CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 2: BEHAVIORAL HEALTH PROVIDERS

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.2 GENERAL INFORMATION

Verify benefits

Behavioral health benefits vary by product and by group. In some instances, a group may purchase medical health care coverage through Highmark, but behavioral health care coverage through another company.

To determine whether a member has behavioral health care coverage through Highmark and if authorization is required, always verify the member's benefits prior to providing services. Eligibility and benefits can be verified via NaviNet® or the applicable HIPAA electronic transaction. If you do not have electronic access, call Highmark Behavioral Health Services or the benefits telephone number on the member's identification card.

NaviNet® Eligibility and Benefits Inquiry

To verify behavioral health benefits via NaviNet, select the **Eligibility and Benefits Inquiry** transaction from the main menu on Highmark Plan Central. Click on the **Additional Benefit Provisions** link on the Eligibility and Benefits Detail page. From the pop-up box, select **Behavioral Health/Substance Abuse** for detailed behavioral health benefits.

What Is My Service Area?

Contact information

To reach Highmark's Behavioral Health Services, please call:

- PA Western & Northeastern Regions: **1-800-258-9808**
- PA Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245;** for Medicare Advantage Freedom Blue PPO, please call **1-800-269-6389**

Standard business hours for the Behavioral Health Services department are:

- Monday through Friday from 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

Medical management services

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

Continued on next page

4.2 GENERAL INFORMATION, Continued

Utilization management	For most Highmark products, authorization is required to receive coverage for **all inpatient behavioral health services**. Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission. In addition, authorization is required for partial hospitalization and for intensive outpatient services. Highmark Behavioral Health Services provides timely utilization management determinations for all members and providers based on established medical necessity criteria. Each utilization management determination is handled in a manner consistent with the clinical urgency of the situation and with legal and regulatory compliance requirements. For more information, please see **Chapter 5.4: Behavioral Health**.
Virtual behavioral health	Highmark participating behavioral health provider s have the option of providing "virtual" behavioral health visits for Highmark members via telecommunications technology. The services performed must fall under the scope of the provider's license, and the sessions must be conducted following Highmark's recommended service and security guidelines. For more information, please see **Chapter 2.5: Telemedicine Services**.
Referrals to in-network providers	When recommending inpatient services, be sure that the member is to receive care from a provider that participates in the network associated with the member's program and, when applicable, is in the highest benefit tier.

4.2 LEVELS OF CARE

Least restrictive setting

Highmark Behavioral Health Services operates from the foundational principle that optimal, high quality care occurs when the member receives the services that meet his or her needs in the least intensive, least restrictive setting safely available within the scope of his or her benefit plan.

Levels of care

Highmark Behavioral Health Services has defined five levels of care for mental health and substance abuse treatment services:

1. Inpatient hospitalization
2. Psychiatric residential treatment and substance abuse residential treatment
3. Partial hospitalization programs (PHPs)
4. Intensive outpatient programs (IOPs)
5. Traditional outpatient treatment

Coverage and requirements may vary by product and benefit plans

Behavioral health benefits may vary by product and may also vary by the specific contract under which the member has coverage. All levels of care may not be covered by the member's benefit plan. In addition, pre-certification and concurrent review requirements apply and may vary by benefit type.

Always verify a member's plan specific benefits via NaviNet® or by calling Highmark Behavioral Health Services prior to providing services.

Inpatient hospitalization

Inpatient hospitalization is the highest level of skilled psychiatric and substance-abuse treatment services. It is provided in facilities such as freestanding psychiatric hospitals or distinct-part psychiatric or detoxification units of an acute care hospital.

Settings eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.

Residential treatment centers

The residential treatment center level of care is defined as a non-hospital setting that provides twenty-four (24) hour residential care to persons with long-term or severe mental disorders and persons with substance-related disorders. These programs feature the following:

- Treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs
- Training in the basic skills of living, as determined necessary for each patient

Licensure requirements for this level of care vary by state.

Continued on next page

4.2 LEVELS OF CARE, Continued

Partial hospitalization programs (PHPs)

Partial hospitalization programs (PHPs) are defined as structured and medically-supervised outpatient day or evening treatment programs. Although the patient is not considered a resident, the services provided are of essentially the same nature and intensity as those provided in an inpatient setting.

