

Section 7: Behavioral Health Services

Definition of Behavioral Health

Behavioral Health Services are services for any mental health diagnosis, any substance abuse diagnosis, or any combination thereof. Substance abuse includes drug and alcohol abuse, and the detoxification and withdrawal treatment that may be required.

Referral Authorizations for Behavioral Health Services

DCHP members do not require referral authorizations for **initial evaluation** from an in network behavioral health provider. Following the initial evaluation, the behavioral health provider must contact DCHP for ongoing services, including the initial evaluation. It is necessary for DCHP to require authorizations to ensure that benefit limits are not exceeded. PCP referral is not required for members to access BH services.

PCPs may provide Behavioral Health Services for members, if it is within the scope of his/her practice. A referral for BH services is not required for treatment and management for members with BH diagnosis.

Pre-authorization

Pre-authorization is required for inpatient mental health hospitalizations, inpatient detoxification, chemical dependency rehabilitation, partial hospitalization, intensive structured outpatient and outpatient practitioner referrals, except for initial evaluation. Case Managers have the authority to approve all situations that meet criteria and refer potential denials or questionable cases to the Medical Director or Associate Medical Director for review. A Case Manager, or a Crisis Intervention Specialist (from 24/7 BH hotline) after hours, manages all requests for any treatment that is urgent or emergent. A Case Manager has the authority to approve all requests for pre-authorization using the Medical Necessity Criteria. A Case Manager manages all inpatient and outpatient requests. The Texas Referral Authorization Form is required for pre-authorization request by calling or faxing to the numbers shown on this page. A referral to a licensed psychologist is appropriate when psychological testing is indicated.

DCHP Provider Services 1-877-DCH-DOCS (324-3627)

Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)

Case Management: 1-877-222-2759 (FAX 1-866-741-5650)

CHIP Member Services: 1-877-451-5598 STAR Member Services: 1-877-220-6376

Member Services FAX: 361-904-0187

CHIP 24 Hour Behavioral Health Hotline: 1-877-330-3312

STAR 24 Hour Behavioral Health Hotline: 1-877-224-4142

Psychological testing pre-certification can be obtained by the provider faxing a pre-certification for psychological testing form to the Behavioral Health Case Management department for approval prior to testing being initiated.

Concurrent Review

Case Managers conduct frequent concurrent review via telephone on all members admitted to inpatient mental health hospitalizations, inpatient detoxification, chemical dependency rehabilitation, partial hospitalization and intensive outpatient treatment. Concurrent review includes review of medical necessity, discharge planning and researching, and coordinating alternatives to inpatient care. Case Managers use the Medical Necessity Criteria to assist with all concurrent review determinations. The Case Managers are responsible for ensuring that the member's treatment is appropriate and effective. A Medical Director or Associate Medical Director is available to review difficult cases and reviews all potential denials or questionable cases. Concurrent review of outpatient services is managed through a written request from the treating provider for additional sessions citing the clinical criteria including current mental status, treatment goals and progress towards meeting the treatment goals. Case Managers review the requests against predetermined criteria for authorization. The purpose of the concurrent review function is to continue coordination of patient care with the treating facility or provider to determine the best course of treatment for the member.

Retrospective Review

Retrospective reviews are conducted upon request to determine the medical necessity of treatment that was rendered without pre-authorization. Case Managers have the authority to approve all treatment that meets the Medical Necessity Criteria and refer potential denials or questionable cases to a physician reviewer for review.

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Case Management

Case management addresses a member's longitudinal course of care including continuity and coordination among practitioners and sites of care both within behavioral health and between behavioral health and physical health. Case management includes assisting members to access behavioral health care within the most efficient time frame by the most appropriate practitioner or in the most appropriate treatment setting. This includes assisting and encouraging members to have seven (7) and thirty (30) day follow-up after inpatient stay. It is necessary to promote efficient use of benefits to maximize member and family access to necessary care. In addition, DCHP has implemented intensive case management for members who have been identified as high risk due to diagnosis, multiple admissions, life threatening suicide attempts or who require additional services and have complicating factors that, without intensive intervention coordinated by DCHP, would result in further deterioration in the severity of illness.

