Blue Essentials℠, Blue Advantage HMO℠, and Blue Premier℠ Provider Manual - Behavioral Health Services

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials℠, Blue Advantage HMO and Blue Premier℠. These network requirements will be noted with the network name.

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Magellan Behavioral Health Providers of Texas, Inc.
(Magellan) provides and coordinates all behavioral health care and services for Blue Essentials, Blue Advantage HMO and Blue Premier members. Members will be required to select behavioral health providers and facilities participating in the Magellan behavioral health network. Primary care physician/providers (PCP) referrals are not required. Members may call Magellan directly to access care.

Service Access
Requests for behavioral health services (mental health and/or chemical dependency) should be directed to Magellan. For eligibility information, benefits information, referral to a behavioral health provider or for preauthorization of services, Magellan personnel are available to assist you.

Telephone Number and Hours
Magellan - call toll-free at 800-729-2422

Important note: The telephone number listed above is answered 24 hours a day for crisis intervention and preauthorization of inpatient admissions.

For routine calls, phone hours are 8 am to 5 pm (CT), Mon - Fri except holidays.

Benefit Management Responsibilities
Magellan utilizes Customer Service Representatives and Care Managers to provide:

- Verification of benefits and eligibility
- Preauthorization for inpatient and outpatient care
- Referral services
- Case Management
- Assistance in the selection of a network behavioral health provider
- Crisis intervention
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Preauthorization Requirement
Preauthorization is required for all behavioral health services, including all outpatient procedures (i.e. psychological testing), inpatient facility-based care, partial day treatment and intensive outpatient treatment programs. For non-emergency admissions, preauthorization is required prior to the admission.

Important Note
In emergencies, the provider must first ensure that the member is safe. Preauthorization will then occur prior to or concurrent with, but not more than 48 hours following the admission.

Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Member Appointment Access Standards
All Magellan behavioral health providers have contractually agreed to offer appointments to our members according to the following standards:

- Routine: Within 10 working days
- Urgent: Within 24 hours
- Non-life threatening emergency: Within six (6) hours
- Life threatening/emergency: Within one (1) hour

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Referral Procedures
During the preauthorization process, if a referral is necessary, the following procedures will apply:

- **Blue Essentials, Blue Advantage HMO and Blue Premier.** These network specific requirements will be noted with participating physicians or professional providers should contact Magellan rather than referring a member directly to a behavioral health professional or facility.

  *Note: The member or a representative for the member may also contact Magellan directly.*

- Participating behavioral health providers must admit patients to a Magellan participating facility unless an emergency situation exists that precludes safe access to a Magellan participating facility, or if the admission is approved for a non-Magellan participating facility because of extenuating circumstances.

- If the admission was not approved for a non-Magellan participating facility, the patient should be transferred to a Magellan participating facility as soon as medically possible. In non-emergency situations, the patient, having been fully informed that the providing entity out-of-network and that subsequent services will incur increased cost liability, makes the decision to seek out-of-network treatment at a lower reimbursement level.

*Questions, call Magellan at 800-729-2422*
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## Magellan Care Management Program

**Magellan** Utilization Management/Review is referred to as Care Management. Care Management is a process that reaches beyond the simple approval/denial response of utilization management and helps a behavioral health provider formulate a clinically appropriate and cost-efficient treatment strategy. This approach assists members in maximizing the use of their benefits and facilitates comprehensive treatment planning.

Maximizing the behavioral health benefit is particularly important in the case of a member with a chronic or recurrent behavioral health diagnosis. Using the most clinically appropriate, yet least restrictive setting preserves benefits for future care of long-term care. The components of the Magellan Care Management program include:

- Inpatient
  - Preauthorization
  - Concurrent review
  - Discharge planning
- Outpatient
  - Preauthorization/Referrals
  - Concurrent review
- Crisis Intervention
- Case Management
- Retrospective Review

## Limitations and Exclusions

Services determined to be not medically necessary are not covered. To obtain a copy of the medical necessity criteria, please access the BCBSTX website at bcbstx.com/provider, under UM/QI/Medical Management, click on Behavioral Health Medical Necessity Criteria. If you do not have access to the website, you may write to **Magellan**, P.O. Box 1619, Alpharetta, GA. 30009-9930 or call **800-729-2422** and request a copy of the medical necessary criteria. Many group contracts specifically exclude services rendered in conjunction with a diagnosis of adolescent behavioral disorders. This exclusion varies from contract to contract. It is strongly recommended that you confirm benefit coverage **prior** to the delivery of care by calling the **Magellan** toll-free number.