Highmark treats partial hospitalization as a professional service and, if eligible, is considered part of a member's outpatient mental health or substance abuse treatment benefit.

Partial hospitalization services are designed to address a mental health or substance abuse disorder through an individualized treatment plan provided by a coordinated multidisciplinary team. Highmark defines partial hospitalization programs as providing, at a minimum, the following treatment:

- Psychosocial assessment within the first program day
- Substance abuse evaluation within the first two program days
- Clinical assessment once daily
- Individual/group/family therapy at least four (4) hours per day, three (3) or more days per week
- Psychiatric/medication evaluation once per week
- Toxicology screen/self-help or education groups as needed

Note: School-based programs must also adhere to the hourly requirements regardless of the number of days a member is treated per week (e.g., three (3) hours per day, five (5) days per week **does not** meet criteria).

Intensive outpatient programs (IOPs)

Intensive outpatient programs (IOPs) provide planned and structured services to address mental health and/or substance-related disorders.

Highmark defines intensive outpatient programs as providing, at a minimum, the following treatment:

- Psychosocial assessment within the first visit
- Substance abuse evaluation within the first two visits
- Individual/group/family therapy at least two and one-half (2.5) hours per day, two (2) or more days per week
- Psychiatric/medication evaluation as needed
- Toxicology screen/self-help, 12-step, or education groups as needed

Continued on next page

4.2 LEVELS OF CARE, Continued

Intensive outpatient programs (IOPs) (continued)

The coordinated and integrated multidisciplinary services provided by an intensive outpatient program may include the services listed below:

- Group, individual, family, or multi-family group psychotherapy
- Multiple or extended treatment/rehabilitation/counseling visits
- Professional supervision and support
- Crisis intervention, psychiatric/psychosocial rehabilitation, or day treatment models
- Psycho-educational services
- Adjunctive services such as medical monitoring

Note: These services are provided by an intensive outpatient program-contracted facility or agency.

IMPORTANT: Self-help programs

While treatment for substance abuse typically involves participation in self-help programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), these programs are offered without charge by community volunteers and cannot be included as billable time in an intensive outpatient program.

Medical Director required for PHPs & IOPs

All facilities providing partial hospitalization and/or intensive outpatient programs **and** submitting claims via 1500 must have a Medical Director. Claims for services provided are submitted under the Medical Director.

The Medical Director must be a medical doctor (MD) or doctor of osteopathic medicine (DO) with a board certification in psychiatry in good standing who is credentialed and participating with Highmark.

Facilities contracting for substance abuse only can alternatively have a medical doctor (MD) or doctor of osteopathic medicine (DO) who is also certified in addiction medicine by a Member Board of American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or American Society of Addiction Medicine (ASAM).

Traditional outpatient treatment

Traditional outpatient treatment is typically individual, family, and/or group psychotherapy and consultative services, including nursing home consultation and psychiatric home health visits.

Service duration ranges from fifteen (15) minutes (e.g., medication checks) to fifty (50) minutes (e.g., individual or family psychotherapy) and can extend as long as two (2) hours (e.g., group psychotherapy).

Continued on next page

4.2 LEVELS OF CARE, Continued

Supervised living is not a covered service	Supervised living services, which provide assistance but not medically necessary care, are **not covered** under Highmark benefit plans.

4.2 OPIOID TREATMENT PROGRAM BENEFIT

Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 is aimed at addressing the nation's opioid overdose epidemic.

As required by the SUPPORT Act, the Centers for Medicare & Medicaid Services (CMS) will pay Medicare-enrolled Opioid Treatment Programs (OTPs) through bundled payments for Opioid Use Disorder (OUD) treatment services provided to Medicare beneficiaries in an episode of care effective January 1, 2020. OTPs must enroll in the Medicare program in order to receive reimbursement when these services are provided to Medicare patients.

Medicare Advantage plans are also required to include the OTP benefit effective January 1, 2020, and can contract with Medicare-enrolled OTP providers in their service area.

Opioid Treatment Programs defined

Opioid Treatment Programs provide medication-assisted treatment for people diagnosed with OUD. The programs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body.

For SAMHSA certification, OTPs must comply with all pertinent state laws and regulations and all regulations enforced by the Drug Enforcement Administration.

