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**CHAPTER 13: MENTAL HEALTH CLINICS**

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**SECTION 13.4: CLAIMS FILING AND REIMBURSEMENT**

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**CLAIMS FILING AND REIMBURSEMENT**

**Claims Filing**

Mental Health Clinic services are billed on the CMS-1500 claim or the electronic 837P which is the preferred method. Instructions for the CMS 1500 are included at the end of this section under CMS 1500 Instructions for MHCs. All claims must be submitted to the Fiscal Intermediary (FI) for processing (see Contact/Referral Information, appendix B).

Additionally, items to be completed are either required or situational. **Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted timely by the provider. **Situational** information may be required but only in certain circumstances as detailed in the instructions below.

When billing for dates of service the provider will use the standard procedure codes found in this document (appendix A).

**General Provisions for Reimbursement**

Mental Health Clinics (MHCs) are responsible for enrolling in both Medicare and Medicaid for crossover purposes and billing Medicare for dual eligible recipients.

A particular service must be excluded from coverage if it is determined to be the legal liability of any third party who is or may be liable to pay the expenditure for that service.

Services determined to be duplicate will not be reimbursed. Providers must not bill Medicaid for MHC services at the same time they bill another funding source for the same service. Duplicate claims will be denied and may be considered fraud and referred to the Program Integrity Section for further action.

When a recipient is admitted to an institution or hospital, the provider may bill for services provided up to the time of admission. The provider may resume billing for services after the recipient is discharged from the institution or hospital. No services can be billed while the recipient is in an inpatient facility.

The creation and transfer of information files and the submission of claims are related but separate processes. Providers are responsible for submitting claims to the FI in a timely manner. Any questions regarding a claim should be addressed to the FI Provider Relations Unit (see Contact/Referral Information, Appendix B).

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**CMS 1500 (08/05) Instructions for Professional Services (includes NDCs)**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	<b>Required</b> – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  <b>NOTE:</b> The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	<b>Situational</b> – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).  Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	Patient Status	<b>Optional.</b>	

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9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<b>Situational</b> – If recipient has no other coverage, leave blank.  If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block (the carrier code list can be found at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the <b>Forms/Files</b> link).  Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	
9b	Other Insured's Date of Birth  Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	<b>Situational</b> – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth  Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	
12	Patient's or	<b>Situational</b> – Complete if appropriate	

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	Authorized Person's Signature (Release of Records)	or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	<b>Optional.</b>	
15	If Patient Has Had Same or Similar Illness Give First Date	<b>Optional.</b>	
16	Dates Patient Unable to Work in Current Occupation	<b>Optional.</b>	
17	Name of Referring Provider or Other Source	<p><b>Situational</b> – Complete if applicable.</p> <p>In the following circumstances, entering the name of the appropriate physician is <b>required</b>:</p> <p>If services are performed by a CRNA, enter the name of the directing physician.</p> <p>If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.</p> <p>If services are performed by an independent laboratory, enter the name of the referring physician.</p>	
17a	Unlabelled	<b>Situational</b> – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is <b>required</b> to be entered.	<b>The PCP's 7-digit referral authorization number must be entered in block 17a.</b>
17b	NPI	<b>Optional.</b>	<b>The revised form accommodates</b>

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			the entry of the referring provider's NPI.
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Reserved for future use. Do not use.	Usage to be determined.
20	Outside Lab?	Optional.	
21	Diagnosis or Nature of Illness or Injury	Required -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	
22	Medicaid Resubmission Code	Optional.	
23	Prior Authorization Number	Situational – Complete if appropriate or leave blank.  If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Situational – Applies to the detail lines for drugs and biologicals only.  In addition to the procedure code, the <b>National Drug Code (NDC)</b> is required by the Deficit Reduction Act of 2005 for <b>physician-administered drugs</b> and <u>shall be entered</u> in the shaded section of 24A through 24G. <u>Claims for these drugs shall include the NDC from the label of the product administered.</u>  To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the <b>Qualifier N4</b> followed by the <b>NDC</b> . Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.	Physicians and other provider types who administer drugs and biologicals must enter this new drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only.  This information must be entered in addition to the procedure

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		Providers should then leave one space then enter the appropriate <b>Unit Qualifier</b> (see below) and the <b>actual units administered in NDC UNITS</b> . Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.	<b>code(s).</b>  <b>Please refer to the NDC Q&amp;A information posted on <a href="http://lamedicaid.com">lamedicaid.com</a> for more details concerning NDC units</b>
		The following qualifiers are to be used when reporting NDC units:  F2 International Unit ML Milliliter GR Gram UN Unit	<b>versus service units.</b>
24A	Date(s) of Service	<b>Required</b> -- Enter the date of service for each procedure.  Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	<b>Situational</b> – Complete if appropriate or leave blank.  When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.	<b>This indicator was formerly entered in block 24I.</b>
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).	
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“1”, “2”, etc.) in this block.	

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		More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	<b>Required</b> -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D	<b>Please refer to the NDC Q&amp;A information posted on <a href="http://lamedicaid.com">lamedicaid.com</a> for more details concerning NDC units versus service units.</b>
24H	EPSDT Family Plan	<b>Situational</b> – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	<b>The revised form accommodates the entry of I.D. Qual.</b>
24J	Rendering Provider I.D. #	<b>Situational</b> – If appropriate, entering the Rendering Provider’s Medicaid Provider Number in the shaded portion of the block is <b>required</b> . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is <b>optional</b> .	<b>The revised form accommodates the entry of NPIs for Rendering Providers</b>
25	Federal Tax I.D. #	<b>Optional.</b>	
26	Patient’s Account No.	<b>Situational</b> – Enter the provider specific identifier assigned to the	

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		recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.  If TPL does not apply to the claim, leave blank.	
30	Balance Due	<b>Situational</b> – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Required</b> -- The claim form <b>MUST</b> be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.  <b>Required</b> -- Enter the date of the signature.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	

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32a	NPI	Optional.	The revised form accommodates entry of the Service Location NPI.
32b	Unlabelled	<p><b>Situational</b> – Complete if appropriate or leave blank.</p> <p>When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the <b>Qualifier LU</b> followed by the <b>three digit site number</b>. Do not enter a space between the qualifier and site number (example “LU001”, “LU002”, etc.)</p>	If PCP, enter Site Number and Qualifier of the service location.
33	Billing Provider Info & Ph #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	The revised form accommodates the entry of the Billing Provider’s NPI.
33b	Unlabelled	<b>Required</b> – Enter the billing provider’s 7-digit Medicaid ID number.	Format change with addition of 33a and 33b for provider numbers.