



CBHNP PROVIDER INFO AD04-002

Administrative Update

Authorization and Billing for Outpatient Services

In an effort to clarify issues brought to our attention CBHNP Capital Area is offering this bulletin to clarify an expectation or procedure. Please share these clarifications immediately with staff responsible for these activities. File this *Provider Info* in your CBHNP Capital Area *Provider Manual*. Additionally, you are invited to check the corporate web site (www.cbhnp.org) for more information.

Additional questions related to this information may be directed to your Provider Relations Representative at 888-772-8646.

CBHNP has identified an issue relative to incorrect billing of outpatient CPT Codes. This Provider Info serves to provide clarification for Providers to assure proper billing. Providers should consider purchasing a CPT coding reference book such as Ingenix “Coding and Payment for Behavioral Health Services”. You may visit the AMA website at <http://www.ama-assn.org/ama/pub/category/3113.html> for more information on CPT Codes.

1. Background

Since the implementation of HIPAA compliant code sets, CBHNP claims staff has recognized some common billing errors in outpatient services relative to the codes listed below:

Code	Description
90804	Individual Psychotherapy 20 – 30 minutes
90805	Individual Psychotherapy 20 – 30 minutes with Med Eval
90806	Individual Psychotherapy 45 – 50 minutes
90807	Individual Psychotherapy 45 – 50 minutes with Med Eval
90808	Individual Psychotherapy 75 – 80 minutes
90809	Individual Psychotherapy 75 – 80 minutes with Med Eval

The following examples are both incorrect:

Providers have been billing multiple units per day to achieve a specific number of minutes of service provided. For example, 75 minutes of service was provided. The provider bills one unit of 90804 AND 1 unit of 90806. Providers have also attempted to bill for 20 to 30 minutes using 90806 but billing for half the unit cost.

2. Appropriate use of CPT Codes and Authorizations:

2.1 Provider billing must match CPT code definition. For example, a 20-minute session of psychotherapy must be billed as a 90804, a 50-minute session must be

billed as a 90806 and a 75-minute session must be billed as a 90808. If you go over the amount of time described on the CPT code, you would round down to the most appropriate code. CBHNP will only pay for one unit of psychotherapy per day.

3. Authorization

- 3.1 When requesting authorization for outpatient psychotherapy services, Providers should continue to request 90806 for individual psychotherapy. CBHNP recognizes that there are times when a 50-minute session is scheduled but only 20 to 30 minutes are delivered. As long as you have authorization in place for a 90806 valid on the date of service, the claim for a 90804 (the appropriate code) will be paid. This only applies to 90804.
- 3.2 The need to use CPT code 90808 is rare. Therefore, if you need to bill for a 90808 (75 to 80 minutes of psychotherapy), you must submit a request for that code and provide an explanation in the "comment" section of the request form. The request must be submitted within five days, excluding Federal Holidays, before 5:00. Requests received after 5:00 will be marked as received on the following business day. We anticipate that this should be a relatively infrequently used code.

Some instances of appropriate use of 90808 are listed below:

- 3.2.1 It is permissible to use the code 90808 for initial therapy sessions; however the code is for 75-80 minutes of direct, face-to-face time with the Member. Time spent completing paperwork is not compensable.
- 3.2.2 It is permissible to use the code 90808 for crisis or emergency situations as long as the time is face-to-face with the Member.
- 3.2.3 It is permissible to use the code 90808 for a one-time evaluation. Again the full 75-80 minutes must be spent face-to-face with the Member.

4. Requesting correction of an authorization

4.1 Providers must review authorizations upon receipt to assure that they are correct. If you find that an authorization is incorrect, Providers have 30 days from the authorization date to request correction. Corrections submitted beyond 30 days may be addressed through the Administrative Appeal process, if appropriate. Please refer to Provider Info AD03-007 for more information on Administrative Appeals. Corrections can be made with a phone call (888-722-8646) or fax (717-671-6515) to Member services.

5. Reminder:

When submitting authorization requests for outpatient services, Providers are required to report dates used to demonstrate the network's ability to meet access standards.

Providers routinely report the following three data elements:

- 5.1 Date the Member first requested services
- 5.2 Date the Provider first offered an appointment and
- 5.3 Date the Member was first seen

CBHNP wishes to clarify that these dates must be reported for new referrals and also every time there is a request for a new service. These date fields are clearly indicated on the Outpatient Treatment Request Forms.

For example, if a Member has been receiving psychotherapy from an organization but has recently been recommended for a psychiatric evaluation, new dates should be reported when requesting the psychiatric evaluation. Providers would use the date the recommendation was made to the Member and the Member agreed to the evaluation as the "Date Member first requested." Providers will also report the "Date Provider first offered an appointment" as well as the "Date the Member was first seen". This would also apply if the Member was receiving medication management services and was recommended to begin psychotherapy.

Beginning January 2004, Provider Relations Representatives will begin looking at Member Records to verify dates reported to dates recorded in the Member record during the course of site visits.