TheHealthPlan

Chapter 7

Behavioral Health

Provider Manual

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 the THP member holistically and provide the best possible outcomes. The care manager may link the member to primary care, specialty care, and behavioral providers as well as address social determinants of health.

Refer to **Chapter 9 - Clinical** for information that may assist in obtaining integrated care for 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 providers and members.

Behavioral health admissions may be reported by phone to 877-221-9295 (reverts to voicemail after regular business hours) or email at behavioralhealthdocuments@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. In cases where 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 Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. InterQual® review worksheets are available upon request.

THP uses InterQual® guidelines for most procedures and services other than for MHT groups for whom West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services (see provider manuals at wvdhhr.org/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

The Behavioral Health Prior Authorization Requirements are available on THP's corporate website.

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 fully funded or governmental line of business. However, prior authorization may be necessary for these and all other services for employer-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. Only elective admissions require a prior authorization. Admissions to residential facilities for Substance Use Disorder (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 allow the first 30 sessions free of authorization for participating providers. Forms used in requesting review for services are available on THP's provider portal Resource Library.

Reviews are expected on the day of admission with the exceptions described above. If the admission occurs late in the day, on a holiday or weekend, the facility 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 provider. This does not apply to admission reviews governed by state law. THP abides by mandated guidelines.

If the information submitted does not meet review criteria for admission and/or continued stay, THP nurse navigator will forward the clinical information for review to a physician for evaluation. The physician 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 of the facility clinical staff with THP medical directors. The provider will be notified when a determination is made. If there is an adverse decision, the provider can request reconsideration and further review. THP member or their designated representative may appeal as per policy for the line of business. A provider may request a peer-to-peer consultation with a THP physician 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 and individually at least three times per week, three hours per day, depending on the structure of the program. IOP for WV Medicaid members must be conducted in programs certified by the Bureau for Medical Services. The first 30 sessions are permitted without authorization for in network providers.
Facilities are expected:

- Additional Intensive Outpatient services beyond the 30 sessions can be requested by submitting a request by fax, phone or electronic transmission as noted above. 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 number of additional sessions approved. This will continue until discharge.
- Discharge clinical may be submitted for continuity of care.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for physician review prior to denial of services.
- IOP services for providers not in network, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Facilities providing IOP to WV Medicaid members must be certified by the Bureau for Medical Services.

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 for, traditional inpatient care for THP members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. THP members participate in this structured program up to five days per week, four to five hours per day. Medication management is an integral aspect of partial hospitalization services. The initial 30 sessions are permitted without authorization for in network providers.

Facilities are expected:

- Additional Partial Hospitalization services beyond the initial 30 sessions can be requested by submitting a request by fax, phone, or electronic transmission as noted above. 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 may be submitted for continuity of care.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for medical director review to determine medical necessity.
- Partial Hospitalization services for providers not in network, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Facilities providing partial hospitalization to WV Medicaid members must be certified by the WV Bureau for Medical Services.

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 physician. 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 primary care physician (PCP), referring participating specialist or admitting provider/practitioner with the nurse inpatient navigators.

Notification of urgent/emergent admissions by the admitting facility is required at the time of admission. Clinical information is expected within 48 hours of admission. This activity is performed for early discussion of member's needs as related to the admission, alternative health care services and discharge planning. THP has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization medical and behavioral care and services out of plan or when network providers are temporarily not available or accessible.

All-network services require prior authorization Clinical information is reviewed for availability of service within the in-plan network, urgent/emergent situation, or other extenuating circumstances and should be supplied by the behavioral health provider.

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 or behavioral health member advocate 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, facilities, and community-based providers to assure for successful delivery of behavioral health transition of care services that promote continuity of care and discharge planning. Concurrent review is performed telephonically.

Inpatient Rehabilitation Facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as Substance Use Disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities for Medicaid individuals under age 21 (PRTF), for adult psychiatric rehabilitation facilities depending on benefit plan and short-term residential eating disorder programs depending on the terms of a specific benefit plan. All such treatment must meet medical necessity criteria and must be authorized. t The program must be approved by the Bureau for Medical Services for WV Medicaid members. Please call customer service 1.877.847.7901 to obtain information regarding a member's specific benefit plan.

Outpatient Prior Authorization and Referral Management

Members are afforded direct access to behavioral health providers. No prior authorization is necessary for crisis visits or any urgent or emergent service. Authorization is no longer needed for psychotherapy visits if the member(s) group follows THP prior authorization list.

Psychological testing may be provided without authorization depending on the specific benefit plan.

Contact THP if you have a concern regarding a particular procedure or test.

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

Additional services that require prior authorization include procedure(s) that may have limited coverage under the plan benefit. Also, high-cost procedures and new technologies 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 determination. The medical director may contact the behavioral health provider for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to THP member's needs.

