



An Independent Licensee of the Blue Cross and
Blue Shield Association

Behavioral Health Guide

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Service Contacts

March 2011

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Preface

The *Wellmark Provider Guide* and specialty guides are billing resources for providers doing business with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota. The guides are referenced in your provider agreement, and include information that applies to all benefit plans in Iowa and South Dakota unless specified within the text.

Explanation of Terminology

Wellmark	Throughout the guides, the term Wellmark indicates Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota.
Member	Individuals with health coverage through Wellmark are referred to as members.

Provider Guide Updates

Wellmark's provider guides are continually updated to bring you the most current information. The following items identify when the guide or section was last changed.

- The most current date is printed on the front cover and inside pages. The date of the version replaced is also printed on the front cover.
- A *Summary of Changes* page lists all the substantial changes made in the most current update. The page(s) affected and a brief explanation of the change is linked from the *Summary of Changes* page to the change within the document.
- Changed text is in blue type.

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Behavioral Health Guide Summary of Changes - March 2011

Throughout: Updated phone numbers and mailing addresses for our Des Moines office.

Page 4

Wellmark no longer performs an initial office review for psychiatrists applying to contract. (Instruction removed from guide.)

Page 5

Updated information on precertification requirements for psychiatric medical institutions for children (PMICs).

FEP no longer requires precertification for outpatient behavioral health/chemical dependency services.

Page 6

Precertification is required before an FEP member is admitted for inpatient care, including behavioral health/chemical dependency admissions and admissions for other medical care, or within two business days following a hospital admission for emergency care. Failure to precertify will result in a benefit reduction of \$500. If the stay is not medically necessary, no benefits will be paid.

Page 11

Updated information on billing behavioral health services.

Page 12

Clarification of information on cognitive rehabilitation services.

Page 14

Updated copy of the Cognitive Rehabilitation Treatment Plan.

Page 17

Updated information on appropriate revenue codes for services provided under an intensive outpatient program or a partial hospitalization program.

Page 18

Updated information on billing neuropsychological testing.

Page 19

Clarification of billing instructions for social workers.

Page 20

Update on billing psychological testing with report.

Behavioral Health

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Scope Information in this guide applies to networks and products offered or administered by Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Blue Cross and Blue Shield of South Dakota, and Wellmark Health Plan of Iowa, Inc. The guidelines may also apply to Select First, the network administered by First Administrators, Inc., but as guidelines will vary, please check Select First coverage at <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

I Introduction

Section overview Behavioral health services are provided for mental disorders and/or conditions resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV-TR)*. In this guide, we will cover contracting and employer/employee relationships as they relate to behavioral health services, discuss precertification/notification and continued care requirements depending on the member's benefit plan, and provide billing, payment, and medical record documentation information.

II Eligible Contracting Practitioners and Facilities

Direct Contracting

In order to contract with Wellmark directly, **an eligible provider** must submit all appropriate applications and pass specific credentialing criteria. Once approved, *the direct contracting practitioner or group is accountable for all contract requirements.*

Eligible contracting providers Wellmark currently contracts direct with the following facilities and practitioners for behavioral health services in our various networks. Other facilities and practitioners are not eligible for direct contracts with Wellmark.

Licensed Facilities/Entities	Wellmark Blue Cross and Blue Shield of Iowa	Wellmark Health Plan of Iowa, Inc.	Wellmark Blue Cross and Blue Shield of South Dakota
Facilities			
Freestanding Substance Abuse Facility	✓	✓	
Chemical Dependency Treatment Facility			✓
Hospital	✓	✓	✓
Psychiatric Medical Institute for Children	✓	✓	
Entities			
Community Mental Health Center	✓	✓	

(Chart continued on page 2)

Licensed Practitioners	Wellmark Blue Cross and Blue Shield of Iowa	Wellmark Health Plan of Iowa, Inc.	Wellmark Blue Cross and Blue Shield of South Dakota
Practitioners			
Advanced Registered Nurse Practitioner (psychiatry)	✓	✓	
Certified Nurse Practitioner			✓
Doctors of Osteopathic Medicine	✓	✓	✓
Licensed Mental Health Counselor	✓	✓	
Licensed Marriage & Family Therapist	✓	✓	✓
Licensed Professional Counselor - Mental Health			✓
Medical Doctor	✓	✓	✓
Physician Assistant	✓	✓	✓
Psychologist (PhD, PsyD, EdD) with an HSP in Iowa	✓	✓	
Psychologist (PhD, PsyD, EdD)			✓
Qualified Mental Health Professional			✓
Social Worker (LISW) (LCSW)	✓	✓	
Certified Social Worker Private Independent Practice (CSW-PIP)			✓

Employer/Employee Relationship

Only those behavioral health practitioners and facilities eligible to contract with Wellmark direct can receive payment (either direct from Wellmark to the practitioner/facility in a contracting situation, or from Wellmark to the member in a non-contracting situation) for services provided. Eligible behavioral health providers may also submit services on behalf of employed licensed behavioral health practitioners who may or may not be eligible to contract direct.

Employer responsibilities

As an employer, you are responsible to do the following:

- carry malpractice insurance for all staff performing care
- withhold taxes from wages
- set work standards, including attendance requirements, work hours, compensation, and other benefits
- employ or contract with appropriate personnel to meet any supervision requirements necessary to submit services provided by employees
- if you employ a medical director, define and monitor his/her responsibilities to assure supervision requirements are satisfied

There may be situations when a practitioner who is not eligible to contract with Wellmark direct hires or contracts with eligible practitioners as a consultant, and uses the eligible practitioner's direct contracting status with Wellmark to file claims and receive payment. Such arrangements are not considered appropriate by Wellmark. If you have questions, please call your Network Relations Manager in Iowa at **515-376-5167** or in South Dakota at **800-700-9137** or **605-373-7460**.

