Behavioral Health

EPHSPP9452407

Behavioral Health Services

- Behavioral health services are covered services for the treatment of mental or emotional disorders and substance use disorders.

- El Paso Health has defined "behavioral health" as encompassing both acute and chronic psychiatric and substance use disorders, as referenced in the most recent International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS).

Behavioral Health and Primary Care Provider Coordination

- El Paso Health recognizes that communication is the link that unites all the service components, and is a key element in any program's success.
- To advance this objective, providers are required to obtain a consent for release of information from the member-permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.
- If the member refuses to release the information, they should indicate their refusal on the Release of Information Form. In addition, the provider will document the reasons for refusal in the patient's medical record.

Behavioral Health Crisis Line

El Paso Health offers STAR PLUS members a crisis line for assistance with behavioral health.

- Crisis Line staff is bilingual
- Interpreter services are available, if needed
- Open 24 hours a day, 7 days a week

STAR PLUS 1-877-377-2950

What is Senate Bill 58?

Texas Legislation which integrates in the Medicaid Managed Care program the following services for Medicaid-eligible persons:

- Behavioral health services, including Targeted Case Management (TCM) and Mental Health Rehabilitation (MHR) services.
- Physical health services.

Managed Care Organizations (MCOs) that contract with the commission under this chapter shall develop a network of public and private providers of behavioral health services and ensure that adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

- Targeted Case Management and Mental Health Rehabilitative services for Medicaid (STAR, STAR Health, STAR Kids and STAR+PLUS) members are included in the managed care benefit package.

Assessment of Services

- Rehabilitative and TCM services may be provided to individuals with a Severe and Persistent Mental Illness (SPMI) or a Severe and Emotional Disturbance (SED), and who require services as determined by the Adults Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths Assessment (CANS).

- EPH is required to utilize the Department of State Health Services (DSHS) Texas Resilience and Recovery (TRR) Utilization Management (UM) Guidelines. To review these guidelines, please visit https://www.hhs.texas.gov/doing-businesshhs/provider-portals/behavioral-health-services-providers/behavioral-healthprovider-resources/utilization-management-guidelines-manual.

Mental Health Rehabilitative Services (MHR) and Targeted Case Management (TCM)

- Targeted Case Management services are case management services to clients within targeted groups.
- The target population that may receive Mental Health Targeted Case Management (MHTCM) as part of the Texas Medicaid Program are clients, regardless of age, with a single diagnosis of chronic mental illness or a combination of chronic mental illnesses as defined in the latest edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), and who have been determined via a uniform assessment process to be in need of MHTCM services.
- Clients of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are **not eligible for MHTCM services.**

Mental Health Rehabilitative and Targeted Case Management Services

- Services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.
- MHR services include:
    - Crisis Intervention Services (H2011).
    - Medication Training and Support Services (H0034).
    - Psychosocial Rehabilitative Services (H2017).
    - Skills Training and Development Services (H2014).
    - Day Program for Acute Needs (H2012). Please note:
- The information above and on the following slides comes from the Texas Medicaid Provider Procedures Manual (TMPPM), which is updated monthly. For the latest information, please visit https://www.tmhp.com/resources/providermanuals/tmppm.
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MHR/TCM Provider Requirements

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA)
- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG)
- Attestation from provider entity to MCO that organization has the ability to provide, either directly or through subcontract, the Members with the full array of MHR and TCM services as outlines in the RRUMG
- HHSC established qualification and supervisory protocols

Intellectual Developmental Disability (IDD)

- Intellectual or Development Disability (IDD): includes many severe, chronic conditions that are due to mental and/or physical impairments.
- IDD can begin at any time, up to 22 years of age which usually lasts throughout a person's lifetime and the term includes related conditions.

IDD Services

Members who would be eligible for IDD services:

- have an Intellectual Quotient (IQ) equal to or less than 75;
- have IDD and live in an Intermediate Care Facility (ICF-IDD) or IID facility; and
- receive services through the Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Home and Community-based Services (HCS).
- Texas Home Living (TxHmL) waivers will be enrolled in the STAR+PLUS program effective 9/1/14.
- Acute Care Services only.
- Waiver services will continue to be supplied by state
- Texas IDD member population statewide is approximately 23,000.
- Members typically reside in a small community-based facility.