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Quick Reference Guide
 Obtaining Preauthorization and/or a Referral Authorization for service:

1. The facility, provider, PCP, specialty care physician or professional provider or member may obtain an initial referral or preauthorization for “evaluation and treatment” by calling Magellan Customer Service Department at:

   800-729-2422

2. All non-emergency care requires preauthorization prior to the delivery of services. In order to obtain preauthorization or authorization for service, call Magellan at 800-729-2422. In consultation with the physician, professional provider or facility representative, Magellan care managers will obtain required clinical data, assist in the selection of a specific, participating behavioral health provider where appropriate, and preauthorize the inpatient or facility-based outpatient care based on medical necessity criteria. Magellan criteria for medical necessity will be used to determine whether mental health services will be certified. The State of Texas criteria will be used to evaluate medical necessity for chemical dependency treatment. A copy of these criteria can be obtained by accessing the BCBSTX website at bcbtx.com/provider, under UM/QI/Medical Management, click on Behavioral Health Medical Necessity Criteria. If you do not have access to the web site, you may request a copy of the State’s criteria by writing to Magellan, P.O. Box 1619, Alpharetta, GA. 30009-9930 or by calling 800-729-2422.

3. Assignment of a network attending physician is required. All referrals from facilities to behavioral health providers must be preauthorized by calling Magellan at 800-729-2422. Magellan will coordinate all behavioral health service referral authorizations.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Behavioral Health Services, cont’d

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Coordination of Care with Physicians and other Medical Care Providers

Communication and coordination of care among all physicians or 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 Mental Health Substance Abuse (MHSA) services.

Process

When communicating with the patient’s PCP, the process below should be followed:

1. The behavioral health provider should review and complete the Consent to Release Information to Primary Care Physician/Provider form with the patient as soon as it is therapeutically appropriate. This should be done as early in the evaluation or treatment episode as possible. The levels of disclosure that the member may select are as follows:
   - Release of any applicable information to the PCP,
   - Release any medication information only to the PCP, or
   - Not to release any information to the PCP.

2. Applicable information includes, at a minimum, the following:
   - Diagnosis
   - Treatment plan
   - Medications
   - Results of lab tests and consultations
   - Information on how the PCP can contact the behavioral health provider

3. To facilitate the continuity of care, it is expected that the specialty care physician or professional provider communicate with the PCP when any of the following occur:
   - Treatment is initiated
   - Psychotropic medications are administered
   - Significant changes in medication
   - Significant change in the patient’s clinical condition
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Process, cont’d

4. Specialty care physicians or professional providers must also request that appropriate releases be obtained so that the PCP can communicate with the behavioral health provider about any medical information that would be pertinent to the patient’s treatment and diagnosis.

5. Specialty care physicians or professional providers may communicate with the PCP by telephone or in writing. At a minimum, specialty care physicians or professional providers are required to document in the medical record the date that any communication with the PCP takes place.

The specialty care physician or professional provider is to disclose only that content which the patient has authorized on the Authorization to Disclose Information to a Primary Care Physician/Provider form.

Quality Improvement Program

As part of the Quality Improvement Program, compliance with the specialty care/PCP communication process will be monitored during site visits. Specific monitoring activities will include review for:

- Presence of a signed Authorization to Disclose Information form to a PCP in the member’s medical record.

- If authorized, documentation of communication occurrences with the patient’s PCP in the Patient’s medical record noting, at a minimum, when communication took place.