



MESA MENTAL HEALTH  

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CORPORATE HEALTH RESOURCES

**Practitioner Manual**  
**For**  
**Managed Behavioral Healthcare**

**January 2010**

# TABLE OF CONTENTS

<b>TELEPHONE DIRECTORY.....</b>	<b>1</b>
<b>I.CLINICAL PHILOSOPHY.....</b>	<b>2</b>
<b>II.CUSTOMER SERVICE.....</b>	<b>3</b>
<b>III.PLAN INFORMATION.....</b>	<b>4</b>
<b>IV.INITIAL AUTHORIZATION PROCESS FOR MEMBERS.....</b>	<b>6</b>
<b>V.INITIAL AUTHORIZATION LETTER.....</b>	<b>7</b>
<b>VI.REQUESTS FOR CONTINUED STAY.....</b>	<b>9</b>
<b>VII.REFERRALS TO OTHER LEVELS OF CARE.....</b>	<b>11</b>
<b>VIII.COMPLEX CASE MANAGEMENT REFERRAL.....</b>	<b>13</b>
<b>IX.NON-COMPLIANCE PROTOCOL.....</b>	<b>15</b>
<b>X.CLAIMS PROCESS.....</b>	<b>17</b>
<b>XI.QUALITY MANAGEMENT PROGRAM.....</b>	<b>19</b>
<b>XII.EXHIBITS TO MANAGED BEHAVIORAL HEALTHCARE.....</b>	<b>23</b>

## **PRACTITIONER QUICK REFERENCE GUIDE**

**FREQUENTLY ASKED QUESTIONS**

**OUTPATIENT TREATMENT REPORT**

**PSYCHOLOGICAL TESTING REQUEST FORM**

**GUIDELINES FOR PRACTITIONER SITE EVALUATION**

**PRACTITIONER/PROVIDER APPEAL PROCEDURE**

**CLINICAL GUIDELINES FOR CHILDHOOD ATTENTION  
DEFICIT/HYPERACTIVITY DISORDER**

**DSM-IV ADHD CRITERIA (314.XX)**

**CLINICAL GUIDELINES FOR ADULT DEPRESSION**

**CRITERIA FOR MAJOR DEPRESSIVE EPISODE 296.2X AND 296.3X**

**CASE MANAGEMENT REFERRAL FORM**

**MEMBERS' RIGHTS AND RESPONSIBILITIES**

**RELEASE OF INFORMATION (ROI) GUIDE**

**STATE COVERAGE INSURANCE (BLUESCI)  
EMPLOYEE ASSISTANCE PROGRAM MANUAL**

## INTRODUCTION

Welcome to the Mesa Mental Health and Corporate Health Resources practitioner network.

Mesa Mental Health (MMH) has been in business in New Mexico since 1987 and today operates as a Managed Behavioral Healthcare Organization (MBHO). As such, we contract with insurance companies and large self-insured groups to manage the behavioral health component of their health insurance product. Mesa Mental Health's role is to authorize and manage the delivery of behavioral benefits in a manner that is consistent with the guidelines and parameters of the plans we administer and in compliance with all regulatory and oversight bodies. You, our network practitioners, deliver the actual care. We value the relationship we have with you and have developed this manual to enhance the quality of this working relationship.

In 1994, Mesa Mental Health added a second line of business, Employee Assistance Programs (EAPs). EAPs are, by design, both an employee benefit and an employer benefit. They allow employees (and sometimes their family members) access to assessment and possibly brief counseling for the resolution of personal and work related problems, plus they support the employer through a variety of important ancillary services like training, mediation, and organizational development activities.

Early in 2001, Mesa Mental Health made the decision to deliver both EAP counseling services and managed behavioral healthcare via a unified network. This means that practitioners, once credentialed and contracted, are eligible for referrals of clients from both lines of business. The only exception to this is for participating network MDs, who, due to the nature of their work, receive behavioral health referrals only.

As a contracted practitioner with MMH, you have agreed to comply with policies and procedures as set forth in your contract and in the Practitioner Manual. By following these policies and procedures, you will help to ensure efficient delivery of behavioral healthcare and EAP counseling services to our members and clients, and, most importantly, allow us to work with you and your office staff more effectively.

Along with the information contained in this Practitioner Manual, the Mesa Mental Health website offers you a comprehensive overview of our organization. The website was developed to enable providers and members to access information about our organization and the services we provide. For practitioners, you can view and download such information such as Treatment Request forms, Practitioner Alerts, current practice guidelines, HEDIS® data, and other information to better enable you, the practitioner, to serve our clients. Please take the time to browse our website at [www.mmhnm.com](http://www.mmhnm.com) 24 hours a day, seven days a week.

We value your participation as a practitioner in the MMH/CHR network, and we believe that the information contained in this manual will strengthen our working relationship and in turn promote quality care. We hope your relationship with MMH is a successful one.



## **TELEPHONE DIRECTORY** **Mesa Mental Health and** **Corporate Health Resources**

**DEPARTMENT**

**TELEPHONE NUMBER**

**Mesa Mental Health (MMH) Customer Service**

**(505) 816-6791    (505) 816-6792**  
**1-800-583-6372    1-800-333-8829**

Calls regarding:

- Benefit & claim questions
- Member complaints
- Member eligibility
- Referrals

For BCBSNM lines of business

For all other lines of business/Member Services

Fax

(505) 816-6702

**Corporate Health Resources**

(505) 816-6790 or 1-800-348-3232

Employee Assistance Services (EAP)

**MMH Information Request Line**

(505) 816-6703 or 1-800-333-8829  
Ext. 6703

**MMH Network Services**

(505) 816-6737 or 1-800-333-8829  
Ext. 6737

Calls regarding:

- Contractual issues
- Practitioner orientation
- Questions or concerns with manual

**MMH Credentialing Services**

(505) 816-6712 or 1-800-333-8829  
Ext. 6712

**MMH Quality Management/Appeals**

(505) 816-6710 or 1-800-333-8829  
Ext. 6710

**MMH Utilization Review**

Facility Admissions

(505) 816-6709 or 1-800-333-8829  
Ext. 6709

**MMH After Hours On-Call**

**(505) 816-6792 or 1-800-583-6372**

## **I. CLINICAL PHILOSOPHY**

Mesa Mental Health (MMH) is committed to providing high quality behavioral health and substance abuse services through a multidisciplinary network of carefully selected clinicians and facilities. MMH is dedicated to excellence and ethical practice. To ensure clinical excellence, MMH provides members with ready access to high-quality, appropriate care and treatment from many of New Mexico's finest behavioral health and substance abuse practitioners and facilities.

MMH's role is to assure and oversee provision of appropriate care. MMH's staff works in conjunction with the practitioner to establish interventions that are consistent with necessary treatment and the member's healthcare plan. Practitioner's specialized and unique expertise can be combined with that of MMH's professional staff to provide a synergistic treatment plan.

Authorizations by MMH for treatments and evaluations are designed to provide health plan members with easy access to cost-efficient therapies with an emphasis on therapeutic stabilization and/or solution focused treatment. Practitioner reports of progress, member satisfaction, outcome studies, and analysis of utilization data determine effectiveness of treatment.

Please remember that all policies and procedures presented in this manual apply only to insurance benefits and authorizations. In emergent and urgent clinical situations, both legal and ethical standards require that practitioners use their best professional judgment first and then contact us about retrospective authorization.

For "after-hours" clinical situations, MMH utilizes the emergency facility nearest the client for assessment and stabilization services.

## **II. CUSTOMER SERVICE**

Mesa Mental Health maintains a Customer Service Call Center to assist both network practitioners and insurance plan members with a variety of service-related issues. Practitioners may contact our Customer Service Department for general questions or those pertaining to claims. One of our Customer Service Representatives will assist with the resolution of member-focused problems dealing with covered benefits, pre-authorizations, claims status, etc. Calls to Customer Service are handled professionally and expeditiously. Customer Service may be contacted by calling (505) 816-6791 (Albuquerque Area) or 1-800-333-8829 (Toll Free).

### III. PLAN INFORMATION

#### • **Medically Necessary Services**

All care authorized by MMH is based upon the particular health plan member's benefits through their insurer and the MMH definition of medical necessity. MMH's Medical Necessity criteria are:

- Treatment is essential for evaluation and/or treatment of a distinct disorder as defined by the latest version of the Diagnostic and Statistical Manual published by the American Psychiatric Association.
- Treatment can be reasonably expected to result in significant and sustained improvement in member's condition and daily functioning.
- Treatment is consistent with symptoms, functional impairments and diagnoses of the member, and in keeping with generally accepted national and local standards of care.
- Services provided are at least restrictive level of care.

We are always willing to answer questions you or the member might have about members' benefits and Medical Necessity. Please feel free to contact our Customer Service Department.

While contractual language varies, all contracted agents use some concept of "Medical Necessity" as a criterion for coverage. Please be aware of how this impacts members' coverage; it is most helpful if you educate your members about possible limitations of their coverage. When a member is nearing the end of their medically necessary treatment episode, we suggest you inform your member. You may want to discuss possible options if you recommend that they continue treatment. Please be advised that some plans only allow for short-term services.

Effective 10/01/01 Mesa Mental Health became the administrator for Southwest Life and Health Insurance Company, a.k.a. First Care. This plan is **not** affiliated with Blue Cross and Blue Shield even though it follows the same protocol as all other plans administered by MMH.

#### • **Plan Types and Authorization Criteria**

**If a member has not been seen 120 days from last Date of Service, previous treatment episode is considered terminated and a new treatment episode must be initiated. Member must contact MMH Customer Service and begin initial authorization process.**

Benefit structures will vary depending on each individual plan as insurance companies will often tailor health plans to meet the needs of the specific employer group. You will receive information regarding member's plan during initial authorization process.

While MMH makes every effort to verify insurance coverage and obtain current information from members referred to you, there may be times the most current information has not been received. If insurance information you receive from the member is different from what you initially receive from MMH, please contact us immediately to confirm any changes the member may have mentioned in their coverage.

We strongly encourage you to direct members to become informed on the limits and exclusions of their policies. All plans with which we contract offer Customer Service lines to educate their members. If a member has any questions pertaining to their benefits, please refer them to the specific health plan telephone number listed at the front of this manual. (See Exhibits for Utilization Review Criteria for Outpatient Treatment and DSM-IV checklist)

## IV. INITIAL AUTHORIZATION PROCESS FOR MEMBERS

- **Authorization Process**

PCP referrals are no longer required for any BCBSNM plans. However, some plans may offer a different level of benefit if they coordinate their care with their Primary Care Physician.

Once the initial call has been made to the PCP (depending on the member's benefit), the member must then contact MMH.

**→→→→Practitioners may not schedule a member  
without prior authorization from MMH. ← ←←←**

When the member contacts MMH, he or she will first speak with a Customer Service Representative. At this time, basic data such as demographics will be collected from the member. If the member has already selected a practitioner, services will be authorized and a referral is made to that practitioner. Unless the member is using his or her out-of-network benefit, the practitioner selected must be credentialed by MMH for the services requested (i.e., Children, Adolescents, Adults, Substance Abuse, and/or Neuropsychological Testing). If the member **has not** pre-selected a practitioner, the member will speak with a Case Manager who will suggest three practitioners appropriate for the requested service. After selecting a practitioner, the member must notify Customer Service and the authorization for care will be issued.

- **Co-pays, Co-insurance, or Applicable Deductibles**

All members are responsible for paying their co-pay to the practitioner. This co-pay includes a portion of the maximum allowable fee. When submitting a claim to MMH, we will reimburse the practitioner the contracted allowable amount less the applicable co-pay. **Remember, it is the responsibility of the practitioner to collect this co-pay from referred members.** The member is always informed of the co-pay when calling for authorization and referral.

- **Use of Pseudonyms**

Occasionally, a member's situation will necessitate altered measures to assure confidentiality of services. In those instances, Mesa Mental Health will assign a pseudonym and pseudo-number in place of the individual's real name and ID number. The entire system at MMH will reflect use of the pseudonym and pseudo-number and not the individual's real name or number. Therefore, it is necessary for all practitioners, facilities, and other providers to use the pseudonym and pseudo-number in dealings with MMH. Requests for continued visits, claims, and all other inquiries **must** be submitted via the pseudonym and pseudo-number and not the individual's real name. Using the real name will result in a denial because the real name is not entered into the MMH information system. The rest of the form(s) should be filled out as usual.

## V. INITIAL AUTHORIZATION LETTER

Initial authorizations for care from master's level practitioners to psychologists and Psychiatrists are generally issued for twelve (12) visits with a one-year expiration date. Psychiatric authorizations for medication management codes (90862 and 90805) are for unlimited visits.

Practitioners seeking authorization for care beyond the amount and/or time period of the initial authorization must make the request in writing through use of the OTR (Outpatient Treatment Report). The OTR is reviewed, and the practitioner is notified in writing whether the additional treatment was authorized, pended, or denied. If there are questions about medical necessity or treatment, the OTR will be forwarded to Case Management. Case Management may then contact the practitioner to discuss the case or request chart documentation before additional visits can be authorized. Practitioners denied additional hours and wishing to appeal this decision may do so via a letter to the Quality Management Department at MMH.

- **Appointment Access**

**If a practitioner is no longer accepting new member referrals or cannot offer an appointment to a member within ten (10) business days, he or she is reminded to notify MMH per the contractual agreement.**

If the practitioner or his/her office staff has not notified MMH of any changes, we will assume the practitioner is accepting new clients within the guidelines stated in his/her contract.

- **Routine New Member Appointments**

If a Case Manager determines that a member's course of treatment is routine, the member must be seen within ten (10) business days.

- **Urgent New Member Appointments**

If a Case Manager has determined that a member's situation is urgent, the member must be seen within forty-eight (48) hours of referral as stated in the practitioner's contract.

- **Emergent New Member Appointments**

If a Case Manager has determined that a member's need is emergent, but non-life threatening, the member must be seen within six (6) hours of referral as stated in the practitioner's contract.

- **Life Threatening Emergencies**

If a Case Manager has determined that a member's need is emergent and life threatening, the member must be seen immediately and/or may be referred to a hospital emergency room as stated in the practitioner's contract.

- **After-Hours Coverage**

Practitioners must have after-hour and emergency arrangements for Members. These arrangements should offer direct contact via a receptionist, pager, cell phone, answering service, or professional arrangement (i.e., sharing on-call duties). Practitioners will have coverage arrangements if the practitioner is unavailable due to sickness or time away. Practitioners may not use 911 or Emergency Room as primary response to Members' emergencies.

