SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.7 BEHAVIORAL HEALTH

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

BEHAVIORAL HEALTH

Our members must access network behavioral health providers based on the provider network associated with their member benefit plan for in-network benefits. Behavioral Health claims are processed directly by Blue Cross.

Blue Cross has partnered with Lucet to manage the authorization, case and disease management processes for behavioral health services.

Refer to the chart below for the appropriate provider network for each of our member benefit plans.

Benefit Plan Type	Network	Authorizations
PPO	Preferred Care PPO network of professional and facility providers	Lucet
HMO (HMO-HMO & HMO-POS)	HMO Louisiana network of professional and facility providers	
Blue Connect	Blue Connect network of professional and facility providers	
BlueHPN	Blue High Performance Network$_{SM}$ (BlueHPN$_{SM}$) of professional and facility providers	
Community Blue	Community Blue network for professional and facility providers	
Precision Blue	Precision Blue network for professional and facility providers	
Signature Blue	Signature Blue network for professional and facility providers	
Federal Employee Program (FEP)	Preferred Care PPO network of professional and facility providers	
OchPlus	OchPlus network of professional and facility providers	

Our members receive a higher level of benefits when they use providers in their network. Benefits are reduced when services are rendered outside of the network meaning the member is subject to higher cost shares. Always verify a member's benefits prior to rendering services. Patient eligibility, claim status, allowable charges, payment information and medical policies are available online through iLinkBlue.

Services provided by behavioral health facilities are paid on a per diem basis. The per diem payment includes all professional and facility services provided to the member when they are enrolled in an outpatient or inpatient program (intensive outpatient program or partial hospital program) for the entire duration. The covered services paid as part of the per diem include, but are not limited to, psychiatric treatment, group or individual therapy, lab testing (professional and technical), medication management and any other ancillary services provided on the same date of service or relative to their participation in the inpatient or outpatient program.

Authorizations

Authorizations are required for all inpatient behavioral health services. Authorizations may be required for some outpatient behavioral health services. Blue Cross has partnered with Lucet to manage the authorization process for behavioral health services requiring an authorization.

Behavioral health services that require an authorization:

- Applied Behavior Analysis (ABA)
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)

For FEP Members at RTCs:

- Facility must be licensed and accredited.
- Pre-service approval must be obtained prior to admission.

Authorization requests may be completed on iLinkBlue. Click on the "Authorizations" menu option, then choose "Behavioral Health Authorizations" to access the Lucet WebPass Portal. Facilities should use this tool to request authorizations for behavioral health services, eliminating telephone time in requesting authorizations.

Access to the behavioral health authorizations portal (WebPass) must be granted by your organization's administrative representative. Additionally, without access to iLinkBlue, you cannot access WebPass.

The Lucet medical necessity criteria for behavioral health services can be found on the Lucet website at www.lucethealth.com/providers/plan/blue-cross-and-blue-shield-of-louisiana under "Policies & Manuals."

Behavioral Health Medical Necessity Appeals

First-level appeals on behavioral health services denied for medical necessity should be sent directly to Lucet at the address found on our Quick Reference Guide. If the decision is made to overturn denial, a letter is sent to member and provider letting them know the denial was overturned and processing instructions are communicated to Blue Cross to pay claim. If the decision is made to uphold the denial, a letter is sent to member and provider directing them how and where to file a second-level appeal request.

Upon receipt of the second-level appeal, Blue Cross or the member's group (applies for some self-funded groups) will have an Independent Review Organization (IRO) review the case. This is a specialty-matched review. If the IRO upholds the denial, a letter is sent to provider and member and appeals are exhausted. If the IRO overturns the denial, claims are paid.

Post-discharge Standards

Discharge planning should include the utilization review staff, discharge planner, the member's family, significant others, guardian or others as desired by the member.

Admitting facilities should ensure that patients are provided follow-up appointments within seven days of discharge from an acute inpatient setting with a behavioral health provider.

The seven-day appointment does not need to be with a psychiatrist; instead can be scheduled with a therapist or other behavioral health provider.

Lucet now offers post-discharge scheduling, on our behalf, to ensure our members schedule outpatient appointments. Their case managers and care transitions staff are now calling providers to schedule post-discharge appointments within seven days. To take advantage of this service, contact the Lucet After-care Follow-up Assistance Line at 1-877-317-4847, option 2.

Applied Behavior Analysis (ABA)

Effective for claims authorizations for dates of service on or after January 1, 2019, our methodology for the billing of applied behavioral analyst (ABA) services, was updated to incorporate the Category I CPT® codes put in place to address ABA.

ABA Modifier Billing Guidelines

Provider Type	Billing Guidelines	Modifier
Licensed Behavior Analyst (LBA)	• Can bill directly • Services must be billed with modifier	TG
State-certified Assistant Behavioral Analysts (SCABA)	• Cannot bill directly • Services must be billed through the supervising LBA with the appropriate codes and modifier	TF
Registered Line Technician (RLT) with a Bachelor's degree	• Cannot bill directly • Services must be billed through the supervising LBA	HN
RLT without a Bachelor's degree	• Cannot bill directly • Services must be billed through the supervising LBA	No modifier

Use one of the following CPT codes with appropriate, required modifiers for ABA services:

Code	Units	Clinician Type	Modifier
97151	15 min	SCABA	TF
		LBA	TG
97152	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97153	15 min	RLT with Bachelor's	HN
		SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97154	15 min	SCABA	TF
		LBA	TG
		RLT without Bachelor's	
97155	15 min	SCABA	TF
		LBA	TG
97156	15 min	SCABA	TF
		LBA	TG
97157	15 min	SCABA	TF
		LBA	TG
97158	15 min	SCABA	TF
		LBA	TG
0362T	15 min	SCABA	TF
		LBA	TG
0373T	15 min	SCABA	TF
		LBA	TG

Full descriptions for these codes and CPT time-rules are available from the American Medical Association.