Services covered under the OTP benefit

As defined by CMS, the following services used for the treatment of OUD are covered under the OTP benefit:

- Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- The dispensing and administering of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing, which includes both presumptive and definitive testing
- Intake activities
- Periodic assessments

Continued on next page

4.2 LEVELS OF CARE, Continued

OTP services HCPCS codes

Highmark's OTP benefit for our Medicare Advantage plans is similar to the CMS OTP benefit that pays for bundled services under Medicare Part B for Medicare beneficiaries. A bundled payment for the overall management, care coordination, individual and group psychotherapy, and substance use counseling for OUD creates an avenue for clinicians to bill for a group of services in the office setting.

OTP services HCPCS codes (continued)

Codes that have been created, effective January 1, 2020, describe a weekly bundle (HCPCS codes G2067-G2075), with one week defined as seven (7) contiguous days. Additional codes for add-on services (HCPCS codes G2076-G2080) for evaluation/assessment, take-home supplies of medication, or for billing counseling/therapy services that substantially exceed the amount specified in the member's individualized treatment plan. The member's medical records must be documented to show the medical necessity for these add-on services.

These codes are specifically for use by OTPs for OUD treatment services. These codes can only be billed by Medicare-enrolled OTP providers.

As per the Medicare guidelines, the individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as telehealth services using communication technology as clinically appropriate.

Provider enrollment

To provide OUD treatment services to Highmark Medicare Advantage members under the OTP benefit, OTP providers must meet the same requirements as those providing services under Medicare Part B (including enrollment with Medicare). Medicare-enrolled OTPs can submit an application to contract with Highmark to provide these services to Highmark Medicare Advantage members.

Please refer to the **MLN Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet** for more information about the Medicare enrollment requirements and process.

Continued on next page

4.2 LEVELS OF CARE, Continued

Claim submission

Opioid Treatment Program providers must submit all claims for OUD treatment services covered under the OTP benefit via an 837P electronic transaction or the 1500 Health Insurance Claim Form. Include the following information:

- HCPCS codes associated with the OTP service provided to the member
- OTP's NPI in the Rendering Provider Identifier section in Box 24J of the 1500 form or its equivalent on the electronic 837P
- Prescribing or other eligible professional provider's NPI in Box17 (the ordering/referring/other field) of the 1500 form or the equivalent field on the electronic 837P

FOR MORE INFORMATION

For additional information, please see the **Opioid Treatment Programs** page on the CMS website.

4.2 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT

What Is My Service Area?

Overview

Delaware Senate Bill 41was written in an effort to reduce overdose deaths related to the growing opioid epidemic. The bill was enacted into law on May 30, 2017, amending Title 18 of the Delaware Code relating to coverage for serious mental illness and drug and alcohol dependency (Del. Code tit. 18 §§ 3343, 3578).

The law requires coverage for medically necessary inpatient and residential drug and alcohol dependency treatment and immediate access to a 5-day emergency supply of prescription medications. It also prohibits insurers from imposing precertification, prior authorization, pre-admission screening, and referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies, and does not allow concurrent utilization review for the first 14 days of inpatient and residential treatment.

Delaware Senate Bill 109, signed into law on September 29, 2017, also amends Title 18 and further extends the restriction on concurrent utilization review to include 30 days of intensive outpatient treatment and five days of inpatient withdrawal management.

Applicability

Effective **January 1, 2018**, these statutes are applicable to all Highmark Delaware fully-insured individual and group health benefit plans. Self-insured employer groups will be offered the opportunity to adopt the mandate and may or may not elect to follow the mandate. Medicare supplemental plans are exempt from this law.

Definition

Drug and alcohol dependencies are defined as a substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16 of the Delaware Code.

Inpatient and residential treatment requirements

Under this legislation, health plan coverage for drug and alcohol dependencies must include:

- Inpatient coverage; and
- Unlimited medically necessary treatment provided in residential settings as required by the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

Continued on next page

4.2 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT, Continued

Prescription drug coverage for a 5-day emergency supply

If a health plan's coverage includes prescription drugs, the plan must provide immediate access, without prior authorization, to a five (5) day emergency supply of prescription medications for treatment of serious mental illness and drug and alcohol dependencies, including a prescribed drug for opioid withdrawal, stabilization, or overdose reversal, except where otherwise prohibited by law.

