Anthem BlueCross BlueShield

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier care Connect

Behavioral health reference guide

AINPEC-0811-16 08.16

Thank you

for providing great service to Anthem Blue Cross and Blue Shield (Anthem) Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members!

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 the Provider Helpline:

Hoosier Healthwise: 1-866-408-6132
Healthy Indiana Plan: 1-800-345-4344
Hoosier Care Connect: 1-844-284-1798

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Outpatient treatment services

Some codes include add-on codes to designate complex interactions.

The only allowable modifiers are:

- AH: clinical psychologist — not licensed health service provider in psychology (HSPP)
- AJ: clinical social worker
- SA: nurse practitioner/clinical nurse specialist
- HE: licensed mental health counselor/licensed marriage and family therapy

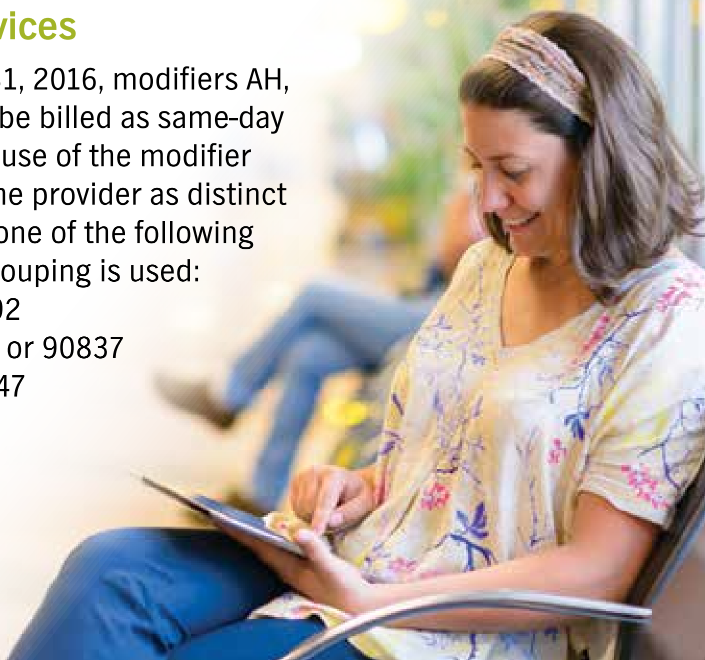
Note: Anthem does not recognize the HO modifier.

Providers seeing a member for an initial appointment should complete and submit a Behavioral Health Treatment Data Sharing form within five calendar days of the initial visit, per state requirements. Once Anthem receives the form, it will be forwarded to the member's PMP, and an authorization will be entered into the system for an initial diagnostic review.

Same-day services

Effective January 31, 2016, modifiers AH, AJ, HE and SA can be billed as same-day services when the use of the modifier clearly identifies the provider as distinct and separate and one of the following procedure code grouping is used:

- 90791 or 90792
- 90832, 90834 or 90837
- 90846 or 90847
- 90853



For participating providers, prior authorization requirements for the services listed below have been removed. 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.

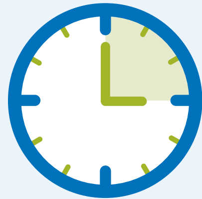
Procedure code:	Service:
90785	Interactive complexity add-on code
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation, with medical service
90832	Individual psychotherapy (20-30 minutes)
90833	30-minute psychotherapy add-on
90834	Individual psychotherapy (45-50 minutes)
90836	45-minute psychotherapy add-on
90837	Psychotherapy (60 minutes), with patient and/or family member
90838	60-minute psychotherapy add-on
90839	Crisis intervention
90840	Crisis intervention — each additional 30 minutes
90846	Family therapy, without patient
90847	Family therapy, with patient
90849	Medical psychotherapy, multi-family group
90853	Group therapy
99406	Behavior change — smoking (3-10 minutes)
99407	Behavior change — smoking (more than 10 minutes)
99408	Alcohol and/or substance abuse structured screening
99409	Alcohol and/or substance abuse structured screening
96150	Assessment health/behavior — initial*
96151	Assessment health/behavior — subsequent*
96152	Intervention health/behavior — individual*
96153	Intervention health/behavior — group*
96154	Intervention health/behavior — family, with patient*
96155	Intervention health/behavior — family, without patient*
99201-99205 & 99211-99215	Pharmalogical management (for evaluation and management [E&M] visits)

ABA modifiers required (see page 8).

Psychological and neuropsychological testing

Psychological and neuropsychological testing requires prior authorization. Prior authorization can be obtained by submitting the following documentation by fax to **1-877-276-5036**.

- 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.

