SUD) treatment

Effective March 1, 2018, IHCP expanded coverage of substance use treatment to include residential treatment. Refer to *IHCP Bulletins BT201801 and BT201821* for billing guidance and program details. These services require PA, which can be obtained through the Availity Portal and must include the state's SUD forms.

Provider requirements for residential treatment

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 11 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

For psychiatric services, managed care members can self-refer to any IHCP-enrolled provider licensed to provide psychiatric services within their scope of practice. However, for BH services from any of the following provider types, self-referrals must be in-network (that is, to providers enrolled within the MCE network):

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Certified psychologists
- HSPPs
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses (APNs), under *Indiana Code IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (under *405 IAC 5-20-8*)
- Mid-level providers enrolled in the medicaid type and specialty outlined in BT2020122

Covered benefits

Hoosier Healthwise (packages A and C), HIP (including 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: Medicaid Rehabilitation Option (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. Notification of 1915(i) services to our care management department are appreciated.

Copays for HIP basic services (see *IHCP Bulletin BT201707*):

- Non-emergent use of the ER: $8
- Outpatient services: $4
- Inpatient services: $75
- Pharmacy: $4 for preferred and $8 for non-preferred

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

- Non-emergent 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 and tobacco cessation services 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, and Indiana Medicaid enrolled mid-level providers.
- 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 BCaBA, BCBA and 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 one business day of request
- Routine, nonurgent requests: seven calendar days
- Retrospective review requests: within 30 calendar 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

BH providers must have a system in place to ensure members are able to call after hours with questions or concerns. Anthem monitors BH provider compliance with after-hours access on a regular basis. Failure to comply may result in corrective action.

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 **1-855-535-7445**.

Standard appeal

A standard appeal allows members or providers acting on the member's behalf 60 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

Additional options in the event of an adverse decision

As of June 2018, a reconsideration process is available for providers following an adverse determination rendered for members during the reconsideration process. Providers will have an opportunity to submit additional information to substantiate medical necessity for a previously denied pre-service or concurrent inpatient stay.

Peer-to-peer — The peer-to-peer (P2P) process gives the provider an opportunity to discuss a medical necessity denial decision with a health plan medical director (or other appropriate practitioner) at any time during the reconsideration process; however, P2Ps are not available after an administrative denial.

Time frames for reconsideration of denied services:

- Reconsideration — within seven business days of denial date
- P2P — within seven business days of a denial date (initial or reconsideration)
- Appeals — within 60 calendar days of denial date

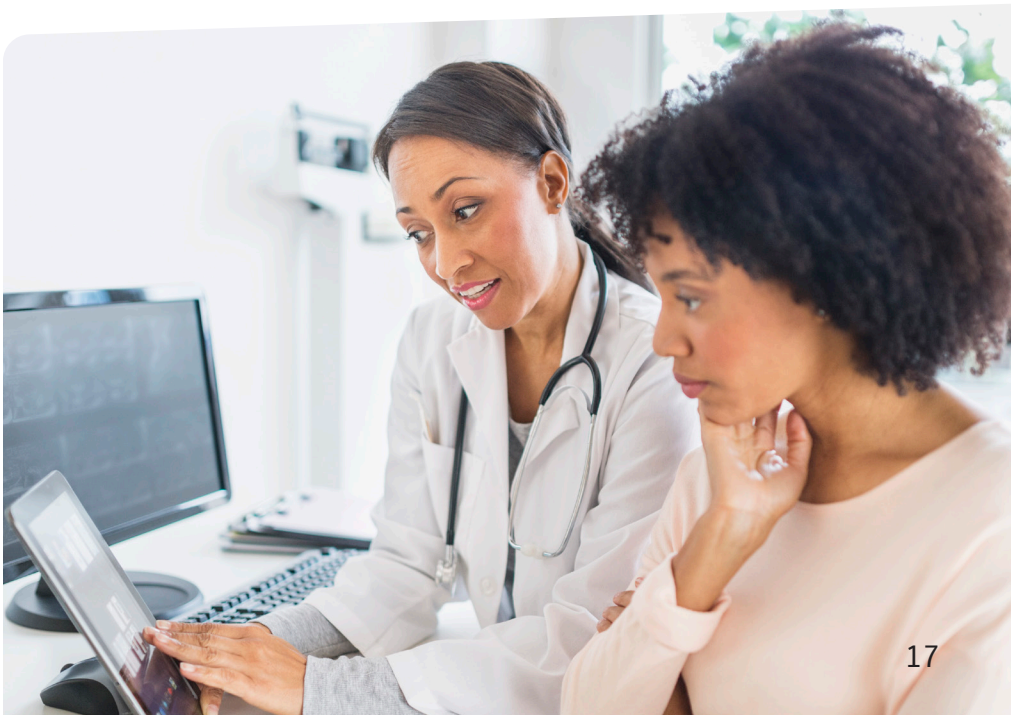
For the reconsideration process, please fax the supporting clinical information and state that the additional documentation is a **reconsideration** on your fax cover sheet. Please send the requested information to the appropriate fax number:

- Pharmacy fax: **1-888-209-7838**
- BH inpatient fax: **1-877-434-7578**
- BH outpatient fax: **1-866-877-5229**

The additional clinical information will be reviewed to determine if medical necessity criteria are met and the initial decision may be overturned. If the reconsideration request cannot be approved, the request will undergo review by an Anthem physician.

Once the health plan medical director (or appropriate practitioner) renders a decision, Anthem will send a fax notification to the provider. If the request has been approved after a reconsideration, the provider will be notified by fax and mail. If the denial is upheld, the provider will be notified by fax only of the decision along with applicable appeals rights.

Reconsideration is **not** an appeal and does not limit the subsequent P2P option or any appeal rights.



Claim Information

Electronic payer identification

Professional: 00630 Institutional: 00130

How to submit a claim payment dispute

We have several options to file a claim payment dispute:

- Verbally (for 1st level dispute only): Call Provider Services.
- Online (for 1st and 2nd level claim payment appeals): Use the secure provider Availity payment appeal tool at **www.availity.com.** Via the Availity Portal, you can upload supporting documentation and will receive immediate acknowledgement of your submission.
- Written (for 1st and 2nd level claim payment appeals): Mail all required documentation (see below for more details), including the *Provider Dispute Resolution Request* form, to:

  Anthem Blue Cross and Blue Shield
  Provider Disputes and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Availity Portal functionality includes:

- Immediate acknowledgement of submission.
- Notification when a reconsideration has been finalized by Anthem.
- A worklist of open submissions to check a reconsideration status.

To learn more about the Availity enhancements, register for a webinar or access a recorded webinar following these steps:

1. Log in to the Availity Portal at **www.availity.com** > Help & Training > Get Trained.
2. From the Availity Learning Center, enroll using one of the following methods:
   - Select the dashboard drop-down arrow and select Catalog > Sessions. Then, choose the date of the webinar and webinar title, and select **Enroll**.
   - While in the Catalog, select **Search**, enter the webinar title and select **Enroll**.

If you have questions, contact Availity at **1-800-282-4548**.

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 any required modifiers.
- 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) 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.

Billing and reimbursement for telemedicine services

When billing telemedicine services, providers must include **all three** of the following on the claim for dates of service on or after August 23, 2019:

- Valid procedure code from the telemedicine code set for the telemedicine service rendered (see *Telemedicine Services Codes*, accessible from the Code Sets page at **in.gov/medicaid/providers**)
- Place of service (POS) code 02 — the location in which health services and health-related services are provided or received, through a telecommunication system
- Modifier 95 – synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

If a claim includes POS code 02 or modifier 95, but not both, the claim detail will deny for *Explanation of Benefits (EOB)* 3428: "Telemedicine services require place of service 02 and modifier 95."