Employer Supervisory Responsibilities

Direct supervision

An employer is ultimately responsible for services performed by employed behavioral health personnel. It must be an employer's intent to be present and immediately available when an employee performs services for patients. The employer should be trained at a similar or higher level to supervise staff.

We realize an employing provider may not *always* be present and immediately available when an employee provides services. However, we expect you to provide clinical supervision and serve as a resource for your employees. When you must leave your office, it may be appropriate to delegate supervisory responsibility to an employee who is a medical doctor (MD), doctor of osteopathic medicine (DO), or licensed psychologist.

If we find that the supervising professional does not regularly and directly supervise employees, this situation could potentially result in the termination of your contract and cause retroactive claims adjustments for previous payments.

Incidental services provided by employees

Wellmark considers payment for an employee's services that are incidental to the professional services of the employer when the:

- employer provides the initial service; and/or
- employer provides subsequent services that reflect active management; and/or
- employer provides direct supervision.

Employers are within our guidelines if the services mentioned above are performed on a regular basis. It isn't always necessary for the employer to provide the initial service to the patient. In fact, there may be times when Wellmark's behavioral health nurses refer a patient to a licensed practitioner within an employer's office for initial care rather than the employer. That is acceptable and does not mean you, as the employer, must *always* provide the initial care.

For more information on an employer's supervisory responsibilities, please refer to the [Contracts and Credentialing](#) section of the *Wellmark Provider Guide*.

Credentialing Criteria

Direct contracting providers must pass NCQA credentialing criteria. If you would like more information on the credentialing process, refer to the [Contracts and Credentialing](#) section of the *Wellmark Provider Guide* or call: **Iowa: 800-708-1342** or **515-376-5100** or **South Dakota: 800-700-9137** or **605-373-7460**.

III. Member Eligibility/Benefit Information

Before a practitioner in your office provides behavioral health services to a member, ask to see his/her identification (ID) card. If there are pre-certification/notification requirements, that information is usually printed on the back.

Eligibility/benefit information To determine a patient's eligibility and/or behavioral health benefits, log in to www.wellmark.com. Select [View Eligibility & Benefits](#). You may also call the appropriate provider service area found at the back of this *Guide*. **Note:** To access this information online, you must have security authorization. To gain first-time access to our secure online tools, apply by selecting the [Register for www.wellmark.com](#) link on our website's Provider page.

Factors considered to determine a member's behavioral health benefits Wellmark considers the following factors to determine if a member has behavioral health benefits:

- terms of the member's contract or benefit plan
- eligibility of the practitioner
- medical necessity of the service
- place of service
- member's diagnosis, including level of function for behavioral health disorders

Even though a practitioner orders, recommends, approves or prescribes certain services, this does not necessarily mean the services are a covered benefit under a member's benefit plan.

Place of Service Affects Behavioral Health Benefits

Behavioral health and chemical dependency benefits [may](#) have different limitations than medical benefits for hospital inpatient and outpatient care, [depending on applicable laws](#).

When you call Wellmark's provider service areas for behavioral health or chemical dependency benefits, please tell the representative where the treatment will take place (inpatient, [residential](#), outpatient, or office). This information helps ensure that we give you accurate benefit information for our members.

IV Provider Directory Information

Most of Wellmark's benefit plans encourage members to seek services from or be referred to a network or Preferred (FEP) behavioral health provider. To access a list of participating behavioral health providers by benefit plan, go to www.wellmark.com > [Find a Doctor or Hospital](#), or call the appropriate provider service area printed on the back of this Guide. To find FEP Preferred providers online, visit www.FEPBlue.org.

V Clinical and Medical Necessity Criteria

Wellmark's behavioral health staff reference *InterQual*® clinical criteria to guide the evaluation of the medical necessity of behavioral health and chemical dependency treatment.

VI Precertification/Notification Requirements

Although Wellmark no longer requires precertification/notification of most behavioral health/chemical dependency services for the majority of our benefit plans, the Federal Employee Program (FEP) and some employer groups have chosen to keep precertification/notification requirements in place. [Always verify the member's benefits before providing services.](#)

Precertification and medical necessity review for PMIC services

Wellmark requires the patient's physician or the facility to precertify with Wellmark *prior to providing* PMIC (Psychiatric Medical Institution for Children) services, to verify the patient meets the state criteria for admission into a PMIC. In order to receive benefits upon admission, a child must be diagnosed with a biologically based mental illness as defined in section 514C.22 of the Iowa Code, and meet the medical assistance program criteria for admission to a psychiatric medical institution for children. If a Wellmark member requires more than 30 days of PMIC services, we require a review for medical necessity, based on inpatient acute care criteria. Please call the case manager who completed the admission review to determine whether inpatient acute care criteria are being met.

FEP requires precertification for inpatient services

FEP *no longer requires* precertification/notification for **outpatient** behavioral health/chemical dependency services. **However, inpatient** behavioral health/chemical dependency services *now require* precertification.

How to verify a member's benefits

You may do one of the following to verify if a member's benefit plan requires precertification/notification for behavioral health/chemical dependency services:

- log in to www.wellmark.com and select [View Eligibility & Benefits](#).
- look on the back of the member's identification card
- call the appropriate provider service phone number, listed on the back of this guide, for assistance

Online precertification

If you have security access, you can precertify/notify us of an admission online. Log in to www.wellmark.com. Under *Provider Tools*, select *Notify/Precertify Admissions*. You may also call the number on the back of the member's ID card.

