SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Member Provider Policy & Procedure Manual

5.6 BEHAVIORAL HEALTH

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Member Provider Policy & Procedure Manual*. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes 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 *Member Provider Policy & Procedure 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.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member 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 our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

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 Louisiana Blue.

Louisiana Blue manages the authorization, case and disease management processes for behavioral health services.

Refer to the chart below for the appropriate network of professional and facility providers for each of our member benefit plans.

Benefit Plan Type	Network	Authorizations
PPO	Preferred Care PPO network of professional and facility providers	Louisiana Blue
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® (BlueHPN®) 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 (e.g., 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. Louisiana Blue manages 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.

Providers can electronically submit authorization requests for behavioral health services through iLinkBlue. Click on the "Authorizations" menu option, then choose "Louisiana Blue Authorizations" to access our authorizations portal. Facilities should use this tool to request authorizations for behavioral health services, eliminating telephone time in requesting authorizations.

Access to the Louisiana Blue Authorizations portal must be granted by your organization's administrative representative. Additionally, without access to iLinkBlue, you cannot access the Louisiana Blue Authorizations portal.

Behavioral Health Medical Necessity Appeals

Appeals on behavioral health services denied for medical necessity should be sent to Louisiana Blue at the address found on our Quick Reference Guide. For more on the Louisiana Blue medical appeals process, please see the Claims Resolutions section of this manual.

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.

Applied Behavior Analysis

Effective for claims authorizations for dates of service on or after Jan. 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

Code	Units	Clinician Type	Modifier
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.

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 Session Note Requirements

Session note requirements must be completed after every session.

All provider notes should:

- Contain identifying information for the member, the registered line technician and the supervising board-certified behavior analyst.
- Include the date of service, session start and end times, service location and signatures of the registered line technician and the board-certified behavioral analyst.
- Include the lessons and objectives addressed by the registered line technician or board-certified behavior analyst during the session.
- Document the member's response to treatment, including any challenging behaviors that occurred.

Assessment (97151 and 97152) notes should:

- Document the assessment activities completed (i.e., record review, interviews, direct observation, probes, standardized assessments, functional assessment activities).
- Summarize assessment findings and clinical impressions.
- Document data collected and analyzed.
- Explain how assessment results will be used to develop or modify treatment recommendations.
- Identify the assessment activities conducted by the technician under board-certified behavior analyst direction for CPT code 97152.
- Document data collected during assessment procedures for CPT code 97152.
- Describe the member's participation and response to assessment activities.
- Document any barriers that affected assessment administration or data collection

Direct treatment (97153, 97154, 97159, 97160 and 97173) notes should:

- Describe the interventions, prompting strategies, behavior-reduction procedures and teaching methods used during the session.
- Include relevant data collected, such as skill acquisition performance, behavior frequency, duration, intensity or other objective measures.
- Document any environmental factors or significant events that affected treatment (e.g., illness, schedule changes, caregiver participation, distractions or setting changes).

Treatment modification (97155, 97173 and 97180) notes should:

- Describe modifications made to the treatment plan (e.g., lessons removed, mastered, updated, etc.), modified teaching procedures (e.g., discrete trial teaching, task analysis, natural environment teaching), or prompting levels and the clinical reason for those changes.
- Detail the feedback given to the technician during treatment modification

Caregiver collaboration (97156 and 97158) notes should:

- Identify the caregivers present.
- Describe the goals, skills, procedures or behavior management strategies taught to the caregiver.
- Document the caregiver's participation, performance and understanding of the material.
- Include feedback, coaching, modeling, role-play or competency assessment provided.
- Document plans for continued caregiver training and implementation.

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.

Psychotherapy E&M Codes

We allow payment for evaluation and management (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.

Intensive Outpatient Program and Partial Hospital Program Services

Louisiana Blue defines an **intensive outpatient program** (IOP) as having the capacity for planned, structured, service provision that occurs three days per week and provides a minimum of nine hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. IOP encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Programming must include documentation of at least one individual counseling session weekly or more as clinically indicated. IOP models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatments." Treatment for substance-related disorders typically includes involvement in a self-help program such as Alcoholics Anonymous or Narcotics Anonymous. The program time as described here excludes time spent in these self-help programs, which are offered by community volunteers without charge.

Louisiana Blue defines a **partial hospital program** (PHP) as a structured program with frequent nursing and/or physician supervision, active treatment each program day and program services provided to patients five days a week and provides 20 hours of weekly clinical services by a professional nurse or a physician, one of which must be by a physician. Programming must include documentation of at least one individual counseling session weekly or more as clinically indicated. A partial hospital program can safely substitute for, or shorten, a hospital stay.

PHP services must essentially be the same nature and intensity (including medical and nursing) as would be provided in a hospital except that the patient is in the program less than 24 hours per day. The patient is not considered a resident at the program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. The range of services offered is designed to address a behavioral health and/or substance-related disorder through an individualized treatment plan. Programs that primarily provide social, recreational or diversionary activities are not considered partial hospitalization.

General IOP and PHP coverage criteria:
IOP and PHP services may be considered for reimbursement (included in the facility's per diem) when criteria are met and the member has coverage. An authorization may be required, based on the member's benefit plan.

