2025 Manual

Behavioral Health

BlueCross BlueShield Kansas

bcbsks.com

Table of Contents

This appendix to the Professional Provider Manual briefly describes the mental health benefits and guidelines available to the members of Blue Cross and Blue Shield of Kansas. The information applies specifically to those providing mental health services, on an inpatient and outpatient basis.

NOTE – The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

I. Eligible Providers and Facilities

Blue Cross and Blue Shield of Kansas (BCBSKS) reimburses outpatient mental health services provided by the following types of providers and facilities, as recognized by the member's contract. Providers who are unlicensed or who are not included among the covered providers listed below will not be reimbursed for psychotherapy or any other services connected with a mental health diagnosis. Supervision of an unlicensed provider or a provider not listed below does not constitute a service being rendered by an eligible provider.
Note - BCBSKS does not allow incident to billing.

1. Licensed Doctor of Medicine, or Doctor of Osteopathy
2. Clinical Psychologist (PhD or PsyD) licensed to practice under the laws of the State of Kansas
3. Licensed Social Worker authorized to engage in private independent practice (LSCSW) under the laws of the State of Kansas
4. Licensed Clinical Marriage and Family Therapist (LCMFT)
5. Licensed Clinical Professional Counselor (LCPC)
6. Licensed Clinical Psychotherapist (LCP)
7. Licensed Marriage and Family Therapist
8. Licensed Master Level Psychologist
9. Licensed Master Level Social Worker
10. Licensed Master Addiction Counselor
11. Licensed Professional Counselor
12. Advanced Practice Registered Nurse (APRN), with a minimum of a master's degree in psychiatric/mental health nursing or related mental health field
13. Autism Specialist (AS)
14. Intensive Individual Support Provider (IIS)
15. Registered Behavior Technician (RBT)
16. Hospital
17. State-licensed Medical Care Facility, defined as:
    a. A psychiatric hospital
    b. A community mental health center

II. Benefits

For member eligibility and benefit verification can be found on Availity® Essentials at Availity.com.

Through Availity Essentials, providers can access both the Availity Essentials web portal and BlueAccess (BCBSKS's secure web portal).

The BCBSKS Provider Benefit Hotline in Topeka can be reached at 785-291-4183 or 800-432-0272.

III. Documentation Guidelines

The importance of documenting services rendered to support medical necessity cannot be over-emphasized.

The following medical record standards are **minimally** required, and if not met, may result in a claim denial and accordingly a **provider write-off.**

Records must:

1. Be **legible** in both readability and content. If not readable, reimbursement will be denied.
2. Contain only those terms and abbreviations easily comprehended by peers of similar licensure. If a legend is needed to review your records, please submit it with your records. If needed and you have not submitted one, Blue Cross Blue Shield of Kansas may request you provide a legend. If not supplied upon request reimbursement will be denied.
3. Contain personal/biographical information in a consistent location including the following:
   - Name (first and last) – should be reflected on every page
   - DOB (date of birth) – should be reflected on every page
   - Home Address
   - Home/work telephone numbers
   - Employer or school name
   - Marital or legal status
   - Medication allergies with reactions
   - Appropriate consent forms/guardianship information
   - Emergency contact information
4. Contain pertinent and significant information concerning the patient's presenting condition. This should include:

- Documentation of at least one mental health status evaluation (e.g. patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control).
- Documentation of past and present use of tobacco, alcohol and prescribed, illicit, and over the counter drugs, including frequency and quantity.
- Psychiatric history which includes:
  - Previous treatment dates
  - Therapeutic interventions and responses
  - Sources of clinical data (e.g., self, mother, spouse, past medical records)
  - Relevant family information
  - Consultation reports including psychological and neuropsychological testing (if available/applicable)
  - Laboratory test results if applicable in physician and nurse practitioner records
- Medication management including medication prescribed; quantity or documentation of no medication; and over the counter medication. For physician and nurse practitioners, this should also include the dosages and usage instructions of each medication and the dates of initial prescription and/or refills.

5. Indicate the initial diagnosis and the patient's initial reason for seeking the provider's care. The **diagnosis is not just an /ICD-10-CM billing code**, but a written interpretation of the patient's condition and physical findings. The diagnosis should be recorded in the record and reflected on the claim form.
6. Document the treatment provided. This would include the dates any professional service was provided. List start and stop times or total time on all timed codes per CPT nomenclature. If dates of services and/or start/stop (or reference to total time) are not recorded, reimbursement may be reduced. Group documentation must indicate each specific encounter for the date of service and each session attended not a collective summary for multiple sessions or dates of service. Documentation should include duration and purpose of the group and medically necessity as indicated by the patient's individual treatment plan.
7. Treatment Plan: The treatment plan contains specific measurable goals, documentation of the treatment plan and/or goals discussed with the patient, estimated time frames for goal achievement, and documentation of the patient's strengths and limitations in achieving the goals. The treatment plan should be individualized for each patient. Document the patient's progress during the course of treatment as it relates to the plan of care and diagnosis.

Continuity and coordination of care should be reflected in the medical record, including communication with or review of information from other behavioral health professional, ancillary providers, primary care providers, and health care institutions. Referrals to community outreach services and higher levels of care should be documented.