Facility benefit reduction

Benefit Reduction Applied for Failure to Precertify/Notify
Some member benefit certificates may require precertification to avoid a benefit reduction. Always check the specifics of the member's benefit plan.

FEP inpatient precertification

Precertification is required before an FEP member is admitted for inpatient care, including behavioral health/chemical dependency admissions and admissions for other medical care, or within two business days following a hospital admission for emergency care. Failure to precertify will result in a benefit reduction of \$500. If the stay is not medically necessary, no benefits will be paid.

Benefit reductions for failure to precertify

Out-of-State Plans

When admitting a patient covered by a Blue Plan in another state, please check the member's identification card or call **800-676-2583** for BlueCard® eligibility and benefit information.

VII. Outpatient Psychiatric Testing

Under Wellmark's benefit plans, psychiatric testing no longer requires precertification or notification. **Note:** Educational testing and some diagnoses are contract [exclusions](#) and will not be covered.

VIII Prescribing Medication for Wellmark Members

Wellmark's Drug List When prescribing medication for Wellmark members, we encourage you to prescribe a suitable generic drug whenever possible. Wellmark pays for prescriptions at different benefit levels, depending on the type of drug prescribed (generic vs. brand-name) and the member's benefit plan. On the [Provider page](#), select [Drug Information](#) under [Provider Quick Links](#) in the right hand column. Click on [Wellmark Drug List](#), and select the appropriate formulary. You may also call **800-600-8065** to receive a paper copy.

hawk-i formulary Blue Access® *hawk-i* members' benefits require members to purchase generic drugs whenever possible. If a member is prescribed a brand-name drug when a generic or generic therapeutic equivalent is available, the member is responsible for the full cost of the drug. To view the *hawk-i* drug list and exceptions to the generic drug requirement, on the [Provider page](#), select [Drug Information](#) under [Provider Quick Links](#) in the right hand column. Click on [Wellmark Drug List](#), and select [hawk-i Wellmark Drug List](#). You may obtain a paper copy of the *hawk-i* drug list by calling **800-600-8065**.

Prior authorization There are certain drugs we must approve before they are prescribed. To see a list of those drugs, visit www.wellmark.com > [Medical Policies & Authorizations](#) > [Authorizations](#) > [Prior Authorizations](#). You may also call Wellmark's Pharmacy Department at **800-600-8065**.

Quantity limit list Wellmark has quantity limits on certain medications. Quantity limits are posted on www.wellmark.com. On the [Provider page](#), select [Drug Information](#) under [Provider Quick Links](#), and then [Quantity Limits](#) under [Related Information](#), both in the right hand column. You may also call **800-600-8065**.

IX. Medical Record Documentation for Behavioral Health Services

Individual Psychotherapy

Individual psychotherapy documentation guidelines

When a practitioner provides either *outpatient or inpatient individual psychotherapy*, a patient's medical record should include the following:

- Date of the therapy session.
- Length of the session (including start and end time).
- Patient's current clinical status, as evidenced by the patient's signs and symptoms. This documents the nature and severity of the patient's condition at the time of the interview.
- Content of the therapy session or the major theme discussed (e.g., angry feelings).
- Therapeutic intervention attempted during the session (e.g., ventilation).
- Treatment goals/plan.
- Patient's degree of progress, or lack of progress, toward the treatment goals. This should include reference to dynamic changes, as well as symptomatic progress (e.g., patient feels less angry).

A general statement such as "the patient is still depressed about the divorce and does not feel ready to face the outside world" in the patient's medical record does not adequately document an hour of psychotherapy. The medical record should include the bullet points listed above in order to sufficiently document the patient's treatment and progress.

Clinical notes should periodically reference the patient's progress in relationship to the established plan of treatment; one to two weeks is suggested for patients undergoing crisis intervention or short-term therapy and three to six weeks for patients undergoing long-term therapy. Progress notes also help the physician or psychologist establish and evaluate a treatment plan and take into account the need for possible change.

Conjoint, Family, and/or Group Psychotherapy

Conjoint, family, and/or group psychotherapy documentation guidelines

Conjoint, family, or group therapy documentation guidelines are similar to those listed for individual treatment. Documentation for these types of therapy sessions should include the following:

- Date of the therapy session.
- Length of the session (including start and end time).
- Number of participants.
- Identification and relationship of the participants to the patient if it is conjoint or family therapy.

- Content of the therapy session (i.e., major themes discussed).
- Individual goal(s)/treatment plan.
- Nature and degree of the patient's participation and the patient's response to the therapy experience if the patient was present.
- A statement summarizing the therapeutic intervention attempted during the therapy session.
- A statement summarizing how the session has influenced the patient (or significant other[s]) as compared with the treatment goals.

Long-term therapy may mean the practitioner will not see changes in the patient's status at each session. However, for each date of service, document the patient's response to treatment, as well as changes made to the treatment plan to elicit a response.

X Release of Medical Record Documentation

Release of Behavioral Health Information to Wellmark

Your provider services contract with Wellmark includes the provision that Wellmark may request that you furnish all reasonably required information, including a member's medical record, to verify and substantiate the provision of services to that member. Your contract also requires you to obtain any consents and authorizations needed from a patient in order for you to provide this information to Wellmark.

Consent and release of information form

To assist you in obtaining the patient's or the patient's personal representative's consent and authorization to release information, Wellmark has developed the following form: *Personal Representative Appointment and Authorization to Release Protected Health Information* (IA: Form C-5674; SD: Form C-3617). This form is available online at [Provider > Communication & Resources > Forms](#). Scroll down to Miscellaneous Forms.

