Table of contents

Welcome

Thank you for joining our network. Independence Blue Cross (IBX) is committed to building collaborative relationships with behavioral health Providers to help ensure quality, equitable care.

Please take time to familiarize yourself with the Behavioral Health section of the Provider Manual, as we've included important information to help you work with us.

Overview

With a commitment to whole person health, IBX contracts and manages our own behavioral health network. This approach to behavioral health takes a Member's whole health and their equitable access to care into account. It is intended to help guide care journeys for our Members that have more acute and chronic care needs. It will also ensure seamless handoffs to IBX case managers for follow-up support.

IBX contracts directly with behavioral health Providers to develop and manage the mental health, substance abuse, and behavioral health benefits for the majority of our Members with HMO, POS, PPO, EPO, Federal Employee Program (FEP), and Traditional (Indemnity) coverage.

IBX's core service offerings include a focus on equitable access to care, care navigation, and managing the connection between behavioral and physical health for both acute and chronic care needs.

In addition, IBX offers a Mental Health Incentive Program (MHIP). The MHIP is comprised of two separate and distinct programs utilizing quality metrics for:

- Mental health outpatient/professional practices
- Mental health inpatient facilities

Both programs exclude substance use disorder (SUD) treatment services. These programs will ensure that practices and facilities are providing quality mental health care and effectively managing the care of their patient population.

Learn more by reviewing the *Behavioral Health resource page* on the Provider News Center.

Key resources

IBX provides a variety of resources listed below:

- *Claims and Customer Service contact information*
- General inquiries and/or questions about contracts
- *Credentialing process*
- *Enroll in our Provider Engagement, Analytics & Reporting (PEAR) portal*
- *Common Provider forms*
- Clinical practice guidelines
- *Behavioral Health FAQs*

Behavioral Health Case Management

Behavioral Health Case Management activities are provided by licensed behavioral health case managers and registered nurses. An essential part of our behavioral health case management program is our integrated physical and behavioral health approach. Our Care Management program cohesively supports the whole person, including behavioral health, preventive health,

new diagnosis, and/or managing chronic or complex health situations. We look at the entire health care continuum to address each and support the whole person, looking at the person's medical condition from all perspectives and providing longitudinal support.

Our Behavioral Health Case Managers are particularly knowledgeable about the resources available in the region and the challenges to accessing needed care. An important part of behavioral health case management is integrated communication between Behavioral Health Case Managers and their medical care management counterparts, Registered Nurse Health Coaches, as well as coordination among all those involved in a Member's treatment.

The behavioral health team works collaboratively with the Plan Care Management team to identify and appropriately refer Members to ensure optimal medical and behavioral health status.

You may refer a Member for Case Management by calling 1-800-688-1911.

In addition, our clinical triage unit, consisting of licensed behavioral health clinicians who are experienced in managing crisis situations, are available to our Members.

The Clinical triage team works hand in hand with customer service to address clinically escalated cases, provide in-the-moment crisis management, and assist with connecting Members to care. The team is knowledgeable in de-escalation, assessment, and resource identification for expedited connection to care.

Triage Case Managers use established screening tools for suicide and SUD that assist with identifying urgency, assess needs, and offer appropriate treatment options, including warm hand offs to available quality Providers.

Members who need ongoing care management are referred to the Behavioral Health Case Management team. The Plan also promotes use of digital tools and other self-service resources to continue to improve the Member experience.

Emergency admissions

Preapproval/Precertification for Emergency admissions is not required. However, hospitals are required to notify IBX — using PEAR Practice Management (PM) — of all Emergency admissions within two business days of admission. If PEAR PM is not available, please contact the Utilization Management (UM) department at 1-800-ASK-BLUE to provide notification.

When submitting the initial authorization request for an Emergency inpatient admission, we require that a full 24 to 48 hours of clinical treatment and patient response be provided. This information can be submitted to us via phone, fax, or secure email.

Obtaining behavioral health services

Utilization Management

IBX performs UM for select behavioral health services, with the exception of Applied Behavioral Analysis (ABA) services, which is provided by Magellan Healthcare, Inc. ("Magellan"), an independent third-party company.