- **Retrospective Authorization**

**All plans administered by Mesa Mental Health require prior authorization for all non-emergent services for members.** If a practitioner provides treatment without prior authorization, those services will be denied. When a service has been denied for lack of prior authorization, the practitioner may request review of the denial. Mesa Mental Health does not reward staff or practitioners for issuing denials, nor do we offer incentives to encourage inappropriate under-utilization. This request must be submitted in writing to Case Management at:

CASE MANAGEMENT  
MESA MENTAL HEALTH  
PO BOX 90607  
ALBUQUERQUE, NM 87199-0607

Requests for reviews should be accompanied by any pertinent information that will assist us in evaluating the case.

## **VI. REQUESTS FOR CONTINUED STAY**

### **• Outpatient Treatment Report (OTR)**

Ongoing review of ambulatory (outpatient) and facility-based services enables us to determine if requests for continued services are medically necessary and if services delivered are at the appropriate level of care. It also allows us to identify cases where behavioral health services may be provided in an alternative setting. Review also allows MMH to ensure services rendered are in compliance with the member's available behavioral healthcare benefit, medical necessity, and appropriate standards of care. As stated above, Mesa Mental Health does not reward staff or practitioners for issuing denials, nor do we offer incentives to encourage inappropriate under-utilization.

### **• Case Management**

MMH's Case Management Department facilitates the coordination between the practitioner and the managed care company. Case Management becomes involved with a client when:

- The client's clinical condition demonstrates a high risk of morbidity.
- The client's pattern of utilization may lead to exhaustion of benefit limits.
- A question of coverage arises out of the utilization review process.
- A quality of care concern has been initiated by anyone associated with the case or its review.

In these situations, the Case Manager may contact the practitioner to ask questions and solicit additional feedback as to the progress of treatment and to suggest other resources available for the client. We will not direct the care of the client, but may at times ask for second opinions or other assessments to help clarify the needs of the client. We ask practitioners for cooperation with this process as it often leads to additional services being made available to the client. Practitioners may also contact the MMH Case Management Department for assistance with other clinical resources, patient non-compliance, or clinical feedback. The MMH Case Management program is designed to help practitioners care for their clients and understand the role of the client's insurance in the treatment process. The Case Management Department may be reached at 505-816-6705 or 1-800-583-6372, Ext. 6705.

### **• Denial of Services**

Services may be denied for a variety of reasons. The most common reasons for a denial are:

- Lack of prior authorization for services.
- The service requested is not a covered benefit under the member's health plan.
- The requested services fall outside the criteria for medical necessity.
- The member has reached his or her maximum benefit for the calendar year.
- The member has reached the maximum lifetime benefit.

The Medical Director issues all denials for authorization of services. Two letters are generated for each denial. One is sent to the practitioner and another to the member indicating what services are being denied and the reason for the denial. A copy of the criteria governing denials may be requested by calling Utilization Management.

All claims denials are automatically generated with the reason for denial on the remittance advice. Appealing denied services may be initiated by the member or practitioner (with the member's permission), and should be sent in writing to:

QUALITY MANAGEMENT DIRECTOR  
MESA MENTAL HEALTH  
PO BOX 90607  
ALBUQUERQUE, NM 87199-0607

See *Exhibits* for Members' Rights and Responsibilities.

## VII. REFERRALS TO OTHER LEVELS OF CARE

During treatment for a given member, the practitioner may need to refer that member for more intensive services and/or additional services. If the member needs psychological testing, evaluation and medication management, a second opinion on a psychological evaluation, or a referral to another contracted practitioner with a different subspecialty, the practitioner should ask the member to contact MMH Customer Service and request appropriate authorization. The Assessment/Case Manager will provide authorization according to the member's health plan benefits.

### • **Psychological Testing**

If a member requires psychological testing and it can be completed in four hours or less, simply call MMH for an authorization.

If the testing requires more than four hours to complete, the practitioner must initiate the authorization process by completing the Psychological Testing Request form and submitting it to MMH for review prior to testing. (See *Exhibits* for form)

Submit to:

MEDICAL DIRECTOR  
MESA MENTAL HEALTH  
PO BOX 90607  
ALBUQUERQUE, NM 87199-0607

The requesting practitioner should document the tests required and clinical rationale for the testing needed. (Some neuropsychological testing may be reimbursed through the member's medical plan.)

### • **Hospital Utilization Review**

For members needing inpatient or partial hospitalization, practitioners are to contact Utilization Management to provide a clinical report and rationale for the intervention being requested. If the request for admission is after-hours or on weekends, practitioners are to contact the Mesa Mental Health on-call clinician for additional directions and possibly for information on the nearest and/or most appropriate contracted facility. The facility then assumes responsibility for contacting the MMH on-call clinician and on the next business day, the MMH Utilization Management department. Please DO NOT have the family contact Mesa Mental Health and, most importantly, do not refer them directly to a specific hospital unless it is an emergency. Mesa Mental Health bases all utilization management decisions on medical necessity, appropriateness of care and service, and benefit structure. As the practitioner, you also have the right to request the medical necessity criteria and/or discuss the case with the physician reviewer. Mesa Mental Health does not reward staff or practitioners for issuing denials, nor do we offer incentives to encourage inappropriate under-utilization. A copy of the medical necessity criteria may be requested by contacting the Utilization Management Department.

Please refer to the following guidelines when determining if the member needs inpatient hospitalization or partial hospitalization:

### **Inpatient Hospitalization**

- The member is at immediate risk of harm to self or others.
- Member has a deteriorating condition and is unresponsive to outpatient treatment.
- Member requires 24-hour nursing intervention.

### **Partial Hospitalization**

- Member is experiencing severe distress on a daily basis.
- Member has disruptive and/or immobilizing symptoms.
- Member is unable to perform essential activities of daily living.

## **VIII. COMPLEX CASE MANAGEMENT REFERRAL TO ASSIST PRACTITIONERS**

Mesa Mental Health (MMH) offers Complex Case Management Services to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services.

The purpose of complex case management services is to facilitate positive treatment outcomes by proactively identifying members who have complex behavioral health needs possibly combined with co morbid medical condition(s).

The program includes:

- Removing barriers to needed services.
- Helping members effectively navigate the service delivery system.
- Coordinating and collaborating services at all levels of care.
- Preventing unnecessary hospitalizations.

MMH's CM Program is multi-focal and services are delivered telephonically. Our CM program has an obligation to the members and plans served to provide expertise and guidance regarding the judicious and responsible use of resources. This involves the following components:

- Comprehensive assessment of the member's condition.
- Determination of available benefits and resources.
- Development of and implementation of a case management plan with performance goals.
- Monitoring progress.
- Follow-up.
- Case closure after completion.

Members with the following conditions, but not limited to, are offered case management services:

- High Utilization of benefits.
- Repeated non-compliance with recommended treatment(s) that resulted in higher levels of care.
- Chronic dangerous behaviors.
- Member need of complex resources and is unable to navigate the process without assistance.
- Insufficient support system.
- Newly diagnosed members who require education about their diagnosis.
- Significant co-morbid medical and behavioral health issues.
- Dual diagnosis members with history of two or more hospitalizations in past year.
- History of AMA discharge with no discharge planning.

Member exclusion criteria:

- Member refuses services.
- Member is unlikely to benefit from the program.
- Member does not meet program admission criteria.

Mesa Mental Health has several avenues for Case Managers to receive referrals for members in need of services. The member, family member, or provider/practitioner, may submit a MMH Case Management Referral Form. The Case Management Referral form is available to practitioners on the MMH Website. The form is filled out and sent to MMH Case Management Services to begin the case management process. Case Managers also accept referrals by phone. Typical points of entry are: Discharge Planner referral, MMH UM, Member self-referral, family member, MCO and practitioner/provider referral. Please feel free to contact a MMH Case Manager at (505) 816-6792 or (800) 583-6372 (outside Albuquerque area) with any further questions or to make a referral. The MMH fax number is (505)816-6702.

## **IX. NON-COMPLIANCE PROTOCOL**

### **• Clinical Non-Compliance**

A member is non-compliant when he/she has demonstrated a pattern of repeatedly disregarding clinical recommendations, resulting in the following:

- There is a continued need for ongoing services when compliance would have resulted in improvement of functioning and discontinuation of need for services.
- There is a need for more intensive services when compliance would have resulted in maintenance of functioning.

Clinical non-compliance is a serious and formal status. It is to be differentiated from cases in which a member may disagree with and disregard clinical suggestions that might be controversial or reasonably debated. For any practitioner who is unclear whether the member's behavior constitutes clinical non-compliance, the MMH Case Manager will provide a formal second opinion. Please use MMH as a resource in handling difficult clients.

The following steps are critical to support the practitioner's case for non-compliance. If a MMH member is non-compliant, the practitioner is asked to do the following:

- Write out a contract specifying the exact behaviors that would constitute compliance. The practitioner can tell the member that he/she will be informing the PCP and their health plan of any conduct that deviates from the contract.
- Have the member sign the contract.
- Carefully document any and all non-compliant behavior.
- Forward your contract and documentation to a Case Manager at MMH.
- Inform the PCP of the case and status, remembering to document your notification.
- If a practitioner feels that he/she cannot work with the member, please call Case Management immediately. We will assign the member to another practitioner.

- **Administrative Non-Compliance**

A member is administratively non-compliant when he/she habitually neglects to pay their co-pays, calls the day of an appointment to cancel, calls incessantly, or does not meet other administrative expectations.

The practitioner is asked to document the non-compliance and notify Case Management immediately if administrative non-compliance becomes so severe that the practitioner can no longer effectively work with the member. MMH wants to be supportive of our practitioners and serve as a resource when such difficulties arise.

## X. CLAIMS PROCESS

### • Submission of Claims

Submission of Electronic Claims:

Mesa Mental Health accepts electronic claims transmitted securely in the HIPAA compliant ASC X12N 837 format. We are payor number 85035. You may use any clearinghouse, and your clearinghouse will route the claims through WebMD to us. We accept both professional and institutional claims.

Mesa Mental Health encourages practitioners and providers to send claims electronically as this eliminates data entry discrepancies and errors and allows us to adjudicate claims very quickly.

All paper claims should be submitted to:

CLAIMS  
MESA MENTAL HEALTH  
PO BOX 92165  
ALBUQUERQUE, NM 87199-2165

Practitioners are to submit claims in a legible and timely fashion. ***There is a 90- day filing guideline from date of service for a claim to be considered for payment.*** Our standard is to reimburse practitioners within a reasonable timeframe from receipt of ***a clean claim.*** In order to ensure quick turnaround time, please submit ambulatory claims on a HCFA 1500, and facility claims on a UB92. For a claim to be regarded as ***clean*** when submitted, include the following information:

- Member's Name
- Member's Date of Birth
- Member's Address
- Member's Gender
- Member's ID Number
- Member's Relationship to Subscriber
- Name of Insurance Company
- Subscriber's Name
- Subscriber's Employer
- Subscriber's Group Number (On ID Card)
- Subscriber's Address (if different from member's)
- Diagnosis using ICD-9 Coding

- Date of Service
- Treatment/Procedure, using CPT-4 coding and modifiers, where applicable
- Units of Service
- Usual Charges
- Practitioner Name
- Practitioner Tax ID Number
- Practitioner Telephone Number
- Referring Doctor's Name (if applicable)
- Authorization Number
- NPI Number

We will make every effort to ensure that practitioners are reimbursed promptly. If any discrepancies in reimbursement are noted, please contact our Customer Service Department so we can correct the error.

**Please remember to notify MMH of any address changes in writing.** Outdated information may prevent the timely processing of claims.

- **Claims Appeal Process**

Mesa Mental Health has a formal appeal process for practitioners who feel that claims have been inappropriately denied. We ask that practitioners first contact the Customer Service Department to verify that the claim was processed correctly. If the claim was denied incorrectly, we will reprocess the claim and payment will be sent out to the practitioner. If the claim was denied correctly, the denial may be appealed by sending a formal written appeal with supporting documentation to the Quality Department. Requests will be reviewed and a determination made. If we reverse our original decision, payment will be made within sixty (60) days. If we uphold our original decision, notification will be made in writing. The **member** may appeal this decision with a formal grievance hearing through their insurance company. **There is a twelve (12)-month filing limit from the date of service for claims appeals.** The following is the address to send all claims appeals:

QUALITY MANAGEMENT DEPARTMENT  
 MESA MENTAL HEALTH  
 PO BOX 90607  
 ALBUQUERQUE, NM 87199-0607

## XI. QUALITY MANAGEMENT PROGRAM

Mesa Mental Health subscribes to and actively supports a Quality Management (QM) program that facilitates ongoing data collection designed to monitor performance and identify opportunities for improvement in a timely manner. We employ a continuous quality improvement approach to identify problems or concerns before they become major systems issues requiring extensive resources and operational change. The component parts of the QM program include credentialing/re-credentialing, satisfaction surveys, complaints and appeals, practice guidelines, regulatory compliance, risk and liability reduction, and health plan reporting requirements.

### • Credentialing/Re-Credentialing

Providers must successfully complete the credentials process before their contract can be fully executed and effective. Practitioners will be notified when conflicting information is obtained during the credentialing process and provided the opportunity to clarify, explain or refute the discrepant information. Practitioners must be credentialed before in-network authorizations can be given.

#### **Initial Credentialing Process:**

MMH must limit participation in the network to those clinicians licensed to practice independently and whose scope of practice allows them to diagnose and treat. Because we maintain a referral based network, we must conduct an initial screening on all interested providers to ensure there is a current need for the type of services being offered and the location in which they are offered. Therefore, the first step in the credentialing process is the *pre-application* process. Please look for the ***Pre-application for Practitioner Participation*** form on the MMH website ([www.mmhnm.com](http://www.mmhnm.com)) to submit to MMH for approval.

Once accepted into the network, the following steps must occur to complete the initial credentialing and re-credentialing process.

#### *Initial Credentialing*

- Submission of the following documents:
  - Application including signed attestation
  - Current license to practice
  - Copy of liability insurance
  - Copy of DEA and/or CSR certificate, if applicable
  - Current curriculum vitae
  - Three peer references
- All applicants must pass a site evaluation conducted by an MMH representative.

### *Re-Credentialing*

The process for re-credentialing is similar to the initial with these exceptions:

- Peer references are not required.
- Practitioners who have moved to a site without an MMH site evaluation will be scheduled for a site evaluation within the recredentialing year.