Release of Behavioral Health Information to Other Practitioners

Coordination of care among practitioners is important across all disciplines. When dialogue takes place between different types of practitioners (e.g., medical and behavioral health), duplication of services can be eliminated and the overall quality and safety of services improved.

Information Wellmark may request from psychotherapy notes

We encourage you to obtain your patient's consent for the release and exchange of confidential information when more than one practitioner is treating him/her.

Release to Wellmark of Psychotherapy Notes Documented by a Medical Doctor or Doctor of Osteopathic Medicine

While a patient's medical record may be shared with Wellmark as necessary, psychotherapy notes will not be requested except under extraordinary circumstances. The information that follows explains that Wellmark may specifically request the following information (which is considered excluded from psychotherapy notes):

- medication prescription and monitoring
- counseling session start and stop times
- the modalities and frequencies of treatment furnished
- results of clinical tests
- any summary of these items:
 - diagnosis
 - symptoms
 - functional status
 - prognosis
 - the treatment plan
 - progress to date

If more than what is considered "excluded information" is needed from psychotherapy notes by Wellmark, we must obtain specific authorization from the member for this purpose **except**:

- to defend a legal action or other proceeding brought by the member
- as required or permitted by law
- as required by the Secretary of Health and Human Services to investigate or determine Wellmark's compliance with the HIPAA-AS Privacy Rules
- as required for the oversight of the originator of the psychotherapy notes
- as permitted for coroner or medical examiner activities
- to avert serious and imminent public safety or health threat

XI. Coding Behavioral Health Services

Bill behavioral health and chemical dependency services according to the written documentation found in the patient's medical record. The two types of coding methods are: 1) Diagnostic, and 2) Procedural.

Diagnostic Coding

Use the ICD-9-CM codes to report a patient's diagnosis

To report a patient's symptom or condition on the claim form, use diagnosis codes from the *International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM)* book. Wellmark does not accept diagnosis codes from any other source (e.g., *DSM-IV-TR*).

Procedural Coding

Refer to the Medicine section in the most current *CPT** for a list of procedure codes you should use to bill psychiatric and chemical dependency services. Psychiatric procedure codes include a management component and should not be billed with an E/M code.

Professional coding books

To order *ICD-9-CM* and/or *CPT* books, contact a local bookstore or refer to the [Claims Filing](#) section of the *Wellmark Provider Guide*, available at www.wellmark.com > [Provider](#) > [Communication & Resources](#) > [Billing Guides](#)

XII. Behavioral Health Billing Information

You can file claims with Wellmark electronically or on paper. Electronic filing is the most effective way to get claims into Wellmark's processing system, track them, and receive payment. We use a third party clearinghouse, EC Solutions, and its electronic interchange network, INet, to receive electronic claims. While there are a number of ways to transmit electronic claims, EC Solutions is the single entry point.

CMS-1500 submitters can send electronic claims to INet through the Internet using the *Create & Submit Claims* feature in Wellmark's secure Web tools.

For details, refer to the "Claims Filing" section of the *Wellmark Provider Guide* at www.wellmark.com.

Billing Provider Numbers on the CMS-1500

A solo contracting practitioner should submit his/her NPI number in field 33 of the CMS-1500. Like-specialty groups need to include the performing practitioner's NPI number in field 24J and the group's NPI billing number in field 33. If the performing provider is an employee who is ineligible to contract direct, enter the NPI number of his or her supervising practitioner in field 24J.

Exception for Iowa CMHCs Unlike Community Mental Health Centers (CMHCs) in South Dakota, CMHCs in Iowa are only required to submit their facility billing number in block 33 and are not required to list any information in field 24J. CMHCs in South Dakota are required to submit an individual NPI number on each line that is tied to the group NPI number submitted in field 33.

Cognitive Rehabilitation

Cognitive rehabilitation is a structured therapy designed to improve a person's ability to think, use judgment, and make decisions after a systemic insult. The term cognitive rehabilitation applies to a variety of intervention strategies or techniques that attempt to reduce, manage or cope with cognitive deficits. It includes an assembly of therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, problem solving, and executive functions. Cognitive rehabilitation may be performed by a physician, psychologist, or a physical, occupational, or speech therapist.

Wellmark's policy regarding cognitive rehabilitation services Wellmark considers cognitive rehabilitation medically necessary for patients following a stroke or traumatic brain injury. For more detail, refer to Wellmark's medical policy on cognitive rehabilitation at www.wellmark.com > [Provider](#) > [Medical Policies & Authorizations](#). If you do not have Web access, please call the appropriate provider service phone number listed on the back of this *Guide* to receive a paper copy. To submit cognitive rehabilitation, use CPT code 97532.*

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Blue Cross and Blue Shield of South Dakota provide benefits for [medically necessary services](#). Unless otherwise stated in the member's contract, [Wellmark may cover up to 20](#) physical medicine and rehabilitation services per calendar year. If the treating physician or psychologist feels the patient needs additional services beyond the 20-visit limit, the *Cognitive Rehabilitation Treatment Plan* form, found on page 14, must be completed and sent to Wellmark prior to the member's 20th visit so that our medical department can review the information for medical necessity before additional services are provided. [Fax or mail the completed and signed form to the appropriate number or address listed on the form.](#)

To access the *Cognitive Rehabilitation Treatment Plan* form online, go to www.wellmark.com > [Provider](#) > [Communication & Resources](#) > [Forms](#). To order paper copies, complete the *Provider Forms Order* found on the same page, and enter form number P-2316 and the number needed.