- Patient must be under the care of a physician who certifies the need for the service as evidenced by the patient's plan of care.
- Services must be incidental to the physician's service; and
- Services must be reasonable and necessary for the diagnosis or treatment of the patient's condition (must be for the purpose of the diagnostic study or reasonably expected to improve the patient's condition).
- Individual and group therapy must be with a physician, psychologist or other behavioral health professional authorized by the state and/or through Louisiana Blue.
- Occupational therapy services may be covered if the patient requires the skills of a qualified occupational therapist. Services must be performed by or under the supervision of a qualified occupational therapist or therapy assistant.
- May include the services of social workers, trained psychiatric nurses and other staff trained to work with behavioral health patients.
- Drugs and biologicals administered by a healthcare professional for therapeutic purposes may be covered.
- Activity therapies may be covered, but only if they are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.
- Family counseling services with members of the household may be covered only where the primary purpose of such counseling is for the treatment of the patient's condition.
- Patient education programs may be covered, but only where the educational activities are closely related to the care and treatment of the patient.
- Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas and to formulate and continue a treatment plan may be covered.
- All laboratory services beyond the scope of treatment must be performed by a network reference laboratory. See the Reference Laboratory section of this manual for more on reference lab services.
- All IOP- or PHP-specific patient eligibility criteria are met.

IOP-specific patient-eligibility criteria:
It is not necessary that a course of therapy have, as its goal, restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric or substance-related patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus not continuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further or require hospitalization, this criterion is met.

The patient must:

- Have a behavioral health or substance-related disorder that severely interferes with multiple areas of daily life, including social, vocational and/or educational functioning.
- Be able to cognitively and emotionally participate in the active treatment process.
- Be capable of tolerating the intensity of an IOP program.
- Require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care.

PHP-specific patient-eligibility criteria:
PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served.

The patient must:

- Require active treatment that incorporates an individualized treatment plan and services that meet the particular needs of the patient.
- Require a multi-disciplinary team approach to patient care under the direction of a physician.

The following IOP/PHP services are generally NOT COVERED (*except as indicated*):

- Services, treatment or supplies otherwise not covered by the member's benefit plan.
- Meals
- Transportation
- Self-administered drugs and biologicals are not considered
- Services for patients who are otherwise psychiatrically stable or require medication management only
- Services to inpatient hospital patients

- Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.
- Activity therapies, group activities or other services and programs that are primarily recreational or diversional in nature. Outpatient psychiatric day-treatment programs that consist entirely of activity therapies are not covered.
- Day care programs for the chronically mentally ill that attempt to maintain behavioral health wellness, where there is no risk of relapse or hospitalization.
- Day care programs that provide primarily social, recreational or diversionary activities, custodial or respite care; including, but not limited to "geriatric day care." Such programs are not covered as they are not considered reasonable and necessary for a diagnosed behavioral health disorder, nor do such programs routinely have physician involvement.
- Psychosocial programs are generally community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they may be covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.
- Vocational training services and prevocational assessments related solely to specific employment opportunities, work skills or work settings are not covered.
- Patients who cannot or refuse to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of IOP or PHP services.

Frequency and duration of IOP/PHP Services:
There are no specific limits on the length of time that services may be covered unless otherwise specified in the member's benefit plan. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, goals of treatment and patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice for the provider type, coverage may be continued as long as the member has benefits that cover the service/treatment(s) at the time of service. If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, the patient's case should be evaluated in terms of the criteria to determine if continued treatment at the facility is a reasonable expectation of improvement.

IOP/PHP Individualized Treatment Plan:

- Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members.

- The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)

IOP/PHP Physician Supervision and Evaluation:

- Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized.
- The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records and patient interviews.
- Physician entries in medical records must support this involvement.
- The physician must provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.
- Continued treatment—in order to maintain a stable behavioral health or substance-related condition or functional level—requires evidence that lesser treatment options (e.g., day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Discharge planning from an IOP/PHP:

- Patients may be discharged by either stepping up to an inpatient level of care, which would be required for patients needing 24-hour supervision, or stepping down to a lesser level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, multimodal treatment.
- May reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

IOP/PHP Expectation of Improvement:

Some patients may undergo a course of treatment that increases their level of functioning, but then reach a point where further significant increase is not expected. Such cases are not automatically considered non-covered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are non-covered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less treatment.

IOP/PHP Documentation Requirements and Physician Supervision:

The following components will be used to help determine whether the services provided were accurate and appropriate.