#### • **Site Evaluations**

Practitioner site evaluations are a Health Plan requirement and an accrediting standard. The purpose is to ensure that members are being seen in office sites that meet certain safety standards and comply with regulatory expectations for privacy, confidentiality, access, and storage of patient treatment records and release of medical record information. To this end, each practitioner and freestanding program must have an initial site evaluation before their credentialing application can be acted upon. Complaints against a practitioner regarding his/her site also warrant a site evaluation. Network Services staff conduct the Practitioner site evaluations with every consideration given to minimal disruption of office functioning. Failure to pass the site evaluation will result in the need for a corrective action plan from the practitioner as well as a repeat evaluation within six months to one year. Failure of certain critical elements may result in an immediate suspension of referrals to the practitioner until the problematic area is remedied. (See *EXHIBITS for Guidelines for Practitioner Site Evaluations.*)

#### • **Satisfaction Surveys**

Mesa Mental Health conducts a practitioner satisfaction survey annually and a member satisfaction survey quarterly. The surveys give us an opportunity to collect practitioner and member feedback on how we are doing in a number of different areas such as utilization management and access to care. We value our customers' feedback, which is why we regularly analyze the survey results to assist in the identification of potential areas of improvement. Aggregate survey results are published in our newsletter once a year and can be reviewed at any time on our website.

#### • **Complaints, Appeals, and Inquiries**

Mesa Mental Health's processes for complaints and appeals are in compliance with NCQA standards and the New Mexico Division of Insurance regulations as outlined in our policies and procedures. Instructions for the appeals process are located in the exhibit section at the back of this manual. These instructions are also available on our website at [www.mmhnm.com](http://www.mmhnm.com). The following is a brief description of each of these types of communications.

- Inquiry – Any communication seeking information or clarification of information. Inquiries will be handled by the Customer Service staff unless complicated or clinical in nature. Every attempt will be made to resolve the issue at initial contact.

- Complaint – An oral or written expression of dissatisfaction with a system, person, facility, or process.
- Appeal – A request to change a previous decision made by the organization. This includes medical necessity and benefit appeals. An appeal may be initiated by the member, a guardian, representative, or provider acting on the member's behalf with the member's express permission.

- **Practice Guidelines**

The development and implementation of clinical practice guidelines is a contractual and accrediting requirement. MMH, through its Clinical Task Force, has developed practice guidelines addressing **adult depression** and **childhood ADHD**. These guidelines were developed for a behavioral health network and are different from the guidelines Blue Cross/Blue Shield uses for its primary care network.

Currently implemented guidelines have been modified over time to more closely reflect input we have obtained from our provider network. They are designed to provide some measure of quality standardization across the network. Adherence to the guidelines is measured yearly through random chart audits. Although there are no individual measurements or penalties, MMH is charged by our health plans to increase the rate of adherence through dissemination and education of our network. Please see *Exhibits* or visit the MMH website at [www.mmhnm.com](http://www.mmhnm.com) for the current guidelines.

- **Regulatory Compliance**

Federal and state regulations regarding the provision of health care, the privacy of patient information, and the rights of members and providers have created the need to monitor compliance with regulations and contractual obligations. Compliance with these regulations is monitored by the Quality Department.

- **HEDIS®**

HEDIS® stands for Healthcare Effectiveness Data and Information Set and is the data report developed by the National Committee for Quality Assurance (NCQA). Mesa Mental Health provides behavioral-related data to Blue Cross/Blue Shield of New Mexico for their participation in HEDIS®. Please visit the official NCQA website for more information about HEDIS® at [www.ncqa.org](http://www.ncqa.org). To view MMH HEDIS® data, please visit our website at [www.mmhnm.com](http://www.mmhnm.com).

- **Practitioner Communication**

Mesa Mental Health values open communication with its practitioners and providers. MMH employs several techniques to achieve this goal, such as the Practitioner Newsletter and the Mesa Mental Health website. The Practitioner Newsletter will be published via the Mesa Mental Health website on a quarterly basis. Results of satisfaction surveys, guideline audits, network access, and availability are just a few of the items that will be covered. Changes in policies, procedures, and contractual and accreditation expectations will also be addressed. In addition, our Network Services Manager is available to assist you with any issues you may have regarding your contractual relationship with Mesa Mental Health.

## **XII. EXHIBITS TO MANAGED BEHAVIORAL HEALTHCARE**

**PRACTITIONER QUICK REFERENCE GUIDE**

**FREQUENTLY ASKED QUESTIONS**

**OUTPATIENT TREATMENT REPORT**

**PSYCHOLOGICAL TESTING REQUEST FORM**

**GUIDELINES FOR PRACTITIONER SITE EVALUATION**

**PRACTITIONER/PROVIDER APPEAL PROCEDURE**

**CLINICAL GUIDELINES FOR CHILDHOOD ATTENTION  
DEFICIT/HYPERACTIVITY DISORDER**

**DSM-IV ADHD CRITERIA (314.XX)**

**CLINICAL GUIDELINES FOR ADULT DEPRESSION**

**CRITERIA FOR MAJOR DEPRESSIVE EPISODE 296.2X AND 296.3X**

**CASE MANAGEMENT REFERRAL FORM**

**MEMBERS' RIGHTS AND RESPONSIBILITIES**

**RELEASE OF INFORMATION (ROI) GUIDE**

**STATE COVERAGE INSURANCE (BLUESCI)**

**EMPLOYEE ASSISTANCE PROGRAM**



PO Box 90607  
Albuquerque, NM 87199-0607  
Fax (505) 816-6702

Website: [www.mmhnm.com](http://www.mmhnm.com)

## PRACTITIONER QUICK REFERENCE GUIDE

### Telephone Numbers:

#### Member Services for Authorization and Claim information:

BCBSNM lines of business: (505) 816-6792 or (800) 583-6372

Mesa Mental Health managed lines of business/Member Services: (505) 816-6791 or (800) 333-8829

**Outpatient Mental Health Services (Ambulatory):** Member must contact Member Services for initial authorizations (Indemnity and PPO members excluded). Additional hours for the episode of care are requested by the practitioner via the Outpatient Treatment Report, which may be obtained by contacting Member Services if one has not been provided with the initial authorization.

**Referrals to Other Levels of Care:** Practitioner directs the member to contact Member Services regarding authorization for medication management, new episode of care (if 120 days has lapsed from last Date of Service) and/or transfer of case to another practitioner.

**Testing:** In the event a member requires testing, a narrative must be sent to the Medical Director. Please include the following: number of hours needed, types of tests to be utilized and clinical rationale.

**Inpatient or Partial Hospitalization and Outpatient or Inpatient Substance Abuse Services:** Practitioner must contact the Utilization Review Nurse at (505) 816-6709 or (800) 333-8829, extension 6709 (outside Albuquerque area) and provide clinical information pertaining to medical necessity.

**Emergency Care:** During business hours practitioners should contact Member Services for referrals to an appropriate facility or level of care. ***If an emergency occurs after hours or on a weekend, call Mesa Mental Health (505) 816-6792 in Albuquerque or (800) 583-6372 outside Albuquerque to have the member referred to an appropriate facility.***

**Claim Filing:** Use the HCFA 1500. To ensure efficient processing of claims include ***all*** of the following:

Practitioner Name, Tax ID Number, NPI  
Dates of Service  
ICD-9-CM Code  
Billed Charges itemized by CPT-4 Codes  
Referring Physician's Name (if applicable)

Member Name & ID Number  
Member Date of Birth  
Name of Insurance Company (e.g., BCBS)  
Employer Name & Group Number

#### Claim Address:

Mesa Mental Health  
ATTN: Claims Department  
PO Box 92165  
Albuquerque, NM 87199-2165

#### Claim Appeals: Send appeals in writing to:

Mesa Mental Health  
ATTN: Complaint Coordinator  
PO Box 90607  
Albuquerque, NM 87199-0607



## FREQUENTLY ASKED QUESTIONS

**Q: Does becoming a Mesa Mental Health (MMH) provider mean that we are now a provider for all Blue Cross Blue Shield of New Mexico (BCBSNM) Behavioral Health programs (BlueCard PPO, BlueSCI, FEP)?**

**A: No.** Being a MMH provider means that you can provide Behavioral Health services for the majority of BCBSNM plans; this is the 'base' contract. There are also lines of business that BCBSNM offers for which you have the option of contracting to become a provider. All contracting packets that MMH sends to you include these additional lines of business (BlueCard PPO and BlueSCI).

In addition, there are a handful of BCBSNM plans that are not managed by MMH but by BCBSNM directly, such as the Federal Employee Program (FEP). To be an in-network provider for these plans, you will want to apply to BCBSNM directly after you have been approved by MMH. Go to [www.bcbsnm.com](http://www.bcbsnm.com) to find the *Application for Provider Participation*. When BCBSNM receives your application, BCBSNM will review the application, and if accepted, you will be sent a contract for FEP/PAR business. The process will take up to 30 days for processing. All claims are handled by BCBSNM. BCBSNM will use your credentialing from MMH; you will not have to credential again.

Provider questions for Mesa Mental Health may call:

Mesa Mental Health Customer Service

(Albuquerque) 816-6791 (toll free) 1-800-333-8829

Paper claims are mailed to: Mesa Mental Health Claims  
PO Box 92165  
Albuquerque, NM 87199-2165

BCBS FEP Hotline at 1-800-245-1609

**Q How do I become a BlueCard PPO provider for out of state BCBS PPO members?**

**A:** As a Mesa Mental Health (MMH) provider, you, or the organization under whose TIN you work, should have received a BlueCard PPO Amendment with the MMH contract to sign and return to us. The effective date is approximately 30 days from the time of execution. This Amendment allows you to provide services to BCBS members with out of state BCBS PPO plans. If preauthorization is required for services, it will need to be obtained from the home BCBS plan. If you're not sure what state carries the policy, call the Blue Card number (800) 676-2583, and you will be given a phone number and transferred to the home plan. See [www.bcbsnm.com](http://www.bcbsnm.com) for additional information.

Claims for BlueCard PPO services are sent to BCBSNM for reimbursement.

Paper claims are mailed to: Blue Cross and Blue Shield of New Mexico  
PO Box 27630  
Albuquerque, NM 87125-7630

Provider questions about BlueCard can also call:

BlueCard Customer Service

1-800-222-7992

**Q: Do I need an authorization to provide care?**

A: **Yes.** All of the plans administered by Mesa Mental Health (MMH) require an initial authorization for care. To begin the authorization process, call the number listed for your client's coverage.

For BCBSNM members call MMH at:

800-583-6372 or 816-6792 (in Albuquerque)

For First Care NM (SW Life and Health) members call:

866-272-8691 or 816-6793 (in Albuquerque)

**Q: Will I submit the claims for my clients?**

A: It depends. *Network providers will always submit claims for their clients.* If you are an Out of Network Provider, you may ask your clients to submit their own claims. To assist them in submitting claims, please be certain to provide them with the following information: date of service; procedure code; diagnosis code; amount billed; provider name and address.

**Claims should be mailed to:**

Mesa Mental Health  
PO Box 92165  
Albuquerque, NM 87199-2165

Claims may also be faxed to (505) 816-6702

**Q: Does Mesa Mental Health accept claims electronically?**

A: **Yes.** The Mesa Mental Health payor number is 85035, and you may use a participating clearinghouse to transmit your claims (<http://www.mesamentalhealth.com/test/providers/claims.html>). Claims will be routed to Mesa Mental Health.

**Q: How can I get more visits for my client after the initial authorization?**

A: Please complete the **two page Outpatient Treatment Report (OTR)** form. It can be found on our website [www.mmhnm.com](http://www.mmhnm.com) (<http://www.mesamentalhealth.com/pdf/forms/otr.pdf>). Fax or mail it to Mesa Mental Health. Our Case Management staff will review your request and advise you of our decision.

**Q: Do I need to be credentialed?**

A: **Yes.** All providers delivering services on behalf of Mesa Mental Health must be credentialed. Only independently licensed providers in behavioral health are eligible for credentialing in most practices. Allow at least two months for the credentialing process to be completed.

**Q: Where do I send BlueSCI claims?**

A: Blue Cross and Blue Shield of New Mexico (BCBSNM) has contracted with NM Medicaid to offer the State Covered Insurance (BlueSCI) Plan. The SCI program was developed to assist uninsured working adults in obtaining affordable health care coverage to individuals and small employer groups with some state funding assistance. Providers and facilities who have agreed to participate in the BlueSCI plan have signed a BlueSCI Amendment.

MMH, through a delegated agreement with BCBSNM is administering the Utilization Management, Customer Service, and Quality Management for the BlueSCI.

Pre-authorizations:

Mesa Mental Health 1 (800) 333-8829 or 816-6792 (in Albuquerque)

BlueSCI Claims address for paper claims:

Medicaid  
PO Box 27838  
Albuquerque, NM 87125-7838

Information:

Blue Cross Blue Shield of New Mexico (505) 816-2000

**Please refer to the State Coverage Insurance (BlueSCI) Exhibit towards the end of this Exhibit section, or the Blues Provider Reference Manual on the [bcbsnm.com](http://bcbsnm.com) web site for a more detailed description of the BlueSCI Program and Policies.**

**Q: Where can I find more information?**

A: Go to our website [www.mmhnm.com](http://www.mmhnm.com) or call a Mesa Mental Health Customer Service Representatives at 1 (800) 333-8829, or 816-6792 in Albuquerque.



## OUTPATIENT TREATMENT REPORT

Provider Name \_\_\_\_\_ Signature \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Date \_\_\_\_\_

### Patient Information

Patient Name		Member ID
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Health Plan
Current Identified Problem(s)		

### Functioning

*Please assess how current symptoms have affected the level of impairment in the following categories:*

Categories	Impairment Level (Circle Level)		
	Mild	Moderate	Severe
Relationships	1	2	3
Job/School Performance	1	2	3
Social	1	2	3
Physical Health	1	2	3
Activities of Daily Living (hygiene, bathing, etc.)	1	2	3
Eating Habits	1	2	3

### Risk Assessment *(check all that apply)*

Factor	Not Present	Ideation	Plan	Means	Prior Attempt	Date
Suicidality						
Homicidality						

Concurrent S/A	Alcohol	Marijuana	Stimulants	Opiates	Other
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### Diagnostic Information

Axis I:	
Axis II (Pers. Dis/MR):	
Axis III (Medical):	
Axis IV (Stressors):	
Axis V (Level of Functioning):	Current _____ Past Year _____

### Treatment Plan, Frequency, and Duration

Date First Seen	Date Last Seen
Service Requested	Frequency

***Prior authorization is required to see the member more than weekly***

Provider Name \_\_\_\_\_ Patient Name \_\_\_\_\_

**Medication**

Has patient been evaluated for medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has patient refused medication evaluation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Prescribing Physician		<input type="checkbox"/> PCP	<input type="checkbox"/> Psychiatrist
<i>List all current psychotropic medications</i>			
Medication	Dosage/ Frequency	Start Date	Medication
			Dosage/ Frequency

**Treatment Goals**

*List goals directed at reducing risk and impairment to functioning as reported on page 1.  
Use Progress Rating Scale, below, when addressing Methods for Achieving Goals.*

<p style="text-align: center;"><u>Progress Rating Scale</u></p> <p>1 = Much Worse 2 = Somewhat Worse</p>	<p>3 = No Change 4 = Slight Improvement</p>	<p>5 = Great Improvement 6 = Resolved</p>
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<b>Measurable Behavioral Goals</b>
1.
2.
3.

