Introduction

THP's nurse navigators (case managers) blend behavioral components such as motivational interviewing with disease management and other aspects of medical and behavioral health case management to address THP member needs. The care manager may link the member to primary care, specialty care, and behavioral health practitioners and address social determinants of health (SDoH).

Refer to **Chapter 8 - Clinical** for information about integrated care for or THP members. THP's 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any THP member needs. This number is answered by nurse navigators who can assist practitioners and members.

Behavioral health admissions may be reported through THP's secure provider portal at myplan.healthplan.org.

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness, allowing for consideration of the needs of the individual member's circumstances, medical history, and availability of care and services within THP network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the Physician Advisory Committee (PAC). When specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Criteria

THP utilizes InterQual® criteria as a screening guideline to assist reviewers in determining the medical appropriateness of health care services. Any participating practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

THP uses InterQual® guidelines for most procedures and services other than for Mountain Health Trust (MHT) groups for whom West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services (see BMS provider manuals at dhhr.wv.gov/bms).

ASAM Criteria

THP utilizes nationally recognized criteria known as ASAM (American Society of Addiction Medicine) for a comprehensive set of guidelines, continued stay and transfer/discharge of patient with addiction and co-occurring conditions.

Please indicate if your request is emergent so that we may expedite the review. Scheduling the testing/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by THP.

Behavioral Health Prior Authorization

Effective January 1, 2017, all practitioners are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If a service is rendered after hours, over the weekend or on a holiday, practitioners are required to request the authorization the next business day. Prior authorization requests received after the next business day will not be processed (voided). Failure to follow prior authorization guidelines will result in denied claims.

The Behavioral Health Prior Authorization Requirements are available on THP's corporate website and secure provider portal.

THP does not require prior authorization for crisis encounters or in plan psychotherapy visits. In plan medication management visits do not require prior authorization for any Commercial Fully Insured, PEIA, Medicare Advantage, or Mountain Health Trust (WV Medicaid and CHIP). However, prior authorization may be necessary for these and other services for self-funded groups based on individual plan documents.

Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation Review

All inpatient services require admission, concurrent, and discharge review by THP. Elective admissions require a prior authorization. Admissions to residential facilities for substance use disorders (SUD) must meet ASAM criteria for the selected level of care and will require authorization. Not all benefit plans will reimburse for residential treatment of substance use disorder. Intensive Outpatient Programs and Partial Hospitalization Programs are outpatient services that provide a less intensive level of care, and THP will not require authorization for the first thirty (30) sessions for participating practitioners.

Reviews are expected on the day of admission with the exceptions described above. If the admission occurs after business hours or on a holiday or weekend, the practitioner should notify THP immediately and provide complete clinical on the next business day. When admission is approved, the date for concurrent review will be established and conveyed to the practitioner. This does not apply to admission reviews governed by state law.

If the information submitted does not meet review criteria for admission and/or concurrent stay, THP nurse navigator will forward the clinical information for review to a medical director for evaluation. The medical director will utilize nationally recognized criteria to provide a clinical review of the case and provide a medical appropriateness determination. A peer-to-peer discussion may be requested by the practitioner with THP medical director(s). The practitioner will be notified when a determination is made. If there is an adverse decision, the practitioner can request reconsideration and further review. THP member or their designated representative may appeal as per policy for the line of business. A practitioner may request a peer-to-peer consultation with a medical director at any time.

Intensive Outpatient Services (IOP)

Intensive outpatient services are an intermediate level of care in which individuals are typically seen as a group at least three (3) times per week, three (3) hours per day, depending on the program's structure THP will not require prior authorization for the first thirty (30) sessions for participating practitioners. Practitioners should be aware of the following:

- Additional IOP services beyond the thirty (30) sessions can be requested. If the sessions meet criteria for continued programming, the nurse navigator or the referral coordinator will continue to allow the course of treatment and inform the practitioner of the number of additional sessions approved. This will continue until discharge.
- Discharge clinical - summaries should be submitted to THP for continuity of care.
- If the reviews do not meet criteria, the information submitted by the practitioner will be sent for medical director review prior to denial of services.
- IOP services for non-participating practitioners, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Practitioners providing IOP to MHT members must be certified by BMS
- IOP services are reviewed in thirty (30) day increments following the initial thirty (30) sessions.