Intellectual Developmental

Intellectual Developmental Disability Does not Include:

- Individuals residing in a state supported living center;
- Dual eligible (receiving Medicare and Medicaid);

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Mental Health Rehabilitation (MHR) Modifiers

Modifier	Description
ET	Individual crisis services
HQ	Group services
TD	Services rendered by Registered Nurse (RN)

MHR/TCM

- **Notification** must be submitted, however **No Prior Authorization is required**.
- A notice for the Level of Care (LOC) is necessary as we are contractually obligated to provide a STATE FAIR HEARING if Member transitions to a lower/higher level of care.

MHR/TCM Benefits – Depending on Level of Care				
Psychiatric Examination	Pharmacological Management	Individual Counseling	Group Counseling	Peer Support
Skills Training and Development	Medication Training & Support	Family Counseling	SBIRT	Case Management

Behavioral Health Benefit - Exclusions

The following services are not benefits of Texas Medicaid:

- Psychoanalysis
- Multiple Family Group Psychotherapy
- Marriage or couples counseling
- Narcosynthesis
- Biofeedback training as part of psychophysiological therapy
- Psychiatric Day Treatment Programs
- Transcranial magnetic stimulation
- Services provided by a psychiatric assistant, psychological assistant (excluding Master's level LPA), or a licensed chemical dependency counselor

Mental Health Rehabilitation (MHR)

A Medicaid provider may only bill for medically necessary MHR services that are provided face-to-face to:

- A Medicaid-eligible person.
- The Legally Authorized Representative (LAR) of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person). –
- The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person).

Rehabilitative services delivered via group modality are limited to an 8- person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

Mental Health Rehabilitations (MHR)

A Medicaid provider will not be reimbursed for a MHR service:

- Not included in the person's treatment plan (except for crisis intervention services).
- Provided to a person receiving mental health case management services (at the same time).
- That is not documented.
- Provided to a person who does not meet the eligibility criteria.
- Provided to a person who does not have a current uniform assessment (except for crisis intervention services).
- Provided to a person who is not present, awake and participating during such service.

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Crisis Intervention

- Crisis intervention services are intensive community-based one-to-one services provided to persons who require services to control acute symptoms that place the person at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting.
- According to TRR UM Guidelines, the utilization of the crisis services array is based on what is medically necessary and available during the psychiatric crisis.
- Procedure code H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination according to medical necessity.

Service	Procedure Code	Unit
Adult Services	H2011	15 minutes

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Medication Training and Support

- Medication training and support services consist of education and guidance about medications and their possible side effects.
- Procedure code H0034 may be reimbursed for up to 8 units (2 hours) per calendar day in any combination according to medical necessity.

Service	Procedure Code	Modifier	Unit
Group services for adults	H0034	HQ	15 minutes

Medication Training and Support

According to TRR UM Guidelines, the average monthly utilization for this service for individual and group for each Level Of Care (LOC) is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1, 2	0.5 hour each (ind and grp)	3.75 hours each (ind and grp)
3	.05 hour each (ind and grp)	4.5 hours each (ind and grp)
4	.05 hour each (ind and grp)	4.5 hours each (ind and grp)
Yes Waiver	.05 hour each (ind and grp)	(4.5 hours each (ind and grp)
YC	.05 hour each (ind and grp)	3 hours each (ind and grp)

TRR Adult Guidelines		
LOC	Standard	High Need
1S	1 hour (ind) .75 hour (grp)	1.75 hours (ind) 1.75 hours (grp)
2	1 hour (ind) .75 hour (grp)	1.5 hours (ind) 2.15 hours (grp)
3	1 hour (ind) .75 hour (grp)	1.5 hours (ind) 5 hours (grp)
4	1 hour (ind) .75 hour (grp)	2.5 hours (ind) 2.75 hours (grp)
TAY	1 hour (ind) .75 hour (grp)	1.5 hours (ind) 5 hours (grp)

Psychosocial Rehabilitative Services

- Psychosocial rehabilitative services are social, behavioral and cognitive interventions that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement and other independent living skills.
- Procedure code H2017 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, for clients 18 years and older according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Individual services provided by RN	H2017	TD		15 minutes
Group services	H2017	HQ		15 minutes
Group services provided by RN	H2017	HQ	TD	15 minutes
Individual crisis services	H2017	ET		15 minutes

Psychosocial Rehabilitative Services

This service is available to adults in LOC 3 and 4.