8. Medical records of minor patients (under age 18) should contain documentation of prenatal and parental events, along with complete developmental histories and evidence of family involvement. Parental informed consent for all prescribed medications should be included.
9. Signature Requirements — In the content of health records, each entry must be authenticated by the author. Authentication is the process of providing proof of the authorship signifying knowledge, approval, acceptance or obligation of the documentation in the health record, whether maintained in a paper or electronic format accomplished with a handwritten or electronic signature. Individuals providing care for the patient are responsible for documentation of the care. The documentation must reflect who performed the service.
   a. The handwritten signature must be legible and contain at least the first initial and full last name along with credentials and date. A typed or printed name must be accompanied by a handwritten signature or initials with credentials and date.
   b. An **electronic signature** is a unique personal identifier such as a unique code, biometric, or password entered by the author of the electronic medical record (EMR) or electronic health record (EHR) via electronic means and is automatically and permanently attached to the document when created including the author's first and last name, with credentials, with automatic dating and time stamping of the entry. After the entry is electronically signed, the text-editing feature should not be available for amending documentation. Example of an electronically signed signature:
   "Electronically signed by John Doe, M.D. on MM/DD/YYYY at XX:XX A.M.
   c. A digital signature is a digitized version of a handwritten signature on a pen pad and automatically converted to a digital signature that is affixed to the electronic document. The digital signature must be legible and contain the first and last name, credentials, and date.
   d. Rubber stamp signatures are not permissible. This provision does not affect stamped signatures on claims, which remain permissible.

Documentation Errors

Listed below are a few documentation errors that are commonly missed.

- Start and stop times or duration
  - Not listing start and stop times or duration – Most CPT codes are time sensitive. It is good practice to document the face-to-face time and/or duration you spend with the patient.
- Treatment planning
  - Indicate if you made changes to the treatment plan goals or if the goals remain unchanged.
- Follow up appointments
  - It is important to indicate when the next appointment is and, as appropriate, any discharge planning.
- Patient's presentation
  - Reflect the patient's presentation in each face-to-face encounter note. This should contain objective and subjective documentation of the patient's presentation.
- Diagnosis
  - Be precise. Update as appropriate.
- Documentation
  - Documentation must match the requirements of the CPT code. Please refer to the most current CPT code book for specific requirements. Also, at www.ndbh.com provider tab, there is documentation on how to determine what codes are most appropriate.

MEAT Note Format

It is essential for the provider to document clinic notes and findings to support medical necessity. A format that may be used is MEAT format. **MEAT** stands for **M**onitoring, **E**valuation, **A**ssessment and **T**reatment.

M – Monitoring by ordering or referencing labs, imaging studies or other tests
Note should reflect: ordering tests, referencing labs/tests, disease progression/regression, symptoms.
E – Evaluation with a targeted part of the physical examination specific to a certain diagnosis
Note should reflect: test results, medication effectiveness, response to treatment, physical exam findings.
A – Assessment of the status, progression or severity of the diagnosis
Note should reflect: review records/discuss, counseling, documenting status/level of condition.

T – Treatment with medication, surgical intervention or lifestyle modification
Note should reflect: prescribing/continuation of medications, surgical /other therapeutic interventions, referral to specialist, plan for management of condition

Documentation - Keeping it Separate

A big challenge for providers is keeping psychotherapy notes separate from progress notes. Providers often keep just one note that documents the session with their client.

It is vital for providers to understand that psychotherapy notes need to be documented and stored separately from the progress notes and from the medical record.

The elements in a psychotherapy note are not required to support medical necessity of a service and claims billed. In contrast, the elements in the progress note do.

Psychotherapy Notes vs. Progress Notes

Maintaining medical records is a standard part of any mental health practice. Mental health records have additional protections not provided to other practices. The health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires psychotherapy notes receive the highest level of protection.

Psychotherapy notes are different from progress notes in critical ways. The key differences between the two are outlined below to keep in mind when documenting the next session.

Progress Notes

One key difference between progress notes and psychotherapy notes is progress notes are subject to being shared with insurance companies, additional providers who share treatment of the client, and other outside parties. As explained in the HIPAA Privacy Rule 45 CFR 164.501, progress notes may include the documentation of medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical test, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Progress notes also may include a brief description of the topics discussed, treatment interventions that were used, and observations and assessment of the client's status.

Psychotherapy Notes

Psychotherapy Notes should not be incorporated into the medical record. Psychotherapy notes are for the provider's own use in conceptualizing the case.

Unlike progress notes, psychotherapy notes may include analyses of the contents of a conversation from a private counseling session, the provider's thought, feelings and impressions about the case, theoretical analysis of the session, and hypotheses to further explore in future sessions with the client.

As long as these notes are kept separate from the medical record, the notes fall under the protection of the HIPAA Privacy Rule and cannot be released without specific authorized written consent form the client.

IV. Limited Patient Waiver

Occasionally BCBSKS may consider a service to be not medically necessary. In situations where services are known to be denied as not medically necessary and the patient insists on the services, the provider must obtain a patient waiver of liability prior to the service(s) being rendered in order for the patient to be held financially responsible. In these cases, a GA modifier should be added to the service on the claim submission to indicate a valid waiver of liability has been signed by the patient. Failure to discuss the above with the patient in advance and obtain the waiver will result in a provider write-off.

