



# Behavioral Health



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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. The information applies specifically to those providing mental health services, on an inpatient and outpatient basis.

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**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.

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 at [Availity.com](https://www.availity.com).

Through Availity, providers can access both the Availity web portal and BlueAccess – BCBSKS's secure web portal – to view secure BCBSKS member claims and eligibility information.

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

### III. Documentation Guidelines

The importance of having the services performed sufficiently documented 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](http://www.ndbh.com) provider tab, there is documentation on how to determine what codes are most appropriate.

### **SOAP Note Format**

It is essential for the provider to document clinical notes and findings to support medical necessity. A format that may be used is a **SOAP** note. **SOAP** stands for **S**ubjective, **O**bjective, **A**ssessment, and **P**lan.

**S** – Subjective notes should reflect the following:

- Patient's reason for seeking care
- Duration of complaint
- Past medical history and treatment history
- Social history, tobacco use, alcohol use, substance abuse, illicit drug use

**O** – Objective notes should reflect the following:

- Visual observation
- Reports from other counselors/therapists
- Results of psychological tests and widely accepted scales to measure the effectiveness of care (i.e. Beck Depression Inventory, Hamilton Depression Rating Scale, etc.)
- Quantifiable terms



**A** – Assessment notes should include the following:

- Initial evaluation
- Short term goals
- Long term goals
- Overall progress

**P** – Plan notes should include the following:

- Referrals
- Interventions
- Anticipated discharge or referral
- Recommendations
- Prognosis with regard to the treatment plan

### **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 from the client.

## **IV. Limited Patient Waiver**

Occasionally BCBSKS does not consider a service to be medically necessary. In such situations the service becomes a provider write-off without advance notice to the patient. In the few 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 in advance of the services 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](http://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.

**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**

Medical necessity is a requirement of good stewardship of member premiums and is a standard of care that is supported by the behavioral health professional as well as all payor sources. Documentation must support the medical necessity and rendering of the service billed.

**Medically Necessary** describes a service or supply performed, referred or prescribed by a provider in the most appropriate setting and consistent with the diagnosis and treatment of the patient's condition in accordance with generally accepted standards of medical practice in the

United States based on credible scientific evidence and not primarily for the convenience of the patient, physician or other health care provider. Services must be considered effective to improve symptoms associated with patient's illness, disease, injury or deficits in functioning.

A copy of the medical necessity criteria and other information for providers is available at:

<https://www.ndbh.com/Providers/BehavioralHealthPlanProviders.aspx>

## VI. Utilization Management

### **New Directions Behavioral Health**

BCBSKS contracts with New Directions Behavioral Health (NDBH) to perform utilization and medical necessity determinations for behavioral health claims.

NDBH 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. Retrospective review of claims not prior authorized
4. Appeals review and reconsideration
5. Review of outpatient treatment plans for medical necessity as specified by plan directives
6. Review of Behavioral Health IOP protocols
7. Review of the following services for medical necessity and appropriateness:
  - Psychological testing
  - Autism services
  - Electroconvulsive Therapy (ECT) (90870)
  - Intensive Outpatient (IOP)

All BCBSKS policies and those secondary to Medicare, are subject to NDBH's review. There are limited exceptions, including Plan 65, and out-of-state policies.

## **Psychiatric Outpatient Program (POP) Criteria**

### **Intensity of Service**

Must meet all of the following:

1. Treatment is provided by either a licensed practitioner or licensed/accredited clinic and complies with generally accepted standards of care within the provider's scope of training/licensure.
2. Coordination with other behavioral and medical health providers as appropriate, but with a minimum recommended frequency of every 60 days.
3. Individualized treatment plan that guides management of the member's care. Treatment provided is timely, appropriate, and evidence-based), including referral for both medical and/or psychiatric medication management as needed.
4. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of an individualized treatment plan.
5. Family participation:
  - a. For adults – Family treatment is being utilized at an appropriate frequency. If family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
  - b. For children/adolescents – Family treatment will be provided as part of the treatment plan. If family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy. The family/support system assessment will be completed within diagnostic evaluation phase of treatment with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care.
  - c. Family participation may be conducted via telephonic sessions.

### **Admission Criteria**

POP must meet items 1 - 4 and either 5, 6, 7 or 8:

1. A DSM diagnosis is the primary focus of active treatment.
2. There is a reasonable expectation of reduction in behaviors/symptoms for the current condition with the proposed treatment at this level of care.
3. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
4. There is documented evidence of the need for treatment to address the significant negative impact of DSM diagnosis in the person's life in any of the following areas:
  - a. Primary Support

- b. Social/interpersonal
  - c. Occupational/educational
  - d. Health/medical compliance
  - e. Ability to maintain safety for either self or others
5. The member requires ongoing treatment/intervention in order to maintain symptom relief and/or psychosocial functioning for a chronic recurrent mental health illness. Treatment is intended to prevent intensification of said symptoms or deterioration in functioning that would result in admission to higher levels of care.

