



Substance Abuse



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

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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 Master Level Social Worker
8. Licensed Marriage and Family Therapist
9. Licensed Master Level Psychologist
10. Licensed Master Level Addiction Counselor
11. Licensed Professional Counselor
12. Advanced Practice Registered Nurse (APRN)
13. Intensive Individual Support Provider (IIS)
14. A hospital
15. A state-licensed Medical Care Facility, defined as:
 - An alcoholic treatment facility
 - A drug abuse treatment facility
 - A psychiatric hospital
 - A community mental health center

II. Benefits

For member eligibility and benefit verification information 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 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 Subjective, Objective, Assessment, and Plan.

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

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

Assessment notes should include the following:

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

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 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 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 renderence and medical necessity 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 substance abuse claims.

NDBH provides the following services:

1. Concurrent review of length of stay authorizations
2. Retrospective review of claims not prior authorized
3. Appeals review and reconsideration
4. Review of outpatient treatment plans for medical necessity as specified by plan directives
5. Review of IOP protocols
6. Review of the following services for medical necessity and appropriateness:
 - Intensive Outpatient (IOP)
 - Partial Hospitalization (PHP)

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 held, 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 when there is a significant geographic or other limitation.

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

9. 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.
10. 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.
11. The member has completed treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

VII. 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 of assessing custody, visitation, parental rights, or 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.

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:

- An alcoholic treatment facility
- A drug abuse treatment facility

Note – Facilities must operate within the scopes of their state licensure (i.e., a licensed drug abuse facility is restricted to treating primary diagnosis of substance abuse).

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. Any assessment against any patient required by a diversion agreement or by order of the court to attend an alcohol and drug safety action program certified by Kansas statutes.

5. Coverage for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, and child custody or child visitation proceedings.

X. Substance Abuse Intensive Outpatient Program (IOP)

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

Requirements

The following are Substance Abuse 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 such as Alcoholics Anonymous or Narcotics Anonymous.
4. All patients must receive a thorough, current standardized substance abuse assessment, such as the Substance Abuse Subtle Screening Inventory (SASSI), Michigan Alcohol Screening Test (MAST), Kansas Client Placement Criteria (KCPC), etc. at admission to the level of care.
5. Twenty-four/seven access to psychiatric and psychological services must be available, either in house or by a referral relationship. Coordination between the mental health provider and the substance abuse provider is required and part of the bundled IOP rate.
6. Drug screens and alcohol breathalyzer must be available either in house or by a referral relationship. The standard of practice is that any patient with a history of drug use should have a baseline drug screen, with follow up screens when clinically indicated.
7. Treatment planning must be individualized and addresses the needs identified in the assessment. Treatment plans should be modified to address any lack of treatment progress. Treatment contracts are strongly encouraged.
8. Group, individual, and family therapies must be available to the patient and used whenever clinically appropriate. The primary modality of IOP is group therapy.

9. Patient participation in community-based support programs is strongly encouraged and may be required as part of the treatment contract.
10. The individualized treatment plan must include a discharge plan that addresses relapse prevention and maintaining abstinence in the patient's home environment. 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.
11. In recognition of the 2013 American Society of Addiction Medicine (ASAM) criteria, guiding principles should be focused on multidimensional assessments, and clinical outcomes. This will move away from fixed length of service to variable length of service based on a broad and flexible continuum of care. Credentialing of the program does not equate with guarantee of paid benefits. Reimbursement from third-party payers and managed care organizations is often based on medical necessity, moving patients to the lowest level of care or clinically appropriate level of care, to meet the patient's specific needs and responses.

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 (if based on ASAM criteria, should be most-recent edition, 3rd 2013).
4. Facilities discharge criteria (if based on ASAM criteria, should be most-recent edition, 3rd 2013).
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 Alcoholics Anonymous (AA), Narcotics Anonymous (NA) Gamblers Anonymous (GA) are NOT BILLABLE for treatment hours and cannot count towards the program hours.)

10. List of the standardized substance abuse assessments utilized at the facility, such as the SASSI, MAST, KCPC, etc. (This would be a current assessment done at the patient's current IOP level of care, not one provided from another facility or for another level of care)
11. 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?
12. What is the facility policy and availability of obtaining urine drug screens (UDS) and breathalyzers? Can these be done in-house or as a referral basis?
13. What is the facility policy for positive UDS or breathalyzer results?
14. What is the facility attendance policy?
15. What is the facility policy regarding family involvement in treatment or why it would not occur?
16. What is the facility policy/expectations regarding attendance in the community-based programs such as AA and NA?
17. What is the facility policy/expectations regarding identification and contact with a temporary sponsor?
18. When is discharge planning initiated? Is care coordinated with outpatient providers, primary care physicians, or other medication managers if indicated? Are community resources provided?
19. What is the facility policy regarding the development of a safety plan?
20. What is the facility policy of development of a relapse prevention plan? When is this initiated?

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.

- 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 and pharmacologic management.
- Contact your Professional Relations representative for further information.

XI. Outpatient Substance Abuse Facility (OSAF) 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 Abuse Facility (OSAF)

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 OSAF KDADS umbrella license, must be billed by the performing provider under their own NPI number, and cannot be billed under the OSAF 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).AMA-CPT:
- The procedure codes and guidelines for OSAF 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 Abuse – 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.

XII. Coding

The following codes for treatment are for informational purposes. They can be billed to BCBSKS if it is within the provider's scope of practice.

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.
- 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 rather than on the key components. 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.

90899 – Unlisted Psychiatric Service or Procedure

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

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, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.
- 96125 – Standardized cognitive performance testing (eg, 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 (eg, 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, [eg, 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 – Codes are time-based and not allowed or acceptable for telemedicine services.

XIII. Telemedicine Services

Effective Jan. 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:

3. Claims must be filed with place of service 02 and a GT modifier to indicate telemedicine services.
4. Provider must be licensed in the state where the patient is located while receiving telemedicine services.
5. Documentation guidelines must be followed and complete.
6. 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 an 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.
	Pages 4-9 – Updated Documentation Guidelines.
	Page 10 – Updated Limited Patient Waiver guidelines.
	Page 11 – Updated Medically Necessity section.
	Pages 11-13 – Updated Utilization Management section.
	Pages 24-26 – Updated Coding section.
	Page 26 – Added Telemedicine Services section.
01/01/2020	Page 21 – Removed instruction on H0015 on same day as S code.
	Page 26 – 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 – Updated Documentation – Keeping it separate section
	Page 10 – Updated Limited Patient Waiver section
	Page 13 – Updated Admission Criteria section
	Page 27 – Updated Telemedicine Services section
01/01/2022	Page 12 – Updated Psychiatric Outpatient Program (POP) Criteria Intensity of Service #5c
	Page 13 – Updated Admission Criteria #2
	Page 20 – Clarified abbreviations under Requirements #5 and #12
	Page 22 Clarified abbreviations under Credentialing #9
07/28/2022	Updated Table of Contents
	Page 14 – Removed BCBSKS/NDBH Authorization Process
	Page 17 – Updated Substance Abuse IOP section to remove prior authorization instruction from IOP requirements
	Page 21 – Updated OSAF section to remove prior authorization instruction from claims filing requirements



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