Methods for Achieving Goal #1:
Progress Since Last Report (Progress Rating # _____)

Methods for Achieving Goal #2:
Progress Since Last Report (Progress Rating # _____)

Methods for Achieving Goal #3:
Progress Since Last Report (Progress Rating # _____)

Discharge Criteria ( <i>specific and measurable</i> )
Additional Comments

**Mail completed form to: ATTN: Case Management  
Mesa Mental Health  
PO BOX 90607, Albuquerque, NM 87199-0607  
Fax completed form to: (505) 816-6702  
Questions? Call (505) 816-6792 in Albuquerque or toll free 1-800-583-6372**



## PSYCHOLOGICAL TESTING REQUEST FORM

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

DOB: \_\_\_\_\_ Age \_\_\_\_\_ Member ID \_\_\_\_\_

Insurance \_\_\_\_\_ Requesting Provider \_\_\_\_\_

Provider Phone \_\_\_\_\_ Provider Fax \_\_\_\_\_

Provider Office Address where Patient will be seen \_\_\_\_\_

**Diagnosis (List if Provisional or Rule Out)**

<b>AXIS I</b>	
<b>AXIS II</b>	
<b>AXIS III</b>	

Current Medications	Other Clinicians Involved in Treatment

**Reason for Psychological Testing/Information to be Gained**


Test and Maximum Time Allowable			Test and Maximum Time Allowable		
	MPPI-2/MPPI-A	1 hour		MCM/MACI	1/2 hour
	Rorschach	2 hours		WRAT III	1/2 hour
	WAIS III	2 1/2 hours		Zung/BDI/CDI	1/2 hour
	WMS III	2 1/2 hours		Report: 1/2 hour for ≤ 2 hours testing	
	WISC III	2 hours		Report: 1 hour for ≥ 2 hours testing	

<b>Other Tests Requested</b>	3.
1.	4.
1.	5.

Approved by: \_\_\_\_\_ Date \_\_\_\_\_

*Mail completed form to: ATTN: Case Management  
 Mesa Mental Health  
 PO BOX 90607  
 Albuquerque, NM 87199-0607  
 Fax completed form to: (505) 816-6702*



## GUIDELINES FOR PRACTITIONER SITE EVALUATION

*\*Indicates critical items that will result in an action plan and follow-up visit if not met.*

### Accessibility/Availability

#### 1. Is parking convenient?

Yes: Parking can be in a garage or surface parking. It should be easily identified, easily negotiated and ample enough to accommodate the offices it serves.

No: The parking is not well identified, in poor shape, difficult to enter or not large enough to accommodate the customers.

#### 2. Is the site handicap accessible?

Yes: Handicap parking is easily identified and adequate for the volume. An access ramp is available. Office setup is accessible to handicap patients. Appropriate measures for handicap access are available.

No: There is no handicap parking; handicap parking is not easily identified and is not adequate; there is no access ramp available; or office setup is not accessible to handicapped patients. Practitioner does not have any plan to accommodate handicap clients.

#### 3. Is the entrance identified?

Yes: The building and/or office are identified with a prominently displayed sign. The entrance is easily identified. If office is in a building, the practitioner's name is on the building directory.

No: The building and/or office are not identified with a prominently displayed sign; the entrance is **not** easily identified; the

practitioner's office is in a building but the practitioner's name is **not** on the building directory.

4. Are hours of service communicated to patient?

Yes: There is communication with patients regarding access to services during office hours either in writing, on the door or on the voice message.

No: There is **no** evidence of office hours being communicated to the patients.

5. Is the office able to schedule a new & established appointment within 7-10 days?

Yes: The office is able to offer an appointment for routine care within 7-10 days.

No: The office is **unable** to offer an appointment for routine care within 10 days.

6. Is the office able to schedule a new and established urgent appointment within 48 hours?

Yes: The office is able to offer an urgent care (acute) care appointment within 48 hours.  
(Review of appointment book/schedule may be beneficial.)

No: The office is **unable** to offer an urgent (acute) care appointment within 48 hours.

7. Are you accessible for a non life-threatening emergency appointment within six hours for established patients?

Yes: In an emergency, the practitioner sees the patient the same day, or talks to the patient in person, triages and refers patient to an appropriate colleague or crisis facility.

No: The practitioner is **unable** to see the patient the same day or talk to the patient in person and refer patient to an appropriate colleague or crisis facility.

**Emergency Coverage (Directions only to call 911 or go to the nearest ER are not Acceptable)**

\*8. Explain your After-Hour Emergency coverage:

Yes: There is information regarding access to a treating practitioner or back-up practitioner for an after-hour emergency situation. This information is available to all patients. A recording to go to the emergency room or call 911 after hours is not acceptable.

.No: There is **no** information regarding access to mental health services after office hours or in an emergency situation. There are **no** arrangements for on-call coverage. There is a recording to go to the emergency room or call 911 after hours instead of a number for an on-call practitioner.

\*9. Explain your coverage when unavailable due to illness/time off:

Yes: There is information regarding access to a treating practitioner or back -up practitioner when practitioner is either ill or planning to take time off. This information is available to all patients. A recording to go to the emergency room is not acceptable.

No: There is no information regarding access to a treating or back-up practitioner when practitioner is either ill or has taken time off. There is a recording to go to the emergency room during this timeframe instead of a number for an on-call practitioner.

## Waiting Area/Office Environment

10. Is the office clean and unobstructed?

Yes: The waiting area and the offices are neat and clean. These areas appear to be cleaned regularly and are free of excessive clutter. For example, the trash can is not overflowing.

No: The waiting area and/or the offices are **not** neat and clean. These areas do **not** appear to be cleaned regularly and are **not** free of excessive clutter.

11. Is there adequate waiting room space with comfortable seating?

Yes: There is an adequate and comfortable waiting room and seating space.

No: There is **not** an adequate and comfortable waiting room and seating space.

12. Are there current multipurpose OSHA approved fire extinguishers?

Yes: There is a Category C (Multipurpose) fire extinguisher that is checked annually.

No: There is no fire extinguisher, it is not a multi-purpose extinguisher, or it has not been checked within the last year.

13. Are the fire exits identified?

Yes: Practitioner's office has fire exit signs that are visible.

No: Practitioner's office **does not** have fire exit signs that are visible.

14. Are smoke detectors present?

Yes: Practitioner's office has a smoke detector that is in operation. (Batteries should not be dead)

No: Practitioner's office **does not** have a smoke detector or one that is in operation. (Batteries are dead)

### **Patient Risk Minimization**

\*15. Is there a mechanism for tracking cancellations and no shows for ensuring patient safety?

Yes: The office has a procedure for tracking cancellation and no shows for ensuring patient safety.

No: The office **does not** have a procedure for tracking cancellation and no shows for ensuring patient safety.

\*16. Is the office set up to maintain patient confidentiality, i.e., telephone conversations with patients are private?

Yes: Office is set up to maintain patient confidentiality. Telephone conversations are kept private and patient names are not used around non-office staff.

No: Office **is not** set up to maintain patient confidentiality. Telephone conversations can be overheard, and patient names are used around non-office staff.

\*17. Does the procedure for release of medical information meet state guidelines?

Yes: Practitioner's office has and uses a release form that meets state guidelines regarding sending or obtaining medical records to/from another provider, the specific information being exchanged, and an expiration date for the consent.

No: Practitioner's office **does not** have a form or the form does not meet state guidelines regarding the above requirements.

\*18. Are medical records stored in a secured place?

Yes: Practitioner's office has a secured place for the storage of medical records.

No: Practitioner's office **does not** have a secured place for the storage of medical records.

\*19. Is there communication with other treating professionals as appropriate?

Yes: Practitioner's office has a process to communicate with other treating professionals.

No: Practitioner's office **does not** have a process to communicate with other treating professionals.

\*20. Is there a confidentiality statement that all employees, including billing assistants, sign?

Yes: Practitioner's office has a written confidentiality statement and the staff is aware of the policy.

No: Practitioner's office **does not** have a written confidentiality statement and the staff is **not** aware of the policy.

NA: There is no staff. The clinician is the only one in the office; schedules his/her own appointments and does his/her own billing.

\*21. Are sample drugs locked (if applicable)?

Yes: All sample drugs are locked and accessible only to appropriate office personal.

No: Sample drugs **are not** locked. They are easily accessible to others.

NA: The office has no sample drugs.

\*22. Are narcotics double locked (if applicable)?

Yes: All controlled substances (narcotics) are clearly labeled and double locked.

No: All controlled substances (narcotics) **are not** clearly labeled and double locked.

NA: The office does not have any controlled substances (narcotics). (Controlled substances include Tylenol #3, Valium, Morphine, etc.)

\*23. Are drugs inaccessible to the patient population?

Yes: Drugs are kept in a locked cabinet with no patient access.

No: Drugs **are not** kept in a locked cabinet and/or patients may have access to these drugs as they are not in a secured location.

NA: The office has no sample drugs.

\*24. Is there a system in place for documenting the patient name, the drugs dispensed, amount dispensed, the lot number, the date of dispensing, and name of person dispensing?

Yes: There is a system in place indicating the patient name, the drug dispensed, amount dispensed, the lot number, the date of dispensing, and the name of person dispensing.

No: There is **not** a system in place indicating drug dispensed, amount dispensed, date of dispensing and the name of the person dispensing.

NA: The office does not have any drugs to dispense.

\*25. Are prescription pads secured, not pre-signed or pre-stamped?

Yes: Prescription pads are inaccessible to patients (not left in the open for one to pocket). Pads are not pre-signed or pre-stamped.

No: Prescription pads are accessible to patients; they are left in the open. Pads are pre-signed or pre-stamped.

NA: The office does not have any prescription pads.

\*26. If injections are given or blood drawn in the office, are OSHA standards for disposal of needles and syringes and blood-borne pathogens met?

Yes: Practitioner's office has a proper method for the disposal of needles and syringes and uses Universal Precautions.

No: Practitioner's office **does not** have a proper method for the disposal of needles and syringes and does not use Universal Precautions.

NA: Practitioner's office does not use needles or syringes. Policy and procedures for blood-borne pathogens do not apply.

\*27. If injections are given or blood drawn in the office, do you have a policy and procedure regarding the control of Blood-borne pathogens?

Yes: Practitioner's office has a proper method for the disposal of needles and syringes, and the office has policies and procedures for blood-borne pathogens.

No: Practitioner's office **does not** have a proper method for the disposal of needles and syringes and does not have policies and procedure for blood-borne pathogens.

NA: Practitioner's office does not use needles or syringes. Policy and procedures for blood-borne pathogens do not apply.

### **SCORING GUIDELINES**

Every numbered question must have a response. N=27

Subtract the number of NA's from total possible score of 27: \_\_\_\_\_

Count up the number of YES responses: \_\_\_\_\_

Divide the number of YES responses by the total number of applicable questions:

---

Convert score to a percent

Mark form as "P" or "F" depending upon the score; 85% and up = Passing

### **ACTION PLANS:**

Offices failing the site visit will receive a notification indicating the deficiencies. They will be asked to submit evidence of correction once complete.

Items with an asterisk (\*) that do not have a "yes" or "NA" answer may require an action plan and possibly a follow-up visit in six months. The practitioner may receive a letter notifying him/her what deficiencies need addressing in the action plan. The plan must be submitted in writing to Network Services within 30 days.

A follow-up visit may be scheduled within six months to verify that the deficiency(s) has been corrected. If the practitioner does not pass the site visit the second time, he/she will be notified in writing of a failing score and withdrawn from the network.



## PRACTITIONER/PROVIDER APPEAL PROCEDURE

In keeping with Insurance Division Regulations, NCQA standards ERISA laws and contractual obligations, Mesa Mental Health (MMH) has an appeal process that allows practitioners/providers to question decisions affecting the delivery of behavioral health care services and to request a second review of the issues involved. This document explains the process to be followed if you are dissatisfied with the decisions reached regarding the care or service referenced in this Explanation of Benefits (EOB) or denial letter. **Please note: Some regulatory bodies require you initiate your appeal within six months of the date on the EOB or denial letter.**

### ***Who may initiate the appeal process?***

Any member, guardian, practitioner or provider acting with the member's written permission can request an appeal.

### ***How does a practitioner/provider initiate the appeal process?***

Simply call the UM department locally at **816-6709** or the QM department via the toll free number, **1-800-583-6372**, and tell the customer service representative who answers the phone that you would like to initiate an appeal. You will be instructed where to send the additional information you would like considered in reviewing your case (**PO Box 90607, Albuquerque, NM 87199-0607**).

If you prefer to do this in writing, please send a letter asking to have an internal review of the decision you are unhappy with and why you feel the decision should be changed. Be sure to include additional documentation that supports your request. Send to: **Mesa Mental Health, Attn: QM Dept., PO Box 90607, Albuquerque, NM 87199-0607** OR you may fax it to **(505) 816-6702, Attn: QM Dept.**

### ***What will happen next?***

Mesa Mental Health will send you a receipt letter acknowledging your request for an internal review within one to three working days depending upon the urgency of your case. This letter will let you know how to contact someone at Mesa Mental Health should you have additional questions about the process.

### **NON-MEDICAL ISSUES SUCH AS CLAIMS PAYMENT, BENEFIT LIMITATIONS, NETWORK ISSUES AND ADMINISTRATIVE PRACTICES:**

- A decision will be reached, after reviewing the additional information, within three to twenty (20) working days of submitting your request depending upon type of review needed.
- You will receive a decision letter within twenty (20) working days of MMH receiving the request for an appeal. If the **information needed** and

requested for a decision to be made **is not received** within the allotted timeframe, **the appeal will progress** without the additional information.

## MEDICAL CARE ISSUES INVOLVING MEDICAL NECESSITY, APPROPRIATE LEVELS OF CARE AND BENEFIT LEVELS:

### **Expedited Cases:**

- If the issue is urgent or emergent, you will be notified by phone or fax that MMH is in receipt of your request for an expedited appeal.
- A decision will be rendered within 72 hours of MMH receiving the request.
- You will be verbally notified of the decision within one working day of the decision being made. A letter to you and the member will follow the phone call within two working days of the decision being made.