Providers should instruct Members to call the mental health/substance abuse services telephone number on their Member ID card to access behavioral health services. IBX will provide information for Members to contact for services. Members can also search for a behavioral health Provider by using the online Find a Doctor tool at *ibx.com*.

Preapproval/Precertification and continuing authorizations are not required for routine and medication management outpatient behavioral health services under most IBX benefits plans.

However, Preapproval/Precertification *is required* for inpatient services, residential treatment, partial hospitalization, intensive outpatient, ABA services (provided by Magellan), and Transcranial Magnetic Stimulation (TMS) services. When you call 1-800-688-1911 to obtain an authorization, you will speak to an IBX authorization intake specialist.

Benefits vary based on plan type and employer group. Not all employer groups use IBX for behavioral health benefits. Providers should verify benefits and eligibility by using our *PEAR portal* or by contacting IBX.

Note: When HMO, POS, PPO, and EPO Members receive services from an IBX Provider, the Provider is responsible for obtaining any required Preapproval/Precertification.

HMO/referred (in-network) POS Members

In order for HMO/referred (in-network) POS Members to receive in-network behavioral health benefits, they must use an IBX HMO/referred (in-network) POS Provider. Members can select any participating IBX HMO/referred (in-network) POS network Provider.

All HMO/referred (in-network) POS inpatient, nonEmergency admissions, Partial Hospitalization Programs, Intensive Outpatient Programs, TMS, and home health services must be Preapproved/Precertified. To Preapprove an admission or Partial Hospitalization Program, Intensive Outpatient Program, TMS, or home health service, contact IBX. For ABA services, contact Magellan.

Preapproval/Precertification is *not* required for outpatient routine behavioral health visits or outpatient office treatment for SUD.

Claims submission

IBX is responsible for receiving and paying all claims from behavioral health Providers for IBX Members, including the claims for Members enrolled in HMO/POS and Children's Health Insurance Program (CHIP) benefit plans. Refer to the payer ID grids located at *ibx.com/edi* for the appropriate claims submission information.

PPO/EPO Members

In order for the majority of Members with PPO or EPO coverage to receive in-network behavioral health benefits, they must use the IBX PPO Provider network. Please note that Members with EPO coverage do not have out-of-network behavioral health benefits.

Claims submission

Refer to the payer ID grids located on *ibx.com* for the appropriate claims submission information for PPO and EPO Members.

FEP PPO Members

In order for Members with FEP PPO coverage to receive in-network behavioral health benefits, they must obtain Preapproval/Precertification for inpatient services.

Professional behavioral health services

- FEP Members must use the Highmark Blue Shield Premier Blue Mental Health and Substance Abuse professional Provider network.
- Benefits and eligibility must be obtained from Highmark Blue Shield's Behavioral Health Services unit at 1-800-258-9808. FEP Member eligibility can also be verified by contacting FEP Customer Service at 215-241-4400.

Facility behavioral health services

- FEP Members must use the IBX PPO facility Provider network to receive in-network

behavioral health benefits. Benefits vary based on FEP plan type. All inpatient services must be Preapproved/Precertified by calling IBX.

- Benefits and eligibility can be verified by contacting FEP Customer Service at 215-241-4400.

Claims submission

Refer to the payer ID grids located on *ibx.com* for the appropriate claims submission information for FEP PPO Members.

Traditional (Indemnity) Members

IBX also manages the behavioral health benefits for Traditional Members.

Claims submission

Refer to the payer ID grids located on *ibx.com* for the appropriate claims submission information for Traditional Members.

Network requirements

Access to care: Outpatient appointment and availability standards

To ensure that Members have adequate and timely access to appropriate care, participating Providers are expected to maintain the following standards of availability for appointments:

