Today’s Topics
• Background
• Provider Contracting
• Medical Benefits Covered by BlueChoice HealthPlan Medicaid
• Non-Covered Behavioral Health Benefits by BlueChoice HealthPlan Medicaid
• Program Goals
• Program Objective
• Integration of Care
• Behavioral Health Program
• Behavioral Health Authorization Processes
• Behavioral Health Benefits
• BlueChoice HealthPlan Medicaid: Provider and Member Responsibilities
• Provider Resources
• Claim Filing Guidelines
• Grievances and Appeals
• Contact Information
• Questions and Answers

Background/Overview
• The State has historically covered all outpatient behavioral health services under Fee-for-Service (State Plan) with the exception of 9061 and 9062.
• Beginning April 1, the State has given the responsibility to each Managed Care Organization (four plans) of managing/neighboring outpatient behavioral health services provided by Licensed Independent Practitioners (LIP), including Advanced Practice Nurses, providing care in solo offices, group practices, and Federally Qualified Health Centers and Rural Health Clinics.

Contracting with BlueChoice HealthPlan Medicaid
• BlueChoice HealthPlan Medicaid, via Companion Benefit Alternatives (CBA), is actively contracting with Licensed Independent Practitioners, given BlueChoice HealthPlan Medicaid has never contracted with these providers in the past for the Medicaid product.
  - On behalf of BlueChoice HealthPlan Medicaid, CBA coordinates the credentialing of behavioral health providers and provides behavioral health network support. CBA is a separate company.
  - Organizations and providers may contact CBA via online at CBA.Proven@companiongroup.com or telephonically at 1-800-968-1032, ext. 2074.

Medical Benefits Covered by BlueChoice HealthPlan Medicaid
• Acute Inpatient and Outpatient Hospital Services
• Emergency Services
• Physician Services
• Preventive Services
• Ancillary Services
• FQHC/Rural Health Clinic Services
• Emergency Transportation Services

Please refer to the Provider Operations Manual for a full description of the benefits included in each setting.

MCO Behavioral Health Non-Covered Services
• Referrals from school systems and State agencies are covered under the State Fee-For-Service plan.
  - File claims to the State.
  - Requires a 2SA form from the referring entity.
• Autism spectrum disorders and mental retardation are not covered under the Managed Care Organization (MCO) as a primary condition.
  - We will deny claims submitted with a primary diagnosis of mental retardation and/or Autism Spectrum Disorders.
  - You can submit claims with a covered behavioral health as a primary diagnosis, and autism or mental retardation as a secondary diagnosis.

MCO Behavioral Health Non-Covered Services
• Services these organizations provide are NOT covered under the MCO.
  - Department of Alcohol and Other Drug Abuse Services (DADAS)
  - Department of Mental Health (DMH) clinics (Community Mental Health Centers, Community Service Boards)
• For non-urgent transportation (e.g., rides to medical appointments, members can find whom to call for a ride all.
  - http://www.southpacific.org/transportation-beneficiary-information

MCO Behavioral Health Non-Covered Services
• Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive an all-inclusive, per diem rate for services.
• Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid or MCO reimbursable.
Program Goals
- Make a difference in the lives of our South Carolina enrollees
  - Make fundamental differences in member health outcomes
  - Integrate provider partnerships
  - Enhance care coordination
  - Provide service excellence

Program Objectives
- Create health care efficiencies for our members
  - Implement a fully integrated quality-based managed care program
  - Provide timely access to high-quality health care in both traditional and non-traditional settings
  - Significantly improve quality of care and specific health care outcomes
  - Get innovative, results-oriented quality outcomes
  - Provide care that promotes health and wellness

Why Integration?
- Integration is a vital part of the BlueChoice Health Plan Medicaid program.
- Integration and coordination of care:
  - Ensures member health needs are addressed throughout all levels and types of care.
  - Allows for the expedited referral of members into one or more of the multiple disease management/treatment care programs designed specifically for their needs.
  - Prevents both under and over utilization of services.
  - Mitigates multiple services/medications which are contraindicated.
- FQHC’s and RHC’s are in a unique position to insure full integration of quality health care

Internal Behavioral Health and Medical Integration
- Provides a continuum of care management from initial contact to coordination of care and interventions.
- Care managers within the Utilization Management department support behavioral health and medical services:
  - Both teams share the same medical information system.
  - Medical care managers refer members to behavioral health for coordination of care within our tiered Case Management program.
  - An innovative and integrated approach with medical exists for those members with both behavioral health and medical problems, as well as members with substance abuse difficulties.

