BlueCross BlueShield of New Mexico

# Integrated Behavioral Health Program Frequently Asked Questions

## For BCBSNM Providers Only

***The following Frequently Asked Questions (FAQs) provide information about the Behavioral Health Program.***

### Q1: What is the BCBSNM Behavioral Health program?

Blue Cross and Blue Shield of New Mexico (BCBSNM) is responsible for the effective management of its members' behavioral health benefits. The behavioral health program is a portfolio of resources that help BCBSNM members access benefits for behavioral health (i.e., mental health and substance abuse) conditions as part of an overall care management program.

BCBSNM's behavioral health program aims to support behavioral health professionals and physicians to better manage the needs of members who use behavioral health services. A key goal of the behavioral health program is to support early identification of members who could benefit from co-management of behavioral health and medical conditions.

The behavioral health program is an integrated component of the Blue Care Connection®* (BCC) medical care management program. The BCC suite of programs and services offers personal attention, resources and support that can empower BCBSNM members to take charge of their health.

Using state-of-the-art technology, BCBSNM's staff of behavioral health professionals help members navigate the health care system and may refer members to other BCC care management programs. ** BCC programs are designed to help identify and help close potential gaps in care through evidence-based and member-focused approaches to health care and benefit decisions.

BCBSNM manages behavioral health services for all members who have behavioral health benefits through BCBSNM. Please note: Employee Assistance Program † (EAP) behavioral health services for members who have BCBSNM EAP benefits are administered by Magellan Health Services.

- Blue Cross Community Centennial℠ (Medicaid) behavioral health services will be managed by BCBSNM effective January 1, 2014. Refer to Health Care Management in the Blue Cross Community Centennial section of the *Blues Provider Reference Manual* for information about the Medicaid behavioral health program.
- Federal Employee Program (FEP) members are managed by BCBSNM. FEP members are not required to request preauthorization for any outpatient behavioral health services, including partial hospitalization programs.

** Blue Care Connection is available to members whose employers have purchased this program as part of their health plan.*

*** Members experiencing inpatient hospitalization, complex or special health care needs or who are at risk for medical complications may be referred to BCC programs through a variety of mechanisms such as predictive modeling, claim utilization, inbound calls, self-referrals and physician referrals. If members do not have BCC as part of their group health plans, they will not be referred to other BCC programs.*

**Q2: What are the components of the behavioral health program?**

The behavioral health program includes:

- Care/Utilization Management for inpatient, partial hospitalization, residential treatment services, and some outpatient behavioral health care services.
- Care Coordination Early Intervention (CCEI) Program provides outreach to higher risk members who often have complex psychosocial needs impacting their discharge plan.
- Intensive Case Management provides intensive levels of intervention for members experiencing a high severity of symptoms.
- Condition Case Management provides a comprehensive, integrated approach to the coordination of care for members with the following chronic mental health and substance abuse 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)
- Patient Safety Program provides outreach calls to members that may have the potential of becoming higher risk for readmission(s) and/or frequent emergency room visits. The goal of the outreach is to provide resources and/or to ensure they have access to the treatment they need.
- Eating Disorder Specialty 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 Care Team's focus is to provide expertise and support to families in planning the best course of Autism Spectrum Disorder (ASD) treatment for their family, including how to maximize their covered benefits.
- Outpatient 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, wellness and prevention campaigns

**Q3: What clinical screening criteria are used?**

Our licensed behavioral health clinicians use the nationally recognized, evidence based Milliman Care Guidelines®, Behavioral Health Guidelines as clinical screening criteria for mental health services. BCBSNM utilizes the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for clinical screening criteria for patients with substance use disorders for all levels of care. Our clinicians also utilize BCBSNM Medical Policies and nationally recognized Clinical Practice Guidelines located in the Clinical Resources section of the BCBSNM website.

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

If a behavioral health professional or physician engages in a particular treatment type 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 CPT®/other procedure codes which are appropriate for the treatment type.



**Q4: How do members find a behavioral health professional or physician?**

Members can select an independently contracted and licensed behavioral health professional or physician in their area by using the online Provider Finder® located at *bcbsnm.com* and selecting Find a Doctor. Members can also call the number on the back of their ID cards to request assistance in finding an independently contracted and licensed behavioral health professional or physician.

**Q5: How does the Behavioral Health Focused Outpatient Management Program work?**

The Focused Outpatient Management Program is a claims-based approach to behavioral health care management that uses data-driven analysis and clinical intelligence rules to identify members whose routine care and treatment may benefit from further review and collaboration.

The cornerstone of this model is outreach and engagement from BCBSNM behavioral health clinicians to the identified providers and members to discuss treatment plans and benefit options. The goal is to collaborate with providers and members to maximize the benefits available to the member under his or her benefit plan.