For an example of the Limited Patient Waiver Form, please refer to Policy Memo No. 1, Section X. A sample waiver form can also be found after the last page of Policy Memo No. 1 and also on the bcbsks.com website under "Forms."

NOTE – The waiver form cannot be utilized for services considered to be content of another service provided.

Situations Requiring a Waiver

1. Medical necessity denials
2. Utilization denials
3. Patient demanded services
4. Experimental/investigational procedures
5. HighTech Option is used when a patient requests the provider not file a claim for services to their insurance. Member agrees to pay for the service, and acknowledges they have no

appeal rights. Option 2 on the waiver form must be completed and signed. (NOTE --- using this option must be patient initiated).

The Waiver Form Must Be:

1. Signed before receipt of service.
2. Patient, service, and reason specific.
3. Date of service and dollar amount specific.
4. Retained in the patient's file at the provider's place of business. (The waiver form is no longer required with claims submission).
5. Add a GA modifier for all electronic and paper claims.
6. Presented on an individual basis to the patients. It may not be a blanket statement signed by all patients.
7. Acknowledged by patient that he or she will be personally responsible for the amount of the charge, to include an approximate amount of the charge at issue.

   NOTE – If the waiver is not signed before the service is rendered, the service is considered a contracting provider write-off, unless there are extenuating circumstances.

V. Medical Necessity

Lucet (formerly known as New Directions Behavioral Health) utilizes medical necessity criteria to make medical necessity determinations. The medical necessity criteria set applied varies according to the behavioral health service being requested. A copy of the medical necessity criteria and other information for providers is available at: https://lucethealth.com/providers/resources/mnc/.

VI. Utilization Management

Lucet

BCBSKS contracts with Lucet to perform utilization determinations for behavioral health claims.

Lucet provides the following services:

1. Precertification reviews for approval/denial of pre-admission certification requests for inpatient hospitalizations and partial-day treatment, determining appropriateness by utilizing established criteria
2. Concurrent review of length of stay authorizations

3. Appeals review and reconsideration
4. Review of outpatient treatment plans for medical necessity as specified by plan directives.
5. Review of Behavioral Health IOP protocols

All BCBSKS policies and those secondary to Medicare, are subject to Lucet's review. There are limited exceptions, including Medicare Supplement, and out-of-state policies.

Psychological and Neuropsychological Testing Criteria

Intensity of Service

All of the following:

1. Testing is administered and interpreted by a licensed psychologist or other qualified mental health provider (as defined by applicable State and Federal law and scope of practice). Technician administered and/or computer assisted testing may be allowed under the direct supervision of a licensed psychologist or other qualified mental health provider. Neuropsychological testing must be supervised and interpreted by a licensed psychologist with specialization in neuropsychology.
2. The requested tests must be standardized and have nationally accepted validity and reliability.
3. The requested tests must have normative data and suitability for use with the patient's age group, culture, primary language and developmental level.
4. The requested time for administration, scoring and interpretation of the proposed testing battery must be consistent with the time requirements indicated by the test publisher.

Service Request Criteria

Must meet all of the following:

1. An initial face-to-face complete diagnostic assessment has been completed.
2. The purpose of the proposed testing is to answer specific question(s) (identified in the initial diagnostic assessment) that cannot otherwise be answered by one or more comprehensive evaluations or consultations with the patient, family/support system, and other treating providers review of available records.
3. The proposed battery of tests is individualized to meet the patient's needs and answer the specific diagnostic/clinical questions identified above.
4. The patient is cognitively able to participate appropriately in the selected battery of tests.
5. The results of the proposed testing can reasonably be expected to contribute significantly in the development and implementation of an individualized treatment plan.

Court-Ordered Admissions/Services

BCBSKS consider court-ordered admissions/services eligible if medical necessity is met. These services are also subject to the member's individual contract limitations.

Providers must obtain a waiver on any mental health consultation, testing, or evaluation that is performed by agreement or at the direction of a court for the purpose (i.e. assessing custody, visitation, parental rights, determining damages of any kind of personal injury action), if the service is not otherwise medically necessary. In these cases, a GA modifier should be added to the service on the claim submission to indicate a valid waiver of liability has been signed by the patient.

VII. Diagnoses

ICD-10-CM Diagnoses

BCBSKS requires the use of the ICD-10-CM coding system or the equivalence in the DSM-V coding system.

Comparison of DSM-V and ICD-10-CM

According to the fifth edition DSM-V manual (2013), "the primary purpose of DSM-V is to assist trained clinicians in the diagnosis of their patients' mental disorders as part of a case formulation assessment that leads to a fully informed treatment plan for each individual." The DSM-V was developed primarily by psychiatrists and produced and approved by the American Psychiatric Association.