According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Adult Guidelines		
LOC	Standard	High Need
3	3.5 hours (ind) 2.25 hours (grp)	7 hours (ind) 8.6 hours (grp)
4	5.75 hours (ind) 2.5 hours (grp)	14.25 hours (ind) 8.6 hours (grp)

Skills Training and Development

- Skills training focuses on the improvement of communication skills, appropriate interpersonal behaviors and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers.
- Procedure code H2014 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, according to medical necessity.

Service	Procedure Code	Modifier 1	Unit
Group services for adults	H2014	HQ	15 minutes

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Skills Training and Development

- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	
2, 3, 4	3 hours each (ind and grp)	6 hours each (ind and grp)

TRR UM Adult Guidelines		
LOC	Standard	High Need
1S	2 hours (ind) 0.75 hrs (grp)	3.5 hours (ind) 5 hours (grp)
2	1 hour (ind) 1 hour (grp)	2 hours (ind) 1 hour (grp)
TAY	3 hours each (ind and grp)	6 hours each (ind and grp)

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Day Program for Acute Needs

- Day programs for acute needs provide short term, intensive treatment to an eligible person who is 18 years of age or older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
- It is available to adults in LOC 3 and 4.
- Procedure code H2012 may be reimbursed for up to 6 units (4.5 to 6 hours) per calendar day in any combination, for clients 18 and older.

Service	Procedure Code	Unit
Adult day program for acute needs	H2012	45-60 minutes

Targeted Case Management (TCM)

Targeted Case Management (T1017):

- Assist persons in gaining access to needed medical, social/behavioral, educational and other services and supports.

Include monitoring of service effectiveness as frequently as necessary (at least annually). *–TCM services are carved-out of Medicaid managed care and must be billed to TMHP for payment consideration.*

- Service Coordinators coordinate with providers to ensure integration of behavioral and physical health needs of enrollees.

- Service Coordinators refer non-eligible enrollees to Local Mental Health Authorities (LMHAs) that can provide indigent mental health care.

Targeted Case Management (TCM)

The following activities are included in the Mental Health Targeted Case Management (MHTCM) rate and will not be reimbursed separately: –

- Documenting the provision of MHTCM services.
- Ongoing administration of the Uniform Assessment to determine amount, duration and type of MHTCM.
- Travel time required to provide MHTCM services at a location not owned, operated or under arrangement with the provider.

MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services.

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Targeted Case Management (TCM)

- Routine case management services are primarily office-based activities that assist a person, caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the person's needs.
- Routine Case Management is available to adults in LOC 1M, 1S and 2.

Routine Case Management

- According to TRR UM Guidelines, the average monthly utilization for routine case management is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1	0.5 hour	1 hour
2	1 hour	2 hours
3	1 hour	6 hours
4	2 hours	6 hours
Waiver	4 hours	8 hours

TRR UM ADULT GUIDELINES		
LOC	Standard	High Need
1 M	0.5 hour	2.15 hours
1S	0.75 hour	1.25 hours
2	0.25 hour	1 hour

Intensive Case Management

- According to TRR UM Guidelines, the average monthly utilization for intensive case management is the following

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1	4 hours	8 hours
4	4 hours	8 hours
Waiver	3.75 hours	6.25 hours

Targeted Case Management Modifiers

Modifier	Description
TF	Routine Case Management
TG	Intensive Case Management
HA	Child/Adolescent Program
HZ	Funded by criminal Justice agency

Please note: According to TRR UM Guidelines, routine case management and intensive case management cannot be provided concurrently.

Service Codes and Modifiers

- Procedure code T1017 may be reimbursed up to 32 units (8 hours) per calendar day.

Service	Procedure	Modifier 1	Modifier 2	Unit
Routine Mental Health Target Case Management (Adult)	T1017	TF		15 minutes
Intensive Case Management (Child and Adolescent)	T1017	HA	TG	15 minutes

Service Coordination

El Paso Health's Service Coordination department can assist with:

- Case management services and assistance with scheduling outpatient appointments.
- Face-to-face visits with enrollees in inpatient settings.
- Assisting inpatient facilities with discharge planning.
- Assisting with 7-day follow-up.
- Providing licensed clinicians that are available for enrollees with greater needs.
- Assisting enrollees with obtaining resources in their area.

Behavioral Health Care Management

El Paso Health has experienced Registered Nurses (RNs), Licensed Professional Counselors (LPCs) and Licensed Clinical Social Workers (LCSWs) who can assist members in coordinating all aspects of their care. Care Managers work closely with the Member's Service Coordinator to align services avoid duplication of effort. Care management services are available for any members.