For contracted providers, the following procedure codes for medical management services **do not** require prior authorization:

- E&M code plus 90833
- E&M plus 90863

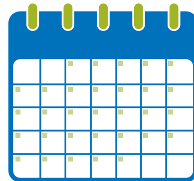
Note: Anthem does not routinely authorize services retrospectively.

Inpatient and partial hospitalization and IOP

Inpatient services

- All inpatient services require prior authorization, which can be received by calling the appropriate intake department 24/7.
- Anthem **does not** accept the Universal Prior Authorization (UPA) form for inpatient services.

Transition appointments



- Anthem recommends that members being discharged from an acute psychiatric facility be scheduled for a transition appointment.
- Licensed mental health practitioners should conduct this therapy session **after** discharge but **before** the member actually leaves the facility.
- The transition appointment should be **billed on form UB-04**, using HCPCS code T1015 and revenue code 0513.

Partial hospitalization services

- All partial hospitalization services require prior authorization, which can be received by calling the appropriate intake department 24/7.
- Anthem **does not** accept the UPA form for partial hospitalization services.

IOP

- Hoosier Healthwise and Hoosier Care Connect members **do not** have an IOP benefit. However, Healthy Indiana Plan members **do** have an IOP benefit.
- Authorization for IOP services can be obtained by calling **1-866-398-1922**. IOP services **cannot** be authorized via the Outpatient Treatment Request (OTR) Form.

Health and behavioral assessment services

- For contracted providers, authorization is **not required** for health and behavioral assessment services, and there is no **calendar limit** for contracted providers. For noncontracted providers, prior authorization **is required** for these services.
- These codes are limited to eight units per date of service (code is filed in 15-minute units).
- MDs and HSPPs will be reimbursed for health and behavioral assessment codes 96150-96155. If the services are provided by mid-level providers with the modifiers AJ, AH, HE and SA, they will be reimbursed. (See the Indiana Health Coverage Programs [IHCP] bulletin BT201606 regarding codes 96150-96155 for ABA services).

Case management (CM)

- Healthy Indiana Plan and Hoosier Care Connect members who are discharged from inpatient stays are provided CM support for a minimum of 90 days post discharge.
- Hoosier Healthwise members who are discharged from inpatient stays are provided CM support for a minimum of 180 days post discharge.

Applied behavioral analysis (ABA)

Effective February 6, 2016, applied behavioral analysis (ABA) therapy is covered for the treatment of autistic 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 prior authorization, subject to the criteria outlined in Indiana Administrative Code 405 IAC 5-3 for members age 20 and younger. **(For more information, see IHCP bulletin BT201606.)**

Provider requirements

For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician
- Licensed HSPP
- Licensed pediatrician
- Licensed psychiatrist
- Other behavioral health (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 technician (RBT)

Note: Services performed by a BCaBA or RBT must be under the direct supervision of a BCBA, BCBA-D or an HSPP. Services performed by an RBT under the supervision of a BCBA, BCBA-D or HSPP will be reimbursed at 75% of the rate on file. ABA services rendered by a BCBA-D, BCBA, BCaBA or RBT must be billed under the NPI of an IHCP-enrolled physician or HSPP, as behavior analysts are not currently enrolled independently. Providers must bill using the appropriate modifier (U1, U2 or U3) to indicate which practitioner rendered the services. Services rendered by a nonapproved provider will not be reimbursed.

Benefit overview

Self-referral services

- Members may self-refer (they do not need a PMP referral) for psychiatric and BH services if they see an in-network provider.
  - It is the provider's responsibility to contact Anthem for authorization for these services.
- Hoosier Healthwise members may see any IHCP psychiatrist, regardless of the psychiatrist's participation in the Anthem network.
  - It is the psychiatrist's responsibility to contact Anthem for authorization of any service beyond 90791 or 90792, E&M code plus 90833 or E&M plus 90863.

Covered benefits

Hoosier Healthwise (packages A, C and Healthy Indiana Plan maternity), Healthy Indiana Plan and Hoosier Care Connect covered benefits:

- Inpatient services
  - Except inpatient services provided in a state psychiatric hospital or psychiatric residential treatment facility (PRTF) as Hoosier Care Connect members are disenrolled upon admission
- Partial hospitalization services
- Outpatient services, including psychological testing
- PMP medication management services
- Outpatient ambulance services provided by federally qualified health centers and rural health centers
- Nonemergency ambulance services
- Smoking cessation services
- Telemedicine
- Intensive outpatient services
  - Only for Healthy Indiana Plan members that are medically frail under the Medicaid rehabilitation option (MRO) benefit

Note: 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.

