BEHAVIORAL HEALTH SYSTEMS

BHS Provider Guide
Authorization and Claims Procedures

Welcome to BHS!

We are pleased that you have chosen to affiliate with our provider network. BHS has been cited as one of the top 25 fastest growing specialty PPOs in the country thanks to the involvement of quality providers such as you. Please take a few minutes to read through this information to familiarize yourself with BHS.

We ask that BHS covered members contact our office prior to receiving behavioral health services. Speaking directly with the member allows us to perform our intake process, verify the member's eligibility, and explain plan benefits and any applicable cost-sharing. Once we have verified eligibility and coverage, we will contact you to schedule the initial appointment, discuss the availability of EAP visits and provide you with copayment, coinsurance, plan deductibles, and any additional benefit information you may need. We will also advise you of any pre-authorization requirements specific to the member's plan and answer any additional questions you may have.

Emergencies

In an emergency, patient safety is the highest priority. Our covered members should first seek the care they need rather than attempt to call the BHS office. The member or a family member should contact us as soon as possible after emergency care has been obtained. However, if a BHS member in crisis calls you or presents to your office, a BHS Care Coordinator will be available should you wish to discuss any crisis services provided, revised treatment recommendations, or to advise us of the patient's condition. A BHS Care Coordinator is available 24 hours a day/7 days a week.

Authorization Procedures

BHS administers many different EAP/Mental Health/Substance Abuse benefit plans. The authorization requirements and covered services may differ from one plan to the next. However, all plans require that any recommended treatment or services be determined medically necessary by BHS either before, during or after care is rendered. BHS evaluates each treatment plan on the basis of problem acuity, degree of functional impairment, and the appropriateness and effectiveness of the treatment that is recommended and/or provided. Each case is individually evaluated and there is no pre-defined course of treatment for "like" conditions.

If the member's plan requires pre-authorization or if you would like a courtesy predetermination of benefits, please take the following steps after completing your initial assessment:

1. Contact the referring BHS Care Coordinator after the initial visit to give your preliminary report and recommendations.
2. Forward the BHS forms (which include the Clinical Assessment Report and Treatment Plan, and Patient Information/ Authorization forms) to our Clinical Services Division by fax or mail.
3. BHS will send you written notification of the authorization of coverage for continued treatment.

Pre-Authorization

Most, but not all, of BHS' clients' benefit plans require pre-authorization of certain outpatient services. These typically include, but may not be limited to, psychological testing, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Intensive Outpatient Programs, and Applied Behavioral Analysis (ABA). Contact BHS for information regarding our pre-authorization forms, review processes and additional instructions if your recommended treatment plan includes any of these treatment services or you would like to confirm whether pre-authorization is required for a particular type or intensity of service.

Authorization for Psychological Testing

If the member's plan requires preauthorization or for a courtesy predetermination of benefits, psychologists should submit the **Psychological Testing Preauthorization Request** prior to conducting any psychological tests.

Authorization for ECT

If the member's plan requires preauthorization or for a courtesy predetermination of benefits, please submit a completed **ECT Preauthorization Request** prior to the initial treatment. If the patient subsequently requires additional treatments, please submit another request form and a note summarizing the patient's progress to the initial treatments.

Required Clinical Documentation

We attempt to keep paperwork to a minimum. These guidelines should assist in identifying which forms, if any, are needed for certain visits:

1. ***Patient Information/Authorization*** – To be completed by the client/patient at the first visit.
2. ***Clinical Assessment Report and Treatment Plan*** To be completed by the treating provider for the following:
   a. The majority of BHS' clients' benefit plans comply with the Mental Health Parity and Addiction Equity Act. For this reason, there is no pre-authorization requirement for most outpatient office-based services such as initial assessment, psychotherapy and evaluation/management of psychiatric medications. For those plans which require outpatient pre-approval, you must complete this form following the initial assessment and submit it to BHS for review and approval. Even for plans that do not require outpatient pre-authorization, you may submit this form to BHS for a courtesy predetermination of coverage.
   b. If at any point in an episode of care it is necessary to determine the medical necessity of the treatment being recommended/provided, BHS will send written notification to you. The notification letter will include a request for an updated Clinical Assessment Report and Treatment Plan. Your updated report must reflect the

patient's current diagnosis, problems, symptoms, areas of functional impairment, and treatment goals and objectives, present at the time your Clinical Assessment Report and Treatment Plan form is completed.

c. Complete and submit this form for BHS' review if you feel the patient requires continued treatment or more intensive treatment than that approved by BHS, or if at any point there is a change in the patient's diagnosis, reported problem, or recommended treatment plan.