- Levels of care management include:
  - Care Coordination – Lowest level; mostly short term needs, social assistance, stable chronic conditions.
  - Care Management – Intermediate needs; may require additional time or resources to ensure member's needs are addressed.
  - Complex Care Management – Significant illness burden and complexity; members require longer term, ongoing assistance to address care gaps and service needs.

Utilization Management

El Paso Health's Utilization Management department is made up of licensed counselors who can assist with:

- Monitoring the delivery of services through retrospective review.
- Giving feedback on quality of care and compliance concerns.
- Assisting with questions regarding the TRR UM Guidelines and the Texas Administrative Code (TAC) requirements of MHR and TCM.

Behavioral Health and Substance Abuse Services

The following benefits are available to EPH Dual Option STAR+PLUS enrollees and are a responsibility of El Paso Health:

- Mental Health Hospitalization
- Mental Health Outpatient Services
- Psychotropic Drugs
- Mental Health Services within the scope of a primary care physician
- Psychologists
- Psychiatrists

Follow-up outpatient visit with a behavioral health provider is required within 7 days of discharge from the hospital for a behavioral health stay, Service Coordinator must verify that Member received the services within 7 days.

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Substance Use Disorder (SUD)

When submitting a prior authorization request for a EPH member to receive Detox, Residential Treatment Center (RTC), Partial Hospital Program (PHP) or Intensive Outpatient Program (IOP) services, clinical documentation must be included. This documentation must be sent via fax or electronically submitted through EPH's Provider Portal.

Please include any additional clinical information or documentation to support the treatment request. If EPH needs more information to process this request, please include the best contact information to reach you/your office.

Below are examples of clinical information or documentation needed based on request.

Admissions:

All relevant and updated information and medical records related to the level of care necessary to complete the review [28 TAC §19.1707(b)], including:

- Member family/social dynamics, living/recovery environment, legal status, transportation and support system.
- Any medical or psychiatric issues which could interfere with treatment.
- Any lab results, assessment results, vital signs, acute and/or post-acute withdrawal symptoms.
- Information regarding recent social, occupational and academic functioning.

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SUD (Continued)

All relevant and updated information and medical records related to the level of care, necessary to complete the review [28 TAC §19.1707(b)], including:

- DETOX – information from within last five programming days: Doctor of Medicine (MD)/Registered Nurse (RN) notes, vital signs, withdrawal assessment scales and symptoms, medication and withdrawal protocol, relevant and updated information and medical records necessary to complete review, treatment plan and discharge plan.

- RTC – information from within last seven calendar days: MD notes, relevant and updated information and medical records necessary to complete review, symptoms, functional impairments in role performance and/or social relationships, treatment plan, discharge plan, relapse prevention plan, medication records and proof of 24-hour staff monitoring.

- PHP/IOP – information from within last seven calendar days: o MD/RN notes, relevant and updated information and medical records necessary to complete review, list of group attendance with date and times, symptoms, functional impairments in role performance and/or social relationships, treatment plan, discharge plan, relapse prevention plan and housing/support/transportation.

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Substance Use Disorder (SUD)

SUD services may include the following:

- Withdrawal Management Services
- Individual and Group SUD Counseling in an Outpatient Setting
- Residential Treatment services
- Medication Assisted Treatment
- Evaluation and Treatment (or referral for treatment) for co-occurring physical and behavioral health conditions

SUD Requirements

Level of care (e.g., outpatient, residential, inpatient hospital) and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, as those outlined in the current edition of the:

- American Society of Addiction Medicine's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions,
- As well as the licensure requirements outlined in 25 TAC §448 pertaining to standards of care.

SUD treatment services (outpatient or residential) may only be delivered in a licensed chemical dependency treatment facility (CDTF). Medication assisted treatment to include opioid treatment (MAT) may also be delivered by appropriately trained physicians, nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) in the office setting.

The following SUD services Require a Prior Authorization.

- Inpatient (detox, rehab.)

- Residential (SUD)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a benefit available for Members who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders.

SBIRT is used for intervention directed to individual clients and **not for group intervention**.

Who can provide SBIRT?

physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs).