The 5-day emergency supply may be subject to copayments, coinsurance, and annual deductibles if consistent with those imposed on other benefits within the health benefit plan. However, a plan **may not impose an additional copayment or coinsurance** on a covered person who receives a subsequent 30-day supply of the same medication in the same 30-day period in which the person received the emergency supply.

What Is My Service Area?

Benefit management restrictions

As per the legislation, Highmark Delaware may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies at a Highmark Delaware network participating facility.

In addition, concurrent utilization review is prohibited during the first fourteen (14) days of medically necessary inpatient and residential treatment by a network participating facility approved by a nationally recognized health care accrediting organization or the Division of Substance Abuse and Mental Health; thirty (30) days of Intensive Outpatient Program treatment; or five (5) days of inpatient withdrawal management.

However, the facility must comply as follows:

- The facility must notify Highmark Delaware of both the admission and the initial treatment plan **within forty-eight (48) hours** of the admission.
- The facility must perform daily clinical review and periodically consult with Highmark Delaware to ensure that the facility is using the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by ASAM or, if applicable, any state-specific ASAM criteria and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

Continued on next page

4.2 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT, Continued

Retrospective review

Highmark Delaware may perform retrospective review for medical necessity and appropriateness of all services provided during an inpatient stay or residential treatment, including the initial 14 days of treatment; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management.

Highmark Delaware may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by ASAM or any state-specific ASAM criteria.

The Highmark Delaware member does not have any financial obligation to the facility for inpatient and residential treatment other than any applicable copayments, coinsurance, or deductible amounts required under their benefit plan.

What Is My Service Area?

REMINDER: Verify Benefits

You can verify benefits, including whether the member's benefit plan follows the mandate, via NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

If NaviNet is not available, please call the Highmark Delaware Provider Service Center at**1-800-346-6262**.

4.2 HIGHMARK BEHAVIORAL HEALTH PROGRAMS

Overview

The need for more access to behavioral health resources is a growing trend among health care consumers. To meet the needs of our members, Highmark is taking a hands-on approach to enhancing various behavioral health programs available to our members. Professionally trained staff are available to members, their families, significant others, and providers to coordinate the services needed to meet our members' needs.

Case and condition management programs

Highmark offers health coaching through behavioral health case management and chronic condition management approaches. The objective of the programs are to facilitate the member's self-management plans for lifestyle improvement and activities relative to their specific circumstances or diagnosis, address potential barriers to goal achievement, and assist in referrals to providers, community, and/or other resources and support.

For example, the condition management services specific to depression help members identify symptoms of depression; overcome the reluctance that many people have to getting help; decide if formal treatment is indicated and, if so, what the right treatment may be; locate services; manage barriers; and assist in tracking progress.

Role of the behavioral health specialist

The behavioral health specialist plans, implements, coordinates, monitors, and evaluates the preferences and services to meet the member's behavioral health care needs. The behavioral health specialist assesses the member throughout the case management or condition management process, working with the member to identify short and long-term goals that address the member's specific needs.

Highmark's behavioral health specialists are licensed behavioral health professionals who receive formal training in motivational interviewing and other behavior change approaches. This training enables behavioral health specialists to communicate effectively with members via telephone and other approved technologies to establish and monitor both short and long-term goals for improved health management.

Utilization management team's role

The utilization management team assists in applying medical necessity criteria to avoid variation in the delivery of services, recommends clinically appropriate alternative levels of care, and assists in discharge planning. Highmark behavioral health utilization management has become an integral part of ensuring timely and appropriate discharge planning and triaging referrals to other programs in Highmark. The care managers on the team promote continuity of care.

Continued on next page

4.2 HIGHMARK BEHAVIORAL HEALTH PROGRAMS, Continued

Recommending a member to a behavioral health program

Providers are encouraged to recommend members who may benefit from these programs. To verify patient eligibility, please check the *Eligibility and Benefits Inquiry* selection in NaviNet.®

To recommend patients to Highmark behavioral health programs, providers should call Highmark Behavioral Health Services at:

- Pennsylvania Western & Northeastern Regions: **1-800-258-9808**
- Pennsylvania Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**

The Behavioral Health Services department is available:

- Monday through Friday from 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m.

What Is My Service Area?