1. Initial Psychiatric Evaluation/Certification - Upon admission, a certification by the physician must be made that should identify the diagnosis and psychiatric need for the program treatment. Program services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured services that are reasonable and necessary to treat the presentation of serious psychiatric or substance-related symptoms and to prevent relapse or hospitalization.
2. Physician Recertification Requirements
    a. Signature - The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.
    b. Timing - The first recertification is required as of the 18th calendar day following admission to the program. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
    c. Content - The recertification must describe the following:
        - The patient's response to the therapeutic interventions provided by the IOP;
        - The patient's psychiatric or substance-related symptoms that continue to place the patient at risk of hospitalization; and
        - Treatment goals for coordination of services to facilitate discharge from the program.
3. Treatment Plan - IOP and PHP programs provide active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as IOP/PHP services.
4. Progress Notes - must document necessary and sufficient information that shows that services were provided and to determine the billable services to the Plan. A provider may submit progress notes to document the services that have been provided upon request from the Plan. The progress notes should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

IOP and PHP Billing Instructions:

When filing a UB-04 claim for IOP/PHP services the following combination of HCPCS/revenue codes are appropriate to ensure accurate reimbursement per your provider contract. The combination to use will be determined based on the primary reason the member is receiving IOP/PHP services:

Level of Care	Type of Service	Revenue Code	Required HCPCS Code (with short description)*	Service Units
IOP	Psychiatric	905	S9480: intensive outpatient psychiatric services, per diem	1
IOP	Chemical Dependency	906	H0015: alcohol and/or drug services; intensive outpatient treatment	1
PHP	Chemical Dependency or Psychiatric	912	H0035: mental health partial hospitalization treatment less than 24 hours	1
PHP	Chemical Dependency or Psychiatric	913	H0035: mental health partial hospitalization treatment less than 24 hours	1

**Please refer to the most current HCPCS books for complete descriptions.*

As outlined in your provider agreement, billed services that are not defined in your IOP or PHP network agreement are not separately payable.

When the UB-04 Statement Covers Period, Block 6, is longer than one day, each date of service should be billed on a separate claim line and include Revenue Code, HCPCS, service unit of one and Total Charges, Blocks 42-47.

Louisiana Blue does not accept decimals for units of service. Please use whole numbers when reporting units.

IOP and PHP Telehealth:

1. Providers should adhere to the following guidelines for delivering intensive outpatient program (IOP) services via telehealth.
    - Provider must operate within the scope of its license to deliver IOP services through telehealth encounters.
    - Provider must accept Louisiana Blue's allowable charges.
    - The telehealth visit must be fully documented in the patient's medical record.
    - Services must be provided using a non-public-facing platform for telehealth services that is either HIPAA-compliant or approved by the Health and Human Services Office of Civil Rights.
    - Provider must deliver IOP services through audio-visual telehealth encounters, not solely telephonic. Telephonic-only interactions are not appropriate for IOP level of care.

2. Billing guidelines for telehealth IOP services:
    - Louisiana Blue will allow reimbursement for IOP telehealth encounters that meet the criteria for in-person IOP services as defined in this section of the *Member Provider Policy & Procedure Manual*.
    - Providers filing outpatient hospital claims for IOP telehealth services should bill with the appropriate CPT/HCPCS code, along with Modifier GT or 95. IOP providers must continue to follow the IOP guidelines outlined in this section of the *Member Provider Policy & Procedure Manual*.
3. PHP Services:
    - Louisiana Blue will not reimburse partial hospitalization program (PHP) telehealth encounters (revenue codes 0912 and 0913) due to the complexity of services. PHP services are typically six hours in length and must essentially be the same nature and intensity (including medical and nursing) as would be provided in a hospital, except that the patient is in the program less than 24 hours per day.

Residential Treatment Center (RTC)

Louisiana Blue defines a residential treatment center as a 24-hour, non-acute care treatment setting for the active treatment of specific impairments of mental health or substance abuse. A psychiatric RTC provides services to individuals under age 21, in a residential setting. A substance abuse RTC provides non-emergency residential treatment services 24 hours a day, seven days a week and includes a planned, professionally implemented regime for people suffering from substance use disorders.

Residential Treatment for Behavioral Health

Facility providers in our networks treating behavioral health conditions in a residential setting must be licensed and credentialed by the state to do so. All residential treatment must receive prior authorization to provide these services. Providers are to bill these services under their Treatment Center (RTC) taxonomy code and with the 1001 revenue code.

Residential Treatment for Chemical Dependency

Facilities that are licensed and credentialed by the state to provide residential inpatient detoxification (license types at ASAM Levels II-D, III.2D or III.7D) must receive prior authorization for these services through Louisiana Blue. Providers are to bill for detoxification services under their Chemical Dependency Unit (CDU) taxonomy code and with the 1002 revenue code. Residential treatment provided after the detoxification services may bill under the Residential Treatment Center (RTC) taxonomy code and with the 1001 revenue code.

Services provided by behavioral health facilities—including residential treatment, chemical dependency, intensive outpatient and partial hospitalization services—are paid on a per diem basis. The per diem payment will include all professional and facility services provided to the member when they are enrolled in an inpatient or outpatient program for the entire duration.

The covered services paid as part of the facility per diem include, but are not limited to, psychiatric treatment, group or individual therapy, lab testing (professional & technical), medication management, plus any other ancillary services provided on the same date of service or relative to their participation in the inpatient or outpatient program.

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 Louisiana Blue. Louisiana Blue requires that patient consent obtained by the provider include consent to disclose information to Louisiana Blue 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 stipulates the content that must be included in a patient consent form. **By disclosing substance use disorder information to Louisiana Blue, 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.