BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual

Section I

Behavioral Health Services

Important Notes:
Throughout this provider manual there will be instances when there are references unique to Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "Plan" is referenced, the information will apply to all products.

Capitated Medical Groups - Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
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1 Behavioral Health Program Overview

The Behavioral Health Program is a portfolio of resources that helps Blue Cross and Blue Shield of Texas members access benefits for behavioral health (mental health and substance use disorder) conditions as part of an overall care management program. The integration of behavioral health care management with medical care management allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

The Behavioral Health program supports behavioral health professionals and physicians to better assess the needs of members using these services and engage them at the most appropriate time and setting.

Providers should check eligibility and benefits before rendering services by:

- Calling the Behavioral Health number on the member's ID card
- Using Availity® or your preferred vendor

This step will also assist in determining if you are in-network for your patient and whether prior authorization is required or recommended clinical review is applicable and who to contact.

For information on prior authorization or recommended clinical review for BH services refer Behavioral Health Behavioral Health Medical Necessity Criteria and Prior Authorizations section on the Behavioral Health Care Management page on the provider website. In addition, refer to the Utilization Management page for specific code lists.

The Behavioral Health Care Management page on the provider website provides additional information on our BH Programs.

BH services are managed as follows for plan members:

Magellan

- Blue Advantage HMO℠ and Blue Advantage Plus℠
- MyBlue Health℠

Medical Management at BCBSTX:

- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- HealthSelect of Texas®
- TRS ActiveCare Primary and TRS ActiveCare Primary+
- Blue Cross Medicare Advantage HMO℠
- Blue Cross Medicare Advantage Dual Care℠ (HMO SNP)

Members can select a contracted and licensed behavioral health professional or physician in their area by using the online Provider Finder® located at bcbstx.com and selecting **Find Care** and then Find a Doctor or Hospital or contacting Magellan if care is managed by Magellan.

Refer to the Behavioral Health Services Managed by Magellan section below for specific information on Magellan managed behavioral health services.

2 Coordination of Care with Physicians and other Medical Care Providers

Communication and coordination of care among all physicians or professional providers participating in a member's health care are essential to facilitating quality and continuity of care. When the member has signed an authorization to disclose information to a PCP, the behavioral health provider should notify the PCP of the initiation and progress of services for behavioral health or substance use disorders.

When communicating with the patient's PCP, the process below should be followed:

1. The behavioral health provider should review and complete the ***Consent to Release Information to Primary Care Physician/Provider*** form with the patient as soon as it is therapeutically appropriate. This should be done as early in the evaluation or treatment episode as possible. The levels of disclosure that the member may select are as follows:

- Release of any applicable information to the PCP,
- Release any medication information only to the PCP, *or*
- Not to release any information to the PCP.

2. Applicable information includes, at a minimum, the following:
   - Diagnosis
   - Treatment plan
   - Medications
   - Results of lab tests and consultations
   - Information on how the PCP can contact the behavioral health provider

3. To facilitate the continuity of care, it is expected that the specialty care physician or professional provider communicate with the PCP when any of the following occur:
   - Treatment is initiated
   - Psychotropic medications are administered
   - Significant changes in medication
   - Significant change in the patient's clinical condition

4. Specialty care physicians or professional providers must also request that appropriate releases be obtained so that the PCP can communicate with the behavioral health provider about any medical information that would be pertinent to the patient's treatment and diagnosis.

5. Specialty care physicians or professional providers may communicate with the PCP by telephone or in writing. At a minimum, specialty care physicians or professional providers are required to document in the medical record the date that any communication with the PCP takes place.

The specialty care physician or professional provider is to disclose only that content which the patient has authorized on the *Authorization to Disclose Information to a Primary Care Physician/Provider* form.

As part of the Quality Improvement Program, compliance with the specialty care/PCP communication process will be monitored during site visits. Specific monitoring activities will include review for:

- Presence of a signed ***Authorization to Disclose Information*** form to a PCP in the member's medical record.
- If authorized, documentation of communication occurrences with the patient's PCP in the Patient's medical record noting, at a minimum, when communication took place.