There are many similarities between DSM-V and ICD-10-CM, but there are also significant differences. Some of the differences between the two include the following:

1. Code descriptions in DSM-V may differ from the same ICD code description in ICD-10-CM.
2. Not all codes in ICD-10-CM, chapter five (Mental, Behavioral, and Neurodevelopmental Disorders) are included in DSM-V.
3. The diagnosis for Asperger's Disorder has been removed from DSM-V and is now in the Autism Spectrum Disorder (F84.0) category; ICD-10-CM lists Asperger's Disorder as a separate diagnosis (F84.5).
4. Crosswalks will not necessarily provide an accurate ICD-10-CM code as there are a number of "one to many" relationships. When comparing the code listed in DSM-V with a corresponding code in ICD-10-CM, there may be multiple options.

5. Crosswalks will not include all of the coding notes. For example, instructions regarding additional codes that should be included, which code should be coded first and codes that should not be coded together.

Tobacco Disorder

ICD-10-CM codes are for nicotine dependence are in the F17 expanded code range, and Z72.0 – for Tobacco use.

Tobacco use disorder is processed as an eligible psychiatric benefit when performed by an eligible provider of service.

Exclusions

The following exclusions apply only to Outpatient Coverage for Mental Conditions. All other general exclusions as described in the member's contract also apply.

1. Services received while the patient is an inpatient at a hospital or medical care facility.
2. Non-medical services. This includes (but not limited to) legal services, social rehabilitation, educational services, vocational rehabilitation, and job placement services.
3. Services of volunteers.
4. Coverage for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, and child custody or child visitation proceedings.

VIII. Behavioral Health Intensive Outpatient Program (IOP)

Intensive Outpatient Psychotherapy – Adult

Intensive Outpatient Psychotherapy (IOP) can be a freestanding or hospital-based program. IOP services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social/interpersonal, occupational, educational, health/medical compliance, etc.).

Services are goal-oriented interactions with the individual or in group/family settings. This community-based service allows the individual to apply skills in “real world” environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures and clinical protocols.

The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs.

Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. The goals, frequency, and duration of outpatient treatment will vary according to individual needs and response to treatment. Overall treatment is provided along a continuum of care placing patient at the level that is clinically and medically necessary. Patients can participate in only one level of care at a time. When in IOP, services cannot be unbundled.

Requirements

The following are Behavioral Health IOP program requirements:

1. The facility/agency is licensed by the appropriate agency to provide IOP treatment.
2. All direct service staff have the appropriate training and license to provide IOP. Services provided by volunteers, interns, trainees, etc., are not reimbursable.
3. The program provides a minimum of nine hours of direct services per week. Typically, this is a minimum of three hours per day, three days per week. Direct services are face to face interactive services spent with licensed staff. This does not include watching films or videos, doing assigned readings, doing assignments or filling out inventories or questionnaires, or participating in community-based support groups.
4. During the first week of treatment patients must receive:
   a. A thorough, current, comprehensive bio-psychosocial assessment. The initial diagnostic interview must be conducted by a physician (psychiatrist preferred), Licensed Clinical Psychologist, (LCP) Licensed Specialist Clinical Social Worker, (LSCSW) or Advanced Practice Registered Nurse (APRN) within the first week of treatment. ICD-10-CM diagnosis is the primary focus of active treatment each program day. Assessments and treatment should address mental health needs, and potentially, other co-occurring disorders. Physician evaluations must be available as clinically indicated, but no less than once per week.
   b. Appropriate lab work should be obtained such as urine drug screens when appropriate (UDS) and Fasting Blood Glucose (FBG) levels for patients on antipsychotic medications and other lab work if medically indicated.

5. Consultation and/or referral for general medical, psychiatric, and psychopharmacology needs should be part of the program and is the provider's responsibility to coordinate with other treating professionals.
6. Twenty-four hours/seven days a week (24/7) access to psychiatric and psychological services must be available, either in house or by a referral relationship. Coordination between the mental health provider and other community provider is required.
   a. An Individualized treatment/recovery plan, including discharge, safety/crisis plan should be developed with the individual within the first week. Treatment planning must be individualized and address the needs identified in the assessment. Treatment goals should be set that are specific to the individual, measurable, attainable, relevant and time-focused. Treatment plans should be modified to address any lack of treatment progress. Treatment contracts are strongly encouraged. This plan should be signed by all team members including the individual (the plan should consider community resources, family, current mental health providers, primary care providers and other supports). These plans should be reviewed on an ongoing basis and adjusted as medically indicated. Coordination of care with other providers is essential to quality treatment planning and successful discharge planning.
   b. Discharge planning should begin at day of admission and include coordination of care with current therapist, family, and follow up services/resources in the patient's home community. Discharge follow up appointments should be scheduled early in the program to ensure the availability of resources within seven days of discharge.
7. Group, individual, and family therapies must be available to the patient and used whenever clinically appropriate. The primary modality of IOP is group therapy but must include at least one hour of individual therapy a week with an appropriately licensed provider. This is included in the IOP rate of care. Members can participate in only one level of care at a time.
   a. Psycho-educational components will be utilized as appropriate to the individual's needs.
   b. If family treatment is documented as a clinical need, clear documentation and early involvement is expected. Family meetings should occur in person whenever possible. Clear documentation as to level of family involvement and whether this was completed in person or telephonically.
8. The agency must have written policies and procedures related to their program. Examples include:
   - Admission and discharge criteria
   - Attendance expectations

- Use of illegal substances (positive UDS)
- 24/7 availability to medical services
- Maintaining current licensure for providers
- Reporting of critical incidents

Certification Requirements

Review of protocols to support this level of care is required. The following form will need to be completed and submitted for review. Notification of decision will be provided after the review is complete. Please submit the completed form to your professional relations representative.