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

- Nonemergent 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 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.
- Doctoral and clinical psychologists who are state licensed.
- Master-level clinical social workers, mental health counselors, and marriage and family therapists who are state licensed.
- Master-level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified, as well as licensed by the state.
- Other behavioral care specialists, such as licensed or board-certified behavior analysts, including bachelor-level (BCaBA), master-level (BCBA) and doctoral-level (BCBA-D) behavior analysts who are licensed, certified or registered by the state to practice independently.

To join the Anthem network, an online Provider Maintenance form must be submitted. The form can be found at **www.anthem.com**.

Access standards and access to care

Prior authorization: timeliness of decisions

- Urgent preservice requests: within 72 hours of request
- Urgent concurrent requests: within 24 hours of request
- Routine, nonurgent requests: seven days
- Retrospective review requests: within 30 days of request

Access to care standards

- Emergent: immediately
- Emergent, nonlife-threatening/crisis stabilization: within six hours of request
- Urgent: within 48 hours of referral/request
- Routine outpatient: within 10 business days of request
- Outpatient following discharge from an inpatient hospital stay: within seven days of discharge

Claims information

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.

Standard appeal

A standard appeal allows members or providers acting on the member's behalf 30 days from the date of action notice to request an appeal. Appeals should be done in writing and mailed to:

Anthem Blue Cross and Blue Shield
<Department>
P.O. Box 6144
Indianapolis, IN 46206

Departments:

- Claims
- Claims correspondence
- Claims disputes/appeals
- Appeals and Grievances department
- Utilization management appeals

Electronic payer identification:
Professional: 00630
Institutional: 00130

It is very important to note that professional services must be filed on a CMS-1500 form to avoid claim payment problems. If these types of services are filed on a UB form, there will be problems with adjudication and subsequent payment.

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 and degree level of the IHCP supervising provider.
- Box 24D should include the modifiers noted below.
- 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 32a and 33a should be populated with the group's NPI number.
- Mid-level practitioners should put their NPI in box 19 and the supervising providers' NPI in box 24J.
  - **Hoosier Healthwise:** Use the alpha prefix YRH along with the 12-digit member number provided by the state.
  - **Healthy Indiana Plan:** Use the alpha prefix YRK along with the 9-digit member Anthem ID number.
  - **Hoosier Care Connect:** Use the alpha prefix YRH along with the 12-digit member Anthem ID number.

Claim tips for package B and P (presumptive eligibility)
Always include a diagnosis of pregnancy on the claim. It does not have to be the primary diagnosis but should be the secondary diagnosis if it is not the focus of treatment.

UB claim tips:

- **Do not** file professional services on a UB form.
- 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.

Telemedicine:
For Hoosier Healthwise, BH telemedicine services are reimbursed. Services should be filed on a CMS-1500 form, utilizing the procedure code Q3014 with the GT modifier. A separate authorization for Q3014 is not required.

The Healthy Indiana Plan does not currently reimburse for telemedicine services; however, the claim platform is being reconfigured to adjudicate and reimburse for these services.

Important phone numbers

Behavioral Health Case Management department:
1-866-902-1690, select option 4

Prior authorizations — BH:
Hoosier Healthwise
Phone: **1-866-408-7187**
Fax: **1-877-276-5036**

Healthy Indiana Plan
Phone: **1-866-398-1922**
Fax: **1-877-276-5036**

Hoosier Care Connect
Phone: **1-866-408-7187**
Fax: **1-877-276-5036**

Provider Helpline:
Hoosier Healthwise: **1-866-408-6132**
Healthy Indiana Plan: **1-800-345-4344**
Hoosier Care Connect: **1-844-284-1798**

Customer Services (for members):
Healthy Indiana Plan and Hoosier Healthwise:
1-866-408-6131 (TTY 711)
Hoosier Care Connect: **1-844-284-1797 (TTY 711)**

24/7 NurseLine:
1-866-800-8780 (TTY 1-800-368-4424)

LCP Transportation (LCP)
LCP provides transportation to Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members. LCP requires 48-hour advance notice for scheduling. Hoosier Care Connect members only pay $1 for each one-way trip.
Phone: **1-800-508-7230 (TTY 1-877-224-5785)**
Website: **www.lcptransportation.com**

Transportation-related grievance and appeals:
LCP Transportation
Attn: Appeals department
4308 Guion Road, Suite D
Indianapolis, IN 46254

Behavioral Health contact information

Main contact

Donnica Hinkle
Senior Behavioral Health Network Education Representative
donnica.hinkle@anthem.com
1-317-617-7097

Department staff

Dheeraj Raina, Behavioral Health Medical Director
Dr. Lynn Bradford, Program Director of Behavioral Health
Julie Kirby, Manager Behavioral Health Case Management
La-Risha Ratliff, Manager Behavioral Health Utilization Management

www.anthem.com/inmedicaiddoc

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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.