### **Standard Cases:**

- For standard utilization management appeals, you will be notified in writing within one working day of MMH receiving your request for an appeal.
- A decision will be made within twenty (20) working days of receiving the request. If the additional information needed cannot be obtained within the allotted timeframe, an automatic denial will be issued.
- You will be notified of the decision by phone within one working day of the decision being made. A letter to you and the member will follow the phone call within three working days confirming the decision and instructing the member on what other options they have available

### ***What will this letter say?***

The written decision letter will tell you:

- The name, title and qualifications of the person conducting the review
- What the reviewer understood the issue to be and the facts involved
- A clear and complete explanation of the reasons behind his/her decision
- Identification of the documents used to make the decision
- A statement that says the decision is binding unless the member submits a request for a Grievance Hearing to Blue Cross Blue Shield of New Mexico (BCBSNM) within ten working days of receiving the letter
- An explanation of how to request a Grievance Hearing, the name, title and phone number of a contact person at BCBSNM, and any required forms.

### ***What if I am unhappy with the Mesa Mental Health Appeals decision?***

The **member** has the right to request a grievance hearing from the insurance carrier. For Blue Cross Blue Shield of New Mexico members this means submitting a request within ten working days of receiving the MMH decision letter to: **Blue Cross Blue Shield New Mexico, Attn: Appeals Unit, QMID, PO Box 27630, Albuquerque, NM 87125-7630; 1-800-205-9926, option #4 or option #7 or locally at 505-816-2226.**



## **CLINICAL GUIDELINES FOR CHILDHOOD ATTENTION DEFICIT/HYPERACTIVITY DISORDER**

### **Includes the following DSM-IV diagnoses:**

- Attention Deficit/Hyperactivity Disorder, Combined Type (314.01)
- Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type (314.00)
- Attention Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type (314.01)
- Attention Deficit/Hyperactivity Disorder Not Otherwise Specified (314.9)

### **Defined Population:**

Members ages 6 to 12 receiving an assessment for ADHD from a behavioral health practitioner.

### **Guiding Principles:**

- ADHD is one of the most common behavioral health diagnoses in this identified population.
- In reviewing MMH claims data and member records, there was a wide variability in the process of diagnosing ADHD.
- Consistency and accuracy of diagnosis is the first step in initiating evidence based clinical guidelines.
- Research demonstrates the clear efficacy of pharmacotherapy for ADHD.

### **Core Elements:**

1. The diagnosis of ADHD should be validated by the following:
  - a) A valid, reliable ADHD screening tool (e.g., Connors) is administered in two different physical environments (e.g., school, home)
  - b) Documentation of DSM-IV criteria (may use ADHD symptom checklist provided by MMH)
2. Members meeting criteria for ADHD should be referred for medication evaluation.
3. If newly prescribed an ADHD medication, patients should have at least three follow-up care visits with a prescribing practitioner within a ten month period, one of which is within 30 days of when the first ADHD medication was dispensed.
4. Members on medication should be assessed for efficacy and side effects at least twice a year.
5. Members receiving only psychotherapy services for 12 weeks with no significant improvement should be referred for medication assessment.
6. Members not responding to medication after 12 weeks of treatment should receive a medication reassessment and/or be referred for psychotherapy services.



Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

## DSM-IV ADHD CRITERIA (314.XX)

A.  Meets **either 1 or 2**

1. **Six or more** of the following symptoms of inattention have persisted for **at least six months**:

- a. Fails to give close **attention to detail**; makes **careless mistakes**.
- b. Difficulty **sustaining attention** in tasks or play.
- c. **Does not seem to listen** when spoken to directly.
- d. Does not follow through on instructions and **fails to finish** schoolwork or chores.
- e. Often has **difficulty organizing** tasks and activities.
- f. Often avoids, dislikes, or is reluctant to engage in tasks requiring **sustained mental effort**.
- g. Often **loses items** necessary for tasks or activities.
- h. Often **easily distracted** by extraneous stimuli.
- i. Often **forgetful** in daily activities.

---

2. Meets **six or more** of the following symptoms of hyperactivity-impulsivity in 2:

### **Hyperactivity**

- a. Often **fidgets** with hands or feet or squirms in seat.
- b. Often **leaves seat** in classroom or other situations where remaining seated is expected.
- c. Often **runs about** or climbs excessively in situations where it is inappropriate.
- d. Often has **difficulty playing** or engaging in leisure activities **quietly**.
- e. Often **“on the go”** or often acts as if “driven by a motor”.

### **Impulsivity**

- f. Often **talks excessively**.
- g. Often **blurts out answers** before questions have been completed.
- h. Often has **difficulty waiting turn**.
- i. Often **interrupts** or intrudes on others.

---

### **Meets all of the following:**

- B.  Some hyperactive-impulsive or inattentive symptoms were **present before age 7 years**.
- C.  Some impairment from the symptoms is **present in two or more settings**.
- D.  Clear evidence of clinically **significant impairment** in social, academic, or occupational function.
- E.  **Symptoms do not occur** exclusively during the course of a **Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder** and are not accounted for by another mental disorder.

- 314.01 ADHD Combined Type
- 314.00 ADHD Predominately Inattentive Type
- 314.01 ADHD Predominately Hyperactive/Impulsivity
- 314.9 ADHD NOS

Clinician Signature \_\_\_\_\_

Date \_\_\_\_\_



## **CLINICAL GUIDELINES FOR ADULT DEPRESSION**

### **Includes the following DSM-IV diagnoses:**

- Major Depressive Disorder, Single Episode (296.2x)
- Major Depressive Disorder, Recurrent (296.3x)
- Dysthymic Disorder (300.4)
- Depressive Disorder, NOS (311)
- Adjustment Disorder with Depressed Mood (309.0)
- Adjustment Disorder with Mixed Anxiety and Depressed Mood (309.28)
- Mood Disorder with Depressed Features (293.83)

### **Defined Population:**

Adult members receiving an assessment for depression from a behavioral health practitioner.

### **Guiding Principles:**

- Depression is one of the most common behavioral health diagnoses seen in the outpatient population.
- Consistency and accuracy of diagnosis is the first step in initiating evidence-based clinical guidelines.
- Current research validates the efficacy of both psychotherapy and pharmacological interventions.

### **Core Elements:**

1. The diagnosis should be made using objective criteria with documentation of appropriate DSM-IV criteria used to reach the diagnosis.
2. Members who exhibit significant risk to self and others for any reason should be immediately assessed for hospitalization.
3. Medication intervention should be considered for members with a GAF score below 50.
4. If antidepressant medications are initiated, they should be continued for 12 weeks to assess effectiveness.
5. For members already on medications for depression, the efficacy of those medications should be evaluated as part of the initial assessment and periodically thereafter as appropriate.
6. For members showing no improvement after eight weeks of psychotherapy alone, the practitioner should refer the member for a medication evaluation.



Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

### DSM IV CHECKLIST CRITERIA FOR MAJOR DEPRESSIVE EPISODE 296.2X AND 296.3X

- A. **Five (or more)** of the following symptoms present **during same 2-week period** and represent a change from previous functioning: **at least one** of the symptoms is **either (1) depressed mood** or **(2) loss of interest or pleasure**.
  - 1. **Depressed mood** most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation by others (e.g., appears tearful). In children & adolescents, can be irritable mood.
  - 2. Markedly **diminished interest or pleasure** in all, or almost all, activities most of the day, nearly every day (subjective account or observation by others).
  - 3. Significant **weight loss** when not dieting **or wt. gain** (e.g., change of >5% of body wt. in a month), or ↓ or ↑ in **appetite** nearly every day. In children, consider failure to make expected wt gains.
  - 4. **Insomnia** or **hypersomnia** nearly every day.
  - 5. **Psychomotor agitation** or **retardation** nearly every day (observable by others, not subjective feelings of restlessness or slowed down).
  - 6. **Fatigue** or **loss of energy** nearly every day.
  - 7. Feelings of **worthlessness** or excessive or inappropriate **guilt** (may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
  - 8. Diminished ability to **think** or **concentrate**, or **indecisiveness**, nearly every day (by subjective account or observed by others).
  - 9. Recurrent **thoughts of death** (not just fear of dying), **recurrent suicidal ideation** w/o a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet criteria for a Bipolar Mixed Episode.

### Criteria for Dysthymic Disorder 300.4

- A. **Depressed mood** for most of day, for more days than not, indicated by subjective account or observation by others, for **at least 2 yrs.** In children & adolescents, mood can be irritable & duration must be at least 1 yr.
- B. Presence, while depressed, of **2 or more of following**:
 

<input type="checkbox"/> Poor appetite or overeating	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Insomnia or hypersomnia	<input type="checkbox"/> Poor concentration or difficulty making decisions
<input type="checkbox"/> Low energy or fatigue	<input type="checkbox"/> Feelings of hopelessness
- C. During the 2-yr. period (1 yr. for children or adolescents) of the disturbance, **the person has never been without the symptoms** in Criteria A & B for more than 2 months at a time.
- D. **No Major Depressive Episode** has been present **during the first 2 yrs. of the disturbance** (1 yr. for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

### Criteria for Adjustment Disorder with Depressive Features 309.0

- A. The development of emotional or behavioral symptoms in **response to an identifiable stressor(s)** occurring **within 3 months of the onset** of the stressors.
- B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
  - Marked distress in excess** of what would be expected from exposure to the stressor
  - Significant **impairment in social or occupational** (academic) functioning
- C. The stress-related disturbance **does not meet the criteria for another specific Axis I disorder** & is not an exacerbation of a preexisting Axis I or Axis II disorder.
- D. The symptoms **do not represent Bereavement**.
- E. **Once the stressor** (or its consequences) **has terminated**, the symptoms **do not persist** for more than an additional **6 months**.
- F. **Depressed mood**.

Clinician Signature \_\_\_\_\_

Date \_\_\_\_\_



## Mesa Mental Health Behavioral Health Case Management Referral Guidelines

To qualify for case management referral, the member must have a behavioral health diagnosis and at least one of the following (please check all that apply):

1.  High utilization of benefits (examples):
    - Frequent Emergency Room visits for behavioral health-related crisis.
    - Member close to exhausting their behavioral health benefits.
    - Member who is close to or has reached their catastrophic cap due to high utilization of behavioral health services.
    - Members with multiple providers (i.e., drug-seeking behaviors) without coordination of care.
  2.  Repeated non-compliance with recommended treatment(s) that resulted in usage of higher levels of care (two or more inpatient behavioral health admissions within six months).
  3.  Chronic suicidal, lethal, dangerous behaviors and those that could cause harm to children/others.
  4.  Need for linkage to community support, community resources or alternative funding sources and/or assistance in navigating the process of comprehensive or complex resources and the member is **unable** to navigate the process without assistance.
  5.  Members with insufficient or minimal family, social or financial supports causing significant impairment or stress.
  6.  Newly diagnosed members who require education about their behavioral health illness and available resources the member and/or family are **unable** to research without assistance.
  7.  Significant co-morbidity of medical and mental health issues needing facilitation of communication between primary care and behavioral health providers.
  8.  Dual diagnosis clients with a history of two or more relapses or psychiatric hospitalizations within one year.
  9.  History of AMA discharge with no discharge planning.
  10.  Other: \_\_\_\_\_
- 

### Exclusions

- Member refuses
- Legal guardian refuses

To make a Behavioral Health Case Management referral, please fax the completed form to:

**Case Management Department  
Mesa Mental Health  
Fax: 505-816-6702**



## MEMBERS' RIGHTS AND RESPONSIBILITIES

**All plan members seeking services through Mesa Mental Health (MMH) have the right.....**

- To be treated in a courteous manner that respects your privacy and dignity as a person.
- To the confidential handling of all communications, including medical and financial information, maintained by MMH or its health care providers as provided by law and professional medical ethics.
- To be provided with information about your behavioral health care benefits including covered practitioners, excluded services and other limitations, prior authorization and utilization management requirements, clinical guidelines, and rights and responsibilities as a MMH member.
- To participate with practitioners in the decision making regarding your treatment planning.
- To voice dissatisfaction with services received or the care provided to MMH administrative personnel, your health plan or to the Superintendent of Insurance.
- To be represented at or participate in person with the MMH appeals process/panel, that of your health plan, and/or the NM Department of Insurance External Review Process and to receive a response in a timely manner.
- To receive, upon request, a copy of the criteria used in making care or service decisions.
- To discuss appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To make recommendations regarding members' rights and responsibilities.
- To request and obtain information about any financial arrangements between MMH and its practitioners that might restrict referral or treatment options or limit services offered to Members.
- To seek care from an Out-of-Network Practitioner and be advised of your financial responsibility if you receive services from an Out-of-Network Practitioner or receive services without required preauthorization.
- To refuse care, treatment, medications and/or a specific practitioner, after the practitioner has explained the care, treatment or other advice in language you understand, and informed you of the potential consequences of refusing care or treatment.
- To have adequate access to qualified health professionals near where you live or work.
- To receive information from your practitioner, in terms that you understand, including an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable alternatives.
- To have new technologies and interventions evaluated and, if appropriate, recommended for inclusion as a covered benefit.
- To the availability and accessibility of medically necessary urgent and emergent services 24 hours a day, seven days a week.
- To deny the release of your identifiable medical information except where required by law.



## **MEMBERS' RIGHTS AND RESPONSIBILITIES**

**All plan members seeking services through MMH have the responsibility.....**

- To provide, to the extent possible, information that MMH and its practitioners and providers need in order to care for you.
- To keep the insurance company apprised of your current and correct address and phone number.
- To follow the plans and instructions for care that you have agreed upon with your practitioners.
- To participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- To understand the information in your member handbook regarding your behavioral health benefits.
- To know the proper steps for accessing your behavioral health benefits.
- To consult your PCP, when required by your health plan, for direction prior to receiving medical care, unless your situation is life-threatening.
- To ask questions of your plan's practitioner and seek clarifications until you fully understand the care you are receiving.
- To provide honest and complete information to those providing care.
- To express your opinions, concerns, or complaints to the appropriate people, and to follow the plan's established appeals and grievance process when dissatisfied with the plan's actions or decisions.
- To allow communication between your behavioral health therapist and your primary care physician for continuity and coordination of care.



## **RELEASE OF INFORMATION (ROI) GUIDE**

The following is not meant to be a definitive or legal interpretation but a guide for firming up your ROI so that it is more comprehensive and better protects your practice. ROI's need to be very specific and should inform the Patient about their rights so that they are giving informed consent to release information.

Important to include in an ROI is a specific description of the type of information to be released or obtained, with whom the information will be exchanged, and whether the information is being released to or obtained from the other entity.

