Behavioral HealthCare Program Provider Manual

MaineHealth Accountable Care Organization

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Why Behavioral HealthCare Program?

There are many advantages to our non-profit, integrated, collaborative clinical system of care. We are a known group of clinical providers. We can be more creative and innovative in treatment planning. We assign patients to clinicians according to therapist training, interest and expertise. We have the ability to answer questions (clinical and administrative) in a timely manner. We are committed to equitable reimbursement. The Behavioral HealthCare Program recognizes what a clinician and a subscriber expect from an integrated system.

Behavioral HealthCare Program Q&A

Q: What is the MaineHealth Accountable Care Organization's (MHACO) mission?

A: To support the member physicians and hospital(s) in the delivery of value-based, integrated health care that is patient centered through application of systems and programs that support improved clinical processes and outcomes, efficiency, better practice management and appropriate recognition and reimbursement.

Q: What is MaineHealth Accountable Care Organizations (MHACO) role in the mental health program?

A: MHACO sponsors the Behavioral HealthCare Program. MHACO is not a Health Maintenance Organization (HMO).

Q: What is the Behavioral HealthCare Program and how does it differ from other mental health/substance abuse programs?

A: We believe that mental health and substance abuse services should not be carved out and managed by a third party administrator. We believe mental health providers should work collaboratively with other health care providers and not be segregated. This requires that we provide cost effective, quality mental health services that meet the needs of the patients while accepting financial responsibility for these services. We are committed to the idea that this is best done by local coordination and strong provider involvement.

Furthermore, provider involvement is critical to the success of this program. The proposed authorization and treatment plan process, fee schedule, clinical guidelines, etc. are subject to change based upon provider input. The Quality Improvement Committee will be responsible for evaluating program details and making recommendations. If you are interested in participating in this committee, please indicate when you return your application.

Q: How do I receive a copy of the clinical criteria used by Behavioral HealthCare Program?

A: Please contact us at 1-800-538-9698 and we would be happy to send you a copy of our clinical criteria. You can also access the criteria on our website BHCP.org.

Q: What is the process for obtaining initial authorization and additional visits (if necessary)?

A: A member or provider accesses the system by calling 1-800-538-9698 for an authorization to an in network provider. A copy of the authorization will be mailed to your attention. If additional visits are required, you must complete an outpatient treatment form and submit it to:

MHACO-Behavioral HealthCare Program
110 Free Street
Portland, ME 04101-3908
Fax: 207-761-3079

Q: What is my reimbursement?

A: The fee schedules for the Behavioral HealthCare Program can be found in the contract.

Credentialing

The Behavioral HealthCare Program contracts with the following categories of licensed mental health providers. These providers are credentialed by the MaineHealth Accountable Care Organization committee in accordance with the Behavioral HealthCare Program credentialing plan.

- Psychiatrists
- Clinical Psychologists
- Licensed Clinical Social Workers (LCSW, LICSW)
- Licensed Clinical Professional Counselors (LCPC, LMHC, LCMHC, Pastoral Counselors)
- Licensed Marriage and Family Counselors (LMFT)
- Master's Level Clinical Nurse Specialists or Psychiatric Nurse (APRN-PMHNP)
- Licensed Alcohol and Drug Counselors (LADC)
- Licensed Psychological Examiners
- Addictionologists

The Behavioral HealthCare Program reserves the right to limit network participation based on the business needs of the network without respect to level of competence or skill, for any of the following reasons:

  - Lack of need for additional practitioners within the specialty
  - Lack of need for practitioners based on geographic location of practice

The Martin's Point Generations Advantage plans managed by the Behavioral HealthCare Program have limits on the credentials that are acceptable to those contract members. Following Medicare guidelines, the following license types **are not covered** under the Generations Advantage plans:

- **Drug and Alcohol counselors (LADC, MLADC, CADC)**

If a provider is a Medicare provider, he or she must sign the Medicare Addendum, which is included in the initial credentialing packet, and include his or her Medicare identification number.

Documentation Guidelines

Treatment Records

Definitions:

Facility—An institution or organization providing health care services.

Member—A Subscriber or eligible dependent of a Subscriber.

Practitioner—A clinician licensed, certified, registered or otherwise legally authorized to practice independently by applicable state or federal regulation.

Treatment Record—The same as "Medical Record". "Medical Record" is the record in which clinical information related to providing physical, social, and mental health services is recorded and stored. A medical record may be maintained in a paper, electronic, magnetic, optical or other format.

