Priority Health	BILLING POLICY No. 054
BEHAVIORAL HEALTH	
Date of origin: Nov. 11, 2024	Review dates: 2/2025

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

POLICY NAVIGATION

POLICY SPECIFIC-INFORMATION

Residential treatment

Definition

Residential treatment for behavioral health is defined as 24-hour care in a subacute facility with structured, licensed healthcare professionals. This treatment must be medically monitored and include the following services 24 hours a day, 7 days a week: medical services, licensed nursing and clinical staff onsite and physician emergency on call availability.

Medical policy

Behavioral Health Residential Treatment (#91625)

Policy specific information

One claim should be submitted for the full period of care. Separate claims shouldn't be submitted for services included in the period of care.

Revenue codes

- **1001**: Behavioral Health Accommodations – Residential – Psychiatric
- **1002**: Behavioral Health Accommodations – Residential – Chemical Dependency
- **1003**: Behavioral Health Accommodations – Supervised Living
- **0128**: Room & Board – Semiprivate (Two Beds) - Rehabilitation

Documentation requirements

Documentation may be required to support medical necessity. Documentation must include all services performed.

Place of service

Residential treatment is billed with type of bill 86

Applied behavior analysis (ABA) therapy

Definition
Applied behavior analysis (ABA) is a style of therapy designed to improve social and emotional skills using interventions based on how people learn.

Medical policy
Behavioral Health Residential Treatment (#91625)

Policy specific information
CPT Codes

- **97151**: Behavior identification assessment, by a physician or other qualified healthcare professional, per 15 minutes Time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
- **97153**: Adaptive behavior treatment by protocol, per 15 minutes Administered by technician under the direction of a BCBA, face-to-face with one patient
- **97154**: Group adaptive behavior treatment by protocol, per 15 minutes Administered by technician under the direction of a BCBA, face-to-face with two or more patients
- **97155**: Adaptive behavior treatment with protocol modification, per 15 minutes Administered by BCBA, which may include simultaneous direction of technician
- **97156**: Family adaptive behavior treatment guidance, per 15 minutes Administered by BCBA, with or without patient present, face-to-face with guardian(s)/caregiver(s)
- **97157**: Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
- **97158**: Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

Modifiers

- **XP**: When billing ABA code with a Speech Therapy code modifier XP must be billed on the ABA code.

Documentation requirements
Documentation must include a treatment program that's developed and supervised by a Board-Certified Behavior Analyst. Documentation must show measurable progress in the treatment plan to be considered for continuation of treatment.

Electroconvulsive therapy

Definition
Electroconvulsive therapy (ECT) is a procedure done under general anesthesia, in which small electric currents are passed through the brain intentionally triggering a brief seizure. ECT can cause changes in brain chemistry that can reverse symptoms of certain mental illnesses.

Policy specific information
CPT/revenue codes

- **90870**: Electroconvulsive therapy with monitoring; single seizure
- **0901**: Electroshock Treatment
- **00104**: Anesthesia for electroconvulsive therapy

For ECT codes 0901 or 90870, the anesthesia service is considered part of the bundled rate and won't be separately reimbursed.

Documentation requirements
To determine medical necessity for ECT, the Priority Health Behavioral Health department relies on InterQual Behavioral Health criteria.

Detoxification services

Definition
Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. It denotes a clearing of toxins from the body of a patient who's acutely intoxicated and/or dependent on substances of abuse. Detoxification seeks to minimize the physical harm caused by the abuse of substances.

Medical policy
Detoxification (#91104)

Policy specific information
Revenue codes
Inpatient only:

- **0110**: Room & Board - Private - General
- **0111**: Room & Board - Private - Medical/Surgical/GYN
- **0120**: Room & Board - Semiprivate
- **0121**: Room & Board - Semiprivate - Medical/Surgical/GYN
- **0130**: Room & Board - Three and Four Beds - General
- **0131**: Room & Board - Three and Four Beds - Medical/Surgical/GYN
- **0200**: Intensive Care Unit - General
- **0201**: Intensive Care Unit - Surgical
- **0202**: Intensive Care Unit - Medical

Non-medical detoxification:

- **0116**: Room & Board - Private - Detoxification
- **0126**: Room & Board - Semi-Private Two Bed - Detoxification
- **0136**: Semi-Private - Three & Four Beds - Detoxification
- **0146**: Private (Deluxe) - Detoxification
- **0156**: Room & Board Ward – Detoxification

Distinction between medical and substance use disorder detox must be made for appropriate application of member benefits.

Documentation requirements
Intoxication alone isn't an indication for medical detoxification admission. The medical record must show necessity for inpatient admission to monitor withdrawal symptoms. See our Detoxification medical policy (#91104) for further information.

Transcranial magnetic stimulation

Definition
Transcranial magnetic stimulation (TMS) is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression. TMS is typically used when other depression treatments haven't been effective.

Policy specific information
TMS treatment must be administered under direct supervision of prescribing physician. The device used to administer TMS must be FDA approved and cleared to provide treatment in a safe and effective manner.

CPT codes

- **90867**: Therapeutic repetitive transcranial magnetic stimulation treatment; initial, including cortical mapping, motor threshold determination, delivery and management
- **90868**: Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management, per session
- **90869**: Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent motor threshold re-determination with delivery and management
    - TMS retreatment may be considered for those who successfully completed original round of treatment and subsequently has a relapse of depressive symptoms.

Documentation requirements
Documentation should include the following for TMS to be considered medically necessary:

- A confirmed diagnosis of major depressive disorder, **AND**
- One or more of the following:
    - A lack of significant response to treatment with psychopharmacological agents
    - Intolerance of psychopharmacologic agents
    - History of successful TMS
    - TMS as a less invasive option to electro-convulsive therapy
    - **AND**
- No significant improvement after an adequate duration of psychotherapy, **AND**
- Order for TMS by a psychiatrist that has examined the patient and reviewed their history.

Partial hospitalization program

See our Partial hospitalization program (PHP) billing policy.

Care management

See our Care management billing policy.

Psychological E/M of non-mental health disorders

Psychological E/M services are performed to address difficulties associated with an acute or chronic illness, prevent a physical illness or disability and maintain health that don't meet criteria for a psychiatric diagnosis. Find details for reporting these E/M services in our Provider Manual.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section