Include a statement regarding that the Patient's records will be kept private and confidential, that the Patient voluntarily authorizes this release of information, that the Patient has the right to examine and copy the information disclosed unless deemed that such disclosure is not in their best interest, and that the Patient has the right to revoke their authorization at any time.

The following form is a sample of an ROI that you may modify to fit your needs. Feel free to research ROI information to make sure that your form is up to HIPAA standards.

**Provider Name**  
Provider Address  
Provider Phone Number

**AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL CLIENT INFORMATION**

I, \_\_\_\_\_ hereby authorize **(Provider Name)** to: \_\_\_\_\_ Release \_\_\_\_\_ Obtain the information designated below for:

Client Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

To the following individual/organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorized the release of information for the areas indicated below for the purpose of coordinating treatment:

- |   |   |
|---|---|
| _____ Attendance and cooperation with treatment | _____ Psychotherapy Progress Data       |
| _____ Discharge Summary                         | _____ Psychological/Educational Testing |
| _____ Psychological/Psychiatric Evaluation      | _____ School Records                    |
| _____ Insurance Claims                          | _____ Verbal Only                       |

\_\_\_\_\_ Other \_\_\_\_\_

**Revocation:**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **(Provider Name)** at the above address. I further understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Expiration:**

Unless sooner revoked, this consent expires on the following date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ or as otherwise indicated: \_\_\_\_\_

**Conditions:**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that **(Provider Name)** will not condition my treatment on whether I give authorization for the requested disclosure. I understand I have the right to examine and copy the information to be disclosed unless deemed that such disclosure is not in my best interest. However, it has been explained to me that failure to sign this authorization may have the following consequences:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact **(Provider Name)**.

A photocopy of this authorization that contains my signature shall be considered as effective and as valid as the original and shall be honored by those to whom it is provided. I release **(Provider Name)** from liability and claims of any nature pertaining to the disclosure of the health information identified in this authorization.

---

Signature of Patient/Client Date

---

Signature of Parent, Guardian or Personal Representative Date

---

Signature of Staff Witness Date

Check here if patient/client refuses to sign authorization

---

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations also restrict any use or disclosure of information to criminally investigate or prosecute any alcohol or drug abuse client.



**MESA**  
MENTAL HEALTH

# **State Coverage Insurance (BlueSCI)**

## **A Supplement to the Mesa Mental Health Practitioner Manual**

**2010**

# TABLE OF CONTENTS

<b>BLUESCI OVERVIEW AND INTRODUCTION .....</b>	<b>1</b>
<b>BLUESCI INSTRUCTIONS FOR PRACTITIONERS/PROVIDERS .....</b>	<b>1</b>
<b>PROGRAM OVERVIEW .....</b>	<b>3</b>
<b>CUSTOMER SERVICE .....</b>	<b>5</b>
<b>AUTHORIZATIONS .....</b>	<b>5</b>
<b>CLAIMS PROCESS .....</b>	<b>5</b>
<b>COMPLIANCE WITH BLUESCI POLICIES.....</b>	<b>7</b>
<b>QUALITY IMPROVEMENT PROGRAM .....</b>	<b>8</b>
<b>UTILIZATION MANAGEMENT/CASE MANAGEMENT .....</b>	<b>8</b>
<b>PROVIDER SATISFACTION SURVEY.....</b>	<b>9</b>
<b>APPEALS PROCESS.....</b>	<b>9</b>
<b>SANCTIONS UNDER FEDERAL HEALTH PROGRAMS AND STATE LAW</b>	<b>9</b>
<b>CREDENTIALING AND RE-CREDENTIALING OF PARTICIPATING PROVIDERS .....</b>	<b>10</b>
<b>APPEAL PROCESS FOR PROVIDER PARTICIPATION DECISIONS.....</b>	<b>11</b>
<b>MEDICAL RECORDS .....</b>	<b>11</b>
<b>MEMBER RIGHTS AND RESPONSIBILITIES (MEMBER BILL OF RIGHTS) 12</b>	
<b>QUICK REFERENCE GUIDE.....</b>	<b>14</b>

## BLUESCI OVERVIEW AND INTRODUCTION

HCSC Insurance Services Company (HISC), a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, has contracted with the State of New Mexico, Human Services Department, Medical Assistance Division (HSD/MAD), to offer the State Coverage Insurance (BlueSCI) Plan. Blue Cross and Blue Shield of New Mexico (BCBSNM), as an operating division of HCSC has contracted with HISC to administer this plan. MMH, through a delegated agreement with BCBSNM is administering the Utilization Management, Customer Service, and Quality Management for the BlueSCI plan.

The SCI program was developed to assist uninsured working adults in obtaining affordable health care coverage to individuals and small employer groups with some state funding assistance.

This supplement to the MMH Practitioner Manual applies to MMH network practitioners, providers, and facilities who have agreed to participate in the BlueSCI plan and who have signed a BlueSCI Amendment. The MMH Practitioner Manual plus this supplement explain the policies and procedures as set forth in your contract and in the Practitioner Manual. We hope this supplement provides you with helpful information as you care for our members and clients. The information in this supplement is intended to provide guidance in most situations you will encounter while participating in the BlueSCI Plan. This supplement only pertains and is applicable to the Operation of the BlueSCI plan.

***Please refer to the Blues Provider Reference Manual on the [bcbsnm.com](http://bcbsnm.com) web site for a more detailed description of the BlueSCI Program and Policies.***

## BLUESCI INSTRUCTIONS FOR PRACTITIONERS/PROVIDERS

Behavioral Health and Substance Abuse Services: The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to twenty-five (25) days per benefit year with prior authorization.

### **Behavioral Health Services:**

- Outpatient office visits for mental health evaluations and treatment. Prior authorization is required for over seven (7) visits.
- Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital--prior authorization is required.

## **Substance Abuse Services:**

- Outpatient substance abuse including visits, detoxification and intensive outpatient care limited to forty-two (42) days per benefit year; and
- Inpatient substance abuse detoxification--prior authorization is required.

***Covered Services and Limitations on coverage: The SCI benefit package is limited to \$100,000 in benefits payable per member per benefit year.***

## **Medically necessary services are behavioral health services that:**

- are essential to prevent, diagnose or treat behavioral health conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific behavioral health care needs of the individual;
- are provided within professionally accepted standards of practice and national guidelines; and
- are required to meet the behavioral health needs of the individual and are not primarily for the convenience of the individual, provider or the payer.

## **Behavioral Health and Substance Abuse Services:**

- Inpatient mental health and substance abuse services/partial hospitalizations are limited to twenty-five (25) days per benefit year.
- Inpatient substance abuse detoxification is limited to seventy-two (72) hours per occurrence as part of the twenty-five day benefit for inpatient mental health services.
- Outpatient substance abuse detoxification services are limited to ten (10) days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to forty-two (42) days per benefit year.

## **Services excluded from the SCI benefit Package:**

The following behavioral health services are not covered:

- Behavioral health services that are rendered in connection with a disorder not classified in the international classification of diseases 9th revision, clinical modification (ICD 9-CM).
- Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.
- Court ordered: Court mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO.

- Learning disorders: Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance.
- Marital therapy or counseling.
- Inpatient substance abuse other than detoxification.
- Telephone visits.

## **Services for Individuals with Special Health Care Needs (ISHCN)**

MMH will identify Individuals with Special Health Care Needs (ISHCN) or members with complex physical and behavioral health care needs, for the purpose of facilitating access to appropriate services. The ISHCN program is defined as individuals who have or are at an increased risk for a chronic physical, developmental, behavior, neurobiological or emotional condition, or have low to severe functional limitations and who also require health and related services of a type or amount beyond that required by individuals generally. Examples of common diagnosis include:

- Asthma
- Diabetes
- Congenital Anomalies
- Metabolic Disorders
- ADHD
- Behavioral Health Diagnosis
- Congenital Heart Disease

## **Coordination of Physical and Behavioral Health Services**

The Behavioral Health Practitioner/Provider shall communicate with the member's PCP for the purposes of coordination of care. The behavioral health practitioner/provider shall regularly exchange information with the PCP such as but not be limited to the following in order to better serve the member:

- Medication history
- Lab results
- Treatment plans
- Hospitalizations
- Suicide attempts

## **Balance Billing**

You cannot bill a member for non-covered services unless:

You have informed the member in advance that the service is not covered, and the member has agreed, in writing, to pay for the services if they are not covered.

## **PROGRAM OVERVIEW**

Participating practitioners are expected to provide coverage for BlueSCI members 24 hours a day, 7 days a week. When a participating practitioner is unavailable to provide services, the practitioner must ensure that he or she has arranged for coverage from another practitioner. Hospital emergency rooms or urgent care centers are not substitutes for coverage. Practitioners may contact MMH's Customer Service Department with questions regarding which providers participate in the BlueSCI Network.

## **Appointment Access**

Practitioners are expected to provide 24-hour access to behavioral health care. The following are MMH's care access guidelines for emergent, urgent, and routine care needs.

- **Life-threatening Emergencies**

Immediately

- **Emergent non-life threatening Appointments**

If the member's need is emergent, but non-life threatening, the member must be seen within six (6) hours of referral as stated in the practitioner's contract.

- **Urgent Appointments**

The member must be seen within twenty-four (24) hours of referral.

- **Non-urgent Routine Appointments**

The request-to-appointment time shall be no more than ten days.

## **Emergency Care**

Emergency care services necessary to evaluate and stabilize an Emergency Medical/Behavioral Health Condition are covered by BlueSCI. Members with an Emergency Medical/Behavioral Health Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require preauthorization. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral; health could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member.

## CUSTOMER SERVICE

MMH maintains a Customer Service Call Center to assist both practitioners and members. Practitioners may contact our Customer Service Department for general questions at (800) 583-6372. One of our Customer Service Representatives will assist with the resolution of member-focused problems dealing with covered benefits, pre-authorizations, etc.

## AUTHORIZATIONS

Unless otherwise prohibited by law, prior authorizations are necessary for certain services before they are rendered. Authorizations are based on benefits as well as medical necessity, which are supported through clinical information supplied by requesting practitioners/providers. Prior authorizations can be obtained by calling (505) 816-6792 or (800) 583-6372 for both inpatient and outpatient care.

### ***Outpatient Services:***

- Prior authorization is required ***after the first seven (7) visits*** for Outpatient Behavioral Health Services. After the seventh visit, practitioners/providers may request prior authorization by completing Mesa's Outpatient Treatment Authorization (OTR) Report which is available on our website at [www.mesamentalhealth.com](http://www.mesamentalhealth.com).

### ***Inpatient Services:***

- Prior authorization is required ***for all Inpatient*** Mental Health Services and Partial Hospitalization. Prior authorization for inpatient services may be obtained by calling (505) 816-6792 or (800) 583-6372.

## CLAIMS PROCESS

Claims should be submitted as follows:

- Claims should be submitted electronically through Availity Health Information Network for processing.
- The BlueSCI Electronic Payer ID # for Participating Physician/Professional Providers and Participating Facilities is 00790.
- For information on electronic filing of claims, contact Availity at 1-800-282-4548.
- Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. BlueSCI Practitioners and Providers may not seek payment from the Member for claims submitted after the 180 day filing deadline.
- Paper claims must be submitted on the Standard CMS-1500 (Physician/Professional Provider) or CMS-1450 (UB04 – Facility) claim form to:

### **Medicaid**

**PO Box 27838  
Albuquerque, NM 87125-7838**

- Claims (electronic and paper) must be filed with the Member's complete ID number exactly as it is shown on the member's ID card, including the following 3-digit alpha prefix: YIF.

Claims containing substantially all the required data elements necessary for accurate adjudication ("clean claim") without the need for additional information pay within thirty (30) calendar days of receipt.

Duplicate claims may not be submitted prior to the applicable 30-day claims payment period.

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the BCBSNM Provider Customer Service Department at the number listed on the Key Contacts page.

You may not bill a Member for a non-covered service unless:

- 1) You have informed the Member in advance that the service is not covered, and,
- 2) The Member has agreed in writing to pay for the services if they are not covered.
- 3) You also may not bill members for provider errors, timely filing issues or failures to obtain prior authorization.

MMH is required to report ALL services rendered to BlueSCI members to the New Mexico Human Services Department (HSD). The reporting of these services, also known as encounter reporting, is an extremely critical element to the success of BlueSCI. HSD uses encounter reporting data to evaluate health plan compliance on many vital issues.

Regardless of whether the service you provide is capitated or fee-for-service, claims should be submitted to BCBSNM within 50 days of the date of service to accommodate the State of New Mexico's request for timely encounter data. This would also include claims for which you expect no reimbursement from because another payer has already paid the claim in full.

## COMPLIANCE WITH BLUESCI POLICIES

BlueSCI Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered services in a manner consistent with standards related to medical practices that are generally accepted in the medical and professional community at the time of treatment. Participating Providers must also comply with BlueSCI standards, which include but are not limited to:

- All federal, state, and local laws regarding the conduct of their profession

Participating Practitioners/Providers must also comply with BlueSCI policies and procedures regarding the following:

- Preauthorization requirements and timeframes
- Participating Practitioner/Provider credentialing requirements
- Accessibility of Member medical record information to fulfill the business and clinical needs of BlueSCI
- Providing treatment to patients at the appropriate level of care; and
- Providing equal access and treatment to all BlueSCI Members

Participating Providers acting within the lawful scope of practice are encouraged to advise Members about:

- The patient's health status, appropriate medically necessary care or treatment (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Such actions shall not be considered non-supportive of BlueSCI and BlueSCI will never adopt any policy or practice that prohibits Participating Practitioner/Providers from advising members about their health status, medical care or treatment options.

## QUALITY IMPROVEMENT PROGRAM

MMH subscribes to and actively supports Quality Improvement projects. MMH's QM Program:

- Incorporates information from customer service, utilization management, credentialing, and provider relations.
- Has a policy making body (Management Team) that evaluates the effectiveness of the QM Program.
- Is annually evaluated for strategy, progress, and development.
- Is the designated responsibility of the Quality Management Director
- Assures participation from affiliated providers through committee participation.
- Assures the incorporation of member input.
- Has a data collection system that is capable of collecting member and provider characteristics and other such data needed to guide the selection of performance improvement topics.

Please see the Quality Management Program section in the MMH Practitioner Manual for more information.