- Non-licensed Providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider.
- Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

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SBIRT Training

- Providers that perform SBIRT must be trained in the correct practice of this method and will be required to complete at least four hours of training.
- The same SBIRT training requirements apply to non-licensed providers.
- Proof of completion of SBIRT training must be maintained in an accessible manner at the provider's place of service.
- Information regarding available trainings and standardized screening tools can be found through the Substance Abuse and Mental Health Services Administration at www.samhsa.gov

SBIRT is limited to clients who are 10 years of age and older.

Prior Authorization is NOT required.

Peer Specialist Services

Peer specialist services (procedure code H0038) for mental health conditions or substance use disorders are a benefit of Texas Medicaid for persons who are 21 years of age and older, and who have peer specialist services included as a component of their person-centered recovery plan.

Peer specialist services may include the following:

- Recovery and wellness support services, which include providing information and support for recovery planning.
- Mentoring, which includes serving as a role model and helping find needed community resources and services.
- Advocacy, which includes providing support during stressful or urgent situations and helping to ensure that the person's rights are respected. Advocacy may also include encouraging the person to advocate for him or herself to obtain services.

Peer Specialist services DO NOT Require Prior Authorization

Peer Specialist

Peer specialist services are based on a mutual relationship between the peer specialist and the Medicaid eligible person.

A peer specialist uses his or her lived experience to support the person with the following:

- Achieving the goals and objectives of the person’s individualized recovery plan
- Skill development
- Problem solving strategies
- Coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder

Peer specialist services can be delivered individually or in a group setting.

Peer Specialist Requirements

Must be employed by any of the following Medicaid-enrolled providers:

- Clinic/group that treat BH conditions
- Physicians (M.D.s), osteopaths (D.O.s), nurse practitioners (NP), clinical nurse specialists (CNS), and physician assistants that treat BH conditions
- LMHAs
- Federally qualified health clinics
- Chemical dependency treatment facilities
- Opioid Treatment Providers
- Rural health clinics

Peer Specialist Criteria

Peer Specialist must meet the following criteria:

Be at least 18 years of age.

- Have lived experience with a mental health condition, substance use disorder, or both.
- Have a high school diploma or General Equivalency Diploma (GED).
- Be willing to appropriately share his or her own recovery story with the person receiving services.
- Demonstrate current self-directed recovery.
- Pass criminal history and registry checks

A peer specialist may not:

- Practice psychotherapy
- Make clinic or diagnostic assessments
- Dispense expert opinions
- Engage in any service that requires a license
- Falsify any documentation related to application, training, testing, certification, or services provided

Psychotherapy Overview

- Individual – Focuses on a single member.
- Group – Involves one or more therapists working with several members at a time.
- Family – Focuses on the dynamic of the family where the goal is to strengthen the family's problem-solving and communication skills.
  - Only reimbursable for one Medicaid-eligible member per session, regardless of the number of family members present per session.
- Psychotherapy (individual, family or group) is limited to 4 hours per member, per day. Psychotherapy is limited to 30 individual, group.
  - Psychotherapy services do not require prior authorization unless requesting greater than 30 visits per calendar year.
- If the member changes providers during the year, the new provider should make an attempt to obtain complete information on the member's previous treatment history

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Court Ordered Commitments

- Up to the annual limit, El Paso Health will provide inpatient psychiatric services to Members who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities.
- El Paso Health will not deny, reduce or controvert the medical necessity of any inpatient psychiatric services provided pursuant to a court-ordered commitment.
- Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A Member who has been ordered to receive treatment under the provisions of Chapters 573 or 574 of the Texas Health and Safety Code can only appeal the commitment through the court system and cannot appeal the commitment
- El Paso Health is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. $200,000 annual limit on inpatient services does not apply for adult STAR and STAR+PLUS members.

Coordination with the Local Mental Health Authority

- El Paso Health will coordinate with the Local Mental Health Authority and state psychiatric facilities regarding admission and discharge planning and treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.
- Our Service Coordinators will work with their counterparts at the LMHA to coordinate care for the Member.
- MCO must notify an LMHA or LBHA upon notification, but in no event later than three Business Days, that a Member is admitted to a Hospital for inpatient psychiatric services, with or without a court order, if the LMHA or LBHA has provided Covered Services to the Member in the 12 months preceding the admission.
- If the Member has received Covered Services at more than one LMHA or LBHA in the 12 months preceding the admission, the MCO must notify only the LMHA or LBHA which last delivered Covered Services to the Member.
- The MCO is required to comply with additional BH Services requirements relating to coordination with the LMHA or LBHA and care for special populations.