Psychiatric Intensive Outpatient
Intensity of Service Questions

Facility Name: _____
Name of Person Completing the Form: _____
Title: _____
Date Completed: _____
Ages treated: _____

Is your facility accredited? YES☐ NO ☐
If yes, by which organization: _____

Is the facility licensed by the appropriate state agency?
YES☐ NO ☐
If Yes, please provide state agency: _____
Please provide copy of licensure
If the answer is no, please explain with further detail:
_____
_____

Please review the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) documentation at the link below and attest that you meet the criteria as defined here.
LOCUS & CALOCUS Criteria

I attest that I've reviewed the LOCUS & CALOCUS Criteria for this level of service and meet the requirements as defined.
YES☐ NO ☐
If no, please explain with further detail:
_____
_____

Please provide copy of program description and relevant policies supporting the LOCUS & CALOCUS criteria and below requirements for this level of care.

1. Drug screens and relevant lab tests are completed and documented upon admission, as clinically indicated.
YES☐ NO ☐
If the answer is no, please explain with further detail:
_____
_____

2. There is an evaluation within one week of admission to the program by a psychiatrist who remains available as medically indicated for face-to-face evaluations.
YES☐ NO ☐
If the answer is no, please explain with further detail:
_____
_____

3. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition.

   YES☐ NO ☐

   **Please note: this plan should reference the following to develop treatment and discharge plans focused on the member:*

   a. Precipitants to admission, including social determinants of health YES NO
   b. Family/other support systems available after discharge YES NO
   c. Community resources YES NO
   d. Need for supportive living placement to continue recovery YES NO
   e. Need for services for comorbid medical or psychiatric conditions YES NO

   If the answer is no, please explain with further detail:

   _____
   _____
   _____

4. Treatment programing includes and documents one individual counseling session weekly or more as clinically indicated.

   YES☐ NO ☐

   If the answer is no, please explain with further detail:

   _____
   _____

5. The members receive daily treatment by a licensed behavioral health practitioner.

   YES☐ NO ☐

   If the answer is no, please explain with further detail:

   _____
   _____

6. Licensed behavioral health practitioners supervise all treatment.

   YES☐ NO ☐

   If the answer is no, please explain with further detail:

   _____
   _____

7. Mental Health and Medical services are available 24 hours per day, seven days per week, either onsite, via telehealth, or offsite by arrangement.

   YES☐ NO ☐

   If the answer is no, please explain with further detail:

   _____
   _____

8. Your program is a multidisciplinary treatment program that occurs three days a week and provides six hours of weekly clinical services and two hours of supportive services to comprehensively address the needs identified in the member's treatment plan.
   YES☐ NO ☐
   Please indicate the hours per week of
   a. Non-psychiatric clinical services _____ hours/week
   b. Support services _____ hours/week

   Note: *The intent of the standard for weekly treatment program (groups, activities, and psychotherapies) is that they are evidenced based and are explicitly focused on the alleviation of the current condition as opposed to providing general recreation activities, watching videos, etc. and other facility offerings that are not tied back directly to the treatment plan.*
   If the answer is no, please explain with further detail:
   _____
   _____

9. For Members receiving boarding services, during non-program hours the member is supported in and allowed the opportunity to function independently and develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
   YES☐ NO ☐ N/A ☐
   If the answer is no, please explain with further detail:
   _____
   _____

10. Safety plan including access for the member and/or family/support system to professional supports outside of program hours are made and documented.
    YES☐ NO ☐
    If the answer is no, please explain with further detail:
    _____
    _____

11. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 5 days of admission.
    YES☐ NO ☐
    If the answer is no, please explain with further detail:
    _____
    _____

12. Family participation:
    a. Family treatment is provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    YES☐ NO ☐ N/A ☐
    If the answer is no, please explain with further detail:
    _____
    _____

    b. For children/adolescents: The family/support system assessment is completed with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur as clinically indicated.
    YES☐ NO ☐ N/A ☐
    If the answer is no, please explain with further detail:
    _____
    _____

    c. For children/adolescents: The family/support system assessment is completed within 5 days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.
    YES☐ NO ☐ N/A ☐
    If the answer is no, please explain with further detail:
    _____
    _____

    d. Family participation is conducted via telephonic sessions when there is a significant geographic or other limitation.
    YES☐ NO ☐
    If the answer is no, please explain with further detail:
    _____
    _____

Coding

S9480 – Intensive outpatient psychiatric services, per diem.

- Any provider wanting to bill this procedure code must have their protocols reviewed to establish actual level of care that is being provided. Approved providers will be given permission to bill this code, and guidelines to follow.
- This is a per diem code, and includes the following services: coordination of care, individual/group/family psychotherapy, evaluation and management service in the clinic setting and pharmacologic management. These services should not be billed in addition to code S9480.
- Contact your Professional Relations representative for further information.