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Instances when the Cognitive Rehabilitation Treatment Plan is not required

Please *do not* submit a Cognitive Rehabilitation Treatment Plan in the following instances:

- *Member Contract Limit* — When a member has a contract benefit limitation (such as a dollar or visit limit), we typically cannot approve additional visits for these members.¹ You may check benefits on our website or call our Provider/Customer Service representatives to determine if a patient has such a limit.
- *Wellmark Health Plan of Iowa Coverage*—If a member is covered by Blue Advantage®, Blue Access®, or Blue Choice®, the 20-visit maximum does not apply.
- *Review of Denied Services* — To request a review of a service denied because the member received more than 20 visits in a calendar year, submit a *Provider Service Inquiry* form with documentation that supports the medical necessity of your care.

The Wellmark member contracts that include a specific limitation on physical medicine rehabilitation services cannot be reviewed for additional benefits, unless the contract specifically indicates review for medical necessity.

Concurrent Care

A billing situation common for services provided in an inpatient setting is "related" concurrent care. Related concurrent care is when one or more M.D.s or D.O.s of different specialties provide services to a patient on the same day for the same or a similar condition.

We allow benefits for related concurrent care in the following situations:

- when the patient's condition requires the services of more than one physician on an attending rather than a consultative basis, and
- when the services provided by each physician are medically necessary for the management of the patient's condition, as determined by our medical department.

Dates of Service

To bill dates of service for outpatient or office behavioral health care, submit a separate date for each service billed. Separate line items for each *service* and each *date of service* help identify the service(s) provided and ensure the correct copayment, deductible and coinsurance amounts are calculated for our members.

Electroconvulsive Therapy

Wellmark does not cover both electroconvulsive therapy and individual psychotherapy (90804*-90829) performed on the same day.

Eye Movement Desensitization and Reprocessing Therapy (EMDR)

Wellmark allows benefits for up to 10 one-hour sessions of EMDR for the treatment of post-traumatic stress disorder (PTSD), provided the services are medically necessary. Services for EMDR therapy are considered individual psychotherapy and should be billed using procedure codes 90804 – 90807.

¹Some contracts may include a specific limit, and then require review for medical necessity (example: allow 15 visits, then based on medical necessity). We can review benefits for these members beyond the 15 visits.



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COGNITIVE REHABILITATION (97532*) TREATMENT PLAN

Use a Provider Service Inquiry form to request a review or denied claims.

Please print or type:

Patient Name: _____ ID#: _____

DOB: ____/____/____ Male Female Occupation: _____

Diagnosis: _____

Date of Injury/Condition: ____/____/____ Date First Seen for this Injury/Condition: ____/____/____ Days Lost from Work: _____

Cause of Injury: _____

Number of times the Patient has been treated for this condition, this calendar year: _____

Work Restrictions: _____

Effects on Activities of Daily Living: _____

Coordination of Care with Other Specialists: _____

Type of Care Given: _____

Current Examination & Diagnostic Findings, and Cognitive Deficits: _____

Treatment Goals with Expected Treatment Outcomes: _____

Describe Progress From Start of Care or Previous Review: _____

Requested Care



Provider Type: Psychologist D.O./M.D./P.A. Speech Therapist

Procedures: _____

Anticipated Frequency & Duration: _____

Anticipated Date of Care: From ____/____/____ To ____/____/____

Provider Name: _____ Individual NPI (not group NPI): _____

Return Address: _____

Fax Number: _____ Phone Number: _____

Provider Signature: _____ Date: ____/____/____

Wellmark Use Only

Benefits Approved*: Beginning with Services On or After: _____

Number of Visits Approved: _____

Type: Psychologist D.O./M.D./P.A. Speech Therapist

Frequency and Duration: _____

Benefits Denied: Not a benefit for this condition

Appears maintenance or supportive

Medical necessity not evident or treatment plan

_____/_____/_____ _____

Date/Initials, Osteopathic/Medical Consultant

*Approvals are granted on the basis of the terms of this patient's contract benefits in effect on the date of the approval. If the patient's coverage changes before the service is provided, other limitations may apply; contact Wellmark for verification of membership.

In Iowa: fax to 515-376-9068 -or- mail to Treatment Authorization Sta 5C139 Wellmark Blue Cross and Blue Shield of Iowa, PO Box 9232, Des Moines, IA 50306-9232.

In South Dakota: fax to 605-373-7298 -or- mail to Medical Management Sta 343, Wellmark Blue Cross and Blue Shield of South Dakota, 1601 W Madison Street, Sioux Falls, SD 57104.

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Freestanding Substance Abuse Facility Billing Information

Use the following revenue codes in form locator 42 of the UB-04 to submit inpatient and outpatient chemical dependency services.