Medical Necessity

- All services require documentation to support the medical necessity of the service rendered, including mental health services. Most behavioral health and substance use disorder services (except routine outpatient and emergency services)

- The documentation must support the medical necessity of the treatment for its entire duration.

- Mental health services are subject to retrospective review to ensure that the documentation in the member's medical record supports the medical necessity of the services provided.

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Twelve Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of patients seen for outpatient mental health services:

- Psychologist.
- Advanced Practice Registered Nurse (APRN).
- Physician Assistant (PA).
- Licensed Clinical Social Worker (LCSW).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Professional Counselor (LPC).

Services not subject to 12 hour limitation:

- *Court-ordered and DFPS directed services are not subject to the 12-hour per provider, per day system limitation when billed with modifier H9.*
- *Physicians are not subject to the 12-hour system limitation since they can delegate and may submit claims in excess of 12 hours per day.*
- *Psychologists can delegate to multiple LPAs, PLPs, interns, or post-doctoral fellows and therefore delegated services are not subject to the 12-hour system limitation since they may submit claims for delegated services in excess of 12 hours per day.*

Behavioral Health Case Management

El Paso Health has Case Managers available to assist Members with a diagnosis of Severe and Persistent Mental Illness (SPMI) and Seriously Emotionally Disturbed (SED).

A Service Coordinator (SC) is available to all Members who request one, EPH must assign a SC when it is determined, through assessment of the Member's health and support needs Case Managers will:

- Collaborate with Providers as part of the Interdisciplinary Team to assist our Members and their families
- Assess Member's condition and environment
- Provide Education regarding benefits and condition
- Coordinate Care for Medical, Behavioral Health and Social Needs
- Develop a Service Plan to identify Member goals, progress, and interventions
- Refer Members to Specialty Providers
- Refer Members to Community Agencies

Additional Case Management Activities

- **Identify** needs and strengths of the Member and their family
- Address **Non-Medical Determinants of Health** (social determinants of health or SDoH) like health care access, housing, transportation, and education
- In an effort to improve health outcomes and minimize readmission. EPH inpatient Utilization Reviewers will contact members within 72 hours but not to exceed 7 days post-discharge to complete a medication assessment and identify any discharge coordination needs.
- Post discharge **follow-up** at 7 day and 30 days

CASE Management Referral Form

CASE MANAGEMENT/SERVICE COORDINATION REFERRAL FORM

To: El Paso Health ATTN: Case Management Phone: (915) 532-3778 ext. 1500 Fax: 915-298-7866	FROM: ______ (Physician's Office Name) OFFICE CONTACT PERSON: ______ FAX NUMBER: ______ TELEPHONE NUMBER: ______

Member Name:	Medicaid/CHIP ID #:	DOB:
Member Contact Number:	Member Address:	

REASON FOR REFERRAL (check all that apply and add comments when applicable):

- ☐ HIGH RISK PREGNANCY
- ☐ BEHAVIORAL HEALTH
- ☐ ASTHMA
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ SPECIAL HEALTH CARE NEEDS (individuals who have a behavioral/medical condition that is expected to last more than 12 months)
- ☐ SOCIAL WORK/SOCIAL DETERMINANTS OF HEALTH
- ☐ OBESITY

PRESENTING CONCERN:

- ☐ Assistance locating covered services
- ☐ Coordination of care
- ☐ Non-compliance with treatment plan
- ☐ Assistance obtaining durable medical equipment/medical supplies (i.e. nebulizer, peak flow meter)
- ☐ Patient education (i.e. symptom management, self-management strategies, diabetes education)
- ☐ Assistance accessing treatment for behavioral health diagnosis
- ☐ Social concerns (i.e. SDOH), please specify concern(s): ______
- ☐ High risk pregnancy, please specify condition/concern: ______
- ☐ Access to community resources (i.e. support/advocacy groups, basic needs)
- ☐ Positive Maternal Depression Screening

Contact Information

Vianka Navedo-Sanchez

Health Services Director

(915) 532-3778 ext. 1135

Celina Dominguez

Health Services Administrative Manager

(915) 532-3778 ext. 1091

Carolina Castillo

Utilization Management Manager

(915) 532-3778 ext. 1122

Jesus Ochoa

Care Coordinator Manager

(915) 532-3778 ext. 1017

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(915) 532-3778

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