3 Appointment Access Standards

Behavioral Health providers have contractually agreed to offer appointments to our members using the following access standards:

- **Initial/Routine:** Within 10 business days
- **Follow up Routine:** Within 1-3 months
- **Urgent:** Within 48 hours
- **Non-life Threatening Emergency**: Within in six (6) hours or refer to the emergency room
- **Life Threatening/Emergency**: Within one (1) hour or refer immediately to ER

4 Telehealth and Telemedicine Services

Telehealth or telemedicine services give our members greater access to care. Members may be able to access their medically necessary, covered benefits through providers who deliver services through telehealth or telemedicine services including intensive outpatient program services. Check the member's eligibility and benefits for coverage information.

5 HEDIS® Indicators

BCBSTX is accountable for performance on national measures, like the Healthcare Effectiveness Data and Information Sets. Several of these specify time frames for appointments with a BH professional.

- Expectation that a member attends a follow-up appointment for a mental health or substance use diagnosis following a mental health or substance use inpatient admission within 7 and/or 30 days.

- For children (6-12 years old) who are prescribed ADHD medication:
    - One follow-up visit, the first 30 days after medication dispensed (initiation phase).
    - At least 2 visits, in addition to the visit in the initiation phase with provider in the first 270 days after initiation phase ends (continuation and maintenance phase).
- For members treated with a new diagnosis of alcohol or other drug dependence:
    - Treatment initiation through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization program or telehealth or medication treatment within 14 days following the diagnosis (initiation phase).
    - At least 2 visits/services, in addition to the treatment initiation encounter, within 34 days of initiation visit (engagement phase)

6 Clinical Screening Criteria

Our Behavioral Health Team utilizes nationally recognized, evidence based and/or state or federally mandated clinical review criteria for its behavioral health clinical decisions. For group and retail membership, our licensed behavioral health clinicians with BCBSTX utilize the MCG care guidelines for mental health conditions. For addiction disorders, we utilize the American Society of Addiction Medicine's *The ASAM Criteria* (addiction disorders). In addition to medical necessity criteria/guidelines, BH licensed clinicians utilize our Medical Policies, nationally recognized clinical practice guidelines (located in the Clinical Resources section of the BCBSTX provider website), and independent professional judgment to determine whether a requested level of care is medically necessary.

The availability of benefits will also depend on specific provisions under the member's benefit plan. Our BH licensed clinicians utilize the following hierarchy of clinical criteria to assist in determinations for the most appropriate level of care for our members:

- National Coverage Determinations
- Local Coverage Determinations
- MCG care guidelines (mental health disorders)
- American Society of Addiction Medicine's ASAM Criteria (addiction disorders)
- BCBSTX Medical Policies
- Nationally recognized clinical practice guidelines

The appropriate use of treatment guidelines requires professional medical judgment and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the healthcare delivery and management process that should include consideration of the individual circumstances of any member. The guidelines are not intended as a substitute for this important professional judgement.

If a specific claim or authorization request is denied and there is an appeal, BCBSTX will provide the applicable criteria used to review the claim or authorization request upon request by the behavioral health professional, physician or member.

If a behavioral health professional or physician engages in a particular treatment modality or technique and requests the criteria that BCBSTX applies in determining whether the treatment meets the medical necessity criteria set forth in the member's benefit plan, BCBSTX will provide the applicable criteria used to review specific diagnosis codes and procedure codes which are appropriate for the treatment type.

The State of Texas criteria will be used to evaluate medical necessity for chemical dependency treatment. A copy of these criteria can be obtained by accessing the BCBSTX website at bcbstx.com/provider, under Clinical Resources/Behavioral Health, then select Behavioral Health Medical **Necessity Criteria and Prior Authorization.** If you do not have access to the website, you may request a copy of the State's criteria by calling the number on the back of the member's ID card.

7 Prior Authorization or Recommended Clinical Review

Prior authorization (also called precertification or pre-notification) is the process of determining medical appropriateness of the behavioral health professionals and physician's plan of treatment by contacting BCBSTX or the appropriate behavioral health vendor for approval of services

Providers are responsible for checking eligibility and benefits through Availity® or their preferred vendor which will also determine if prior authorization is required or RCR is applicable and whether BCBSTX or Magellan manages the care for the member. Providers are responsible for requesting prior authorization or RCR on the member's behalf.

Members can select a contracted and licensed behavioral health professional or physician in their area by using the online Provider Finder® located on the provider website.

Prior authorization may be required or recommended clinical reviews may be available to determine medical necessity for inpatient and residential treatment center admissions.