## UTILIZATION MANAGEMENT/CASE MANAGEMENT

MMH's UM Standards include the following:

- Using written criteria based on sound clinical evidence for making UM decisions
- Using qualified healthcare professionals to assess the clinical information used to support UM decisions
- Making preauthorization decisions for inpatient and ambulatory care following written policies and procedures that reflect medical coverage rules, practice guidelines, and current standards of practice
- Providing Referral Services, if required
- Offering Case Management and Care Coordination Services
- Providing assistance in the selection of a Participating Physician/Professional Provider
- Providing Crisis Intervention
- Assisting Practitioners with Discharge Planning
- Ensuring that there are mechanisms in place to detect under and over utilization of services
- Ensuring that there are mechanisms in effect to ensure consistent application of review criteria
- Ensuring that there are clinical peers to review decisions to deny authorization based on Medical Necessity

- Ensuring that UM activities are not structured so as to provide inappropriate incentives for denial
- Policies that do not prohibit Practitioners from advocating on behalf of members in the Utilization Management process.

## PROVIDER SATISFACTION SURVEY

MMH will conduct an annual Provider Satisfaction Survey for MMH providers following NCQA guidelines and provide the results to the New Mexico Human Services Department (HSD) and the Medical Assistance Division (MAD).

## APPEALS PROCESS

BCBSNM will be managing all Complaints, Appeals and Grievances related to BlueSCI relative to denial of or limited authorizations or reduction, suspension or terminations of previously authorized Behavioral Health care service. Please mail or fax non-expedited requests to:

**BlueSalud/BlueSCI Appeals**  
**PO Box 27630**  
**Albuquerque, NM 87125-7630**  
**Fax number: 1-505-816-3837**

**For Expedited Appeals Only, call (877) 232-5520**

## SANCTIONS UNDER FEDERAL HEALTH PROGRAMS AND STATE LAW

Participating Practitioners, Providers, and Facilities must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other Federal Health Care Programs are employed or subcontracted by the Participating Practitioner, Provider, or Facility.

Participating Practitioners, Providers, and Facilities must disclose to MMH whether they or any staff member or subcontractor has any prior violation, fine, suspension, termination, or other administrative action under Medicare or Medicaid laws; the rules or regulations of the State of New Mexico; the Federal Government; or any public insurer. Participating Practitioners, Providers, and Facilities must notify MMH immediately if any such sanction is imposed on the Practitioner, staff member, or subcontractor.

## CREDENTIALING AND RE-CREDENTIALING OF PARTICIPATING PROVIDERS

MMH verifies that all practitioners/providers meet applicable federal and state requirements for licensing, certification and accreditation for the type of care or services within the scope of practice as defined by federal statutes and state law. This is achieved through the initial credentialing and re-credentialing process as outlined below:

### **Initial Credentialing Process:**

If the provider is approved for inclusion in the MMH Network, the Credentialing Vendor (CVO) will be informed of such and will contact the practitioner/provider for the following:

- Application including signed attestation
- Current license to practice
- Copy of liability insurance
- Copy of DEA and/or CSR certificate, if applicable
- Current curriculum vitae
- Five peer references

Once the CVO has collected all required documents from the provider, the complete file will be shipped to MMH for final processing.

### **Re-Credentialing Process:**

MMH re-credentials its practitioners/providers every three years. The CVO will contact the practitioner/provider again to request the required documentation for re-credentialing. These documents will be similar to those required for initial credentialing with the following exceptions:

- Peer references are not required.
- A random sample of providers due for re-credentialing will be selected for a site evaluation.

## **Site Evaluations**

Practitioner site evaluations are a Health Plan requirement and an accrediting standard. The purpose is to ensure that members are being seen in office sites that meet certain safety standards and comply with regulatory expectations for privacy, confidentiality, access, and storage of patient treatment records and release of medical record information. To this end, each practitioner and freestanding program must have an initial site evaluation before their credentialing application can be acted upon. Complaints against a practitioner also warrant a site evaluation. Network Services staff conducts the Practitioner site evaluations with every consideration given to minimal disruption of office functioning. Failure

to pass the site evaluation will result in the need for a corrective action plan from the practitioner as well as a repeat evaluation within six months to one year. Failure of certain critical elements may result in an immediate suspension of referrals to the practitioner until the problematic area is remedied.

## APPEAL PROCESS FOR PROVIDER PARTICIPATION DECISIONS

If MMH decides to suspend, terminate, or non-renew a Practitioner, Provider, or Facility's participation status, MMH will give the affected person, group, or facility written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the practitioner. MMH will allow the practitioner, provider, or facility to appeal the action to a hearing panel, and give written notice of their right to an appeal hearing and the process and timing for requesting a hearing. MMH will ensure that the majority of the hearing panel members are peers of the affected person, group, or facility. A recommendation by the hearing panel is advisory and is not binding on MMH.

If a reduction, suspension, or termination of a BlueSCI participating practitioner, provider, or facility is final and as a result of quality of care deficiencies, MMH will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted provider groups must certify that these procedures apply equally to practitioners within those groups.

## MEDICAL RECORDS

### **BlueSCI Standards for Medical Records**

Participating Providers must have a system in place for maintaining medical records for a period of not less than ten (10) years that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the Member's medical chart. Each medical record chart must include all of the elements as specified in the MMH Provider Manual. MMH annually conducts a medical record review of practitioner records for compliance to the standards based on a sampling methodology. Access to practitioner records for this and other quality related purposes is required per the Behavioral Health Services Agreement (BHSE) or practitioner contract.

### **Confidentiality of Member Information**

Participating Providers must comply with all state and Federal guidelines and HIPAA Law concerning confidentiality of health and other information about members. Participating Providers must have internal policies and procedures regarding use and disclosure of health information that comply with all applicable laws.

## MEMBER RIGHTS AND RESPONSIBILITIES (MEMBER BILL OF RIGHTS)

BlueSCI Members have the right to timely, high quality care, and treatment with dignity and respect. Participating Providers must respect the rights of all Members.

Members have been informed that they have the following rights and responsibilities, including, but not limited to:

- The right to health care when medically necessary as determined by their doctor and BCBSNM, 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined by the member handbook
- Choose a PCP or provider from the BCBSNM network and be able to refuse care of certain providers (a prior authorization may be necessary to see some providers)
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage; if the information is not clear, an explanation will be provided to next of kin, guardian, agent or surrogate, if able, and documented in Member's medical records
- To actively participate in decisions regarding their health and treatment options and give informed consent for medical services
- Members who have a disability have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act
- To file a complaint or appeal about BCBSNM or the care that you received and receive an answer within a reasonable time
- To be able to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands
- To have an interpreter when the Member does not speak or understand the language that is being spoken
- The right to talk to their provider about new uses of technology
- Members have the right:
  - To be treated with dignity and respect and to have their right to privacy recognized
  - To exercise these rights regardless of the Member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care
  - To confidential treatment of all communications and records pertaining to the Member's care
  - To access, copy and/or request amendment to the Member's medical records consistent with the terms of HIPAA

- To extend their rights to any person who may have legal responsibility to make decisions on the Member's behalf regarding the Member's medical care
- To refuse treatment or leave a medical facility, even against the advice of Participating Physicians/Professional Providers (providing the Member accepts the responsibility and consequences of the decision)
- To complete an Advance Directive, living will or other directive and have it filed with their medical records
- To know the name and job title of people giving them care
- To be free from restraint or seclusion when used as a means of force, discipline, convenience, or retaliation
- Members have been informed that they have the following responsibilities:
- To become familiar with their coverage and the rules they must follow to receive care as a Member
- To give their Participating Physician/Professional Provider and other Providers the information they need to care for the Member, and to follow the treatment plans and instructions that the Member and his/her Participating Physician/Professional Provider agree upon
- To be sure to ask their Participating Physician/Professional Provider if they have any questions
- To keep, reschedule or cancel an appointment rather than to simply not show up
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities
- To let BCBSNM know if they have any questions, concerns, problems or suggestions
- To report all information regarding other insurance coverage to the Income Support Division (ISD) case worker assigned to the Medicaid member
- To supply their Member ID card to their provider for insurance confirmation

## QUICK REFERENCE GUIDE

### BlueSCI Key Contacts List

Provider Customer Service	(505) 816-6792 or (800) 583-6372
Member Customer Service	(866) 689-1523
Mesa Mental Health Network Services/ Contracting Department	(505) 816-6737
Electronic Claim Questions, or Problems	
The Availity Health Information Network	(800) 282-4548
Web Site Address	www.availity.com
BlueSCI Claims Address (for submission of paper claims)	Medicaid PO Box 27838 Albuquerque, NM 87125-7838
Preauthorizations	
Mesa Mental Health	(505) 816-6792 or (800) 583-6372
Mesa Mental Health Mailing Address	PO Box 90607 Albuquerque, NM 87199-0607
Mesa Mental Health Web Site Address	www.mesamentalhealth.com
Utilization Management Appeals (BCBSNM)	(877) 232-5520
Blue Cross/Blue Shield of New Mexico	
Phone	(505) 816-2000
Website	www.bcbsnm.com



MESA MENTAL HEALTH  

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CORPORATE HEALTH RESOURCES

# **Employee Assistance Program Services Manual**

**2010**

# **TABLE OF CONTENTS**

## **MMH/CHR EMPLOYEE ASSISTANCE PROGRAM SERVICES**

<b>1.HISTORY OF EMPLOYEE ASSISTANCE PROGRAMS.....</b>	<b>1</b>
<b>2.THE EAP CARE PHILOSOPHY .....</b>	<b>1</b>
<b>3.HOW EAP CLIENTS GET TO PRACTITIONERS.....</b>	<b>2</b>
<b>4.Filing Claims for EAP ASSESSMENT &amp; Counseling Services.....</b>	<b>2</b>
<b>5.. TRANSITIONING CLIENTS TO BEHAVIORAL HEALTH BENEFITS AND ALTERNATE RESOURCES .....</b>	<b>3</b>
<b>6.ACCEPTING CLIENTS ON SUPERVISORY REFERRALS .....</b>	<b>4</b>
<b>7.SEEING CLIENTS WITH SUBSTANCE ABUSE ISSUES.....</b>	<b>5</b>
<b>8.CASE MANAGEMENT ACTIVITIES.....</b>	<b>5</b>
<b>9.EAP FORMS .....</b>	<b>6</b>

## **INTAKE ASSESSMENT**

**CONSENT FOR DISCLOSURE OF INFORMATION FROM THE EMPLOYEE ASSISTANCE PROGRAM TO THE SUPERVISOR**

**CONSENT AND AUTHORIZATIONFOR RELEASE OF INFORMATION**

**ACTION PLAN**

**CLIENT CONTACT RECORD**

**HICFA CLAIM FORM SAMPLE**

**TERMINATION SUMMARY**

# **MMH/CHR EMPLOYEE ASSISTANCE PROGRAM SERVICES**

## **1. HISTORY OF EMPLOYEE ASSISTANCE PROGRAMS**

Today's Employee Assistance Programs (EAP) are an outgrowth of programs developed and implemented in the early 1900's to address the problem of alcoholism in the workplace and its significant impact on absenteeism, worker performance, and productivity. World War II saw escalation in the popularity of EAPs as production demands pushed for increased employee efficiency. After the war, the attention on EAPs seemed to diminish. However, with the increases in substance abuse seen in the 1960's and 1970's, employers once again began to look for ways to address the impact of this issue in their workplaces. Contributing to this phenomenon was a continually increasing government presence in the form of regulatory and oversight legislation. Still, at this point, EAPs functioned predominantly as counseling agents with services focused on alcohol and substance abuse. In recent years and in response to changes in the workforce, EAPs have expanded to deal with a variety of home and family-based problems that negatively impact employee morale and job performance. EAPs today have taken on many diverse and varied forms. Some exist simply as a counseling resource, not far removed from the origin of the product. Some offer "concierge" and similar services seemingly unrelated to employee/employer welfare. **CORPORATE HEALTH RESOURCES**, the EAP owned and operated by Mesa Mental Health, believes that an effective and valuable EAP functions as a business partner, providing services to address and support the overall well-being of an organization and those individuals who comprise it. As such, CHR takes a very "hands on" approach to service delivery. Each of our client companies has a dedicated Account Manager that works in concert with a designated liaison within the client company to maximize the benefits of an EAP program.

## **2. THE EAP CARE PHILOSOPHY**

Because CHR delivers the counseling piece of its EAP program via the credentialed and contracted network participants, it's crucial that those clinicians understand how behavioral health therapy and EAP work are alike and how they are different. Legitimate similarities exist between EAP counseling and behavioral health therapy services. Confidentiality, record keeping, licensure of practitioners, risk assessment, family history, and level of client functioning are all integral to both disciplines. Beyond this, however, EAP becomes a very different entity, and moving from one to another requires a significant shift in the practitioner's thinking and in the approach to the client.

The key to the successful practitioner/EAP client encounter is the thoroughness of the initial assessment. The practitioner's approach should be one of "triage", ultimately developing an action plan that may or may not include counseling with that practitioner. The action plan should focus on the issue that is causing the client problems in the workplace. The practitioner needs to establish rapport with the client, but bonding is inappropriate in the context of situation-based problem solving. The practitioner must be ever mindful of other resources that are available in the community. *EAP clients should be kept for counseling only if the practitioner reasonably believes that substantial problem resolution can be achieved in the sessions available to the client through his or her employer's EAP plan model.* Otherwise, the client should be referred to alternate resources at the conclusion of the initial assessment. EAP works with "problem identification" as opposed to a diagnosis. Clearly, some clients will present with issues that are not suited to management within the context of the EAP problem resolution model. In these cases, it is critical for the practitioner to refer the client to appropriate care after completing the assessment. CHR's clinical and case management staff are always available to network practitioners to assist in identifying alternate community resources or in transitioning clients to care via behavioral health insurance benefits.

### **3. HOW EAP CLIENTS GET TO PRACTITIONERS**

Calls requesting counseling services for CHR client company employees and their eligible household members are received and responded to by the MMH/CHR Call Center staff. All persons accessing the EAP benefit ultimately speak with a Case Manager. After collecting and recording triage information, callers are given the names of several practitioners. These referral suggestions are based on the client's identified need/s, proximity to the practitioner, practitioner specialty, etc. The client makes a selection, schedules an appointment, and reports their choice to CHR. The practitioner is then issued an authorization for visits based upon the employer's EAP plan model.

### **4. FILING CLAIMS FOR EAP ASSESSMENT AND COUNSELING SERVICES**

**CHR requires that your EAP claims be submitted on the standard HCFA-1500 claim form.**

We are asking that you use specific diagnosis and procedure codes for EAP visits so that we may gather certain data in order to report back to our client companies.