Important phone numbers

Behavioral Health Case Management referrals/ Right Choices Program		Phone: **1-866-902-1690**
Prior authorizations – BH	Hoosier Healthwise	Phone: **1-866-408-6132** Fax – inpatient: **1-844-452-8074** Fax – outpatient: **1-844-456-2698**
	HIP	Phone: **1-844-533-1995** Fax – inpatient: **1-844-452-8074** Fax – outpatient:**1-844-456-2698**
	Hoosier Care Connect	Phone: **1-844-284-1798** Fax – inpatient: **1-844-452-8074** Fax – outpatient: **1-844-456-2698**
Provider Services	Hoosier Healthwise	Phone: **1-866-408-6132**
	HIP	Phone: **1-844-533-1995**
	Hoosier Care Connect	Phone: **1-844-284-1798**
Availity		Phone: **1-800-282-4548**
Member Services and 24/7 NurseLine (for members)	Hoosier Healthwise and HIP	Phone: **1-866-408-6131** (TTY: **711**)
	Hoosier Care Connect	Phone: **1-844-284-1797** (TTY: **711**)
Transportation for members to covered services[1]		Phone:**1-844-772-6632** (TTY: **1-866-238-9816**) Email: indianatransportationpa@anthem.com

1 Anthem provides non-emergent transportation to Hoosier Healthwise, HIP and Hoosier Care Connect members. Two business days advance notice is required for routine transportation scheduling. Hoosier Care Connect members pay a $1 copay for each one-way trip (except members who are under age 18, pregnant, American Indian/Native Alaskan or receiving pregnancy/family planning services).

Behavioral Health department contact information

Contact your assigned BH Network Relations Relations consultant or email anthembehavioral@anthem.com.

SUD resources

- SUD facts in Indiana: **https://bit.ly/36hx5Aj**
- Fact sheet: **https://www.in.gov/recovery/files/oud-facts-sheet.pdf**
- BeWell Indiana SUD resources: **https://bewellindiana.com/substance-use-disorder-resources**
- Identification and Treatment of Substance Use Disorders: **http://anthem.ly/3t4KrK7**
- Anthem SUD presentation: **https://bit.ly/3ovly6S**
- IHCP update: **http://provider.indianamedicaid.com/ihcp/Bulletins/BT202104.pdf**
- Link to Anthem *Medical Policies* and *Clinical UM Guidelines*: **https://www.anthem.com/provider/policies/clinical-guidelines/search**

Opioid resources

- CDC opioid resources: **https://www.cdc.gov/rxawareness/information/index.html**
- Indiana State Department of Health opioid prescribing guidelines: **https://www.in.gov/isdh/28027.htm**
- Substance Abuse and Mental Health Services Administration (SAMHSA) opioid overdose prevention toolkit: **https://bit.ly/3t2krPz**
- American Hospital Association opioid toolkit: **https://bit.ly/3qY3bsN**
- Treatment resources in Indiana: **https://www.in.gov/recovery/1029.htm**
- SAMHSA — finding treatment: **https://www.samhsa.gov/find-treatment**
- Clinic and provider locater: **https://www.opiateaddictionresource.com**

Foster care resources

- Indiana Department of Child Services facts for foster parents: **https://www.in.gov/dcs/files/DCS_FosterFactsSheet09-07.pdf**
- Children's Bureau — helpful links for foster parents: **https://www.childrensbureau.org/our-services/foster-care**
- Anthem foster care flier: **https://mss.anthem.com/in/inin_caid_hcc_fostercare.pdf**
- Trauma awareness: **https://bit.ly/3t2tCzv**
- *Foster Parent Bill of Rights*: **https://www.in.gov/dcs/files/Foster_Parent_Bill_of_Rights.pdf**

Notes

** Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.*

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.

AINPEC-3038-21