Coordination with the Primary Care Provider
- Behavioral health case managers:
  - Work closely with primary care providers (PCP), specialists, behavioral health providers, members and community resources to:
  - Provide additional education and training for both behavioral health and primary care clinicians to enhance their knowledge and skills needed to provide integrated care.
  - Provide the PCP with a Behavioral Health Profile, which includes key information regarding the services the PCP's member is receiving such as:
    - Member's behavioral health utilization
    - History of mental and/or substance use disorders
    - Primary behavioral health diagnosis for which the members are being treated
    - Treatment compliance
    - Medication protocol
  - Work closely with primary care providers (PCP), specialists, behavioral health providers, members and community resources to:

Communication and Collaboration with the Primary Care Provider
- Behavioral health case managers:
  - Communicate directly with PCPs, for integrated care plan development, when any significant events occur in members' treatment.
    - i.e., hospitalization, emergency services, etc.
  - Referral of members in securing necessary community support services.
  - Encourage member and PCP interaction.

Disease Management Programs
- Co-existing Depression and Anxiety (CODA) Program
- Maternity Depression Program (MDP)
- Bipolar Disease Management Program
- Attention Deficit Hyperactivity Disorder (ADHD) Program
- New Start Anti-Depressant Depression Program
- Tiered Case Management Program
- Follow-Up After Hospitalization

Co-existing Depression and Anxiety
- Provides for members enrolled in medical disease management or medical case management an avenue for early identification of co-morbid depression
- Provides in-depth depression and anxiety screenings for members with chronic medical conditions
- Offers education and resources for the appropriate behavioral health services
- Ensures treatment compliance and coordination of care between diverse treatment teams

Maternity Depression Program
- Goal is to provide depression screenings, education and support to members during pregnancy and following delivery.
- We work with our Future Mom’s program and medical providers to assist members who are experiencing difficulties with chronic mental health and/or substance abuse disorders.
- We work to identify, triage and enroll women in two distinct but coordinated behavioral health programs:
  - Tiered Behavioral Health Case Management
  - Maternity Depression Programs
Maternity Depression Program

- All pregnant members will be screened for perinatal and postpartum depression.
- Both screenings will include the use of Patient Health Questionnaire 2 (PHQ-2) and/or the Maternal Mental Health Survey to assess the severity and level of depression.
- Coordination of care is a key piece of this comprehensive program.

Bipolar Disease Management

- Provides timely, proactive, and collaborative coordination of benefits and services for members enrolled in the program with bipolar disorders.
- Uses daily reports from pharmacies to identify new starts and late refills of prescribed medications.
- Offers direct outreach to both the member and physician to provide:
  - Support and education to members
  - Critical treatment compliance information to physicians
  - Offers both member and provider interventions to support the appropriate diagnostic, treatment and referral of members with bipolar disease.
- Focuses on improving quality by encouraging medication compliance.

Attention Deficit Hyperactivity Disorder

- Provides a Medication Review Card to the parents of children under the age of 18 who are newly started on medications used to treat ADHD, which includes:
  - Neurobehavioral take away
  - Signs/Indicators to report to the prescribing physician
  - Educational information regarding side effects and where to contact the prescribing physician
- Offers resources for getting more information on ADHD
- Offers a personalized contact to discuss the Medication Review Card
- Conducts outreach with parents/guardians of members age 6–12 newly started on ADHD medications.
- Purpose of the call: encourage follow-up with the prescribing provider to monitor effectiveness of the medication

New Start Anti-Depressant Depression Program

- Provides a Personalized Health Information Brochure to members 18 years of age and older who are newly started on medications used to treat depression.
- Brochure includes:
  - Education on anti-depressant medications
  - Resources/Information
  - Educational information regarding side effects and where to contact for pre-existing depression
- Teaches importance of medication adherence
- Provides outreach telephone calls via IPP to remind members who are late refilling their prescription of the importance of medication compliance.