Outpatient services may require prior authorization or an RCR may be applicable for the following intensive outpatient behavioral health services before initiation of services for most plans

- Applied Behavior Analysis
- Intensive Outpatient Program
- Outpatient Electroconvulsive Therapy
- Transcranial Magnetic Stimulation
- Partial Hospitalization Programs
- Psychological and Neuropsychological testing in some cases; BCBSTX would notify the provider if prior authorization is required for these testing services

Refer to the Utilization Management page on the provider website for more information.

7.1 Behavioral Health Authorization Process

Providers may refer to the **Authorization Process** section of the provider manual or the Utilization Management page on the provider website for the most current process to request prior authorization or RCR.

When required, elective or non-emergency hospital admissions must be prior authorized at least one day before admission or within two business days of an emergency admission.

When BCBSTX manages the BH outpatient services, they may require completion of a form(s), See BH Forms section below.

Once a prior authorization or RCR determination is made for services, the member and the behavioral health care provider will be notified. A renewal of an existing prior authorization or RCR can be requested up to 60 days before the expiration of the existing prior authorization or RCR.

Members can consult with our licensed behavioral health staff professionals, who can:

- Provide guidance regarding care options and available services based on the member's benefit plan
- Help find network providers that best fit the member's care needs
- Improve coordination of care between the member's medical and behavioral health provider
- Identify potential co-existing medical and behavioral health conditions

7.2 Prior Authorization Exemptions

Under Texas House Bill 3459, providers may qualify for an exemption from submitting prior authorization requests for particular health care service(s) for all fully insured and certain Administrative Services Only groups. Refer to the Prior Authorizations Exemptions page on the provider website for the current applicable ASO groups and additional information.

We request you submit a notification to determine the initial length of stay or initial units for service(s) with a PA Exemption. Notification can be submitted via Availity® Authorizations & Referrals or by calling the number on the member's ID card. A Notification Acknowledgement for the specific service(s) allowable per the PA exemption will be provided. Any days/units beyond what is outlined in the Notification Acknowledgement or covered by the initial PA Exemption if a notification is not submitted, will require submission of an extension request (or concurrent review) and may be subject to a medical necessity review.

For more information refer to the Prior Authorization Exemption page on the provider website.

7.3 Behavior Health Forms

Prior authorization or RCR for certain BH outpatient services managed by BCBSTX may require completion of a form(s) located under Education and Reference/Forms section on the provider website. BH forms are available on the BCBSTX provider website under Education and Reference, Forms and then go to the Behavioral Health section or by calling **800-528-7264**.

Note: There are separate specific forms for Employee Retirement System of Texas or Teacher Retirement System of Texas participants.

Standard Authorization Forms and other HIPAA Privacy Forms can be located on the member Form Finder page on www.bcbstx.com.

7.3 Failure to Prior Authorize

If contracted providers do not request prior authorization when required for behavioral health treatment, it may result in the same benefit reductions or denials that apply to medical services. Clinical information may be requested from the provider for a clinical medical necessity review. Claims determined to be medically unnecessary will not be covered and in-network providers cannot bill the member.

8 Behavioral Health Services Managed By Medical Management At BCBSTX

When BCBSTX is responsible for coordinating behavioral healthcare services for Plan members, the member will be required to select behavioral health providers and facilities participating in their Plan network.

8.1 Behavioral Health Program Components

Our Behavioral Health program includes:

Care/Utilization Management:

- **Inpatient Management** for inpatient and residential treatment center services.
- **Outpatient Management** for members who have outpatient management as part of their BCBSTX behavioral health benefit plan includes management of intensive partial hospitalization program and some outpatient services.

Case Management Programs:

- **Intensive Care Management** provider intensive levels of intervention for members experiencing a high severity of symptoms.
- **Condition Case Management** for chronic BH conditions such as:
    - *Depression*
    - *Alcohol and Substance Abuse Disorders*
    - *Anxiety and Panic Disorders*
    - *Bipolar Disorders*
    - *Eating Disorders*
    - *Schizophrenia and other Psychotic Disorders*
    - *Attention Deficit and Hyperactivity Disorder*
- **Active Specialty Management Program** for members who do not meet criteria for Intensive or Condition Case Management but who have behavioral health needs and could benefit from extra support or services.
- **Care Coordination Early Intervention (CCEI)® Program** provides outreach to higher risk member who often have complex psychosocial needs.

