12 – Behavioral Health Services

Overview

Introduction

The Integrated Behavioral Health (BH) program is a portfolio of resources that helps Blue Cross and Blue Shield of New Mexico (BCBSNM) members access benefits for behavioral health (mental health and chemical dependency/substance abuse) conditions as part of an overall care management program. BCBSNM has integrated behavioral health care management with our member Blue Care Connection® (BCC) medical care management program to provide better care management service across the health care continuum. 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.

BCBSNM’s Integrated Behavioral Health program supports behavioral health professionals and physicians in better assessing the needs of members who use these services and engage them at the most appropriate time and setting. This program is available only to members enrolled in a BCBSNM health plan that includes behavioral health benefits through a variety of group, government and retail products. Similar behavioral health programs are available across product lines but requirements may vary. Please refer to the respective product provider manual for the most current information.

Contents

This section contains the following topics:

<table>
<thead>
<tr>
<th>Section</th>
<th>See Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1 Behavioral Health Program Components</td>
<td>12-2</td>
</tr>
<tr>
<td>Focused Outpatient Management Program</td>
<td>12-2</td>
</tr>
<tr>
<td>Clinical Screening Criteria</td>
<td>12-3</td>
</tr>
<tr>
<td>12.2 Preauthorization Requirements</td>
<td>12-4</td>
</tr>
<tr>
<td>12.3 Services Requiring Preauthorization</td>
<td>12-5</td>
</tr>
<tr>
<td>12.4 Preauthorization Process</td>
<td>12-6</td>
</tr>
<tr>
<td>Appointment Access Standards</td>
<td>12-6</td>
</tr>
<tr>
<td>HEDIS Indicators</td>
<td>12-7</td>
</tr>
<tr>
<td>Continuity and Coordination of Care</td>
<td>12-7</td>
</tr>
<tr>
<td>Clinical Appeals</td>
<td>12-7</td>
</tr>
<tr>
<td>12.5 Submitting Claims</td>
<td>12-8</td>
</tr>
<tr>
<td>12.6 Forms</td>
<td>12-8</td>
</tr>
</tbody>
</table>
12.1 Components of the Program

The integrated Behavioral Health program includes:

- Care/Utilization Management for inpatient, residential, and partial hospital behavioral health care
- Intensive Case Management
- Condition Case Management (seven conditions)
  - Depression
  - Alcohol and substance abuse disorders
  - Anxiety and panic disorders
  - Bipolar disorders
  - Eating disorders
  - Schizophrenia and other psychotic disorders
  - Attention Deficit and Hyperactivity Disorder (ADD/ADHD)
- Outpatient care/utilization management for members who have outpatient management as part of their behavioral health benefit plan through BCBSNM. The behavioral health outpatient program includes management of intensive and some routine outpatient services.
- Referrals to other BCC medical care management programs and wellness and/or prevention campaigns

The Focused Outpatient Management Program is a claims-based approach to behavioral health care management of routine outpatient services that uses data-driven analysis and clinical intelligence rules to identify members whose care and treatment may benefit from further review and collaboration. The cornerstone of this model is outreach and engagement from BCBSNM BH clinicians to the identified providers and members to discuss treatment plans and benefit options.

When a member is identified through the program as potentially benefiting from further review and collaboration, BCBSNM will contact the provider by letter and request additional clinical information about the member’s care and treatment. The provider will be asked to complete an enclosed Clinical Update Request form and return it to BCBSNM within 30 days of the date of the letter. Clinical information provided will be reviewed by behavioral health clinical staff that will collaborate with the provider to discuss further recommendations and determine coverage based on member benefits.

Continued on next page
12.1 Components of the Program, Continued

**Focused Outpatient Management Program (continued)**

BCBSNM also sends a letter to the member to inform him or her that the provider has been asked to provide clinical information to BCBSNM to ensure the member is receiving medically necessary and appropriate quality care and treatment. The letter will explain that the member’s current treatment is approved during this 30-day period. If the provider does not submit the requested information within the 30-day time frame, BCBSNM may not be able to determine if the care and treatment provided is medically necessary or appropriate. As a result, authorization for continued services may be discontinued and the member may be financially responsible.

**Clinical Screening Criteria**

BCBSNM’s licensed behavioral health clinicians use the nationally recognized evidence-based *Milliman Care Guidelines®* as clinical screening criteria for mental health disorders for all levels of care. Our clinicians utilize the American Society of Addiction Medicine Criteria -- *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* -- as the clinical screening criteria for patients with addiction disorders for all levels of care. Our clinicians also utilize nationally recognized Clinical Practice Guidelines located in the [Clinical Resources section](#) of the BCBSNM website.

For Blue Cross Community Centennial℠ membership, our licensed behavioral health clinicians base authorization decisions on medical necessity as defined by the State of New Mexico Human Services Department and Medical Assistance Division (MAD-MR: 08-10 8.305.1 NMAC.) and as outlined in the Centennial Care Behavioral Health Level of Care Guidelines. Additionally, BCBSNM can utilize *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* for Blue Cross Community Centennial members with addiction disorders.