4.2 ACCESSIBILITY EXPECTATIONS FOR BEHAVIORAL HEALTH

Accessibility expectations

To stay healthy, members must be able to see their providers when needed. To support this goal, we are sharing with you Highmark's expectations for accessibility of behavioral health providers. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Note: Standards for Pennsylvania Children's Health Insurance Program (CHIP) enrollees are available in **Chaper 2.3: Other Government Programs** and may differ from the expectations noted below.

BEHAVIORAL HEALTH PROVIDER EXPECTATIONS		
Patient's Need:	**Performance Standard:**	
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response	
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within 6 hours	
Urgent care • Timely evaluation is needed to prevent deterioration of patient condition	Office visit within *24 hours* *Why blue italics?*	
Routine office visit • Patient's condition is considered to be stable	PA ONLY, WV ONLY	Office visit within 10 business days
	DE ONLY	Office visit within 7 calendar days
After-hours care • Access to providers after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the provider or answering machine message telling caller how to reach the provider after hours)	
In-office waiting times • Providers are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes What Is My Service Area?	

Continued on next page

4.2 ACCESSIBILITY EXPECTATIONS FOR BEHAVIORAL HEALTH,
Continued

Acceptable after-hours methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

ANSWERING PROCESS	RESPONSE/MESSAGE	COMMENTS
Answering Service or Hospital Service	Caller transferred directly to provider	
	Service pages the provider on call (see comments)	A provider or clinical staff person is expected to return the call within 30 minutes.
Answering Machine	Message must provide the caller with a way to reach the provider on call by telephone or pager	Provide clear instructions on how to record a message on a pager (i.e., "you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A provider or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment)	A provider or clinical staff person is expected to return the call within 30 minutes.

4.2 TREATMENT INFORMATION AND PATIENT PRIVACY

Consent is required for release of treatment information

Under Federal and state laws, providers of substance abuse and mental health treatment may be required to obtain members' written consent before releasing certain mental health and substance abuse information to insurers and/or to other health care providers for the management of patient care.

As a contracted provider, it is your responsibility to obtain appropriate consent for release of information.

Restrictions on substance abuse information

Pennsylvania Code Subsection 255.5(b) limits the substance abuse treatment information providers can release to an insurer, even with written member consent. Providers practicing in Pennsylvania are advised to ensure that the information they communicate to Highmark Behavioral Health Services is compliant with these regulations.

When practicing in any of Highmark's service areas, contracted providers are expected to be compliant with any applicable federal or state regulations.

4.2 BEHAVIORAL HEALTH PROVIDER AND PCP COMMUNICATION

Introduction

Patient care and clinical outcomes are enhanced when health care professionals share information and coordinate patient care. Communication between behavioral health providers and PCPs is vital, especially when medications are prescribed or changed or when counseling is provided.

Open and timely communication is particularly important considering that members may contact their behavioral health providers without coordinating care with PCPs.

Member consent

The member's consent may be required to permit the behavioral health provider to release certain information to the PCP. The member should be informed of your policy about sharing information with other health care professionals involved in coordinating treatment.

If a patient refuses to give consent, the behavioral health provider should document this refusal in the patient's behavioral health treatment record.

Behavioral health provider and PCP communication

Highmark's network participating behavioral health providers and PCPs are encouraged to communicate with one another to ensure continuity and coordination of care for members.

Member's role in communication

Neither PCPs nor behavioral health providers should require members to take responsibility for communicating findings, reports, lab results, etc. to another provider.

Communication procedure

PCPs and behavioral health providers should communicate in the following ways to ensure continuity of patient care, provided patient consent has been granted:

- If the PCP has directed the member, the PCP should provide relevant clinical information to the behavioral health provider before the member's visit to the provider. Acceptable forms of communication are formal letter and/or copies of relevant portions of the patient's medical chart.
- Within one week after the second visit and/or after changes in the member's treatment or condition, the behavioral health provider should provide the PCP with information about his or her visit with the member, with the member's consent if applicable, using the same forms of communication.

Continued on next page

4.2 BEHAVIORAL HEALTH PROVIDER AND PCP COMMUNICATION,
Continued

What should be communicated?

The following list indicates the type of information that may be communicated:

- Clinical findings/diagnosis (include written description in addition to diagnosis code)
- Test results
- Treatment plans
- A summary report at the conclusion of the treatment period

What Is My Service Area?

