BlueCross BlueShield of Minnesota

REIMBURSEMENT POLICY

Mental Health-Targeted Case Management Services

Active

Policy Number: Behavioral Health - 007
Policy Title: Mental Health-Targeted Case Management Services (MH-TCM)
Section: Behavioral Health
Effective Date: 09/04/17

Description

Mental Health-Targeted Case Management (MH-TCM) services help adults with a serious and persistent mental illness (SPMI) and children with a severe emotional disturbance (SED) gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to the recipient's mental health needs. Coverage is a health plan responsibility for Blue Plus® Minnesota Health Care Program (MHCP) groups.

Policy Statement

MH-TCM services are eligible for Minnesota Health Care Programs (MHCP) subscribers.

Billing

MH-TCM is a professional service billed on an 837P claim format. When billing for MH-TCM, submit the contracting provider NPI number currently on file with Blue Plus®. In addition, an individual rendering NPI number is required when a county contracts providers to do this and they bill under a Behavioral Health Clinic, and individual NPI number is required on the claim. Without an individual NPI, claims reject as needing one. When a county bills through a Social Service Agency, an individual NPI in not needed.

Codes	Modifiers	Brief Description	Service Limitations
T2023	HE, HA	Child/Adolescent program, face-to-face contact between case manager and recipient under age 18 years	1 unit per month
T2023	HE	Face-to-face contact between case manager and recipient age 18 or older	1 unit per month
T2023	HE, U4	Telephone contact (recipient 18 years or older)	1 unit per month
T1017 for HIS/638 and FQHC billing only	HE, HA	Face-to-face encounter (child under age 18 years)	1 unit per encounter
T1017 for HIS/638 and FQHC billing only	HE	Face-to-face encounter (age 18 or older)	1 unit per encounter

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Provider Eligibility

Contracted providers must meet MHCP eligibility criteria and be designated by Blue Plus® in order to be eligible for reimbursement for MH-TCM services.

Providers are responsible for checking the subscriber's eligibility prior to rendering services. Resources available for verification include:

- MN-ITS – www.mn-its.dhs.state.mn.us
- Provider web self-service – availity.com

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the Medicaid Codes established by DHS. Reimbursement will be 100% of the then current statewide rate established by Blue Plus.

The following applies to all claim submissions.
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be reimbursed according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT / HCPCS Modifier:	HE, HA, U4
ICD-Diagnosis:	N/A
ICD-Procedures:	N/A
HCPCS:	T2023, T1017

Revenue Codes: N/A

Deleted Codes: N/A

Policy History

Initial Committee Approval Date: May 19, 2015

Code Update: N/A

Policy Review Dates: June 9, 2016
January 18, 2017
August 2, 2017

Cross Reference: N/A

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