Outpatient Behavioral Health/Substance Use Disorder Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to professional providers who render outpatient behavioral health (BH) and substance use disorder (SUD) services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary behavioral health and substance use disorder (BH/SUD) services rendered in an outpatient or office setting, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Opioid Treatment Program Requirements

In accordance with CMS § 410.67, opioid treatment programs (OTPs) may provide opioid use disorder services (OUDs) when they meet all of the following criteria:

1. Be enrolled in the Medicare program
2. Have in effect a certification by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the opioid treatment program
3. Be accredited by an accrediting body approved by the SAMHSA
4. Have in effect a provider agreement under 42 CFR 489.

Refer to the CMS Opioid Treatment Program for more information.

Pharmacology Visits

Visits are covered as medical services after the initial medical evaluation. These visits do not count against a member's BH benefit; however, cost share may apply.

Psychological and Neuropsychological Testing

Testing is covered as a medical service and is not considered part of a member's BH benefit.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals, prior authorizations or inpatient notifications are required for outpatient BH/SUD services for in-network services. The PCP, if applicable, should be contacted directly by the BH provider with any questions. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Procedure Codes for All Clinicians

Code	Description
90791	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)
90832	Psychotherapy, 30 minutes with patient or family member
90834	Psychotherapy, 45 minutes with patient or family member
90837	Psychotherapy, 60 minutes with patient or family member
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family psychotherapy (without patient present), face-to-face office visit
90847	Family psychotherapy (with patient present), face-to-face office visit
90853	Group psychotherapy, face-to-face office visit

Psychological and Neuropsychological Testing

Code	Description
96116	Neuropsychological status exam by physician or psychologist, time with member, interpreting test results and report preparation
96121	Neuropsychological status exam; each additional hour (list separately in addition to code for primary procedure)
96130	Psychological testing evaluation; first hour
96131	Psychological testing evaluation; each additional hour (list separately in addition to code for primary procedure)
96132	Neuropsychological testing evaluation; first hour
96133	Neuropsychological testing evaluation; each additional hour (list separately in addition to code for primary procedure)
96136	Psychological or neuropsychological test administration and scoring by physician; 2+ tests, any method, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring; each additional 30 minutes (list separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, 2+ tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician; each additional 30 minutes (list separately in addition to code for primary procedure)
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, automated result only

Codes for Prescribing Clinicians (psychiatrists, nurse clinical specialists and BH clinics)

Code	Description
90792	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient/family member with an E&M service
90836	Psychotherapy, 45 minutes with patient/family member with an E&M service
90838	Psychotherapy, 60 minutes with patient/family member with an E&M service
99202	New patient, office or outpatient visit, expanded problem-focused
99203	New patient, office or outpatient visit, low complexity
99204	New patient, office or outpatient visit, moderate complexity
99205	New patient, office or outpatient visit, high complexity
99211	Established patient, office or outpatient visit, 5 minutes
99212	Established patient, office or outpatient visit, 10 minutes
99213	Established patient, office or outpatient visit, low complexity
99214	Established patient, office or outpatient visit, moderate complexity
99215	Established patient, office or outpatient visit, high complexity
99304	Initial nursing facility care, per day, for the E&M of a patient, low severity, 25 minutes
99305	Initial nursing facility care, per day, for the E&M of a patient, moderate severity, 35 minutes
99306	Initial nursing facility care, per day, for the E&M of a patient, high severity, 45 minutes
99307	Subsequent nursing facility care, per day, for the E&M of a patient, 10 minutes
99308	Subsequent nursing facility care, per day, for the E&M of a patient, 15 minutes
99309	Subsequent nursing facility care, per day, for the E&M of a patient, 25 minutes
99310	Subsequent nursing facility care, per day, for the E&M of a patient, 35 minutes

Additional Procedure Codes for Psychiatrists Only

Code	Description
90849	Multiple-family group psychotherapy
90870	Electroconvulsive therapy
90882	Environmental intervention for E&M
90887	Consultation with family

Health and Behavior Assessment and Intervention

As listed in the CPT AMA codebook, “Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.”

CPT codes 96156–96171 may be billed for services when the primary diagnosis is a medical condition. E&M, as well as psychological services codes, should not be billed on the same day by the provider.

Methadone Maintenance

Code	Description
H0001	Alcohol and/or drug assessment
H0004	Behavioral health counseling and therapy, per 15 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0020	Alcohol and/or drug services; methadone administration and/or services (provision of the drug by a licensed program)

Telehealth Services for Opioid Treatments

Code	Description
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes; list separately in addition to code for primary procedure

Opioid Use Disorder Treatment Codes

Note: Providers should submit claims using Place of Service code 58 (non-residential opioid treatment facility) when billing for OTP services, in accordance with CMS.

Code	Description
G2067	MAT, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2068	MAT, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2069	MAT, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2070	MAT, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2071	MAT, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2072	MAT, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2073	MAT, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2074	MAT, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing, if performed
G2075	MAT, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed
G2076	Intake activities, including initial medical examination; list separately in addition to code for primary procedure
G2077	Periodic assessment; list separately in addition to code for primary procedure
G2078	Take-home supply of methadone; up to 7 additional day supply; list separately in addition to code for primary procedure
G2079	Take-home supply of buprenorphine (oral); up to 7 additional day supply; List separately in addition to code for primary procedure
G2080	Each additional 30 minutes of counseling or group or individual therapy in a week of MAT; list separately in addition to code for primary procedure

Self-Administered Esketamine

Code	Description
G2082	Office or other outpatient visit for the E&M of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
G2083	Office or other outpatient visit for the E&M of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Facility Fee Reduction

BH providers who perform services in a hospital may be subject to a facility fee reduction. This reduction is consistent with Medicare's site of service differentiation built into Medicare fees and parallels the facility fee reduction CarePartners of Connecticut applies to medical office visits in these settings. Refer to your current contract for details regarding outpatient compensation provisions.

Vagus Nerve Stimulation

CarePartners of Connecticut does not routinely compensate neurostimulator procedures (insertion, replacement, revision, removal, or analysis) if billed with a diagnosis of depressive disorders.

Additional Resources

Inpatient Behavioral Health and Substance Use Disorder Facility Payment Policy

Document History

- June 2024: Annual policy review; administrative updates
- August 2023: Annual policy review; administrative updates
- February 2023: Annual code updates
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- October 2020: Added existing billing requirement for POS 58 for OTP services
- February 2020: Replaced CPT codes 96151-96155 with 96156-96171 effective January 1, 2020; added certification requirements for OTPs; added OUD treatment and self-administered esketamine codes, effective for dates of service on or after January 1, 2020
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.