Triage and Initial Assessment

DCHP has clinicians available 24 hours a day, seven days a week to assist members with referrals to practitioners, referrals to facilities, urgent or emergent care and crisis calls. The Customer Service Representative verifies eligibility and answers benefit inquiries during operational business hours (Monday through Friday, 8:00 to 5:00). The Case Managers or Crisis Intervention Specialist (through the BH hotline) assists members with clinical determinations, urgent and emergent care, crisis calls and referrals to facilities. The goal of the referral and triage process is to provide accurate information and referrals to appropriate providers.

Utilization Decisions

Consistency of Application of UM Criteria

DCHP Medical Necessity Criteria are used for all utilization management decisions that are clinically based. The criteria is used by utilization and case management staff and by the Medical Director/Associate Medical Director. All pre-authorization, concurrent, and retrospective review decisions as well as appeal determinations will reference the appropriate medical necessity criteria and indicate why the criteria were met or not met.

Denials

The Associate Behavioral Health Medical Director or his designee reviews all potential denials.

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A physician makes all medical necessity denial determinations for inpatient mental health and chemical dependency partial hospitalization, intensive structured outpatient and outpatient services provided by a physician. The physician may contact the provider requesting services for additional information or to discuss alternatives to care. The provider requesting services may request to consult with the DCHP Medical Director or Associate Medical Director. The Medical Director or Associate Medical Director will make at least two (2) attempts to contact the member's provider regarding a denial. Members and providers receive written notification of all denials. Denial notifications include the reason for the denial and instructions for requesting an appeal.

Appeals

Members, providers, or providers/someone acting on behalf of the member, may appeal denial decisions. Expedited appeals are available when an adverse determination is made prior to or during a course of inpatient, residential, partial hospital or intensive outpatient treatment or during a course of traditional outpatient treatment, and there is reason to believe that delaying the appeal decision might seriously jeopardize the life or health status of the member or when an adverse determination has been made related to emergency care or care of a life-threatening condition. Expedited appeals are processed within 24 hours by the Medical Director or Associate Medical Director. Standard appeals are available when an adverse determination or administrative denial determination is made prior to or during a course of inpatient, residential, partial hospital or intensive outpatient treatment, or prior to or during a course of outpatient treatment or when the member would like to continue in treatment with a participating provider following an adverse determination. Standard appeals are processed within thirty (30) calendar days by a physician in the same or similar specialty. Appeals received from a member or on behalf of a member are offered the internal level of appeal. If the denial was for inpatient stay, or other hospitalization, an expedited appeal may be requested. Appellant may also request an Independent Review Organization (IRO), instead of an expedited appeal. Appellant may also request a specialty review if requested in writing (within ten working days of the adverse determination). The IRO appeal may be requested by contact DCHP and completed the appropriate forms that are then submitted to the Texas Department of Insurance. For more information regarding appeal process, contact Provider Services.

DCHP 24-hour/7 days a week Behavioral Health Crisis Hotline

The member may call the crisis hotline phone number 24/7 at **1-877-330-3312 (CHIP)** or **1-877-244-4142 (STAR)**, which is listed on the members ID card, and a Crisis Intervention Specialist will be available to screen the needs of the member and direct the member for an initial psychiatric or therapist evaluation. An authorization is not required for initial evaluation. Once member is seen, it is the responsibility of the contracted provider to fax a completed Texas Referral Authorization Form to the Utilization Management prior authorization number shown

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on this page for continued recommended treatment visits.

The following circumstances indicate that a referral to a physician is recommended:

- The member is receiving psychoactive medication for an emotional or behavioral problem or condition.
- The member has significant medical problems that impact his/her emotional well-being.
- The member is having suicidal and/or homicidal ideations.
- The member has delirium, amnesia, a cognitive disorder, or other condition for which there is a probable medical (organic) etiology.
- The member has a substance use disorder such as substance-induced psychosis, substance-induced mood disorder, substance-induced sleep disorder, etc.
- The member has or is likely to have a psychotic disorder, major depression, bipolar disorder, panic disorder, or eating disorder.
- The member is experiencing severe symptoms or severe impairment in level of functioning or has a condition where there is a possibility that a pharmacological intervention will significantly improve the member's condition.
- The member has another condition where there is a significant possibility that somatic treatment would be of assistance. Conditions include dysthymia, anxiety, adjustment disorders, post-traumatic stress disorders, and intermittent explosive disorders.