**If in-home therapy is requested, must additionally meet 6 through 8:**

6. The member is experiencing an acute crisis or significant impairment in primary support, social support, or housing, and may be at high risk of being displaced from his/her living situation (e.g., interventions by the legal system, family/children services or higher levels of medical or behavioral health care).
7. The member requires intensive support to ensure compliance with medications and/or treatment recommendations.
8. The member is engaged with or needs assistance engaging with multiple providers and services, and needs brief intervention (including in-home services) to ensure coordination and continuity of care amongst the providers and services.

**Benefit Denial Reasons**

1. Despite intensive efforts, the member refuses to cooperate with the treatment plan and there is no longer a reasonable expectation of reduction in symptoms/behavior with treatment at this continued level of care.
2. There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the member's current behaviors and symptoms meet criteria for another level of care.
3. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

**VII. BCBSKS/ NDBH Authorization Process**

Authorization is required for the following services:

- Autism services (See separate Autism manual at <https://www.bcbsks.com/providers/professional/publications/manuals>)

- Electroconvulsive Therapy (ECT) (90870)

Authorization is recommended for psychological testing needing more than five hours.

Upon receiving an authorization request for treatment, NDBH will make a determination based on the clinic information provided by the provider. It is in the best interest of the provider to notify NDBH of any service request prior to beginning treatment (if possible) as this will allow for clarifications regarding member benefits, and possible non-covered services.

For services approved, denied, or extended, letters will be mailed and/or faxed.

NDBH will analyze claims data for all behavioral health providers in the BCBSKS network. As we identify variances in practice patterns, we will share information and educational materials with you. The goal is to ensure appropriate utilization and reduce outlier variation while supporting quality outcomes. Utilization will be compared based upon the mix of patient and case characteristics. Additional objectives are:

- To establish a partnership with providers to positively impact the patient's experience in receiving outpatient behavioral health services.
- To provide information on practice guidelines to providers.
- To improve the efficiency of outpatient behavioral health services.
- To identify and connect patients with additional support resources.
- To identify and reduce health-care spending that does not improve the outcome.
- To decrease variation in patterns of care not associated with differing clinical outcomes.
- To provide education and solicit feedback to promote alignment in practice patterns.

Providers whose practice patterns vary significantly from their peer group will undergo review based on Medical Necessity Criteria. If such review determines services provided are not medically necessary, providers may be referred for an ongoing review process. Services denied under this review process also may result in recoupment of payment if denied as not medically necessary. This approach is consistent with how reviews are handled for medical service providers as well.

NDBH will review claims on behalf of BCBSKS and may occasionally request treatment records (progress notes) for specific patients. When requested, the treatment records should be sent to NDBH within the time allowed. NDBH will not be requesting private psychotherapy notes, which should be separate from the treatment records. Even if there is no authorization required for treatment, documentation is still required.

Process for services requiring Clinical Review Forms:

- Request submitted via WebPass
- Clinical Review forms can be completed electronically via WebPass process.
- To access WebPass, go to [www.ndbh.com](http://www.ndbh.com), follow the Provider link to BCBSKS, Provider WebPass.
- Additional Sessions required – Submit a new Clinical Review Form via WebPass with start dates identified. Otherwise, the date the provider signs the Clinical Review form is the date used to begin the next authorization.
- Approval – NDBH will mail and fax your approved authorizations, with the start and end date. PROVIDERS will need to track visits for future authorizations.
- WebPass allows providers to see an approval or requests for additional information. You can answer the questions electronically and resubmit them.
- Letters received from BCBSKS requesting progress notes will require you to resubmit a new claim for the date of service and provide an OVERVIEW or SUMMARY for the date of service to support medical necessity and services provided.
- Letters are sent when a current authorization is not in place to cover the date of service. This information should be sent to BCBSKS Customer Service department. Information is then imaged on to NDBH for review and authorization.
- When completing Clinical Review Form through WebPass, keep your clinical records handy so you can provide all the information requested.

### **WebPass Clinical Review Process**

WebPass is the preferred and most efficient way to request authorizations.

In order to request authorizations from New Directions, please use the appropriate Clinical Review form, which is available at [www.ndbh.com](http://www.ndbh.com).

- Authorization for Admission to Care, use Initial Review.
- Authorization for Ongoing Care Request and Care Coordination, use:
  - Discharge Clinical Review
  - Concurrent Review

### **To use WebPass**

Providers/facilities must sign up using the following instructions:

- Send an email to New Directions with the name of the administrator for your group. The administrator will then be responsible for managing facility users, including adding and



deleting users, and resetting passwords. Email should be addressed to [prwebpass@ndbh.com](mailto:prwebpass@ndbh.com).

- Include the facility Tax ID
- Indicate individual users first name, last name and email address
- Once New Directions receives and processes the request, we will send an email to each user. It will include a username and instructions on how to complete the set up process.

### **Getting Started in WebPass**

- The first time you log in to WebPass, enter your username. You will be prompted to review the Terms of Use. After you click "Agreed," you will receive a second email that contains your individual password.
- Before selecting a Clinical Review form, you will need to first look up a member.
- You will then access the Clinical Forms link, and begin the authorization process.

NDBH Customer Service 800-952-5906

NDBH Fax 816-237-2364

### **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. The court order does not negate the prior authorizations requirements.