When a member is identified through the program as potentially benefiting from further review and collaboration, BCBSNM will contact the member's 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 for further recommendations and determination of coverage based on member benefit plans.

In addition to the provider outreach and collaboration described above, BCBSNM will also send a letter to the member to inform him or her that their provider has been asked to provide clinical information to BCBSNM to ensure the member is getting 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 timeframe, 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.

**Q6: What should I do if I am contacted about behavioral health services?**

Providers will be notified by letter that the member's routine care and treatment may benefit from further review and collaboration through the Behavioral Health Focused Outpatient Management Program. To assist in this effort, you will be asked to complete a Clinical Update Request form which will be included in the initial notification. BCBSNM will review the information provided for further recommendations and make a determination of coverage based on member benefit plans. If BCBSNM does not receive this important clinical information within 30 days from the date of the letter, claim reimbursement for applicable services may be denied. If BCBSNM is unable to determine that these services meet the criteria for medical necessity as outlined in the member's benefit plan, the member may be financially responsible for those services.

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**PREAUTHORIZATION:**

**Q7: What services require preauthorization?**

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

Preauthorization will continue to be required for the following four intensive outpatient behavioral health services prior to initiation of service:

- Electroconvulsive therapy (ECT)
- Psychological testing
- Neuropsychological testing
- Intensive outpatient programs (IOP)

Non-emergency inpatient care must be preauthorized at least one day prior to admission, and emergency inpatient care must be preauthorized within two business days of admission. As always, all services must be deemed medically necessary as outlined in the member's benefit booklet. Services deemed not medically necessary will not be reimbursed.

All behavioral health professionals and physicians, both BCBSNM in-network and out-of-network, will need to submit clinical information forms/information as requested.

Members are responsible for requesting preauthorization for behavioral health services provided by behavioral health professionals, physicians and facilities when preauthorization is required.

You may request preauthorization for behavioral health services on the member's behalf. A member's family member may also request preauthorization on behalf of the member. *BCBSNM will comply with all federal and state confidentiality regulations before releasing any information about the member.*

**Q8: What happens if a member fails to preauthorize services requiring preauthorization?**

Inpatient Services and Alternative Levels of Care:
Members who do not request preauthorization for inpatient and alternative levels of care (inpatient, residential treatment, partial hospitalization program) behavioral health treatment may experience the same benefit reductions that apply to inpatient medical services. 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.

Outpatient Services:
If a member receives any of the four outpatient behavioral health services requiring preauthorization without requesting preauthorization, BCBSNM will request clinical information from the behavioral health professional or physician for a medical necessity review. Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

These requirements and benefit reductions apply for BCBSNM network services. If a member's benefit plan includes out-of-network options, the same requirements apply.

**Q9: How do members request preauthorization for behavioral health services when preauthorization is required?**

Members can call the number on the back of their ID card to request preauthorization for behavioral health services provided by behavioral health professionals, physicians and facilities, when preauthorization is required. Members should request preauthorization with BCBSNM prior to the initiation of these services.

You may request preauthorization on the member's behalf by calling the number on the back of the member's ID card. A member's family member may also request preauthorization on behalf of the member. *BCBSNM will comply with all federal and state confidentiality regulations before releasing any information about the member.*

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.

In addition to requesting preauthorization, members can consult with BCBSNM's 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 providers
- Identify potential co-existing medical and behavioral health conditions

**Q10: When preauthorization is required, how does the behavioral health professional or physician know that the member has been authorized for care? Can the behavioral health professional or physician continue to see the patient if there has not been a preauthorization?**

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

**Q11: Will the behavioral health professional or physician be reimbursed for behavioral health services requiring preauthorization rendered if the member does not call for preauthorization?**

BCBSNM will request that you submit clinical information for a medical necessity review. Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

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**QUALITY INDICATORS:**

**Q12: What are the expected Behavioral Health Appointment Access Standards?**

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

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

**Q13: What are the national performance measures that specify timeframes for appointments with behavioral health professionals?**

BCBSNM is accountable for performance on national measures, like the Health Effectiveness Data Information Sets (HEDIS). Several of these measures specify expected timeframes for appointments with a behavioral health professional.

- Expectation that a member has a follow-up appointment with a behavioral health 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)

**Q12: Why are continuity and coordination of care important for behavioral health providers?**

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 Primary Care Physician (PCP), the behavioral health provider should notify the PCP of the initiation and progress of behavioral health services.

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**OTHER INFORMATION:**

Updates about the behavioral health program will be communicated in the News and Updates and Clinical Resources sections and in *Blue Review*. Please see the Behavioral Health program page of the Clinical Resources section on for more information.