- Respond within 24 hours to a Member's request for outpatient care.
- Respond within 48 hours to calls from Members in care with the Provider or practice and communicate this response timeframe to new Members and in voicemail recordings.
- Offer appointments as follows:
  - **Initial Routine**: Within 10 business days of the request for Routine Mental Health and SUD.
  - **Follow up Routine**: Within 20 days from the initial visit for non-prescribers and 30 days from the initial visit for prescribers.
  - **Urgent**: Within 48 hours of the request in an urgent situation or from an urgent Referral from IBX.
  - **Emergent**: A Member should be seen within six hours of a non-life-threatening Emergency. An immediate appointment should be offered for a life-threatening Emergency, or the Member should be referred to an appropriate Emergency service Provider, local crisis center, or Emergency department.
- Within seven days, provide follow-up care after hospitalization or Emergency department discharge for mental health conditions or SUD.
- **After Hours and Emergency Care**:
  - Professional Providers shall maintain coverage 24 hours a day, seven days a week, or offer reliable 24-hours-a-day, seven-days-a-week live answering service or voicemail message, whereby Members can receive instructions for how to access assistance in an urgent or Emergency event.
- During the course of care, Providers are expected to continually assess the urgency of the Member's needs and provide services within the timeframe that meets the clinical urgency.

Services rendered by supervising Practitioners

To support access to behavioral health care services, IBX allows reimbursement for services provided by some supervised social workers, therapists, and counselors as long as they are supervised and billed by the supervising, credentialed, and contracted Practitioner. LSWs or LMSWs are Providers who have graduated from social work or social welfare master's degree programs and are in the process of meeting applicable requirements to be licensed as a

Licensed Clinical Social Worker ("LCSW") under the state laws and regulations in which they practice. This includes clinical practice under the supervision of a Supervising Provider of the same state (PA, NJ, DE, or MD).

LAMFTs are licensed as an associate marriage and family therapist and are obtaining supervised clinical experience for the purpose of becoming a Licensed Marriage and Family Therapist under the state laws and regulations in which they practice.

LAPCs are licensed as an associate professional counselor and are obtaining supervised clinical experience for the purpose of becoming a Licensed Professional Counselor under the state laws and regulations in which they practice.

This provision applies only to Commercial Members.

It does not apply to:

- Medicare Advantage
- Members where IBX is secondary
- Where coordination of benefits applies

To be eligible for reimbursement, supervised social workers, therapists, and counselors, as well as their Supervising Provider, must fulfill the following requirements for supervised services:

- The supervised LSW/LMSW, LAMFT, or LAPC must be employed by and work under the supervision of a contracted and credentialed IBX Provider.
- The Supervising Provider, who must be contracted and credentialed, is required to comply with state regulations and requirements, including all state codes pertaining to qualifications and standards for supervisors.
- Services provided must include covered services and be billed by the Supervising Provider (again, credentialed and contracted) using modifier AJ to identify that the Member was treated by another Practitioner under the supervision of the identified rendering Practitioner.
- The Supervising Provider or practice must have procedures in place to ensure that Members are screened, assessed, and appropriately assigned treatment with a provisionally licensed Practitioner.
- The participating Provider must conduct verification for each non-credentialed Provider's training and education.
- Any IBX Member being treated by a provisionally licensed LSW/LMSW, LAMFT, or LAPC practicing under the supervision of a Participating Practitioner must:
  - Be informed of the supervisory relationship;
  - Be provided with the supervising Practitioner's contact information; and
  - Provide written consent to treatment with the provisionally licensed Practitioner.

Labs

Lab benefits should be checked for all Members.

- HMO Members must utilize the appropriate capitated labs designated by their primary care physician.
- All other Members must utilize an IBX participating lab site.

On-site, basic urine drug screening tests shall be considered a Covered laboratory Service and shall be included in the per diem rate. In the event that more extensive laboratory services are required beyond what the Provider is able to perform on-site, Providers shall refer Members to a Participating laboratory Provider in the Member's health plan network.

The in-network laboratory Provider is responsible for billing the health plan for Covered Services rendered to IBX Members.

For Intensive Outpatient Programs (IOP) for a behavioral health or SUD diagnosis, the per diem rates are inclusive of all therapy, clinical, ancillary, diagnostic, and professional services, including but not limited to a basic on-site urine drug screening test.

PCP and Behavioral Health Provider communication

Our *Clinician Collaboration Form* gives Providers the opportunity to communicate vital information to behavioral health Providers. The form can be downloaded from our website at *ibx.com/providerforms*. The form can also be filled out electronically for medical record keeping and electronic transmission purposes.

The form can aid Providers in discussions with patients about behavioral health treatments and promote collaboration in care between primary care Providers and behavioral health Providers.