Tiered Case Management

- Tier I – Call center and outreach calls to members
  - Increased level of interaction with the member to assist with referral to provider or level of care
  - Problem-solving with the member for any obstacles to receiving care, treatment or ambulatory care follow-up services

- Tier II – Increased case management offers interventions on an ongoing or episodic basis for members who have complex situations due to high-risk, co-morbid medical and behavioral conditions placing the member in need of intensive support and treatment, and inpatient admissions for mental health or substance abuse

- Tier III – Intensive case management offers interventions on an ongoing or episodic basis for members who have complex situations due to high-risk, co-morbid medical and behavioral conditions placing the member in need of intensive support and treatment, and inpatient admissions for mental health or substance abuse

Follow-Up After Hospitalization: The Importance of Outpatient Treatment

- Prompt outpatient treatment has been found to greatly reduce hospital readmissions, increase community tenure, and improve the overall quality of member health.
- BlueChoice HealthPlan Medicaid encourages follow-up care to occur within 7 days of discharge from an acute psychiatric facility.
- BlueChoice HealthPlan Medicaid has several programs that are used to promote quality and address coordination of care.

Follow-Up After Hospitalization: Goals and Objectives

- Ensure members are continuing their care in an outpatient setting once they are discharged.
- Ensure members are seen within 7 days of discharge from inpatient care by a behavioral health provider to ensure the members are receiving follow-up care.
- Outpatient care is the key that works to address the reasons the members were inpatient. The goal of outpatient care is to continue stabilization, prevent readmission, and improve functioning long term.
- Outpatient care includes helping with family dynamics, making a plan for emergencies, understanding triggers of relapse, developing coping skills, and making a plan to prevent escalation.

Follow-Up After Hospitalization: Our Case Management Program

- Discuss any bio-psycho-social barriers to treatment recommended during their inpatient stay and ensure an outpatient appointment is scheduled within 7 days of their discharge.
- Remind the member of the upcoming appointment and follow up to ensure the appointment was kept.
- Coordinate transportation services which is often a major barrier to care.
- Focus specifically on each member’s unique needs.
- Assist member’s in obtaining access to medical, social, and educational services.
- Collaborate development of plans for behavioral and physical needs.
- Assist in scheduling of appointments and follow up calls to follow the member’s care.
How You Can Support Member Follow-Up After Discharge

1. Ensure outpatient appointment availability for members recently discharged from the hospital.
2. Consider implementing a Best Practice such as:
   -Offering group appointments for families and their member(s) returning home from inpatient care
   -Implementing a walk-in clinic on specific days to allow outpatient services within 7 days of discharge using the most current evidence-based practice
   -Coordinating with the hospitals in your regions to provide education on your services to both staff and members in the hospital.

Behavioral Health Transition From Fee-for-Service — April 1 – June 30

- For members currently under behavioral health fee-for-service care:
  - Participating and Non-Participating Providers
    - During the transition period (April 1, 2012 – June 30, 2012) we will not require authorization for the following services up to a limit of 12 sessions per provider: Tax (T1) $200 per unit, 1 session.

Behavioral Health Transition From Fee-for-Service — April 1 – June 30

- Non-Participating Providers:
  - Non-participating providers with BlueChoice HealthPlan Medical members still in care should contact a behavioral health care manager at 1-866-935-1896.
  - The behavioral health care manager and non-participating provider will have a clinical discussion regarding the member’s treatment to determine what additional services are needed and the member can:
    - Complete the current episode of care, or
    - Smoothly transition care to a participating provider.