	Revenue Code	Service Units	Standard Revenue Code Description
<i>Inpatient billing</i>	0114	# of Days	Private Room Psychiatric
	0116	# of Days	Private Room Detoxification
	0124	# of Days	Semi-Private Psychiatric
	0126	# of Days	Semi-Private Detoxification
<ul style="list-style-type: none"> Submit ancillary revenue codes in addition to the room and board codes listed above. 			
<i>Outpatient billing</i>	Type of Bill		
	013X	Submit only ancillary revenue codes on outpatient claims.	CPT*/HCPCS codes See examples below
<ul style="list-style-type: none"> Submit a separate claim for outpatient chemical dependency services. Submit ancillary revenue codes with the appropriate CPT/HCPCS codes on outpatient claims (no room and board charges). A separate date of service is required in form locator 45 for each service performed. Please bill outpatient services within the month. Do not span months on one claim. 			
<i>Ancillary codes used to bill inpatient and outpatient chemical dependency services</i>	Ancillary Revenue Codes		
	0250		Pharmacy
	0253		Take-Home Drugs
	0256		Experimental Drugs
	0257		Nonprescription Drugs
	0259		Other Pharmacy
	0270		Medical Supplies
	0273		Take-Home Supplies
	0300	CPT/HCPCS	Laboratory
	0430	CPT/HCPCS	Occupational Therapy
0914	CPT/HCPCS	Individual Therapy (OP) Group Therapy (OP) Drug Rehabilitation Alcohol Rehabilitation	
0915	and		
0944	# of Sessions		
0945			

Refer to the Claims Filing section of the *Wellmark Provider Guide* for interim and series claim filing instructions.

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Intensive Outpatient Program or Partial Hospitalization Program

To report outpatient behavioral health treatment/services or psychiatric/psychological services provided under an intensive outpatient program or partial hospitalization program, use revenue codes 0905–0906, 0911, 0912–0916, or 0918 along with the appropriate CPT*/HCPCS codes. Below is a description of each of the revenue codes:

Revenue Code	Description
0905	Intensive Outpatient Services—Psychiatric
0906	Intensive Outpatient Services—Chemical Dependency
0911	Rehabilitation
0912	Partial hospitalization - less intensive
0913	Partial hospitalization - intensive
0914	Individual therapy
0915	Group therapy
0916	Family therapy
0918	Testing

EAPG/diagnosis code matches

Wellmark's Enhanced Ambulatory Patient Groupings (EAPG) methodology requires providers to submit a CPT/HCPCS code *and* a qualifying diagnosis code (ICD-9) for full- and partial-day mental health and chemical dependency services to be eligible for payment. A complete list of EAPG/diagnosis code matches can be found at http://www.wellmark.com/Provider/CommunicationAndResources/NewsUpdates/20091216_NewOutpatient.aspx

Activity therapy (art, music, dance, movement) performed in conjunction with the partial hospitalization is considered nonessential treatment for the patient's condition and is therefore, a noncovered service. To bill this service separately from the partial hospitalization, submit the activity therapy on a separate line(s) on the UB-04 with revenue code 0904.

Individual Treatment vs. Family Interaction

Wellmark covers medically necessary services that directly relate to a patient's illness or injury. Psychiatric sessions that do not actively involve the patient (codes 90846, 90882, 90887 and 90889) are not considered a covered benefit.

Family counseling without the patient present

Even though counseling, supportive interaction or communication with family members may be necessary or required in the majority of situations, it is not a covered service by itself. In cases where you are treating adolescents or children, and family members are isolated from the patient for part of the treatment for discussion purposes, use procedure code 90847 - family conjoint therapy, to bill the entire session.

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Inpatient Admission

When admitting a patient to the hospital, we recommend the use of the initial hospital care codes found in the E/M section of *CPT*.*

Documentation for an admission should include admitting orders and proof that a history and physical were performed.

Neuropsychological Testing

Neuropsychological testing by psychologist or physician

In the neurobehavioral status exam, a psychologist or physician gathers information to provide an important first analysis of brain dysfunction and the progression and changes in symptoms over time. Bill one unit per hour.

Neuropsychological assessment is used to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. Neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample ability domains known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving). These tests are objective and quantitative and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain.

How to bill neuropsychological testing

Bill codes 96118 and 96119 by the hour with one hour equal to one unit of service. **Services of 30 minutes or less may not be reported. Services of 31 or more minutes in the first or subsequent hours are reported as an initial or subsequent hour. The computer-administered codes are per session, regardless of the number of tests.** Bill code 96120 with one unit of service.

Pharmacologic Management

Wellmark considers pharmacologic management (90862) a medical service

You do not need to precertify a Wellmark member's visits for pharmacologic management. A pharmacologic management service is considered a medical service, and therefore does not count toward a member's annual behavioral health/chemical dependency visits **if applicable**. However, if a member receives treatment *and* pharmacologic management from the same provider on the same day, the outpatient/office treatment will count toward the member's annual visit limit.

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How to Bill Pharmacologic Management/Psychotherapy Performed on the Same Day

Practitioner provides therapy and medication management

If the same practitioner provides psychotherapy and pharmacologic management (90862*) services on the same day, bill the appropriate CPT code that includes psychotherapy and evaluation and management (e.g., 90805, 90807, etc.).

Two practitioners; one providing psychotherapy, the other, pharmacologic management

When two practitioners provide separate services to a member on the same day (e.g., a social worker [LISW, LCSW, or CSW-PIP] performs the individual psychotherapy [e.g., 90806] and a psychiatrist performs the pharmacological management [90862]), follow the billing instructions below.

Alliance SelectSM, Blue Select[®], and Classic Blue[®]

Contracting social worker

If a contracting social worker performs psychotherapy and the patient receives pharmacological management from a physician on the same day **and each practitioner bills independently**, both practitioners should file their services on separate claims, each using his/her NPI number.

Employed contracting social worker

If the social worker has an individual NPI number, but is employed, bill each service on a separate line and enter each practitioner's NPI number on the appropriate line item in field 24J of the CMS-1500. Enter the employer's NPI billing number in field 33.

Employed social worker who does not contract with Wellmark

If a social worker does not contract with Wellmark, but is employed by a contracting provider who provides the pharmacologic management on the same day as the therapy, bill for these services by selecting a CPT code that includes psychotherapy and evaluation and management services (e.g., 90805) using the employer's NPI number.