Specialty Programs:

- **Eating Disorder Care Team** is a dedicated clinical team with expertise in the treatment of eating disorders. The team includes partnerships with eating disorder experts and treatment facilities as well as internal algorithms to identify and refer members to appropriate programs.
- **Autism Response Team** whose focus is to provide expertise and support to families in planning the best course of autism spectrum disorder treatment for their family, including how to maximize their covered benefits.

- **Risk Identification and Outreach** is an industry-leading model for leveraging robust data analytics to optimize solutions for complex healthcare priorities. This multi- disciplinary collaboration between Behavioral Health, Medical, Pharmacy and Clinical Data Technology groups is focused on mining, organizing and visualizing clinically actionable data for at-risk member populations and implementing clinically appropriate and effective interventions at both member and provider levels.

Referrals to other medical care management programs, wellness and prevention campaigns.

8.2 Psychological/Neuropsychological Testing Program

The goal of this program is to ensure the member is receiving the type and amount of medically necessary testing. This program involves periodic auditing of providers to determine whether clinical testing practices are in alignment with BCBSTX policies and the member's benefit plan design.

Audits evaluate whether:

a) testing meets medical necessity criteria,
b) testing is consistent with presenting clinical issues and
c) requested hours for the evaluation meet the established standards of practice and do not vary significantly from the provider's peer group performing similar services.

Providers may be subject to prior authorization for testing if the audit concludes the provider's practice patterns do not align with BCBSTX policies, but that requirement may be waived once the provider has met and maintained alignment with BCBSTX policies for an established time period.

Our **Psychological/Neuropsychological Testing Clinical Payment and Coding Policy** is available as a reference on the Clinical Payment and Coding Policies page of our provider website.

8.3 Behavioral Health Contacts

Our Behavioral Health Care Management services are accessible 24 hours a day, seven days a week, 365 days a year at **800-528-7264** or the number listed on the back of the member's ID card. Normal Customer Service hours are 8 a.m. to 6 p.m. (CST) Monday through Friday.

After hours, clinicians are available to handle emergency inpatient prior authorization. Members who are in crisis outside of normal service hours are joined immediately with a licensed care coordinator who will assist the member in directing them to the nearest emergency room or, when necessary, reaching out to emergency medical personnel (**911**) as appropriate.

- **Fax numbers**: **877-361-7646** or **312-946-3735**

- **Mail:**
  BCBSTX Behavioral Health Unit
  PO Box 660241
  Dallas, TX 75266-0241
- **Behavioral Health Clinical Appeals:**
  - **Call: 800-528-7264**
  - **Mail:**
    Blue Cross and Blue Shield of Texas Attention: BH Unit
    PO Box 660241
    Dallas, TX 75266-0241

Call the phone number on the member's ID card to:

- Request to prior authorize or for recommended clinical review of services
- Obtain or submit clinical forms
- Contact customer service to confirm eligibility and benefits, participating health care providers may contact the appropriate phone number listed below.
  - BCBSTX Behavioral Health Unit: **800-528-7264**
  - Magellan Healthcare: **800-729-2422**
  - Employees of BCBSTX and dependents: **888-662-2395**

When the member does not present an ID card, a copy of the enrollment application or a temporary card may be accepted. The Plan also recommends that the member's identification is verified with a photo ID and that a copy is retained for his/her file.

9 Provider Claims Filing Information

Payment of benefits is subject to several factors, including, but not limited, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any preexisting conditions waiting period, if any. As always, all services must be determined to be medically necessary as outlined in the member's benefit booklet. Services determined not to be medically necessary will not be covered.

Claims should be submitted electronically using:

- **Payor ID 84980**

If the provider is unable to file electronically, paper claims can be submitted to:

- BCBSTX
  PO Box 660044
  Dallas, TX 75266-0044

10 Updates to Behavioral Health Program

Updates about the Behavioral Health program will be communicated in News and Updates, Blue Review and on the Behavioral Health Page under Clinical Resources on bcbstx.com/provider.

11 Behavioral Health Services Managed By Magellan

When **Magellan** is responsible for coordinating behavioral health care and services for **Plan** members, members will be required to select behavioral health providers and facilities participating in the Magellan behavioral health network.

Primary care physician/providers referrals are not required. Members may call Magellan directly to access care.

Requests for behavioral health services (mental health and/or chemical dependency) should be directed to **Magellan**. **Magellan** personnel are available to assist you with eligibility and benefits information, referrals to a behavioral health provider and to request prior authorization or recommended clinical review of services.