Behavioral Health Post Transition From Fee-for-Service — July 1

- Participating Providers:
  - Providers seeing a new member for an initial assessment any time on or after 1 should complete the Behavioral Health Treatment Data Sharing Form within five business days of the first appointment and fax it to 1-877-664-4949.
  - When we receive the form, we will authorize the initial visit plus 11 sessions for a total of 12 sessions. (T1/T2/T3 per unit, 1 session)
  - Additional treatment is needed past the 12 visits, please submit an updated DTR form before the next previously authorized session.
  - Please submit psychological testing requests on the Request for Psychological Testing Preauthorization Form.

Behavioral Health Post Transition From Fee-for-Service — July 1

- Non-Participating Providers:
  - Non-participating providers with BlueChoice HealthPlan Medical members still in care should contact a behavioral health care manager at 1-866-935-1896.
  - The behavioral health care manager and non-participating provider will have a clinical discussion regarding the member’s treatment to determine what additional services are needed and the member can:
    - Complete the current episode of care, or
    - Smoothly transition care to a participating provider.

Behavioral Health Prior Authorization

- We require prior authorization for all facility inpatient behavioral health services:
  - DRGs 424-433: mental health
  - DRGs 521-523: substance abuse
- The MCO only covers inpatient behavioral health services:
  - For a non-state hospital
  - In a general acute care hospital

FEDERA LLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS NUANCES

- Telephonic prior authorization for the first 12 outpatient treatment sessions is not required. However, the provider must notify the behavioral health unit on the Behavioral Health Treatment Data Sharing Form within five business days of the visit to be secure authorization.
- FHHCs and RHCs who submit claims with the T1/T2/T3 code rather than a CPT or other HCPCS code.
- Each unit is “counted” as one session.
- We are not eligible for the codes which do not require authorization up to identified limits as noted on the following slides.

Authorization Guidelines (July 1 – Forward)
All Provider Types and FHHC’s / RHC’s with a Fee-For-Service Contract

- Non-participating providers must have authorization for ALL services.
- Psychiatric Diagnoses Assessments:
  - Up to 10 of any combination of these codes per Tax-10 per benefit year are allowed without authorization for participating providers.
  - 9080
  - 9081
  - 9082
- Psychotherapy, Team Conferences, Evaluation Services:
  - Up to 10 of any combination of these codes per Tax-10 per benefit year are allowed without authorization for participating providers.

[Behavioral health treatment data sharing form image]

[Behavioral health treatment data sharing form image]
Authorization Guidelines (July 1 – Forward)
All Provider Types and FQHC’s / RHC’s with a Fee-For-Service Contract

- Non-participating providers must have authorization for ALL services.
- Other Behavioral Services: *See separate section for authorization.
- Psychological Testing: CPT codes 96100-96115

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<tr>
<th>Service</th>
<th>CPT Code(s)</th>
<th>Authorization Requirement</th>
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<tbody>
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<td>Consulting</td>
<td>96100-96115</td>
<td>Not required for non-participating providers.</td>
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<tr>
<td>Testing</td>
<td>96100-96115</td>
<td>Authorization required.</td>
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Behavioral Health Benefits By Provider Type

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<tr>
<th>Provider Type</th>
<th>Covered Services</th>
<th>Authorization</th>
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<tr>
<td>FQHC’s / RHC’s</td>
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<tr>
<td>Non-participating</td>
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<tr>
<td>Participating</td>
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Behavioral Health Services: Covered Place of Service Codes

Covered behavioral health services can be provided in these Place of Service settings:

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Authorization</th>
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<tbody>
<tr>
<td>21</td>
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Behavioral Health Services: Other Important Information

- OMS National Current Coding Initiative (NCCI) does NOT allow multiple units of the same CPT code to be billed. Attention, BlueChoice HealthPlan Medicaid
  - Reimburse CPT codes 96101 and 96102 for IP services
  - Reimburse CPT codes 96103 and 96104 for IP consultation sessions
  - Reimburse CPT codes 96105 and 96106 as IP service sessions.
- Reimburse the NCCI edit prohibiting reimbursement of multiple CPT codes on the same date of service. BlueChoice HealthPlan Medicaid will allow this billing position as follows:
  - One Individual Therapy service (90801-90804) may be billed on the same date of service as one Family Therapy service (90805-90807), one Support Group service (90808-90809) and Psychosocial Testing service (90917).
  - T9153 NE is exempt from NCCI edit; therefore, more than one unit may be billed on the same date of service.