Please Note: Failure to include a modifier may result in your claim being returned or denied.

Claims filed with a primary diagnosis of autism will be subject to the patient's autism maximum and limitations. Claims filed with a secondary diagnosis of autism will be processed according to the primary diagnosis code listed on the claim.

Concurrent billing will be allowed as follows when both services are administered simultaneously. Medical record documentation should clearly indicate that both services were administered simultaneously:

- For adaptive behavior treatment with protocol modification (97155) and adaptive behavior treatment by protocol, administered by technician (97153). The 97153 service must be face-to-face with the member and the 97155 service must be direction of the technician for protocol modification.
- For treatment with protocol modification (97155) and group adaptive treatment (97154).

ABA Telehealth Encounters:
Providers should follow the telehealth guidelines outlined in Section 5.37 Telemedicine/Telehealth of the *Professional Provider Office Manual* when delivering ABA services via a telehealth encounter.

Billing for the Administration of Spravato

HCPCS codes G2082 and G2083 should be used to bill Blue Cross for the administration and post-administration observation of Spravato. Code G2082 should be used for esketamine ≤56mg; and G2083 should be used for esketamine >56mg. If the drug is not supplied by the provider, then code G2082 or G2083 should be billed with Modifier CG to indicate that only the post-administration observation was performed.

Psychotherapy E&M Codes

We allow payment for E&M codes according to the following payment policies:

- Psychiatrists and psychologists may bill E&M codes, if appropriate for the service provided and licensed to do so.
- Pharmacologic management CPT code 90863 will bundle as incidental to psychotherapy codes.

Provider Responsibility Regarding 42 CFR part 2 Federal Regulations

Providers and facilities are responsible for making sure they are in compliance with 42 Code of Federal Regulations (CFR) part 2 regulations regarding the *Confidentiality of Substance Use Disorder Patient Records*.

Abiding by the part 2 regulations includes the responsibility of obtaining appropriate consent from patients prior to submitting substance use disorder claims or providing substance use disorder information to Blue Cross. Blue Cross requires that patient consent obtained by the provider include consent to disclose information to Blue Cross for claims payment purposes, treatment, and for healthcare operations activities, as provided for in 42 U.S.C. § 290dd-2, and as permitted by the HIPAA regulations. 42 CFR part 2, section 2.31(a) (1-9) stipulates the content that must be included in a patient consent form. **By disclosing substance use disorder information to Blue Cross, the provider affirms that patient consent has been obtained and is maintained by the provider in accordance with Part 2 regulations. In addition, the provider is responsible for the maintenance of patient consent records.** Providers should consult legal counsel if they have any questions as to whether or not 42 CFR part 2 regulations are applicable.

Psychiatric Collaborative Care

Psychiatric collaborative care is a model of behavior health integration where care is typically provided by a team consisting of a primary care physician and a behavioral healthcare manager who work in collaboration with a psychiatric consultant. The model combines primary care oversight with care management support and regular psychiatric inter-specialty consultation between the primary care physician, the behavioral care manager and the psychiatric consultant.

Psychiatric collaborative care services are billed by the primary care physician on a monthly basis using the following CPT/HCPCS codes:

Code	Description	Time Unit	Time Requirement
99492	Initial psychiatric collaborative care management	First 70 minutes during calendar month	Time less than 36 minutes is not billable
99493	Subsequent psychiatric collaborative care management	First 60 minutes during calendar month	Time less than 31 minutes is not billable
99494	Each additional 30 minutes for initial or subsequent collaborative care management	Each additional 30 minutes during calendar month	Less than 16 additional minutes is not billable
G2214	Initial or subsequent collaborative care management	First 30 minutes during calendar month	Time less than 30 minutes is not billable

G2214 may be billed once per month as an alternative to 99492 or 99493, but it cannot be billed in the same month as 99492 or 99493.

Time spent on services reported separately are not included in the time applied to code 99492, 99493, 99494 or G2214. Neither the psychiatric consultant nor the behavioral healthcare manager may separately report service for which the primary care physician reports a psychiatric collaborative care code.

Members under the active outpatient care of a psychiatrist are not eligible for the psychiatric collaborative care.

Collaborative care management procedure codes may be eligible for reimbursement when:

- Submitted with a psychiatric diagnosis code: F10-F16 or F18-F99.
- Submitted by a primary care provider which may be represented by the following specialties:
  - General Practice
  - Family Practice
  - Internal Medicine
  - Pediatrics
  - Geriatrics
  - Nurse Practitioner
  - Physician Assistant
  - Obstetrics and Gynecology

- Documentation includes:
  - An appropriate psychiatric indication and how the psychiatric diagnosis affects medical/surgical treatment.
  - Communication with the mental health primary caregiver.
  - Review of member's symptoms, signs and progress with documentation of any changes to the treatment plan.
  - Member specific treatment goals and interventions which are measurable.
  - Use of standardized rating scales relevant to member's condition which are used to measure progress.
  - Care commensurate with severity of symptoms.