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.

## **VIII. 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 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.

#### **Attention Deficit Disorder**

There is not a definitive test for Attention Deficit Disorder (ADD). If testing is done for ADD, the provider should be specific on the name of test, lab work and/or testing being completed, so benefits can be determined. If actual services being provided are known (i.e., psych testing, lab work, counseling), benefits can be quoted.

#### **Eye Movement Desensitization and Reprocessing (EMDR)**

Please refer to the Eye Movement Desensitization and Reprocessing (EMDR) for Acute Stress Disorder and Post Traumatic Stress Disorder (PTSD) medical policy found at <https://www.bcbsks.com/providers/medical-policies>.

## IX. Outpatient Coverage for Mental Conditions

The conditions described in the member's basic coverage also control this section, except where this section specifically states there is a change.

The Outpatient Services for Mental Conditions section of the member's contract provides for the following information in regard to Definitions, Covered Providers, Covered Services and Limitations and Exclusions.

### Definitions of Terms

**Medical Care Facility** – Any of the following facilities that are licensed by the State of Kansas to provide outpatient diagnosis and/or treatment of a Mental Condition:

- A psychiatric hospital
- A community mental health center

**Note** – Facilities must operate within the scopes of their state licensure.

**Note** – If a facility also meets the definition of "Hospital," it will be considered a Hospital and not a Medical Care Facility. Outpatient services rendered by a hospital and submitted as "professional services" are payable under the Outpatient Nervous and Mental Rider.

**Mental Condition** – A disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association but exclusive of those shown as "not attributable to a mental disorder that are a focus of attention or treatment."

### Limitations

All of the limitations and the exclusions of the Member's basic Contract or Certificate apply to the Rider, except for benefits specifically added by the Rider.

### 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 in 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.

## **X. 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
  - Group size

### **Credentialing**

The following information will need to be submitted for consideration:

1. Copy of license to provide IOP treatment
2. List of current staff providing direct care in the facility, their credentials and licensure
3. Facilities admission criteria
4. Facilities discharge criteria
5. Does the facility have adolescent-specific criteria?
6. Facility policy for how soon the individualized treatment plan and goals are set with the patient.
7. List of all groups and treatment program schedule.
8. Hours and days of service options. (i.e. three days a week for three hours a day may look like M-W-F schedule 9 a.m.- noon). Please provide all options available.
9. For each group/session; what modalities are utilized? Keeping in mind that these must be direct services. (Direct services are face to face interactive services spent with licensed staff.

Time spent watching films or videos, doing assigned readings, doing assignments or filling out inventories or questionnaires, or participating in community based support groups such as anxiety support, depression bipolar support and Breakthrough House are NOT BILLABLE for treatment hours and cannot count towards the program hours.)

10. Outline of the availability to 24/7 psychiatric and psychological services. If services are provided in house, provide the list of providers. If this is a contracted/referral service, who is this service with? How do patients access this?
11. What is the facility policy and availability of obtaining UDS and breathalyzers? Can these be done in house or as a referral basis?
12. What is the facility attendance policy?
13. What is the facility policy regarding family involvement in treatment or why it would not occur?
14. When is discharge planning initiated? Is care coordinated with out-patient providers, primary care physicians or other medication managers if indicated? Are community resources provided?
15. What is the facility policy regarding the development of a safety/crisis plan?
16. What is the facility policy regarding group size?
17. What is the facility policy of reporting critical/sentinel events?

### **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.

## **XI. 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: The patient must be present in order to bill any service to BCBSKS.

### **Evaluation and Management (E&M)**

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

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.

### **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.

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

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.

## XII. Coding

The following codes for treatment are for informational purposes.

### **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 OSAP'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 addition 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 Management Services. These services are considered content of service.

### **Hospital Care (99221 – 99233)**

#### **CPT Guidelines**

- Hospital care by the attending physician in treating a psychiatric patient (inpatient or partial hospitalization) may be initial or subsequent in nature and may include exchanges with nursing and ancillary personnel.
- Reimbursed up to the Maximum Allowable Payment (MAP) or charge, whichever is less.

#### **Inpatient Services**

The psychiatric hospital contracting provider agreement indicates a psychiatric hospital shall:

- Include on all inpatient billings charges for hospital services provided to BCBSKS insureds that are obtained from another organization (related or unrelated), except for the technical components of anatomical laboratory, while an inpatient at your hospital.
- All Milieu therapy including group therapy or activity therapy of any kind is considered to be a portion of the psychiatric hospital per diem, whether the professional provider/therapist is a hospital employee or not.
- Services for individual therapy or psychological testing performed by independently practicing providers can be billed separately.

**Note** – Please report accurate place of service.

### **XIII. 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. A physician and a patient that consists solely of email, text, or fax transmission.

Guidelines when billing telemedicine services:

1. Claims must be filed with place of service 02 and a GT modifier to indicate telemedicine services.
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.

NOTE: 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.

The Q3014 code is appropriate only to be billed when there is a eligible provider at the originating site coordinating care.

This information can be found in our [Professional Provider Report S-1-20](#).

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.



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