If the two codes are billed on the same claim for the same date of service **with the same NPI**, Wellmark will deny 90862 as incidental to the individual psychotherapy service.

Blue Access[®], Blue Choice[®], and Blue Advantage[®]

Under the Wellmark Health Plan of Iowa benefit plans, we consider benefits for each practitioner's service separately when they are performed on the same day. If each practitioner bills independently, complete a separate claim form for each service and submit the claim using the appropriate practitioner's NPI number.

If the social worker is employed by the psychiatrist and you are filing one claim form, bill each service on a separate line and enter each practitioner's NPI number on the appropriate line item in field 24J of the CMS-1500. Enter the employer/group NPI number in field 33.

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*Morbid obesity
surgery evaluation
billing information*

Psychological Evaluation for Morbid Obesity Surgery

When you perform a psychiatric evaluation for a patient who qualifies for morbid obesity surgery, there are certain billing instructions we ask you to follow. The medical condition is the reason the patient is receiving the evaluation; therefore, the service should be billed under a member's medical benefits rather than his/her behavioral health benefits.

To file the claim, bill ICD-9-CM code 278.01 (morbid obesity) as the primary diagnosis. Other medical and/or psychiatric diagnoses may be indicated on the claim, but by using morbid obesity as the primary diagnosis, the claim will process under the member's medical benefits.

Psychological Testing with Report

Documentation should include the actual psychological tests and a written report. *Psychological testing codes are typically time-based; services are reported per hour. Services of 30 minutes or less may not be reported. Services of 31 minutes or more in the first or subsequent hours are reported as an initial or subsequent hour. Computer-administered codes are per session, regardless of the number of tests.*

Units of Service

Units of service on a CMS-1500 claim form indicate the number of services based on the time period or amount designated by the code. The American Medical Association advises that the service and the time assigned each behavioral medicine code in *CPT** is "standard" for behavioral health providers across the country, and should, for the most part, represent services provided. Therefore, select the procedure code that most accurately reflects the service you are billing and submit "1" in the units of service field. Wellmark does not accept more than "1" unit of service for procedure codes 90801–90899.

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XIII. Noncovered Procedure Codes and Services

The following procedures, conditions, and place of service are typically *not covered*, regardless of the diagnosis or credentials of the practitioner. To verify a member's benefits, log in to www.wellmark.com and select *View Eligibility & Benefits*, or call the appropriate provider service number for assistance. The following list is not all-inclusive.

- Family medical psychotherapy without the patient present
- Crisis intervention
- Environmental intervention of medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
- Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient
- Training or educational materials
- Reorientation therapy
- Legal or administrative services
- Self-help services usually considered educational or training (hypnosis for weight control, etc.)
- Counseling
- Marital counseling services
- Milieu therapy
- Pastoral counseling
- Bereavement counseling or services
- Impotence (unless it is the result of a physical illness or injury)
- Certain developmental and learning disorders
- Certain disorders of early childhood (e.g., academic underachievement disorder)
- Communication disorders (e.g., stuttering)
- Impulse control disorders (e.g., gambling)
- Nicotine dependence
- Sensitivity, shyness, and social withdrawal disorder
- Sexual identification or gender disorders
- Services provided at a residential treatment facility

XIV Services Considered Not Medically Necessary

The following behavioral health services are not covered treatment modalities.

- services directed toward making one's personality more forceful or dynamic
- consciousness raising
- vocational or religious counseling
- group socialization
- activities primarily of an educational nature
- behavioral modification
- primary therapy
- rolfing or structural integration
- bioenergetic therapy
- carbon dioxide therapy
- guided imagery
- Z-therapy
- obesity control therapy
- training analysis
- sleep therapy
- sedac therapy
- dance therapy
- music therapy
- art therapy
- massage

XV Information Specific to Wellmark Health Plan of Iowa Members

The following information pertains specifically to Wellmark Health Plan of Iowa's (WHPI) benefit plans (Blue Advantage, Blue Choice, Blue Access, and *hawk-i* Blue Access).

Primary Care Provider's (PCP) Role in Behavioral Health Services

In order to receive benefits (Blue Advantage, Blue Access, and *hawk-i* Blue Access) or benefits at the network level (Blue Choice), **WHPI members must receive services from a WHPI network provider.** All providers in an office or facility may or may not be credentialed for WHPI. Please advise your patients to verify that the practitioner they would like to see or that is being recommended is in the WHPI network. Blue Advantage requires a patient's PCP to refer the patient for specialist services, but paperwork does not need to be submitted to Wellmark.

Behavioral health services provided by a PCP

PCPs may provide office visits and medication checks for WHPI patients with behavioral health diagnoses. If the only diagnosis on the claim is behavioral health, the PCP's services will be covered as long as the services and diagnosis are payable contract benefits.

WHPI Behavioral Health Access to Care Standards

Wellmark Health Plan of Iowa has standards of care for appointment wait times, depending on the urgency of care required (routine office call vs. life-threatening emergency needs). Below are WHPI's standards and goals for behavioral health practitioners.

