2026 Manual

Behavioral Health

BlueCross BlueShield Kansas

bcbsks.com

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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 (BCBSKS). 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.

I. Eligible Providers and Facilities

Blue Cross and Blue Shield of Kansas (BCBSKS) reimburse outpatient mental health services provided by network providers acting within the scope of their license. Providers who are unlicensed 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.

II. Benefits

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 secure web portal).

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

III. Documentation Guidelines

Please refer to Policy Memo #1, Section XI, page 15 found on the Policy Memo section of our website.

Documentation Errors

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 on the provider tab, there is documentation on how to determine what codes are most appropriate.

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 to 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 from the client.

IV. Limited Patient Waiver

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 Forms section of our website.

V. Medical Necessity

Lucet, our behavioral health partner, 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.

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 questions (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' reviews 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 considers 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. Crosswalks will not necessarily provide an accurate ICD-10-CM code as there are a number of "one too many" relationships. When comparing the code listed in DSM-V with a corresponding code in ICD-10-CM, there may be multiple options.
4. 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

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

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 need 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 the 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.

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.

Substance Use Intensive Outpatient Program (IOP)

Substance Use Intensive Outpatient Program (IOP) is a treatment service and support program to treat substance use.

Coding

HCPCS Code H0015 – Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education. These services should not be billed in addition to H0015.

Outpatient Substance Use Facility Services

BCBSKS will cover medically necessary services performed under the umbrella license issued by the State of Kansas, when the services are related to:

- Counseling treatment
- Diagnostic and referral
- Support services

Multiple Locations

BCBSKS requires that each current license be provided when new provider NPI numbers are established, or a new location is added to an already established NPI number.

Outpatient Substance Use Facility

Services performed by a Medical Doctor or Doctor of Osteopathy, a Licensed Clinical Psychologist; Licensed Specialist Clinical Social Worker; or Specially Trained Advanced Practice Registered Nurse, Licensed Clinical Marriage and Family Therapist, Licensed Clinical Professional Counselor, Licensed Clinical Psychotherapist, under their license and not that of the Outpatient Substance Use Facility Kansas Department for Aging and Disability Services (KDADS) umbrella license, must be billed by the performing provider under their own NPI number, and cannot be billed under the Outpatient Substance Use Facility NPI number.

Claims Filing Requirements

- ICD-10-CM Diagnoses – BCBSKS requires the use of the ICD-10-CM coding systems or the equivalence of DSM-V coding system.
- Place of Service – Use POS 57 on claim form (Box 24-B).

- The procedure codes and guidelines for Outpatient Substance Use Facility claims are the same as those of other psychiatric providers, with few exceptions. The procedure codes are in the AMA-CPT code book.
- HCPCS – BCBSKS does not recognize many of the alpha/numeric HCPCS codes. Please contact your professional relations representative for assistance.
- Reporting Units for Substance Use – Most codes within the psychiatric section of the AMA-CPT book are based on per session and do not require, nor are they reimbursed on, multiple units of service.

Please refer to coding section for acceptable codes.

IX. 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. Coverage is dependent on the member's plan, and the credentials of the provider performing the service. Guidelines for billing an E/M code and psychotherapy service 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.

90785 – Interactive Complexity

This is an add-on code. Bill in addition to 90791, 90792, 90832-90834, 90836-90838, 90853, 99201-99255, 99304-99337 and 99341-99350 if interactive complexity was provided.

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.
- This is an add-on code and requires a primary code to 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 www.bcbsks.com.

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 Outpatient Substance Use Facility'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.

96105-96146 – Psychological Testing

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 services.
- G0506 – Care Planning/Management Services. These services are considered content of service.