Please indicate if your request is emergent so that we 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.

Retroactive reviews for utilization: THP reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure that the member met medical necessity criteria for the service in question and to review the quality and appropriateness of the service provided.

Drug Screening and Testing

Urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine located on the ASAM website.

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

This affects the following lines of business: Commercial, Mountain Health Trust (including WV Medicaid, WV Health Bridge, Supplemental Security Income, WV Children's Health Insurance Program) and Medicare.

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

Billing

THP requires credentialing of all independently licensed behavioral health providers within a physician's practice.

Unlicensed personnel may not bill for behavioral health services within a physician's practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to our Mountain Health Trust members. A supervised psychologist must appear in the directory of the West Virginia Board of Examiners of Psychologists located on their website at psychbd.wv.gov/license-info/license-search

THP, incompliance 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 Authorization."

THP defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP's Customer Service Department.

Medicare Advantage and Commercial Fully Insured Plans

THP follows Medicare billing requirements for behavioral health "incident to" services provided by a physician. A summary of these requirements developed by the National Council for Behavioral Health.

To summarize the National Council's analysis: if a licensed behavioral health practitioner is employed or contracted by a physician whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the physician'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 physician's NPI if the scope of the service provided is consistent with the counselor's certification.

To further clarify, if a physician is federally certified as a Medication Assisted Treatment provider, regardless of the physician's specialty, the physician may have behavioral health practitioners employed or contracted in his office billing incident to the physician's services only so long as the service being provided relates to the physician's practice as a MAT provider if the physician's specialization is not traditionally behavioral health (examples: 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 physician 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 physician must provide regular reviews of the patient's status which must be documented in the patient's record.

Medicare will reimburse "incident to" claims at 100% of the established Medicare rate for the service. Conversely if the licensed behavioral health practitioner is listed on the claim as the rendering provider, the claim will reimburse at 85% of the established Medicare rate. All services must be provided at place of service 11, clinic.

Access to Care

To comply with NCQA standards, THP holds to the following standards for access to care for behavioral health cases:

- Providers should provide care within six hours in an emergent, non-life-threatening situation.
- Providers should provide care within 48 hours of a request for service when the need is urgent.
- Providers should provide a follow-up appointment within seven days of discharge from an inpatient facility.
- Providers should provide a new routine office visit within 10 working days of request.
- Prescribing providers should provide a follow-up visit within 30 working days of the initial visit.
- Non-prescribing providers should provide a follow-up visit within 20 working days of the initial visit.

If the provider is not available, the member should be made aware of how to access care. This would apply to after hours and weekend coverage as well as other situations.

Continuity and Coordination of Care

THP Clinical Services Department advocates continuity and collaboration of care between behavioral health and physical health providers. 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 providers whenever clinically appropriate.

It is the responsibility of the behavioral health provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between providers 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. A continuity of care consultation sheet is available on THP's secure provider portal: myplan.healthplan.org under "Forms," "Behavioral Health Forms," "Files" for use in facilitating integrated communication.

Behavioral Health Services Forms

The following forms are provided to assist providers in requesting services for patients and providing information necessary for continuity and coordination of care. Behavioral health prior authorization and review forms can be transmitted to THP via the provider secure web portal. The forms listed below are available online at myplan.healthplan.org . Prior authorization requests are also accepted telephonically, electronically, by fax or by email to behavioralhealthdocuments@healthplan.org. Admission, concurrent, and discharge reviews may be called to the nurse inpatient navigator.

- 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 Medicaid Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – WV Medicaid Line of Business only
- Peer Recovery Support Services authorization request (WV Medicaid Line of Business only)
- Request for ECT
- IOP/PHP Request for Authorization

Please call customer service at 1.800.624.6961 if you have a question about a particular benefit.

Telehealth Services

Telehealth services will be paid to behavioral health practitioners/providers 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/providers who are 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.

THP follows Medicare criteria for telehealth services for all lines of business, with the exception of our WV Mountain Health Trust product line. WV BMS policies are followed for the WV Mountain Health Trust product line.

Telehealth services must be conducted through the use of an interactive audio and video telecommunications system that permits real-time communications between the practitioners/providers 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 Medicare and WV Mountain Health Trust standards.

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 a provider/practitioner within seven days of discharge.

THP is asking for your cooperation and assistance to achieve this important goal.

We would appreciate your facilitating this by:

- Communicating to the hospital discharge planners that follow-up appointments should be scheduled within seven days of discharge.
- Faxing a member's discharge instructions to THP's Clinical Services Department at 1.866.616.6255 if you are a facility provider so that we may help to reinforce your discharge plan.
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within seven days of discharge.
- If you require assistance in this process, please contact our Clinical Services Department for a health care navigator.