If a specific claim or preauthorization request is denied and there is an appeal, BCBSNM will provide the applicable criteria used to review the 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 BCBSNM applies in determining whether the treatment meets the medical necessity criteria set forth in the member’s benefit plan, BCBSNM will provide the applicable criteria used to review specific diagnosis codes and Current Procedural Terminology (CPT®)/other procedure codes which are appropriate for the treatment type.
12.2 Preauthorization Requirements

Preauthorization (also called pre-certification or prior authorization) is the process of determining medical appropriateness of the physician's (or other professional provider's) plan of treatment by contacting BCBSNM for approval of services.

Members are responsible for requesting preauthorization, although providers may request preauthorization on behalf of the member. All services must be medically necessary.

Approval of services after preauthorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, 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, benefits booklet and/or summary plan description as well as any preexisting conditions waiting period, if any.

BCBSNM manages a variety of group, government and retail behavioral health products. Refer to the respective product section of this manual for the most current information and requirements.
12.3 Services Requiring Preauthorization

### Inpatient and Alternative Levels of Care

Preauthorization is required for all inpatient, residential treatment and partial hospitalization admissions.

Elective or non-emergency hospital admissions must be preauthorized prior to admission or within 48 hours of an emergency admission.

Members, or providers on the behalf of members, must determine eligibility and benefit coverage prior to service and determine if Residential Treatment Center (RTC) services are covered. To determine if RTC services are covered, members or providers may call the Behavioral Health number listed on the back of the member’s ID card (888-898-0070 or Fax 877-361-7659).

### Outpatient

The behavioral health outpatient program includes management of intensive outpatient services and some routine outpatient services.

Preauthorization is required only for the following four intensive outpatient behavioral health services prior to initiation of the service. Preauthorization for these intensive services is required to determine that the services are medically necessary, clinically appropriate and contribute to the successful outcome of treatment.

- Electroconvulsive therapy (ECT)
- Intensive outpatient programs (IOP).
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Psychological and Neuropsychological testing in some cases; BCBSNM would notify the provider if preauthorization is required for these testing services.
12.4 Preauthorization Process

Process

Members should call the behavioral health number listed on the back of their identification card. Providers, on behalf of the member, may also place the preauthorization request call. This number directs the preauthorization request call to BCBSNM. Providers may also refer to the respective product provider manual for the most current preauthorization process.

- **Employee Assistance Program (EAP)** – Magellan Health Services administers the Employee Assistance Program (EAP) behavioral health services for all members who have BCBSNM EAP benefits.
- **Blue Cross Community Centennial** behavioral health services are managed by BCBSNM for all members who have BCBSNM Centennial Care medical benefits.
- **Blue Cross Medicare Advantage** – behavioral health services are managed by BCBSNM for all members who have BCBSNM Medicare Advantage medical benefits.

Once a preauthorization determination is made for services requiring preauthorization, the member and the behavioral health professional or physician will be notified, regardless of who initiated the request.

If a member receives any of the behavioral health services requiring preauthorization without calling for preauthorization, the behavioral health professional or physician will be asked to submit clinical information to BCBSNM for a medical necessity review. The member will also receive notification. Claims for services determined not to be medically necessary services will not be reimbursed. The member may be financially responsible for services that are deemed not to be medically necessary.

Appointment Access Standards

Behavioral health providers have contractually agreed to offer appointments to our members according to the following standards:

- **Routine**: Within 10 working days
- **Urgent**: Within 48 hours
- **Non-life threatening emergency**: Within 6 hours
- **Life threatening/emergency**: Within 1 hour

*Continued on next page*
12.4 Preauthorization Process, Continued

**HEDIS Indicators**

BCBSNM is accountable for performance on national measures, like the Health Effectiveness Data Information Sets (HEDIS®). Several of these specify time frames for appointments with a BH professional.

- Expectation that a member has a follow-up appointment with a BH professional following a mental health inpatient admission within 7 and 30 days
- For members treated with Antidepressant Medication
  - Continuation of care for 12 weeks of continuous treatment (during acute phase)
  - Continuation of care for 180 days (continuation phase)
- 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 with provider in the first 270 days after initiation phase ends (continuation and maintenance phase)

**Continuity and Coordination of Care**

Continuity and coordination of care are important elements of care and as such are monitored through the BCBSNM 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. 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 behavioral health services.

**Clinical Appeals**

For information about Behavioral Health Clinical Appeals:

Toll free for HMO and/or PPO: 888-898-0070
Toll free for FEP: 877-783-1385

Attention: BH Appeals
P.O. Box 660235
Dallas, TX 75266-0235
12.5 Submitting Claims

**Process**

BCBSNM strongly encourages the electronic submission of claims. Refer to [Section 9](#) for more information in filing claims electronically.

Paper claims should be sent to:
- Blue Cross and Blue Shield of New Mexico BH Unit
- P.O. Box 660235
- Dallas, TX 75266-0235

12.6 Forms

The forms below are available on the BCBSNM provider website under Education and Reference/Forms, or by calling toll free 1-888-898-0070.

Standard Authorization Forms (SAF) and other HIPAA Privacy Forms can also be located in the Forms section.

- [Clinical Update Request Form](#)
- [Electroconvulsive Therapy (ECT) Request](#)
- [Facility Areas of Expertise Form](#)
- [Intensive Outpatient Program (IOP) Request](#)
- [Outpatient Treatment Request (OTR)](#) (for Medicaid only)
- [Professional Area of Expertise Form](#)
- [Psychological/Neuropsychological Testing Request](#)
- [Repetitive Transcranial Magnetic Stimulation (rTMS) Form](#)
- [Transitional Care Request](#)