Applicable Procedure(s):

8.01 Documentation Guidelines
8.02 Treatment Record-Keeping Practices
8.03 Assessment of Treatment Records
8.04 Treatment Record Performance Goals

8.01	Documentation Guidelines		
	Approval Date	Authorized by	Effective Date
Original:8/2000	9/29/2000		9/29/2000
Review:7/2001	07/2001		
Reviewed:	09/2002		09/27/2002
Reviewed:	9/2006; 9/2007; 9/2008; 9/2009; 9/2010; 9/2011, 7/2012; 7/2013; 9/2014; 7/2015; 9/2016; 7/2017; 9/2018; 9/2019; 9/2020; 7/2021; 7/2022; 7/2023;7/2024		

Procedure:

1. Each page in the Treatment Record contains the patient's name or other unique identifier.
2. The Treatment Record includes the patient's:
   - 2.1. Address.
   - 2.2. Employer or school.
   - 2.3. Home telephone number.
   - 2.4. Work telephone number.
   - 2.5. Emergency contacts.
   - 2.6. Marital status.
   - 2.7. Legal status.
   - 2.8. Appropriate consent forms.
   - 2.9. Guardianship information, if relevant.
3. All entries in the Treatment Record include the responsible clinician's name, professional degree, and relevant identification number, if applicable. Solo practitioners need not use their professional degree or identification number.

4. All entries are dated and the length of therapy session, number of minutes spent with the patient, or the session begin and end time, must be documented in the notes as well in order to receive proper reimbursement for timed codes.
5. Each entry is legible to individuals other than the writer.
6. Relevant medical conditions are listed, prominently identified and revised.
7. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, are documented.
8. A medical and psychiatric history is documented, including:
    - 8.1. Previous treatment dates.
    - 8.2. Provider identification.
    - 8.3. Therapeutic interventions and responses.
    - 8.4. Sources of clinical data.
    - 8.5. Relevant family information.
    - 8.6. Results of laboratory tests.
    - 8.7. Consultation reports.
9. Allergies and adverse reactions or the lack thereof are clearly documented.
10. For children and adolescents (through age 18), the following are documented:
    - 10.1. Prenatal and perinatal events.
    - 10.2. A thorough developmental history including physical, psychological, social, intellectual, and academic development history.
11. For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
12. A mental status evaluation is documented including the patient's:
    - 12.1. Affect.
    - 12.2. Speech.
    - 12.3. Mood.
    - 12.4. Thought content.
    - 12.5. Thought process.
    - 12.6. Judgment.
    - 12.7. Insight.
    - 12.8. Attention.
    - 12.9. Concentration.

12.10. Memory.

12.11. Impulse control.

13. Special status situations, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with BHCP's written protocols.

14. A DSM-V diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.

15. If medications are prescribed, the Treatment Record maintained by:

15.1. The prescribing practitioner documents:

15.1.1. Which medications have been prescribed.

15.1.2. The dosages of each medication.

15.1.3. The dates of initials prescription and refills.

15.2. A non-prescribing practitioner, if any, documents:

15.2.1. Which medications have been prescribed.

15.2.2. The name of the prescribing practitioner.

16. If medications are prescribed, the Treatment Record maintained by the prescribing practitioner documents informed consent for medication.

17. A treatment plan is documented.

18. The treatment plan is consistent with diagnoses and has both:

18.1. Objective measurable goals.

18.2. Estimated time frames for goal attainment or problem resolution.

19. The patient's understanding of the treatment plan is documented.

20. The focus of treatment interventions is consistent with the treatment plan goals and objectives.

21. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.

22. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

23. The Treatment Record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).

24. The Treatment Record reflects continuity and coordination of care between mental health clinicians and the PCP or other non-behavioral medical providers.