IX. AMA CPT Evaluation & Management Codes, Psychiatric Codes & Guidelines

In this section, you will find the more widely utilized CPT psychiatric codes and subsequent BCBSKS billing guidelines. For procedural nomenclature, please refer to your American Medical Association CPT Reference. BCBSKS will be following guidelines as outlined in the CPT book, with one exception:

Evaluation and Management (E&M)

BCBSKS allows Evaluation & Management (E&M) services when billed according to scope of provider license.

Provider types that may **NOT** bill E&M services include (but are not limited to):

- Licensed Clinical Social Workers
- Licensed Clinical Marriage and Family Therapists
- Licensed Clinical Psychotherapists
- Licensed Clinical Professional Counselors
- PhDs
- Master's Level Social Workers:
    - Licensed Marriage and Family Therapist
    - Licensed Master Level Psychologist
    - Licensed Master Level Social Worker
    - Licensed Master Addiction Counselor
    - Licensed Professional Counselor

These providers should bill the appropriate psychotherapy service codes (90832-90853).

Office or Other Outpatient Services

Documentation must support medical necessity of the service(s) rendered.

Selecting the Appropriate E&M Code

The basis for selecting the appropriate E&M code level for an office or outpatient service should be based on time or medical decision making. If using time alone to report an E&M visit, the service should include time spent in activities which are required to be performed by the physician or other qualified health care professional.

Per CPT definition, those activities are:

- preparing to see the patient
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, test, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Please refer to the CPT codebook for guidelines on reporting E&M visits

Counseling and/or Coordination of Care

- Counseling, coordination of care, and nature of presenting problem are considered contributory factors in the majority of encounters.
- When counseling and/or coordination of care dominates “more than 50 percent” of the encounter with patient or family, then TIME (as stated within each code description) shall be the key determining factor for the appropriate selection of the E&M.
- If performing “counseling and/or coordination of care,” your record should include:
  - Reference to start/stop times or total time for the entire encounter;
  - Time spent counseling; and
  - Description of the counseling and/or activities to coordinate care.
- DO NOT include time spent performing psychotherapy as part of the counseling time.

Psychiatric

- Description of speech, including rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language).
- Description of thought processes, including rate of thoughts, content of thoughts (e.g., logical vs. illogical, tangential, circumstantial, intact).
- Description of abnormal or psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions.
- Description of the patient's judgment (e.g., concerning everyday activities and social situation) and insight (e.g., concerning psychiatric condition).
- Complete mental status examination, including:
  - Orientation to time, place and person
  - Recent and remote memory
  - Attention span and concentration
  - Language (e.g., naming object, repeating phrases)
  - Fund of knowledge (e.g., awareness of current events, past history, vocabulary)
  - Mood and affect (e.g., depression, anxiety, agitation, hypomania, liability)

Medical Decision-Making

- Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option.
- The four types of medical decision-making are recognized as:
  - Straight-forward
  - Low complexity
  - Moderate complexity
  - High complexity

  Refer to complexity of medical decision-making table within CPT codebook for more information.

E&M Coding Vignettes

The following coding vignettes were provided by the American Academy of Child and Adolescent Psychiatry.

Reporting of Time/Units for Psychiatric Services:

- Psychotherapy must be 16 minutes or more to be billable.

- Time associated with activities used to meet criteria for an E&M service is not to be included in the time used for reporting the psychotherapy service.
- Time (counseling and coordination of care) must be face-to-face between the provider and patient.

- Document start and stop time OR total time for each service performed. E&M and psychotherapy service should have time documented separately.

  A unit of time is attained when the midpoint is passed.
  - 16-37 minutes bill 30 minutes
  - 38-52 minutes bill 45 minutes
  - 53 or > minutes bill 60 minutes

Billing for an E&M code and psychotherapy services on the same day:

- The services must be significant and separately identifiable.
- Do not use modifier 25 in conjunction with your E&M code.
- All E&M services must meet the requirements as outlined in the CPT codebook.

Examples:

- Patient is seen for 40 minutes in the office for psychotherapy.
  - Use code 90834 (45 minutes of psychotherapy).
- Patient is seen in the office for an E&M visit with psychotherapy. The nature of the patient's presenting problem and documentation meets criteria for a 99212 level E&M code. In addition to time spent on the E&M portion of the visit, 20 minutes is spent providing psychotherapy services.
  - Both 99212 and 90833 (30 minutes psychotherapy add-on) are reported.
- Note – Codes 90833, 90836, and 90838 are add on codes and require a primary Evaluation and Management code be billed.

X. Coding

The following codes for treatment are for informational purposes only. They can be billed to BCBSKS if the service performed is within the providers scope of license.

90785 – Interactive Complexity

This is an add-on code; bill in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837) psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853).

90791-90792 – Psychiatric Diagnostic Evaluation

- When 90791 or 90792 are billed with another psychiatric service, they will be denied content of the other psychiatric service.
- Considered eligible services when billed alone.
- Do not report time or units greater than 001.

90832, 90834, 90837 – Psychotherapy

Do not report time or units greater than 001.

90833, 90836, 90838 – Psychotherapy when performed with an evaluation and management service.