Partial Hospitalization (PH)

Partial hospitalization is an intermediate level of care for behavioral health conditions. Services are rendered by an accredited program in a treatment setting for behavioral health and/or substance use disorder. The program is an alternative to, or a transition from, traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. THP members participate in this structured program up to five (5) days per week, four (4) to five (5) hours per day. Medication management is an integral aspect of partial hospitalization services. THP will not require authorization for the first thirty (30) sessions for participating practitioners.

Practitioners should be aware that:

- Additional Partial Hospitalization services beyond the initial 30 sessions can be requested by submitting a prior authorization request. If the sessions meet criteria for continued programming, the nurse navigator or the referral coordinator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.
- Discharge clinical summaries should be submitted for continuity of care.
- If the reviews do not meet criteria, the information submitted by the practitioner will be sent for medical director review to determine medical necessity.
- Partial Hospitalization services for practitioners not in network will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Practitioners providing partial hospitalization to MHT members must be certified by BMS.

Inpatient Acute Psychiatric and Detoxification Services

Inpatient services are acute psychiatric, or detoxification services delivered in a psychiatric unit of a general hospital or in a free-standing psychiatric facility. The acute care services provided include assessment, individual and group therapies, medication management, and attention to medical problems with all care coordinated by the practitioner. Inpatient hospitalization is usually a short-term stabilization and treatment of an acute episode of behavioral health problems. Discharge planning for continued treatment is an integral part of acute psychiatric care.

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's PCP), referring participating specialist practitioner or admitting practitioner.

Notification of urgent/emergent admissions by the admitting facility is required at the time of admission. Clinical information is required within 48 hours of admission. This process is in place to generate early discussion of the member's needs as related to the admission, identify alternative health care services, and initiate discharge planning. THP has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization for medical and behavioral health care services. THP will assist with members needing care by non-participating practitioners when participating practitioners are temporarily not available or accessible.

All inpatient acute psychiatric and detox services require prior authorization**.** Clinical information is reviewed for availability of service in- network, urgent/emergent situations, or other extenuating circumstances. The information should be supplied by the relevant behavioral health practitioner.

Concurrent review processes are designed to provide oversight of member progress, ensure delivery of quality care, and promote effective discharge planning. At admission, members are referred by the behavioral health inpatient nurse navigator to the behavioral health transition of care manager (BH TOCM) assigned to that facility. The BH TOCM's primary goal is to facilitate communication, either face-to face or telephonically, and work collaboratively with members and practitioners to assure successful delivery of behavioral health transition of care services and promote continuity of care and discharge planning.

Inpatient Rehabilitation Facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as substance use disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities (PTRF)for individuals under age 21, adult psychiatric rehabilitation facilities. and short-term residential eating disorder programs, depending on the terms of a specific benefit plan. Treatment must meet medical necessity criteria and must be authorized. The program must be approved by BMS for MHT members.

Outpatient Prior Authorization and Referral Management

Members are afforded direct access to outpatient behavioral health practitioners. Prior authorization may be required for crisis visits or urgent or emergent services. Prior authorization is no longer required for psychotherapy visits or psychological testing depending on the specific benefit plan Contact THP if you have questions regarding a particular procedure or test.

All non-participating and tertiary requests require prior authorization. Clinical information is reviewed for availability of service in network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health practitioner, PCP, or appropriate participating specialist practitioner.

Additional services that require prior authorization include procedure(s) that may have limited coverage under the benefit plan., Experimental and Investigational procedures that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines.

Any prior authorization that does not meet medical appropriateness review by the nurse navigator or referral coordinator is referred to a medical director for review. The medical director may contact the behavioral health practitioner for case discussion. Availability of services within the practitioner network and alternative levels of care for services may be offered as appropriate to the member's needs.

Practitioners should indicate their request is urgent so that THP may expedite the review. Scheduling the test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after the service is approved by THP.

THP reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure medical necessity and the quality and appropriateness of the service provided.

Drug Screening and Testing

Urine drug testing is most effective when individualized, randomized, and conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine (ASAM) located on the ASAM website.

ASAM recommends against routine use of definitive testing. Practitioner should review the consensus paper available at the link above. Clinical procedures may be subject to post payment review for medical necessity.

This applies to Commercial Fully Insure, Mountain Health Trust (including WV Medicaid, Supplemental Security Income, WV Children's Health Insurance Program), PEIA, and Medicare Advantage.

Self-funded groups default to the individual group plan document.

Behavioral Health Billing

THP requires credentialing of all independently licensed and/or certified behavioral health practitioners within a practitioner practice. Unlicensed personnel may not bill for behavioral health services within a practitioner's practice except for supervised psychologists officially approved by the WV Board of Examiners of Psychology.

