REIMBURSEMENT POLICY

Court Ordered Mental Health Treatment and Evaluation

Active

Policy Number: Behavioral Health – 014
Policy Title: Court Ordered Mental Health Treatment and Evaluation
Section: Behavioral Health
Effective Date: 01/18/17

Description

This policy addresses coverage and coding of behavioral health services that are rendered as a result of a court order.

Definitions

When a court order for mental health treatment is based on evaluation and recommendation by a psychiatrist or licensed Ph.D. level psychologist, Blue Cross will consider the order medically necessary.

Policy Statement

Blue Cross will provide coverage for court ordered services according to the patient's contract benefits.

All fully insured health plans must pay for court ordered mental health services under the following circumstances:

- The services are otherwise covered by the plan and
- The court's order is based on a mental health evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment and
- The care is provided by a participating provider of the health plan; or by another provider if appropriate care is not available through the plan, or if another provider is required by state law or rule.

This court-ordered coverage must not be subject to a separate medical necessity determination by the health plan under its utilization review procedures.
Court Ordered Evaluation Claim Submission Guideline
Blue Cross recognizes that certain court ordered evaluations may be lengthy and wants to ensure equitable reimbursement to providers for these types of evaluations, but the claim submission must be HIPAA compliant including the restriction of units based on the code narrative.

Only one unit of service may be submitted regardless of the time spent with the patient. To alert Blue Cross that this is a court ordered evaluation, an H9 modifier must be appended to 90791 or

90792. Preauthorization is not required; however, the court order for the evaluation must be on file in the patient's medical record.

- HCPCS code: 90791 or 90792
- HCPCS modifier: H9 (court ordered)
- Unit: one unit (regardless of time spent)
- Diagnosis code: appropriate ICD-10-CM mental health or substance use diagnosis
- Coverage of follow-up care will depend upon individual subscriber benefits.

Documentation Submission

Providers should maintain a copy of the court order in the patient's chart and fax in the evaluation and court order to the plan as requested.

Documentation must identify and describe the procedures performed, including total time of the service and participants for family or group services. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Coverage may be subject to legislative mandates, including but not limited to the following, which apply prior to the policy statements:

- Minnesota Statute 62Q.535 Coverage for Court-Ordered Mental Health Services

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies, and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	H9
ICD Diagnosis:	N/A
ICD Procedure:	N/A
HCPCS:	90791, 90792
Revenue Codes:	N/A
Deleted Codes:	N/A

Policy History

Initial Committee Approval Date:	September 22, 2015
Code Update:	N/A
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Cross Reference:	N/A