Do not report time or units greater than 001.

90839 – Psychotherapy for crisis, first 60 minutes

- Used to report the first 30-74 minutes; used only once per day.
- Do not report time or units greater than 001.

90840 – Each additional 30 minutes

Used to report each additional 30 minutes beyond the first 74 minutes.

90845 – Psychoanalysis

Do not report time or units greater than 001.

90846 – Family Psychotherapy (without the patient present), 50 minutes

- Bill under the patient's name and identification number.
- May be billed one time per date of service under the patient whose diagnosis is being treated.
- Do not report time or units greater than 001.

90847 – Family Psychotherapy (conjoint psychotherapy, with patient present), 50 minutes

- Bill under the patient's name and identification number.
- May be billed one time per date of service under the patient whose diagnosis is being treated.
- Do not report time or units greater than 001.

90849 – Multiple-Family Group Psychotherapy

- Bill under the patient's name and identification number.
- May be billed one time per date of service under the patient whose diagnosis is being treated.
- Do not report time or units greater than 001.

90853 – Group Psychotherapy (other than of a multiple-family group)

Do not report time or units greater than 001.

90863 – Pharmacologic Management, including prescription and review of medication, when performed with psychotherapy services

- If the provider's scope of practice allows for reporting E&M codes, report the appropriate E&M instead of 90863. Only practitioners who are licensed to prescribe medications can bill 90863, and only if they cannot bill E&M codes.
- For pharmacologic management, bill the appropriate E&M code. In those instances, when more than 50 percent of the face-to-face encounter is spent providing counseling and coordination of care, the E&M code can be determined on the basis of time or medical decision making. Time in and time out must be documented to support the minimal level of E&M.
- This is an add-on code and requires a primary code be billed.

90865 – Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes

Do not report time or units greater than 001.

90867 – 90869 Therapeutic Repetitive Transcranial Magnetic Stimulation Treatment

Refer to Medical Policy – Transcranial Magnetic Stimulation (TMS) as a Treatment of Depression and Other Psychiatric Disorders. Medical Policies can be found at https://www.bcbsks.com/providers/medical-policies.

90870 – Electroconvulsive Therapy

- Do not report time or units greater than 001.
- Service must go through authorization process.

90875-90876– Individual Psychophysiological Therapy

These codes are considered biofeedback and are non-covered.

90880 – Hypnotherapy

This code is non-covered.

90882, 90885, 90887 – Environmental Intervention, Psychiatric Evaluation of Hospital records, and Interpretation or Explanation of Results

- Addiction specialists and OSAF's **may not** perform this service.
- Not medically necessary or content of another psychiatric service.
- If billed in absence of another service, this code requires a Limited Patient Waiver for patient responsibility. Otherwise, it will be denied as provider write-off.

90889 – Preparation of report of patient's psychiatric status, history, treatment, or progress for other individuals, agencies, or insurance carriers.

This code is considered content of another psychiatric service.

90899 – Unlisted Psychiatric Service or Procedure

Describe service or procedure provided on claim attachment and submit medical records for review.

90901-90911 – Biofeedback Training

Biofeedback is non-covered under most contracts.

Assessment of Aphasia and Cognitive Performance Testing

- 96105 – Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.
- 96125 – Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

Developmental/Behavioral Screening and Testing

- 96110 – Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.
- 96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, first hour.
- 96113 – each additional 30 minutes (List separately in addition to code for primary procedure)
- 96127 – Brief emotional /behavioral assessment (e.g. depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

Psychological/Neuropsychological Testing

Neurobehavioral Status Examination

- 96116 – Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face with the patient and time interpreting test results and preparing the report, first hour.
- 96121 – each additional hour (list separately in additional to code for primary procedure).

Testing Evaluation Services

- 96130 – Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
- 96131 – each additional hour (list separately in addition to code for primary procedure)
- 96132 – Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

- 96133 – each additional hour (list separately in addition to code for primary procedure).

Test Administration and Scoring

- 96136 – Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more test, any method; first 30 minutes.
- 96137 – each additional 30 minutes (List separately in addition to code for primary procedure).
- 96138 – Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes.
- 96139 – each additional 30 minutes (List separately in addition to code for primary procedure).
- 96146 – Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only. Denies content of service to E&M codes 99201-99499 when performed on the same day.
- 98970, 98971, 98972 – Qualified non-physician health care professional online digital E&M service for an established patient.
  Note – Not allowed or acceptable for telemedicine services.
- 99366-99368 – Team Conferences. These services are considered not medically necessary or content of other psychiatric service.
- G0506 – Care Planning/Management Services. These services are considered content of service.

XI. Telemedicine Services

Effective January 1, 2019, the Kansas Legislature passed the Kansas Telemedicine Act.

Telemedicine, including telehealth, means the delivery of health care services while the patient is at an originating site and the health care provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient's health care.

Telemedicine does not include communication between:

1. Health care providers that consist solely of a telephone voice only conversation, email, or fax.
2. Health care providers and a patient that consists solely of email, text, or fax transmission.