THP, in compliance with mental health parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. THP's authorization list is available on the corporate website healthplan.org under the "For Providers," "Prior Authorizations."

THP follows CMS policy as interpreted for Medicare Advantage for THP Commercial plans unless the plan description specifies otherwise. Please refer to **Chapter 5 – Mountain Health Trust** for additional information on unlicensed staff billing MHT members.

Medicare Advantage and Commercial Fully Insured Plans

If a licensed behavioral health practitioner is employed or contracted by a practitioner whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the practitioner's NPI, with no modifiers. Examples of such rendering practitioners would include: LICSW, Psychologist, LCSW, LGSW, and LPC. Certified Addictions Counselors may also bill under the practitioner's NPI if the scope of the service provided is consistent with the counselor's certification.

If a practitioner is a Medication Assisted Treatment practitioner, regardless of the practitioner's specialty, the practitioner may have behavioral health practitioners employed or contracted in his office billing incident to the practitioner's services only so long as the service being provided relates to the practitioner's prescribing of Medications for Opioid Use Disorder (MOUD) if the practitioner's specialization is not traditionally behavioral health i.e., anesthesiology, internal medicine. A psychiatrist may employ or contract with a behavioral health licensed practitioner to provide a much broader range of services than MAT.

The supervising practitioner must see the patient initially for assessment and must order the treatment in the patient record as an aspect of the patient's plan of care. The supervising practitioner must provide regular reviews of the patient's status which must be documented in the medical record.

Medicare will reimburse "incident to" claims at 100% of the established Medicare rate for the service. If the licensed behavioral health practitioner is listed on the claim as the rendering practitioner, the claim will reimburse at 85% of the established Medicare rate. All services must be provided incident to the practitioner must be provided at place of service 11, office, or telehealth place of service 02 or 10.

Continuity and Coordination of Care

THP Clinical Services Department advocates continuity and collaboration of care between behavioral health and medical practitioners. Continuity and coordination are an important aspect in the delivery of quality health care as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical health care practitioners whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner to communicate with the PCP and the PCP to communicate with the behavioral health practitioner. Information that is shared between practitioners should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Clinical Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. THP expects that information be shared accordingly and recognizes the right to keep progress notes private. THP also understands that there are special situations where information cannot be shared.

Behavioral Health Services Forms

The following forms are provided to assist practitioners in requesting services for members and providing information necessary for continuity and coordination of care. The forms listed below are available online at myplan.healthplan.org .

- Admission Review Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Psychological Testing Prior Authorization Request Form
- Treatment Continuation Request Form
- Substance Use Disorder Clinical Review Information Form (for non-MHT)
- Universal Substance Use Disorder Clinical Review form for MHT Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – MHT Line of Business only
- Peer Recovery Support Services authorization request (MHT Line of Business only)
- Request for ECT
- IOP/PHP Request for Authorization

Telehealth Services

Telehealth services must be conducted using an interactive audio and/or video telecommunications system that permits real-time communications between the practitioner and the member in a secure manner compliant with federal and state privacy regulations. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT or HCPCS codes to be billed. The equipment utilized must be HIPAA compliant and meet current CMS and BMS standards.

Telehealth services will be paid to behavioral health practitioners when face-to-face services are not feasible. Services that are eligible for telehealth include, but are not limited to: psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exam.

Practitioners eligible to provide telehealth include but are not limited to: licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

Medical record documentation must include the location of the practitioner and the member, an identification of the service as telehealth in nature, and a description of the methodology (audio/visual, audio only, etc.).

THP follows CMS telehealth service criteria at **https://www.cms.gov/files/document/mln901705-telehealth-services.pdf** for Commercial Fully Insured, Medicare Advantage, and PEIA.

Mountain Health Trust follows BMS policies at **https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.17_Telehealth1.1.22.pdf**

Self-funded/ASO follows plan documents.

Follow-Up Care after Behavioral Health Admissions

It is extremely important in the care of those with behavioral health conditions, to receive timely follow-up care after discharge from an in-patient stay. The HEDIS® standard is for the member to be seen by an outpatient behavioral health practitioner within seven (7) days of discharge.

Practitioners should:

- Communicate to the hospital discharge planners that follow-up appointments should be scheduled within seven (7) days of discharge.
- Upload discharge documentation on the secure provider portal so that THP may help to reinforce the discharge plan
- Schedule appointments for discharging patients within seven (7) days of discharge. If practitioners require assistance in this process, please contact Clinical Services at 1.877.221.9295 for a nurse navigator.