25. The Treatment Record reflects continuity and coordination of care within the behavioral health continuum of care.

26. The Treatment Record documents dates of follow-up appointments or, as appropriate, a discharge plan.

BHCP's Standards for Accessibility

Accessibility Standard	Performance Goal
Average speed of telephone answer	30 seconds or less.
Telephone call abandonment rate	5% or less.
Percentage of telephone calls handled within 30 seconds	85%
Appointment offered with non- life threatening emergency care needs	99% within 6 hours
Prescriber mental health urgent appointments	60% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request
Prescriber mental health new patient routine appointments	60% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request
Prescriber mental health established patient routine follow-up appointments	60% of offices report a third available routine appointment is open for an established patient within 60 days of patient request
Non prescriber mental health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request
Non prescriber mental health new patient routine appointments	85% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request
Non prescriber mental health established patient routine follow-up appointments	85% of offices report a third available routine appointment is open for an established patient within 30 days of patient request

****BHCP Providers should direct members to the ER for emergent care needs.****

Determination of Medical Necessity

POLICY

It is the policy of the BHCP to provide the appropriate level of care for its members. To that end, every member is assessed by licensed clinicians in order to determine the medical necessity of behavioral healthcare services.

SCOPE

In order to maximize the effectiveness of the care provided to the members and manage its limited resources, the BHCP establishes and monitors the most current and sound clinical criteria. These criteria enable the program to efficiently manage its population and educate its practitioners in the best clinical practices.

DEFINITION

CRITERIA

Criteria are the established standards that are used to determine medical necessity.

1. Milliman Care Guidelines Behavioral Health Care 28th Edition, evidence based behavioral health guidelines provided by MCG Health. (For use in ambulatory care and psychiatric hospitalizations and chemical dependency services starting in November 2019).
2. National Coverage Determinations and Local Determinations set forth by Medicare Coverage Guidelines for the Anthem AMH Health Medicare Advantage plan. https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?NCDId=26&ncdver=1&bc=AgAAgAAAAAAA& (effective January 2020)

The above clinical criteria are used in conjunction with relevant clinical information and an understanding of the particular healthcare delivery system.

Customer Service Representatives

Customer Service Representatives receive the intake call and screen the call to direct the member 1) about the authorization process or 2) to the Case Manager for assessment to the most appropriate level of care (for those with urgent concerns).

PROCEDURE OUTLINE

OUTPATIENT

When a call is received through the toll free telephone line, the Customer service representative screens the call and determines the nature of the call. If the member/provider has a routine request for services, the Customer Service Representative begins the authorization process. If the caller is in distress, the call is immediately patched through to a Clinical Case Manager for further assessment. The case manager consults with the Director, Clinical Operations or the BHCP Medical Director as day treatment and intensive outpatient therapies must be pre-approved.

INPATIENT

Hospital admissions require pre- authorization. The Director, Clinical Operations, also evaluates medical appropriateness of admissions to non-participating hospitals.

CONTINUATION OF STAY

A case manager concurrently reviews the continuation of stay. The Director, Clinical Operations and Medical Director of the Behavioral Healthcare Program supervise the pre-certification and concurrent reviews of all hospitalized patients.

DENIAL OF COVERAGE-Authorization

Inpatient

A case manager determines that the information received from the practitioner indicates that the member's condition no longer meets acute inpatient psychiatric criteria. The BHCP Medical Director reviews all available information and makes a decision. The BHCP Medical Director or a physician consultant communicates all denials to the attending physician.

Outpatient

All denials for coverage for outpatient services, based on lack of medical appropriateness, require review and signature of a Medical Director/ Designee. Once a BHCP physician makes an adverse medical necessity decision, all parties are notified within one (1) business day. The decision cites the specific rationale and criteria upon which the decision was made and includes information about the appeals process. The attending physicians, practitioners, and members are informed of the availability of reconsideration from the same Physician Consultant. A member may also request a second opinion from a different Physician Consultant, if they are dissatisfied with the initial reconsideration.

Members Rights and Responsibilities

1. **Members have a right to be treated with respect, dignity, courtesy and fairness.**

2. **Members have the right of easy access to the program and to privacy and confidentiality. This includes evaluation and referral in a timely fashion to a practitioner familiar with the aspects of your problem.**

3. **Members have a right to complete, clear and concise information about their program benefits as well as the program's services, practitioners and clinical guidelines.**

4. **Members have the right to notification of their rights and responsibilities under the program, and to make recommendations about these policies.**

5. **Members have a right to participate in decision making and treatment planning.**

6. **Members have a right to a candid discussion of appropriate or medically necessary treatment options for their condition or problem, regardless of cost or benefit structure or coverage.**

7. **Members have a responsibility to provide needed information, to the extent possible, to the program and its practitioners in order to provide care for the member.**

8. **Members have a responsibility to understand their diagnosis, to participate in treatment planning, and to follow the plans and instructions for care that they have agreed to with their practitioner.**

