BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network®

Provider Manual

Section I

Behavioral Health Services

Important Note: Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge℠, EPO and the Federal Employee Program®. 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.

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1 Integrated Behavioral Health Program Overview

The Integrated 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.

Our Integrated 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.

Refer to the Behavioral Health Program page on the provider website for easy access to information.

2 Continuity and Coordination of Care

Continuity and coordination of care are important elements of care and as such are monitored through the BCBSTX Quality Improvement Program. Opportunities for improvement are selected across the delivery system, including settings, transitions in care, patient safety, and coordination between medical and behavioral health care. Communication and coordination of care among all professional providers participating in a member's health care are essential to facilitating quality and continuity of care.

3 Behavioral Health Program Components

The 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 case Management** provides 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 Use 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 the 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 members who often have complex psychosocial needs impacting their discharge plan.

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.

4 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 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 testing prior authorization 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.Our **Psychological/Neuropsychological Testing Clinical Payment and Coding Policy** is available as a reference on the Clinical Payment and Coding Policies page on the provider website.

5 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

6 Telehealth and Telemedicine Services

Telehealth or telemedicine services give our member 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

7 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.
- Expectation that a member attends a follow-up appointment for a mental health or substance use diagnosis following a mental health or substance use emergency department visit 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)

8 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 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 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 determining the most appropriate level of care for our members.

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

The appropriate use of treatment guidelines requires professional medical judgement and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the health care delivery and management process including 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 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 or physician.

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.

9 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 BCBSTX or the appropriate behavioral health vendor for approval of services. When prior authorization is not required, providers may submit an optional recommended clinical review to determine medical necessity.

Prior authorization may be required 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
- Repetitive Transcranial Magnetic Stimulation
- Psychological and Neuropsychological testing in some cases; BCBSTX would notify the provider if prior authorization is required for these testing services.
- Partial Hospitalization Program

9.1 Responsibility for Prior Authorization or RCR

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.

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.

9.2 Behavioral Health Authorization Process

Providers may refer to the Authorization Process section of the provider manual or 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.

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

For additional support, members can consult with our licensed behavioral health staff professionals, who:

- 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.

A renewal of an existing prior authorization or RCR can be requested by a physician or health care provider up to 60 days before the expiration of the existing prior authorization or RCR.

9.3 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.

9.3 Behavioral Health Forms

Prior authorization or RCR for certain BH outpatient services may require completion of a form(s) located under Education and Reference/Forms section on the provider website.

Note: There are separate forms for Teacher Retirement System of Texas and Employee Retirement System of Texas plans that use the Plan networks.

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

9.4 Failure to Prior Authorize

If contracted providers do not request prior authorization when required for a] behavioral health treatment, it may result in the same member benefit reductions that apply to medical services. BCBSTX may request clinical information from the provider for a clinical medical necessity review. Claims determined to be medically unnecessary will not be covered. The member may be financially responsible for services that are determined not to be medically necessary.

10 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 member ID card. Generally, Customer Service hours are 8:00 a.m. to 6:00 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 BH Clinician. The BH Clinician will assist the member, which may include 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 660240
  Dallas, TX 75266-0240

Behavioral Health Clinical Appeals

For information about Behavioral Health Clinical Appeals:

- **Call:** 800-528-7264
- **Mail:**
  Blue Cross and Blue Shield of Texas
  Attention: BH Unit
  PO Box 660240
  Dallas, TX 75266-0240

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

- Prior authorize or request RCR for services
- Obtain or submit clinical forms
- Check eligibility and benefits
- Contact customer service

To confirm eligibility and benefits, participating health care providers may contact the appropriate phone number listed below. 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 in the member's file.

Plan/Group	Phone Numbers
Blue Choice PPO BlueHPN BlueEdge EPO Federal Employee Program	**800-528-7264**
Indemnity (ParPlan) BlueCard	**800-676-BLUE**

11 Provider Claims Filing Information

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

Refer to the Clinical Payment and Coding Policy page for topics related to Behavioral Health services such as ABA and Psychological/Neuropsychological services.

12 Updates to Behavioral Health Program

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