The form supports the exchange of relevant health information between Providers and includes medication use (to avoid contraindications), past and present medical conditions, allergies, relevant laboratory results, and contact information for the referring Physician.

Providers must secure patient consent to forward personal information.

Autism coverage

The diagnosis and treatment of autism spectrum disorders (ASD) are covered for IBX Members enrolled in a 2+ fully insured commercial group product or CHIP. Before you provide care related to ASD, be sure to verify Member eligibility through Practice Management on the PEAR portal.

Coverage is provided for enrolled individuals under age 21* and requires coverage for the following:

- Evaluations and tests needed to diagnose an autism disorder;
- Medically Necessary prescribed treatments such as ABA and rehabilitative care, blood level tests, psychiatric and psychological services, speech/language therapy, occupational therapy, physical therapy, and prescription drugs.

Services not covered under the Commonwealth of Pennsylvania autism mandate include benefits that are normally excluded from coverage under the Member's medical plan, including services that are not Medically Necessary.

Services for ASD must be Medically Necessary and must have a primary diagnosis of ASD. Depending on the service that is being requested, the Member, or a health care Provider on a Member's behalf, may be required to submit a treatment plan to IBX once every six months for review and approval. Services for ASD will not be subject to any limits on the number of visits.

However, services are subject to applicable Member cost-sharing, policy limits, maximums, exclusions, and Precertification and Referral requirements under the Member’s benefits program.

Self-funded employer groups may elect to cover the diagnosis and treatment of ASD.

**Coverage ends on the Member’s 21st birthday. There is no age limitation for small group (2-50) Members; Members of all ages are eligible to receive benefits.*

Applied Behavioral Analysis

Methodologies to promote learning are believed to enhance verbal and non-verbal communication, improve developmentally appropriate self-care, teach social skills, and reduce maladaptive behaviors (e.g., harm to self or others). These methodologies are based on several model programs, including behavioral, structured teaching, and/or developmental programs.

As set forth in the medical policy for evaluation and management of ASD, coverage of ABA services is contingent on the following:

- A current (within 24 months), documented diagnosis of ASD consistent with the DSM-5 criteria, using validated assessment tools, has been made by a qualified licensed treating professional Provider including a Physician, Physician assistant, psychologist, or certified registered nurse practitioner as is consistent with state licensing requirements.
- The qualified licensed treating professional Provider is other than the behavior analyst Practitioner performing services related to ABA services.
- An individualized, documented treatment plan has been developed by a licensed professional Provider (e.g., MD/DO, licensed psychologist).
- ABA services must be provided by or under the supervision of the following professionals: a Board-Certified Behavior Analyst-Doctoral (BCBA-D) or Board-Certified Behavior Analyst (BCBA)-graduate-level certification in behavior analysis.
- Must be approved by Magellan on behalf of IBX.

For specific coverage information regarding the diagnosis and treatment of ASD, review our medical policy at *ibx.com/medpolicy*. Note that our policy is consistent with applicable state mandates.

Psychological testing

While psychological testing does not require prior authorization, the individual's medical record must reflect medical necessity for the care provided. Please consult IBX medical policy for details on medical necessity and benefit coverage information.

Tele-behavioral health services

In addition to telemedicine services for physical health, tele-behavioral health services are available to IBX Members from IBX Providers Tele-behavioral health care is defined as behavioral health services delivered through interactive telecommunications when the Member and the behavioral health Provider are not in the same physical location.

Telecommunications must be the combination of audio and live interactive video and delivered via a HIPAA-compliant platform. This benefit is available to all Members enrolled in an IBX health plan that offers behavioral health services. Members must have outpatient mental health benefits through their benefit plan with Independence Blue Cross/Keystone Health Plan East.

Coverage for tele-behavioral health services may vary among plans. It is important for Providers to verify coverage prior to rendering tele-behavioral health services. Providers can check the Member's behavioral health coverage using the *Eligibility & Benefits* transaction on PEAR PM.

Additional requirements for telemedicine only services

Practitioners who provide telemedicine services only must be licensed in the state in which the Member to whom the services are provided is located. Practitioners shall be prohibited from providing services to Members in states in which the Practitioner is not licensed.