DCHP Behavioral Health Services Program

Behavioral Health Services are covered services for the treatment of mental emotional disorders and for chemical dependency disorders for both CHIP and STAR members of DCHP.

Primary Care Providers (PCPs) are responsible for coordinating Members' physical and behavioral health care, including making referrals to in-network Behavioral Health providers when necessary. In addition, PCPs must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and

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governmental agencies, such as the National Institute of Health. PCPs may provide behavioral health related services within the scope of their practice.

- All services including pre-authorization related to behavioral health must be coordinated through DCHP.
- For mental health services not covered by Medicaid/STAR, the member must access local resources. DCHP Case Managers can assist the member in locating these resources.
- A list of local resources for behavioral health care alternatives is available through the following public resources:
 - The local Department of Health Services offices
 - The local Public Library
 - The Finding Help in Texas website--www.findinghelpintexas.com

Mental Health and Mental Retardation (MHMR) will accept patients with the primary diagnosis of schizophrenia, bi-polar or severe major depression, along with many other behavioral health diagnoses (ADD, ADHD, post traumatic stress disorder, etc.).

Covered Behavioral Health Services

These services include:

- Inpatient Mental Health Services for children (under age 21 for STAR)
- Outpatient Mental Health Services for children (under age 21 for STAR)
- Inpatient Substance Abuse Treatment Services for children (under age 21 for STAR)
- Outpatient Substance Abuse Treatment Services for children (under age 21 for STAR)

For details about these covered benefits, see Section 4 on Covered Benefits, of this manual.

Responsibilities of Behavioral Health Providers

Behavioral health providers and/or physical health providers who are treating a behavioral health condition, are responsible for appropriate referrals to the Department of Protective and Regulatory Services (DPRS) for suspected or confirmed cases of abuse.

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They are also responsible to assure that any necessary pre-authorization takes place and for the following:.

- Assure the release of information consent form is signed by the member.
- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment; and
- Only provide physical health if a behavioral health provider is licensed to do so;
- Ensure that its patients know of, and are able to avail themselves of, their rights to execute Behavioral Health Advance Directives;
- Assure All STAR and CHIP Members that receive inpatient psychiatric services are scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- Have policies and procedures in place on how to follow-up on member missed appointments;
- Contact Members who have missed appointments within 24 hours to reschedule appointments;
- Make available to PCPs BH assessment instruments;
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of member's behavioral health status to the PCP; and
- Refer the member for needed lab and ancillary services that are at a location that is at a convenient location if not available in the provider's office.

DMS-IV Coding Requirements

Behavioral health documentation and referral requests should include DMS-IV multi-axial classifications. Subsequently, behavioral health claims should be filed using the applicable and appropriate DSM IV diagnostic code to define the patient's condition being treated.

Laboratory Services for Behavioral Health Providers

Behavioral health providers should facilitate provision of in-office laboratory services for behavioral health patients whenever possible, or at a location that is within close proximity to the behavioral health provider's office. Providers may refer members to any network independent laboratory for needed laboratory services.

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Court-ordered Services and Commitments

A Member under the age of 19 who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code must receive the services ordered by that court of competent jurisdiction. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. The Member cannot appeal the commitment through the complaint or appeals process. DCHP is responsible for covering court-ordered commitments, until the Member's benefit has been exhausted.

Confidentiality of Behavioral Health Information

The provider is required to obtain consent for disclosure of information from the member in order to permit the exchange of clinical information between the behavioral health provider and the member's physical health provider.

If the member refuses to sign a release of information, they documentation will need to indicate that they refused to sign. In addition, the provider will document the reasons for declination in the medical record.

Behavioral Health reports and focused studies

Driscoll Children's Health Plan routinely monitors members with BH diagnosis for follow-up care within seven (7) and thirty (30) days of being discharged from an inpatient stay. This information is also tracked by HHSC to monitor member compliance with follow-up visits. Members with BH diagnosis are also monitored for readmission to inpatient facility. Results of these reports and focused studies are available to providers upon request.

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