Form available for PCP communication

The **Communication Document for Behavioral Health Specialists to Primary Care Physician** has been developed to help the behavioral health provider communicate clinical information to the PCP. This form is also available on the Provider Resource Centers in Pennsylvania – select **FORMS**, and then **Behavioral Health Forms.**

The form is not required. Behavioral health providers can choose to communicate all of the information included on the form via another written format. Acceptable formats include typed letters, physician forms, and progress notes.

4.2 DOCUMENTATION STANDARDS FOR OUTPATIENT SERVICES

Overview	When providing outpatient behavioral health services to Highmark members, progress notes must be documented for each office visit or encounter. Clinical documentation should be created at the time of services and/or before a claim is submitted to Highmark.
Initial evaluations	Initial evaluations must have a comprehensive history, full mental status exam, and a treatment plan documented. If the services are performed by a licensed or certified therapist under the supervision of an eligible professional provider, the initial evaluation must include the signature of the supervising provider.
Minimum documentation standards for outpatient office visits	The provider's progress notes for outpatient office visits should, at a minimum, include the following information: • Member's name • Date of service • Length of session (if billing code submitted is time dependent) • Therapy/modality utilized • Appropriate subjective and objective data • Assessment • Treatment plan

4.2 INPATIENT CONSULTATIONS FOR PATIENTS ON MEDICAL UNITS

Determining whether authorization is required

Some patients admitted to a medical unit may require a psychiatric consultation. Whether authorization is required for an inpatient consultation depends on the credentials of the performing provider:

If the inpatient consultation is performed by...	Then...
Psychiatrist	Authorization is **NOT** required
Psychologist	Authorization is required

What Is My Service Area?

Process

STEP	ACTION
1	To request authorization for psychiatric consultation with a patient in an acute care medical unit, the provider calls Highmark Behavioral Health Services at: • PA Western & Northeastern Regions: **1-800-258-9808** • PA Central Region: **1-800-628-0816** • Delaware: **1-800-421-4577** • West Virginia: **1-800-344-5245**
2	The Highmark Behavioral Health Care Manager gathers the following data about the request: • Patient's location • Source of the referral for the psychiatric consultation • Reason for the consultation
3	The Highmark Care Manager enters an authorization for CPT code 99254.

4.2 FOLLOW-UP APPOINTMENTS AFTER HOSPITALIZATION

Overview	Ensuring that behavioral health patients receive appropriate care after an inpatient stay can be challenging. Patient failure to keep an initial outpatient appointment following discharge has been linked to a high risk of relapse and re-admission. Therefore, Highmark has been working to help members who receive such treatment stay connected to the behavioral health care network following discharge in an effort to improve their health and quality of life.
Discharge planning	Discharge planning should begin prior to or upon admission to an inpatient facility. At the time of precertification, the behavioral health care manager discusses discharge planning barriers and assists with any discharge needs.
Follow-up appointment important	To increase the likelihood that a member being discharged from inpatient behavioral health services will receive appropriate aftercare, it is very important that the member leave the hospital with a follow-up outpatient appointment.
Member contact after inpatient discharge	Upon a mental health inpatient discharge, a Highmark behavioral health specialist will attempt to make a post-discharge call to the member. When post-discharge contact is made, the behavioral health specialist will verify that a follow-up appointment has been made or, if necessary, assist the member in obtaining an appointment. The behavioral health specialist will provide education about the importance of adhering to scheduled appointments and will work with the member to resolve any barriers. They will also discuss any questions the member may have regarding discharge instructions, medication changes, and/or any other issues of concern to the member.
When medication is prescribed	The follow-up appointment is particularly important when a patient is discharged with a prescription for psychotropic medication. Follow-up care should be arranged with a behavioral health provider.
If a follow-up appointment is not made	If a member leaves an inpatient facility without an appointment for any reason, the Highmark behavioral health specialist will assist the member with obtaining follow-up services.

Continued on next page

4.2 FOLLOW-UP APPOINTMENTS AFTER HOSPITALIZATION,

Continued

Continuing care coordination	Highmark is committed to working with providers to support members in maintaining the gains made during their inpatient treatment. If the member does not keep the scheduled follow-up appointment, please make every effort to reschedule as soon as possible.