When completing the claim, please include the following:

- The client's name
- The employee's name
- The name of the employer of the employee

While EAP counseling does not include development of a diagnosis, diagnosis codes are required for processing the claim. We have selected two Dx codes for your use in order to meet this requirement. They are as follows:

- 309.9            Unspecified adjustment reaction
- 305.90         Other, mixed or unspecified substance abuse

Procedure codes are as follows:

- 90801 for initial visits
- 90806 for subsequent visits
- 90889 for when the case is closed (Please use this code when you have closed the case. Note that we will reimburse you a one-time fee of \$10.00 for providing us with this information.)
- 90899 for clients referred to their health insurance for treatment (Please use this code only when you have referred the client for services under their health insurance plan. Note that we will reimburse you a one-time fee of \$10.00 for providing us with this information.)

Correctly completed claims should be mailed to:

Mesa Mental Health Claims  
 PO Box 92165  
 Albuquerque, NM 87199-2165

Claims may also be faxed to (505) 816-6702 or filed electronically. For electronic filing, the CHR Payor ID number is 85035.

Incomplete and improperly completed claims will be returned to the practitioner. Practitioner attention to detail and cooperation in completing and submitting clean claims is greatly appreciated and will result in a timelier turnaround.

## **5. TRANSITIONING CLIENTS TO BEHAVIORAL HEALTH BENEFITS AND ALTERNATE RESOURCES**

Clients may need transitional assistance to their behavioral health benefits or alternate resources at two points in their EAP service. First, clients presenting with behavioral health diagnoses or long-term issues not appropriate to EAP solution-focused counseling may, after the initial assessment, need assistance accessing behavioral health benefits through their health insurance plan or through alternate resources. Secondly, clients who have made substantive progress with use of the EAP but need some additional care to close the issue might choose to use behavioral health benefits or other available resources. In

these instances, the client may look to the EAP counselor for guidance. Generally, those clients referred out should be referred to a practitioner (or alternate resource) with those special skills required to address the client's identified need/s. In some cases, depending upon the circumstances, practitioners may refer the client to themselves for continuing care through the client's behavioral health insurance coverage. CHR clinical and case management staff can assist network practitioners with client referrals to behavioral health benefits. Practitioners are reminded that the client's behavioral health benefit is only one of many resources that may be available. Practitioners are urged to remain current on other resources available in their practice area and to make use of these resources for their clients as appropriate. Again, CHR clinical and case management staff are available to assist in identifying alternate resources and in transitioning clients to these resources.

## **6. ACCEPTING CLIENTS ON SUPERVISORY REFERRALS**

Corporate Health Resources works with all its client companies to promote the EAP as a supervisory management tool. Supervisors in contracted client companies are coached on how to formally refer to EAP counseling those employees with behavioral or performance issues negatively impacting the workplace. Therefore, the MMH/CHR Case Manager may, at some point in time, contact contracted practitioners to take a client referred by his or her supervisor. Following is a detailed breakdown of the formal supervisory referral process:

- The supervisor contacts the MMH/CHR call center and speaks to a Customer Service Representative.
- Customer Service collects relevant information and passes the information to the Case Manager.
- The Case Manager calls the supervisor soliciting detailed information regarding the issue(s) for which the employee is being referred.
- The Case Manager will ask the supervisor to have the employee call the Case Manager directly to facilitate the appointment.
- Based on the information from the supervisor and employee, the Case Manager contacts an appropriate network practitioner asking him or her to consider accepting the client.
- The Case Manager will call the employee to finalize the appointment with the employee.
- An authorization is issued to the practitioner after confirming the appointment with the employee and practitioner. The authorization is for the full complement of sessions covered by the employer's contractual arrangement with CHR. The practitioner is provided with the written authorization for care and any other forms or paperwork necessary to process the supervisory referral.
- The practitioner agrees to update the referring Case Manager on the employee's progress as needed.

- The MMH/CHR Case Manager may report to the supervisor only the following: (1) if the client keeps the scheduled appointments and (2) if the client participates in an action plan for problem resolution. *If the employee declines to sign either of the “Consent” forms, the employee is considered to be non-compliant and the practitioner notifies the Case Manager who then notifies the referring supervisor.*
- The supervisor will advise the CHR Case Manager if improvement with regard to the initial problem has not been achieved.

## **7. SEEING CLIENTS WITH SUBSTANCE ABUSE ISSUES**

Clients who present with self-disclosed substance abuse issues are to be assessed and either counseled or referred as would occur with clients with any other presenting issue. Clients should be kept for counseling only if the practitioner believes significant problem resolution can occur within the visits available per the employer’s visit model. For those clients whose situation warrants referral to alternate resources, CHR clinical and case management staff are available to identify and suggest resources for client assistance and to aid in transitioning the client to utilization of those resources.

## **8. CASE MANAGEMENT ACTIVITIES**

All practitioners accepting EAP clients from CHR are expected to provide case management activities to some extent. These activities may include routine follow-up with the client if he or she has been referred to behavioral health or community-based services or making a call regarding a missed appointment. More extensive case management/follow-up activities requiring face-to-face contact should be billed as a 90806 subsequent counseling visit.

## **9. EAP FORMS**

# **EMPLOYEE ASSISTANCE PROGRAM SERVICES**

# INTAKE ASSESSMENT

## EMPLOYEE INFORMATION

Answer all questions below. Omitted information will cause delays.

First MI Last	CHR Account Number (As provided on correspondence)	Date of Birth
Employer	Authorization Number:	
Intake Date		
<i>Presenting Problem:</i>		

### History

Family/Marital Status and Living Arrangements: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Co-habit
Number of Children:
Medical/Psychiatric History:
Medical Conditions/Illnesses:
History of Medical Treatment:
Current Medications:
MD Name/Phone:
History of Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No      When/Where?
Type of Treatment/For What?
Was the treatment helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Assessed Issues – Primary issue = 1, Secondary issue =2, Tertiary issue=3, etc.

Number ALL Applicable Boxes <input type="checkbox"/> Substance Abuse – Employee <input type="checkbox"/> Substance Abuse – Family Member <input type="checkbox"/> Other Addictive Behavior _____ <input type="checkbox"/> Psychological/Emotional <input type="checkbox"/> Self Concept/Esteem <input type="checkbox"/> Stress <input type="checkbox"/> Anxiety <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Family <input type="checkbox"/> Marital/Relationship <input type="checkbox"/> Teenager <input type="checkbox"/> Child <input type="checkbox"/> Child Care/Elder Care <input type="checkbox"/> Anger Management <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Medical <input type="checkbox"/> Financial <input type="checkbox"/> Legal	<input type="checkbox"/> Work-Related <input type="checkbox"/> Positive DOT Screen <input type="checkbox"/> Positive Drug/Alcohol Screen <input type="checkbox"/> Other  Job Performance (Check all that apply) <input type="checkbox"/> Not Affected <input type="checkbox"/> Not Known <input type="checkbox"/> Absenteeism <input type="checkbox"/> Disciplinary Action <input type="checkbox"/> Abuse of Leave <input type="checkbox"/> Quality <input type="checkbox"/> Relationships <input type="checkbox"/> Safety <input type="checkbox"/> Tardy <input type="checkbox"/> Aggressive Behavior <input type="checkbox"/> Alcohol Use on Job <input type="checkbox"/> Drug Use on Job	<input type="checkbox"/> Violence Incident Services <input type="checkbox"/> Initial Intake <input type="checkbox"/> Reopen Case <input type="checkbox"/> Assessment & Referral <input type="checkbox"/> Crisis Debriefing <input type="checkbox"/> Substance Abuse – Self Referral <input type="checkbox"/> Substance Abuse – Dept. Referral <input type="checkbox"/> Substance Abuse – Positive Random <input type="checkbox"/> Substance Abuse – Reasonable Suspicion Formal Supervisor Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Informal Supervisor Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Commercial Drivers License? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	---

### Risk Assessment:

Physical Abuse Reported?  Yes  No      Type:  Child  Adult  Elder      Person:  Self  Other

Suicidal     None at Present     Ideation     Plan  Action Taken \_\_\_\_\_

Homicidal     None at Present     Ideation     Plan  Action Taken \_\_\_\_\_

Previous Attempts?  Yes  No \_\_\_\_\_

Workplace Risk?  Yes  No If yes by whom \_\_\_\_\_

**Depression Assessment: (at least three of the following occur nearly every day)**

- Depressed mood most of the day nearly every day reported subjectively (feels sad or empty) or objectively (tearful)
- Feelings of hopelessness, despair, pessimism
- Appetite changes ( decrease  increase)
- Feelings of fatigue; decrease in energy level
- Insomnia ( early morning awakening  difficulty sleeping)
- Anhedonia (lack of pleasure)
- Difficulty with concentration and/or memory
- Psychomotor changes observable by others ( retardation  agitation)
- Hypersomnia
- Irritability
- Suicidal ideation

**Anxiety Assessment (at least two of the following occur nearly every day)**

- Restlessness or feeling keyed up or on edge
- Difficulty concentrating or mind going blank
- Muscle tension
- Hypervigilance
- Feelings of fatigue
- Irritability
- Insomnia or Hypersomnia

**Brief Substance Abuse Assessment:**

Due to substance abuse you have: <ul style="list-style-type: none"> <li><input type="checkbox"/> Missed Work</li> <li><input type="checkbox"/> Had Legal Problems</li> <li><input type="checkbox"/> Driven Under the Influence</li> <li><input type="checkbox"/> Had Arguments</li> </ul>	Frequency of Use: _____  Amount of Use: _____
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**Brief Mental Status:**

<b>Oriented</b>	<b>Appearance</b>
<input type="checkbox"/> X3	<input type="checkbox"/> Normal
<input type="checkbox"/> Incomplete	<input type="checkbox"/> Unusual
Describe:	Describe:
<b>Affect</b>	<b>Demeanor</b>
<input type="checkbox"/> Within Normal Range	<input type="checkbox"/> Appropriate
<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Inappropriate
Describe:	Describe:
<b>Thought Process</b>	<b>Memory</b>
<input type="checkbox"/> Within Normal Range	<input type="checkbox"/> Intact
<input type="checkbox"/> Distorted	<input type="checkbox"/> Distorted
Describe:	Describe:

**Referred to:**

- 12 Step Program
- Acute Care
- Corporate Health Resources
- Employee Assistance Program
- Insurance Therapy – Mental Health
- Insurance Therapy – Substance Abuse
- Legal
- Medical Evaluation
- Not Applicable
- Psychiatric Evaluation
- Psychological Evaluation
- Self-Help Support Group
- Self-Pay Mental Health
- Self-Pay Substance Abuse Therapy
- Social Security Administration
- Other Referral: \_\_\_\_\_

**My counselor has provided the privacy information to me.**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Counselor Signature**

\_\_\_\_\_  
**Date**

***Consent for Disclosure of Information from the  
Employee Assistance Program to the  
Supervisor***

I, \_\_\_\_\_ authorize \_\_\_\_\_  
Patient Counselor

to disclose to:

*First Contact*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

*Second Contact*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

for the purpose of supervisor follow-up, the following information regarding my assessment and counseling in this program:

1. Confirmation that I did/did/not keep my appointments.
2. Confirmation that a problem has/has not been identified.
3. Confirmation that I have/have not agreed to accept the action plan.
4. Confirmation that progress has/has not been made with the action plan.

I understand that I have the right to inspect and copy any written information to be disclosed. I understand that if I do not consent, the information sought to be disclosed will not be disclosed except as provided by law.

**This consent is subject to revocation in writing at any time, but such revocation can have no effect on disclosures previously made. In any event, this authorization expires without express revocation 90 days from the date that appears below.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

## **CONSENT AND AUTHORIZATION FOR RELEASE OF INFORMATION**

Client Name	Client Date of Birth	Client SS Number

I, (name of client) \_\_\_\_\_ hereby grant (name of CHR contracted counselor) \_\_\_\_\_ permission to release/receive/exchange the following information concerning my diagnosis and treatment to include specifically:

Check All That Apply	Type of Record	Beginning Date	Ending Date
	Testing Records (Specify):		
	Action/Treatment Plan		
	Consultations (Specify):		
	Evaluations/Assessments		
	Discharge Summary		
	Alcohol/Drug Abuse Treatment Information		
	Work/Employment History		
	Other		
	Exchange information while active case, not to exceed one year		

The above information is to be released to/received from/exchanged with:
The purpose for release/receipt/exchange of this information is:

This authorization is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not revoked, it shall be terminated 90 days from the date signed without express revocation. *Exception: Exchange of information is valid while case is active, but NOT to exceed one year.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF REVOCATION IS DESIRED:**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*

# ***ACTION PLAN***

**Questions to consider:**

1. Can I complete this plan within the available EAP visits? \_\_\_\_\_
2. Do these issues require referral to Behavioral Health Resources? \_\_\_\_\_
3. Do these issues require referral to Community Resources? \_\_\_\_\_
4. Do these issues require workplace intervention? \_\_\_\_\_  
(If yes contact CHR company liaison – Call 816-6700)
5. Is a referral needed for another member of the household that is affecting these problem issues? \_\_\_\_\_ (If yes, please have the member call CHR for referral at 816-6790)

**Problem(s) prioritize**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Goal #1 \_\_\_\_\_

Date: \_\_\_\_\_ Objective (time frame) \_\_\_\_\_

Action (responsible party) \_\_\_\_\_

Achieved/Not Achieved (date reviewed) \_\_\_\_\_

Goal #2 \_\_\_\_\_

Date: \_\_\_\_\_ Objective (time frame) \_\_\_\_\_

Action (responsible party) \_\_\_\_\_

Achieved/Not Achieved (date reviewed) \_\_\_\_\_

Goal #3 \_\_\_\_\_

Date: \_\_\_\_\_ Objective (time frame) \_\_\_\_\_

Action (responsible party) \_\_\_\_\_

Achieved/Not Achieved (date reviewed) \_\_\_\_\_

**Additional Comments** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## ***TERMINATION SUMMARY***

Client Name: \_\_\_\_\_

Client Number: \_\_\_\_\_

Date of Last Session: \_\_\_\_\_

Termination Date: \_\_\_\_\_

Reason for Termination:

- Client left without completing Action Plan
- Client completed Action Plan
- Client moved
- Other (specify) \_\_\_\_\_

<b>GOALS (A = Accomplishment; PA = Partially Accomplished; NA = Not Accomplished)</b>	
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**Action Summary:** (response to interventions, contact with other agencies, referrals, future recommendations, etc.)

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**Case Closure Job Performance Status**

- Not Applicable
- Satisfactory
- Some Improvement
- Significant Improvement
- Worse
- Other Closure Status

**Case Closure Job Status**

- Not Applicable
- Same/Active
- Went Part Time
- Leave of Absence
- Transferred
- Retired

- Quit
- Fired
- Deceased
- Other Closure Status

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\_\_\_\_\_  
Counselor

\_\_\_\_\_  
Date