Provider Responsibilities

- Communicates and coordinates care with the member’s primary care physician or other treating provider
- Encourages members to consent to the sharing of substance abuse treatment information
- Delivers treatment in a culturally sensitive manner
- Makes appointments available to members consistent with their needs (emergency, urgent, routine care)
- Makes a follow-up appointment available to all members within seven days of discharge from an inpatient facility
- Seeks authorization for all covered services
- Does not balance bill the member for covered services

Member Rights

- Continuity of Care
  - Ensures uninterrupted ongoing behavioral health care for those who transition from Parx for Services or another MCO
  - Reports to the primary care physician
  - Provides disease management for members with:
    - Co-existing depression and anxiety
    - Malignant depression
    - Bipolar disorder
    - Attention Deficit Hyperactivity Disorder (ADHD)
    - Depression treated with anti-depressant medications
  - Integrates physical health and behavioral health services

Behavioral Health Provider Resources

- Transition of Care
  - Inpatient
    - Collaborates with the new MCO and treating IP facility to ensure appropriate discharge planning issues
  - Outpatient
    - Receives the previous MCO’s authorization for 30 days
    - Facilitates a smooth transfer to a BlueChoice HealthPlan Medicaid
    - Enters into a single-case agreement with the treating provider if clinically or geographically necessary
    - Communicates and coordinates with providers (medical and behavioral health) regarding the member’s ongoing care

Claim Filing Guidelines

- Timely Filing:
  - Participating Providers: 365 Days
  - Non-Participating Providers: 365 Days
- Billing Guidelines:
  - Behavioral health claims should be submitted with either the AH or the HR modifier.
  - It is important that you bill with the NPI number registered with the State of South Carolina, or your claim will not be paid.
  - For information about registering your NPI with the State of South Carolina, please visit its website at https://www.sMisc.state.sc.us/npi/index.jsp
  - NPI/Taxonomy: Your NPI and taxonomy number are required on all claims.

BlueChoice HealthPlan Medicaid Responsibilities

- Continuity of Care
  - Ensures uninterrupted ongoing behavioral health care for those who transition from Parx for Services or another MCO
  - Reports to the primary care physician
  - Provides disease management for members with:
    - Co-existing depression and anxiety
    - Malignant depression
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    - Depression treated with anti-depressant medications
  - Integrates physical health and behavioral health services

Claim Address:

BlueChoice HealthPlan Medicaid
Attn: Medicaid Claims
P.O. Box 10124
Columbia, SC 29202-3124

For those who currently file electronically, the payer ID is 00403.

Claim Filing Guidelines

- Available at www.BlueChoiceSCMedicaid.com
  - Clinical Practice Guidelines
  - Ongoing Treatment Request Form
  - Behavioral Health Treatment Data Sharing Form
  - Provider Operations Manual
  - Pinedge Claims Management Request Form
  - Much, Much More!

To file electronically, visit ProviderAccess:

- Learn how to get connected
- List of approved clearinghouses
- Submit directly if system compatible
- Technical assistance
- Coordination of Benefits (COB) claims must include third party remittance advice and the third party letter explaining the denial or reimbursement
- Electronic Funds Transfer (EFT) is available
Grievances and Appeals

• Mail grievances and appeals to:
  BlueChoice HealthPlan of Indiana
  200 E Market St
  Suite 300
  Indianapolis, IN 46204-3893
  Attn: Grievance and Appeals Department

• You can download the Member Grievance Form at:
  http://bluechoicescmedicaid.com/UserFiles/File/Provider

• Timeframes for filing for your grievance and appeals are:
  – 1-866-757-8286
  – 60 calendar days from the date the Member or Dependent received the Notice of denial or the Notice of encounter from the Health Plan (or the last date the Member had coverage with the Health Plan)

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