Guidelines when billing telemedicine services:

1. Claims must be filed with modifier GT and the appropriate place of service to indicate telemedicine services. The place of service can be filed with 02 for ‘other’ or 10 for patient ‘home’.
2. Provider must be licensed in the state where the patient is located while receiving telemedicine services.
3. Documentation guidelines must be followed and support the medical necessity of the service rendered.
4. Claim will be processed according to the member's benefits.
5. Providers located outside the BCBSKS service area, must file claims to the Blue Plan in the state where they are located/reside

NOTE: Telemedicine must be patient initiated.

A performing provider cannot bill the same member for a telemedicine service at both the distant and originating sites.

The ‘distant site’ is the site that a health care provider is located while providing health care services by means of telemedicine.

The ‘originating site’ is a site that the patient is located at the time of the health care service provided by means of telemedicine.

Revisions

01/01/2019	Redesigned manual.
	Page 4-10 – Updated Documentation Guidelines.
	Page 10 – Updated Limited Patient Waiver guidelines.
	Page 11 – Updated Medically Necessity section.
	Pages 11-13 – Updated Utilization Management section.
	Page 14 – Updated BCBSKS/NDBH Authorization Process section.
	Pages 27-32 – Updated Coding section.
	Pages 32-33 – Updated Telemedicine Services section.
01/01/2020	Page 21 – Removed instruction on H0015 on same day as S code.
	Page 33 – Added codes 98970-98972 to Test Administration and Scoring section.
01/01/2021	Page 4 – Updated Eligible Providers and Facilities section.
	Page 4 - Updated Benefits section.
	Page 9 – Added reference to Newsletter S-3-18.
	Page 10 – Updated Limited Patient Waiver section.
	Page 13 – Updated the Admission Criteria under the Utilization Management section.
	Page 25 – Updated Evaluation and Management (E&M) section.
	Page 34 – Updated Telemedicine Services section.
01/01/2022	Page 4 – Updated Eligible Providers and Facilities section.
	Page 13 – Clarified wording under Psychiatric Outpatient Program (POP) Criteria.
	Page 13 – Clarified Admission Criteria section #2.
	Page 15 – Clarified wording under VII. BCBSKS/NDBH Authorization Process section
	Page 25 Updated E&M, Office or Other Outpatient Services, and Selecting the Appropriate E&M Codes sections.
	Page 26 – Removed Patient Status section.
	Page 27 – Removed Elements – History, Examination Psychiatric Examination, Musculoskeletal sections.
	Page 30 – Updated 90863 section.
	Page 34 – Updated Telemedicine Services - #3.
06/06/2022	Page 15 – Removed Electroconvulsive Therapy (ECT) bullet under section VII. BCBSKS/NDBH Authorization Process section
	Page 19 – Removed Eye movement Desensitization and Reprocessing (EMDR) section.
07/28/2022	Page 12 – Updated New Directions Behavioral Health section - #7
01/01/2023	Page 11 – Updated Section V. Medical Necessity to reflect current practices with New Directions
	Page 12 – Updated Utilization Management section
	Page 17 – Updated Court Ordered Admissions/Services section

	Page 24 – Updated Section XI. AMA CPT Evaluation & Management Codes, Psychiatric Codes & Guidelines to reflect current practices
	Page 27 – Updated E&M Coding Vignettes added fourth bulled and moved Billing for an E&M code and psychotherapy services on same day to be under this section
	Page 33 – Clarified number 1. Under Guidelines when billing telemedicine services
	Page 34 – Added telemedicine must be patient initiated under NOTE
	Page 34 – Added section XIV. MiResource
06/23/2023	Page 23 – Under Credentialing section added bullet #1
01/01/2024	Though out document – Updated manual to reflect our new behavioral health optimization company name and website to Lucet, formerly New Directions Behavioral Health (NDBH)
	Page 5 – Updated Availity information in section II
	Page 5 – Updated section III to reflect current documenting guidelines
	Page 8 – Changed SOAP to MEAT format
	Page 10 – Updated section IV. To reflect current guides for our limited patient waiver
	Page 11 – Added link for medical necessity information
	Page 12 – Updated Plan 65 reference to Medicare supplements
	Page 15 – Updated link and information on accessing webpass
	Page 19 – Updated definitions of terms section
	Page 23 – Updated Section X, under credentialing by adding #1
	Page 33 – Clarified area considered for OOS claims filing
	Page 34 – Updated section X to reflect current providers and current practices
02/13/2024	Page 14 – Added ABA prior auth phone number
05/08/2024	Page 21 – Updated the IOP credentialing section to Certification Requirements to accurately reflect processes
01/01/2025	Page 4 – Added note regarding incident to billing
	Page 11 – Added note at end of Situations Requiring a Waiver section
	Page 12 – Updated services Lucet provides
	Page 12 – Removed POP information
	Page 14 – Removed section VII. BCBSKS Lucet Authorization Process
	Page 15 – Removed WebPass clinical review process
	Page 18 – Removed Section IX. Outpatient Coverage for Mental Health conditions
	Page 21 – Clarified intro paragraph in X. Coding section
	Page 26 – Clarified Evaluation and Management section
	Page 34 – Added planning to G0506

	Page 34 – Removed Hospital care (99221 – 99233) section
	Page 36 – Removed MiResource section

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