



**BlueCross BlueShield
of Illinois**

Blue Cross and Blue Shield of Illinois Provider Manual

Behavioral Health Program 2018

Confidential and Proprietary

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Behavioral Health Program (Mental Health and Substance Use Disorder)

The Blue Cross and Blue Shield of Illinois (BCBSIL) Behavioral Health (BH) Program encompasses a portfolio of resources that help BCBSIL members access benefits for behavioral health (mental health and substance use disorder) conditions as part of an overall care management program. BCBSIL has integrated behavioral health care management with our member Blue Care Connection® (BCC) medical care management program to provide better care management services across the health care community. It also allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

The BCBSIL BH Team utilizes nationally recognized, evidence based and/or state or federally mandated clinical review criteria for all of its behavioral health clinical decisions.

For its group and retail membership, BCBSIL licensed behavioral health clinicians utilize the MCG™ care guidelines for mental health conditions. BCBSIL BH licensed clinicians utilize the American Society of Addiction Medicine's (ASAM's) *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* for addiction disorders. In addition to medical necessity criteria/guidelines, BH licensed clinicians utilize BCBSIL Medical Policies, nationally recognized clinical practice guidelines (located in the Clinical Resources section of the BCBSIL website) and independent professional judgment to determine whether a requested level of care is medically necessary.

The appropriate use of treatment guidelines requires professional medical judgment and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the health care delivery and management process that should include consideration of the individual circumstances of any particular member. The guidelines are not intended as a substitute for this important professional judgment.

The availability of benefits will also depend on specific provisions under the member's benefit plan.

BCBSIL manages behavioral health care services for most **non-HMO** members who have behavioral health benefits (such as BCBSIL PPO and Blue Choice PPOSM members). **Exception:** Behavioral health care services for some employer groups are managed by other behavioral health vendors. If there are questions, call the number on the member's ID card.

BCBSIL also manages behavioral health care services for **Federal Employee Program (FEP)** members. FEP members must request benefit preauthorization for Applied Behavior Analysis (ABA) services but are not required to request benefit preauthorization for any other outpatient behavioral health services, including Partial Hospitalization Programs (PHPs).

BCBSIL does **not** manage behavioral health services for **HMO Illinois®**, **Blue Advantage HMOSM**, **Blue PrecisionSM**, **BlueCare DirectSM** and **Blue FocusCareSM**. For these HMO members, BCBSIL has delegated administration of mental health and substance abuse services to each member's Medical Group/Independent Practice Association (MG/IPA).

Benefit Preauthorization Requirements for Behavioral Health Services

Benefit preauthorization is the process of determining whether the proposed treatment or service meets the definition of “medically necessary,” as set forth in the member’s benefit plan, by contacting BCBSIL or the appropriate behavioral health vendor for approval of services. Benefit preauthorization is required to determine that the services are medically necessary, clinically appropriate and supportive of potentially successful treatment outcomes.

Benefit Preauthorization Requirements for Inpatient and Alternative Levels of Care

Benefit preauthorization is required for all inpatient, residential treatment center (RTC) and partial hospitalization admissions.

- Benefit preauthorization for elective or non-emergency hospital admissions must be obtained prior to admission or within two business days of an emergency admission.
- To determine eligibility and benefit coverage prior to service and to determine if RTC services are covered by a specific employer group, members or behavioral health professionals and physicians may call the Behavioral Health number listed on the member’s ID card.

Note: In emergencies, the physician or other professional provider must first ensure that the member is safe. Benefit preauthorization will then occur prior to or concurrent with, but not more than two business days following the admission. A life-threatening emergency or crisis is a condition that requires immediate interaction to prevent death or serious harm to the member or others. It is characterized by sudden onset, rapid deterioration of cognition, judgment, behavior and is time-limited in intensity and duration. Emergency room care does not require benefit preauthorization and is paid at the in-network reimbursement rate for eligible members.

Benefit Preauthorization Requirements for Outpatient Services

The covered behavioral health services listed below require benefit preauthorization before initiation of the service. To request benefit preauthorization for these services, call the number on the member’s ID card, or 800-851-7498.

- Intensive outpatient program (IOP)
- PHP admission – Benefit preauthorization for non-emergency care must be obtained at least one day prior to admission or within two business days of an emergency admission
- Applied Behavior Analysis (ABA) services
- Outpatient electroconvulsive therapy (ECT)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Psychological/Neuropsychological testing in some cases; BCBSIL would notify the provider if benefit preauthorization is required for these testing services

The above requirement applies only for members who have outpatient management as part of their behavioral health benefit plan through BCBSIL.

Additionally, FEP members must request benefit preauthorization for ABA services but are not required to request benefit preauthorization for any other outpatient behavioral health services, including PHPs.

Responsibility for Benefit Preauthorization

Members are responsible for requesting benefit preauthorization for behavioral health services provided by behavioral health professionals, physicians and facilities when benefit preauthorization is required. Behavioral health professionals, physicians or a member’s family member may also request benefit preauthorization on behalf of the member. *BCBSIL will comply with all federal and state confidentiality regulations before releasing any information about the member.*

Process and Associated Steps for Benefit Preauthorization

Behavioral health professionals and physicians should always verify eligibility and benefits prior to providing services:

- **Online** – Submit an electronic eligibility and benefits (HIPAA 270) transaction to BCBSIL via the secure Availity™ Web portal, or through your preferred vendor portal; or
- **Telephone** – Call the number listed on the member’s ID card.

Inpatient – Process

- Members are responsible for requesting benefit preauthorization for inpatient services. Behavioral health professionals and physicians may request benefit preauthorization on behalf of the member.
- Call the appropriate number on the member's ID card.
- All services must be medically necessary.

Inpatient – Failure to Obtain Benefit Preauthorization

- Members who do not request benefit preauthorization for inpatient behavioral health treatment may experience the same benefit reductions that apply for inpatient medical services.
- Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

Outpatient – Process

- When outpatient benefit preauthorization is required, members should call the benefit preauthorization mental health/substance use (MH/SUD) number listed on their ID card. This number directs the benefit preauthorization call to either BCBSIL or to the appropriate behavioral health vendor. Behavioral health professionals and physicians, or the member's family, acting on behalf of the member, may also place the benefit preauthorization call.
- For these outpatient services, benefit preauthorization requires completion of a form(s) for the outpatient service being requested. These forms can be found under the Behavioral Health section on the [Forms](#) page located on the BCBSIL Provider website.
- If ABA benefit preauthorization is required, providers are to follow the protocol outlined in the [Behavioral Health Outpatient Management Program page](#) located on the BCBSIL Provider website.

Outpatient – Failure to Obtain Benefit Preauthorization

- If a member receives outpatient behavioral health services that require benefit preauthorization without requesting benefit preauthorization, the behavioral health professional or physician will be asked to submit clinical information for a medical necessity review. The member will also receive notification.
- Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary. All behavioral health professionals and physicians, both BCBSIL network and out-of-network, must submit clinical information/forms as requested to:

Fax: -877-361-7656	Mail: Blue Cross and Blue Shield of Illinois Behavioral Health Unit P.O. Box 660240 Dallas, TX 75266-0240
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Resources

Additional information on our Behavioral Health Program can be found on our website at bcbsil.com/provider, in the Clinical Resources section. There you can view [Clinical Practice Guidelines](#) for common behavioral health conditions and the [Medical Necessity Criteria](#).

Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any, at the time services are rendered.

MCG (formerly Milliman Care Guidelines) is a trademark of MCG Health, LLC (part of the Hearst Health network), an independent third party vendor. Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity and MCG. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.