Clinical Progress Report To be completed by the provider and submitted to BHS when requested. A progress report may be needed to furnish additional information on patient progress or to confirm the treatment provided is for a covered diagnosis/ condition. Progress Reports may be requested for specific dates of service, or as a summary description of patient progress for a specified period of time.

BHS forms and other clinical information may be sent via confidential fax or by mail. Our fax number and mailing address is shown below.

Continuing Care Certification

For plans requiring precertification, when you feel the patient requires continued therapy or supplementary service beyond what has been approved, forward an updated ***Clinical Assessment Report and Treatment Plan*** to BHS to show the status of the patient and additional treatment recommended. We will send you written notification regarding authorization of the additional treatment.

Claims Processing

BHS strives to provide a paperless claims process to its members. As a BHS preferred provider, you should submit your claims to us using a CMS-1500 or UB-04 claim form as applicable. Since claim filing limits vary for the EAP/Mental Health/Substance Abuse benefit plans BHS administers, we ask that all claims be submitted to us within 90 days of the date of service. If services are denied because your claim is received by BHS after a plan filing limit, please be aware you may not charge a BHS member for the denied services.

BHS utilizes a monthly "batch" claims process. Valid claims for covered services which are received and processed by the 25th day of the month will be paid at the end of the following month. To ensure timely payment for the services you provide, be sure your claim is prepared using complete and accurate information, and it is sent to BHS promptly following each date of service.

We want to strongly encourage you to submit claims electronically through Change Healthcare. The BHS payor ID number is 63100. Should you experience any problems or have questions regarding electronic claim submissions to BHS, contact your practice management system vendor, or call Change Healthcare customer support at 800-845-6592.

If you prefer, paper claims can be sent to BHS by mail or confidential fax. Our mailing address and fax number can be found below.

Claims Processing

1. Submit claims electronically through Change Healthcare. BHS payor ID: 63100
2. Complete a CMS-1500 or UB-04 form using complete and accurate information
3. Send claims by the 25th of each month for prompt payment

Patient Cost-sharing

Each patient's cost-sharing responsibility will vary depending on the benefit plan and type of service. The BHS Care Coordinator will discuss copayment, coinsurance and/or deductible amounts with you at the time each new referral is made. Also, you will be made aware of any available EAP visits, which are covered at 100% by the plan with no patient cost-sharing. Any applicable copay or coinsurance should be collected by your office at the time of each visit. In the event a BHS member contacts you directly and schedules an appointment, call us to confirm eligibility for coverage and specific benefits. In addition, please direct the member to contact our office to speak with a Care Coordinator by calling 800-245-1150.

BHS Follow Up and Care Coordination

BHS' care management activities are intended to support our members' success in treatment and achievement of positive outcomes through adherence to your recommended plan of care. For those patients diagnosed with a serious mental illness, with a history of hospitalization, at high risk of substance abuse relapse, or other conditions considered by BHS to be acute, you can expect to be contacted periodically by one of our Care Coordinators for brief progress updates. Also, the Care Coordinator will assist in the coordination of additional referrals for evaluation or treatment, or in the location of community-based resources necessary to give patients or family members added support during the episode of care.

Peer-to-Peer Review

Should there be a determination not to certify a behavioral health service prior to or during an ongoing episode of care, BHS' medical necessity review process allows you the opportunity for an immediate peer-to-peer discussion with the physician reviewer involved in the initial determination. If the original physician reviewer cannot be available within one business day, BHS will provide you the opportunity to review the determination with a second physician reviewer. Following the peer-to-peer discussion, you will be notified in writing of the determination. In the event the peer-to-peer discussions does not resolve a medical necessity difference of opinion to your satisfaction, you may request an expedited (for emergency or urgent care) or standard appeal.

Communication

We value each and every one of our providers. With this in mind, building a positive relationship with you is among our highest priorities. Please contact us with any questions or suggestions you may have.

Contact BHS

Phone: 800-245-1150
205-879-1150
Fax: 205-879-1178
Mail: Behavioral Health Systems
P.O. Box 830724
Birmingham, AL 35283-0724

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