11.1 Magellan Telephone Number and Hours

Contact **Magellan** at **800-729-2422**

Important note: The telephone numbers listed above are answered 24 hours a day for crisis intervention and prior authorization of inpatient admissions.

For routine calls, phone hours are 8 a.m. to 5 p.m. (CST), Mon - Fri except holidays.

11.2 Magellan Responsibilities

Magellan utilizes Customer Service Representatives and Care Managers to provide:

- Benefits and eligibility
- Prior authorization for inpatient and outpatient care
- Referral services
- Case Management
- Assistance in the selection of a network behavioral health provider
- Crisis intervention

11.3 Magellan and Emergency Care

In emergencies, the **Magellan** provider must first ensure that the member is safe. Prior authorization will then occur ***prior*** to or concurrent with, but not more than 48 hours following the admission.

Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical or behavioral health conditions of a recent onset and severity, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

11.4 Magellan Referral Procedures

During the prior authorization process, if a referral is necessary, the following procedures will apply:

- **Plan** network specific requirements will be noted where **Plan** participating physicians or professional providers should contact **Magellan** rather than referring a member directly to a behavioral health professional or facility. ***Note:*** *The member or a representative for the member may also contact* ***Magellan*** *directly.*
- Participating behavioral health providers must admit patients to a **Magellan** participating facility unless an emergency situation exists that precludes safe access to a **Magellan** participating facility, or if the admission is approved for a non-**Magellan** participating facility because of extenuating circumstances.
- If the admission was not approved for a non-**Magellan** participating facility, the patient should be transferred to a **Magellan** participating facility as soon as medically possible. In non-emergency situations, the patient, having been fully informed that the providing entity is out-of-network and that subsequent services will incur increased cost liability, makes the decision to seek out-of-network treatment at a lower reimbursement level.

11.5 Magellan Care Management Program

Magellan Utilization Management/Review is referred to as Care Management. Care Management is a process that reaches beyond the simple approval/denial response of utilization management and helps a behavioral health provider formulate a clinically appropriate and cost-efficient treatment strategy. This approach assists members in maximizing the use of their benefits and facilitates comprehensive treatment planning.

Maximizing the behavioral health benefit is particularly important in the case of a member with a chronic or recurrent behavioral health diagnosis. Using the most clinically appropriate, yet least restrictive setting preserves benefits for future long-term care.

The components of the **Magellan** Care Management program include:

- Inpatient
  - Prior authorization
  - Concurrent review
  - Discharge planning
- Outpatient
  - Prior authorization/Referrals
  - Concurrent review
- Crisis Intervention
- Case Management
- Retrospective Review

11.6 Magellan Limitations and Exclusions

Services determined to be not medically necessary are not covered. To obtain a copy of the medical necessity criteria, please access the BCBSTX website at bcbstx.com/provider, under Clinical Resources/Behavioral Health, then select **Medical Necessity Criteria**. If you do not have access to the website, you may write to **Magellan**, PO Box 1619, Alpharetta, GA. 30009-9930 or call the number on the back of the member's ID card and request a copy of the medical necessary criteria.

Many group contracts specifically exclude services rendered in conjunction with a diagnosis of adolescent behavioral disorders. This exclusion varies from contract to contract. It is strongly recommended that you confirm benefit coverage before delivery of care by calling **Magellan.**

11.7 Magellan Quick Reference Guide

Obtaining Prior Authorization and/or a Referral Authorization for service:

1. The facility, provider, PCP, specialty care physician or professional provider or member may obtain an initial referral or prior authorization for “evaluation and treatment” by calling Magellan at **800-729-2422** for Blue Advantage HMO members or the number on the back of the member ID card for other members.
2. N*on-emergency* care may require prior authorization before the delivery of services. Contact Magellan to obtain prior authorization when required. In consultation with the physician, professional provider or facility representative, **Magellan** care managers will obtain required clinical data, assist in the selection of a specific, participating behavioral health provider where appropriate, and prior authorize the inpatient or facility-based outpatient care based on medical necessity criteria.
3. Assignment of a network attending physician is required. All referrals from facilities to behavioral health providers ***must*** be prior authorized by calling **Magellan** who will coordinate all behavioral health service referral authorizations

Submitting claims to Magellan:

The physician or professional provider is responsible for filing claims. Claims should be submitted electronically as indicated in your Magellan contract agreement. if you are unable to submit electronically, contact the number on the back of the member's ID card for appropriate paper filing instructions

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