X. Telemedicine Services

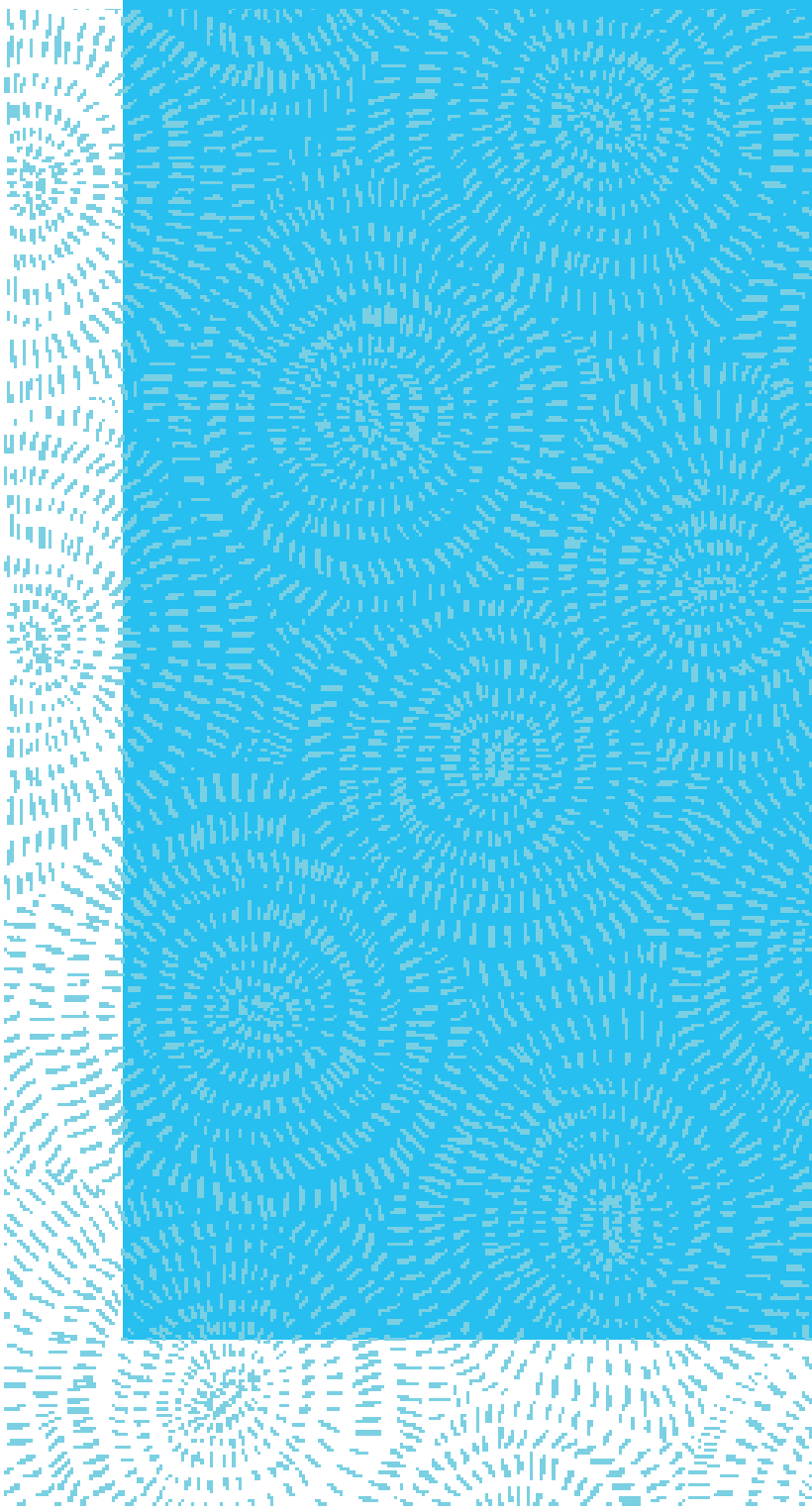
For information on Telemedicine please refer to Policy Memo No. 2, Section VI, Page 5.

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
01/01/2026	Updated sections Eligible Providers and Facilities, Documentation Guidelines, Limited Patient Waiver, Utilization Management, Diagnosis, Behavioral Health

	Intensive Outpatient Program (IOP), AMA CPT Evaluation & Management Codes, Psychiatric Codes & Guidelines and Telemedicine Services to remove duplicate information to other resources
	Page 22 – Added information regarding Substance Uuse Intensive Outpatient Program (IOP) and coding, Outpatient Substance Abuse Facility services, Multiple locations, Outpatient Substance Use Facility and claims filing requirements – Updated any reference to substance abuse to substance use
	Page 25 – Updated Coding section throughout to reflect current practices



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