



# *Substance Abuse Facility*

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## I. General Guidelines

- ❖ BCBSKS follows ASAM III.7 guidelines for inpatient care.
  - 24 hr care (evaluation, observation, medical monitoring, addiction treatment)
  - daily onsite counseling services
  - 24 hr physician service available (can be contracted services).
  
- ❖ The inpatient daily per diem will include all routine ancillary costs. If an inpatient requires medically necessary services for a medical condition and those services are provided by another facility, the other facility may bill too and be reimbursed by BCBSKS for covered services.
  
- ❖ The facility cannot require payment from the member prior to the services being provided except for deductible, coinsurance, and share payment amounts or charges for non-covered services.
  - Up front collection of these amounts is the provider's decision. BCBSKS does not have a policy that requires providers to collect up front.
  - If the member has already satisfied part of their deductible, coinsurance or share payment, providers can only bill up front for the balance.
  - Member responsibility must be calculated based on the BCBSKS allowance and not on the total charge.
  - If the up front collection results in an overpayment that is due the patient, a refund must be made to them timely.
  
- ❖ The facility will not bill the member for services that are medically unnecessary or experimental/investigational unless specific notice was given prior to the service. Refer to section titled Compliance and Appeals for complete details on the [Limited Patient Waiver](#) form.
  
- ❖ Generic or all-encompassing notifications without advanced written authorization by BCBSKS shall not be deemed to meet the specific notification requirement mentioned above.

- ❖ When necessary, the provider agrees to refer and/or transfer BCBSKS members to other BCBSKS contracting providers.
- ❖ Claims must be submitted within 15 months from date of discharge or date of outpatient service. Some groups may impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.
- ❖ In the event initial billings for covered services are not submitted timely, deductibles, coinsurance and shared payments may be recovered from the member. All other balances as it relates to these initial billings will be a write-off to the Contracting Provider.
- ❖ Corrected claims or adjustment requests must also be filed within 15 months of the date of service or discharge. Some groups may impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.
- ❖ If BCBSKS requests additional information or clarification about a claim before it can be processed, the provider will submit this information within 45 days of the date of request.

When requested, complete medical record information will be provided in a format that can be utilized by BCBSKS. The member's contract allows BCBSKS to request and receive medical record information without the need for additional authorization.

## **II. New or Expanded Services**

- ❖ The Contracting Provider agrees to notify BCBSKS of the addition of new services or the expansion of existing services. The purpose of this notification is to allow BCBSKS to determine if the new or expanded service is covered under the terms of the various member contracts.

## **III. Prior Authorization**

- ❖ Inpatient and Partial-Day Services must be authorized through New Directions Behavioral Health prior to services being rendered. Their phone number is 800-952-5906.

#### **IV. Provider Right of Appeal**

- ❖ The Contracting Provider shall have the right to appeal a claim, which has been denied based on lack of medical necessity, a service being experimental/ investigational or an MS-DRG assignment.
- ❖ When the NOPFO was not given to the member and the services are deemed not medically necessary, the provider has appeal rights as outlined in the General Policies and Procedures.
- ❖ See the section in this manual called Compliance and Appeals for complete details.

#### **V. Member Appeals**

- ❖ When the member is determined to be financially responsible for the claim and has signed a [Limited Patient Wavier](#) form the member has appeal rights.
- ❖ The Contracting provider may appeal as the member authorized representative but must follow the appeals procedure stated on the back of the Member's Explanation of Benefits.

#### **VI. Partial Day Treatment Program**

Partial-day treatment programs are defined as:

##### **1. SUBSTANCE ABUSE PARTIAL-DAY TREATMENT DEFINITION**

A substance abuse partial-day treatment program must adhere to the standards outlined by the State of Kansas relating to the development and execution of an individual's treatment plan. The program must include a minimum of fifteen (15) hours per five (5) day week of structured activities geared to meet the individual client's need. Of the minimum fifteen (15) hours required per week, no less than ten (10) hours per week will be structured group, individual and/or family counseling for each client. (Group and family counseling requires the participation of the primary client.)

A substance abuse partial-day program must also meet and adhere to Substance Abuse Prevention, Treatment and Recovery (SAPTR) requirements relating to the development and execution of an individual's treatment plan.

## **2. PSYCHIATRIC PARTIAL-DAY TREATMENT DEFINITION**

A psychiatric partial-day treatment program is a planned program of mental health treatment services provided at least twice per week in four (4) or more hours at a single visit for persons who need broader programs than are possible through outpatient care, but who do not require 24-hour hospitalization. For each day of client participation, a minimum of two hours of structured group, individual and/or family counseling is required. (Group and family counseling requires the participation of the primary client.)

A psychiatric partial-day program must also meet and adhere to the requirements of KDHE.

The following guidelines are applicable:

1. The program must be an approved program by BCBSKS. Submit your program information to your provider consultant for approval.
2. Pre-certification is required for partial-day programs. Our mental health vendor is responsible for the pre-certification review process. Providers should call New Directions at 1-800-952-5906.
3. Benefits paid on partial-day charges are limited to those services that would be eligible under the member's medical BCBSKS contract.
4. Payment will be made to providers using special BCBSKS provider numbers assigned for partial-day programs.

## BILLING GUIDELINES:

### Type of Bill

#### **Outpatient or Partial Day**

- 0131 – Admit through Discharge
- 0132 – Interim – First Claim
- 0133 – Interim – Continuing Claim
- 0134 – Interim – Last Claim
- 0137 – Replacement Claim
- 0138 – Cancelled Claim

#### **Inpatient**

- 0111 – Admit through Discharge
- 0112 – Interim – First Claim
- 0113 – Interim – Continuing Claim
- 0114 – Interim – Last Claim
- 0117 – Replacement Claim
- 0118 – Cancelled Claim

#### **Outpatient Partial Day Program -**

- Revenue Code 090X or 091X
- CPT/HCPCS that is applicable

#### **FREE STANDING FACILITIES, AND LOCAL & BLUECARD MEMBER CONTRACTS**

- Revenue code 0912.
- CPT 90899 or HCPCS code S0201
- Units equal the number of days the patient participated in partial-day during the billing period.

#### **FEDERAL EMPLOYEE PROGRAM (FEP):**

- Revenue code 0914, 0915, 0916
- CPT 90801-90899, whichever is appropriate

#### **Inpatient Partial Day Program –**

- Revenue code 0100
- (All-inclusive Room and Board, Plus Ancillary)

REFERENCE: Blue Cross newsletter [BC-10-2 \(Jan. 19, 2010\)](#)

Revenue code 0913 should not be used.