Wellmark Health Plan of Iowa Behavioral Health Access to Care Standards	Goal
A member has access to a counseling appointment within 10 working days. <i>Example: A member whose symptoms interfere with daily living and/or significant relations, (e.g., family, work, school).</i>	95%
A member has access to a medication management appointment within 10 working days. <i>Example: A member taking a prescribed medication is checking with the clinician regarding side effects or other concerns.</i>	95%
A member with non-life-threatening emergency needs has access to care within 6 hours. <i>Example: A member who is exhibiting erratic and/or irrational behavior and requires supervision to prevent harm to him/herself or others: hallucinations, severe mood swings, increased use of alcohol or drugs.</i>	100%
A member with life-threatening emergency needs has access to care immediately. <i>Example: A member who is threatening suicide or endangering the lives of others.</i>	100%
A member with urgent needs has access to care within 48 hours. <i>Example: A member experiencing new or recent changes in symptoms resulting in significant dysfunction in activities of daily living and/or significant relationships, but not an immediate threat to him/herself or others: loss of employment; death in family; news of a serious illness; or sudden to significant marital/relationship breakdown.</i>	100%

Clinical Guidelines for Treating Depression and ADHD

Wellmark Health Plan of Iowa offers PCPs and psychiatrists clinical guidelines for treating depression in 18–64-year-olds, and guidelines for treating attention-deficit hyperactivity disorder (ADHD) in children ages 6–12. These guidelines are available online at www.wellmark.com > Provider > Communication & Resources > Clinical Guidelines.

How to order paper versions of the guidelines

To order paper copies, complete a Provider Forms order (B-0002) with these form numbers and the amount needed:

- M-51715** clinical practice guideline for treating depression
- M-3203** depression algorithm pocket guide
- P-5132** clinical practice guideline for treating ADHD

Follow-up After Hospitalization for Mental Illness

When a patient is discharged after a hospital stay for mental illness, the first week at home is crucial. For the first seven days following hospitalization, patients are at high risk for:

- suicide
- readmission to the hospital
- discontinuing medication

A follow-up visit within seven days after hospitalization is recommended

Once at home, patients may stop taking medication prescribed in the hospital because of side effects, or because they do not understand why the medication is necessary. Experts recommend that patients being treated for a mental illness have their follow-up appointment within seven days after discharge.

To help prevent complications and to help reduce health care costs, a hospital discharge planner may call your office to schedule an appointment for the patient. Please work with the hospital discharge planner and your patients to schedule an appointment within the suggested parameters to ensure follow-up and continued treatment.

Continuity and Coordination of Care

Wellmark Health Plan of Iowa supports a process of ongoing collaboration between primary care providers and specialty and/or behavioral health practitioners treating the same patient. It is our policy to monitor and identify potential problems in the continuity and coordination of care our members receive. If we identify gaps, we will implement appropriate interventions to improve the coordination of care among PCPs, specialists, and/or behavioral health practitioners.

Wellmark Health Plan of Iowa collects data on continuity and coordination of care from multiple sources within the organization. Some of these sources include, but are not limited to:

Sources of continuity and coordination of care information

- medical record review
- disease management programs
- patient care survey
- information obtained during the care coordination process
- HEDIS®* data
- pharmacy data
- Consumer Assessment of Health Plans Survey (CAHPS)

XVI Summary

This *Guide* offers information to help you file behavioral health services for Wellmark members. If you have questions, please call the appropriate provider service area listed on the back page.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance. (NCQA) NCQA is an independent, not-for-profit organization that evaluates and reports on health care quality in the United States.

Iowa Service Contacts

Wellmark Blue Cross and Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.
Des Moines, IA 50306-9232

Wellmark Blue Cross and Blue Shield of Iowa*
Wellmark Health Plan of Iowa, Inc.*
..... 800-362-2218 or 515-376-4688

Federal Employee Program*
..... 800-532-1537 or 515-376-4784

Tyson Foods
..... 800-526-5710

Iowa Bankers *for benefit questions only*
..... 800-258-1415 (call 800-362-2218 for claims issues)

UI Care, UI GradCare, and UI Select
..... 800-355-2031

Ford Retirees
Physicians ... 800-344-8525; Facilities ... 800-249-5103

Admission Notification, Precertification, and Case Management
..... 800-552-3993

Network Relations
..... 515-376-5167

Contact to discuss contracting opportunities in your area

Pregnancy Program*
..... 866-460-9742

Disease Management Program*
..... 866-816-5264

Network Administration*
.... 800-708-1342 or 515-376-5100

Providing information about:
network participation provider number
address change application status
credentialing/recertification status
taxpayer identification number change

BlueCard® Program*
Out-of-state members' claim status or payment information
..... 800-362-2218 or 515-376-4688
Out-of-state members' eligibility information
.... 800-676-2583

EC (Electronic Commerce) Solutions*
..... 800-407-0267
Providing: Electronic claims and reports information

Pharmacy Department
..... 800-600-8065

South Dakota Service Contacts

Wellmark Blue Cross and Blue Shield of South Dakota
Sioux Falls, SD 57104

Wellmark Blue Cross and Blue Shield of South Dakota*
Provider/Customer Service Center
..... 800-774-3892 or 605-373-7292

Federal Employee Program*
..... 888-800-1359

Tyson Foods
..... 800-526-5710

Admission Notification, Precertification, and Case Management
800-642-9273

Network Relations
.... 800-700-9137 or 605-373-7460

Fax Number
..... 605-373-7498

Contact to discuss contracting opportunities in your area

Pregnancy Program*
..... 866-460-9742

Disease Management Program*
..... 866-816-5264

Network Administration*
.... 800-708-1342

Providing information about:
network participation provider number
address change application status
taxpayer identification number change

BlueCard® Program
Out-of-state members' claim status or payment information
..... 800-774-3892

EC (Electronic Commerce) Solutions*
..... 800-407-0267
Providing: Electronic claims and reports information

Pharmacy Department
..... 800-600-8065



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*You will find e-mail links to these areas from our website at
www.wellmark.com > *Contact Us (top right of page)*. Select
For Providers and on the next screen, choose your state.