9. **Members have the right to voice complaints or appeals about the program or the care provided.**

Clinicians Rights and Responsibilities

1. **You should expect to be treated with courtesy and fairness.**

2. **You should expect to be rewarded on the basis of merit and skill.**

3. **You should expect to receive fair and reasonable fees for your work, and receive them promptly.**

4. **You should expect your paperwork and telephone calls to be kept to a minimum.**

5. **You should expect to receive clear and understandable communications from you third party administrator.**

6. **You should expect to have a source of consultation and referral for your patients who need this.**

7. **You should expect any system of which you are a part to hear and welcome your suggestions.**

8. **You should expect change if change will solve a problem rather than create a new one.**

Overview of the Appeals Process

Procedure:

1. BHCP makes every reasonable effort to avoid disagreement with Members and Practitioners regarding utilization management decisions and the resolution of complaints. If attempts to negotiate a mutually acceptable outcome are not successful, the Member, Subscriber, treating Practitioner acting on the Member's behalf, or designated Member representative (including family member) has the right to initiate an Appeal of the decision.

2. **For USFHP members**, both first and second level appeals are handled by Martin's Point; by the Defense Health Agency for Factual appeals; By KePro (Keystone Peer Review Organization) for Medical Necessity appeals (second level).

3. **For Aetna MaineHealth plans –** Aetna will handle all levels of appeals.

4. **For AMH members –** Anthem handles all levels of appeals. Please contact Anthem directly at 855 662-8599.

5. BHCP maintains a list of Peer Reviewers covering major recognized Sub-specialties within mental health. These include:

    a. General psychiatrists
    b. Child and Adolescent Psychiatrists
    c. Psychiatrists with added qualifications in geriatric psychiatry
    d. Psychiatrists with added qualifications in addiction psychiatry
    e. Addictionologists
    f. Psychologists

6. If a Member completes a course of treatment for which prior authorization or concurrent review was required without the prior or concurrent involvement of BHCP, a retrospective review will be conducted when requested.
    a. This retrospective review takes the place of the prior authorization and concurrent review process.

    b. If the retrospective review results in Adverse Determination, the case may proceed to a standard first level Appeal with Aetna for Aetna MaineHealth members.

Behavioral HealthCare Program
Mental Health/Substance Abuse Services
Authorization Procedures and Treatment Report

The following procedures have been established to provide appropriate access to management of mental health/substance abuse services for BHCP members/providers:

- To get an authorization, the individual member or provider calls:
  - (800) 538-9698 for Aetna MaineHealth
  - (855) 662-8599 for Anthem Medicare Advantage
  - (888) 812-7335 for US Family Health Plan at Martin's Point
  - (800) 708-4532 for Generations Advantage

- Outpatient services do not require authorization if provided by an in-network provider. The only outpatient services that require authorization are TMS services and ECT services.

- ***Please remember that it is the provider's responsibility, as well as the member's, to secure prior authorization.***

- ***In-Network providers <u>cannot</u> bill members for denied services due to a lack of authorization.***

- **<u>For Anthem members</u>:** Please pay special attention to the member's card. The BHCP manages *AMH Medicare Advantage* lines of business only.

- **<u>For Aetna members</u>:** Please pay special attention to the member's card. The BHCP manages *MaineHealth* Aetna lines of business only

- **Please remember to notify us in writing if you have any changes to your contact or billing information.**

Behavioral HealthCare Program
Mental Health/Substance Abuse Services
Claims Procedures

Claims for MH/SA Services must be submitted on a CMS-1500 or UB-04 Form

Aetna MaineHealth starting 1/1/23

Aetna
PO Box 981106
El Paso, TX 79998-1006
Aetna Claims: 833-948-3540

AMH Health Medicare Advantage plans, please mail to:

Anthem BCBS
PO Box 533
North Haven, CT 06473

AMH Health Medicare Advantage Provider Services: 844-895-8159
AMH Health Medicare Advantage Member Services, HMO: 844-209-6376
AMH Health Medicare Advantage Member Services, HMO DSNP: 844-231-0247

For US Family Health Plan and Generations Advantage claims, please mail to:

Martin's Point Health Care
Claims Department
PO Box 11410
Portland, ME 04104-7410

Provider Services: 888-732-7364
USFHP Member Services: 888-674-8734
Generations Advantage Member Services: 866-544-7504