The Center for Provider Education & Training

Maryland AAHAM Third Party Payer Meeting

March 23, 2018

Agenda

- CareFirst Magellan Transition
- Questions from AAHAM
- Post-Acute Placement Process

Magellan Transition Background

- Efforts are underway to bring behavioral health services in-house to;
  - Fully integrate our Behavioral Health and Substance Use Disorder Program with our Total Care and Cost Improvement and Patient-Centered Medical Home programs and provide high-touch local support for members.

- This process began in June 2017 when we transitioned contracted behavioral health providers to the CareFirst BlueChoice network.

- As of April 1, 2018, Magellan Healthcare will no longer provide behavioral health care services, including care coordination, on behalf of CareFirst.

- There will be no impacts to members.

What does this mean to you?

Effective April 1, 2018

- All required planned inpatient notification and outpatient prior authorizations for behavioral health and substance use conditions will no longer be handled by Magellan Healthcare.

- Providers will instead utilize the electronic inpatient notification and prior authorization process within the CareFirst Provider Portal (CareFirst Direct).
  - This is the same process that CareFirst and medical providers have been using for almost 5 years and has worked well.

- The prior authorization for Inpatient and Residential treatment takes the form of a prior authorization process, followed by concurrent assessment performed by Behavioral Health Transition of Care.

Prior Authorization Information

- A subset of behavioral health and substance use services have been chosen for focused clinical review on a pre-service basis.
  - For these services, clinical review is carried out by clinical staff with specialized knowledge, using industry established medical policies and criteria.

- The reason that these subsets of services are reviewed and preauthorized is because they often entail one or more of the following characteristics:
  - safety or abuse concerns,
  - highly variable treatment,
  - excessive cost,
  - and/or high complexity.

- For the vast majority of services, we will be using the nationally recognized Milliman care guidelines.

Services Requiring Prior Authorization & Notification

Outpatient services requiring prior authorization:

- Electroconvulsive Therapy (“ETC”)
- Repetitive Transcranial Magnetic Stimulation (“rTMS”)
- Complex Psychological Testing
- Applied Behavioral Analysis (“ABA”)

Inpatient services requiring notification:

- All Behavioral Health In-Patient Admissions
- Residential Treatment, Psychiatric Adult, Child & Adolescent
- Residential Treatment, Eating Disorders
- Residential Treatment, Substance Use Disorders, Detoxification, Rehabilitation

Questions from AAHAM

What are your top five denial reasons?

- Pre-authorization not obtained
- Duplicate Claim
- Timely filing
- Need medical records
- Description of service (To resubmit the procedure code along with the description of service)

Questions from AAHAM

If you had to stress one or two major points to providers and their billing departments/agencies, what would you reinforce to them?

- Make sure authorizations match the date-of-service.
- Allow appropriate time to process claims before resubmitting the claim again.
- Timely Follow-up on outstanding claims.
- Review error reports from clearinghouse.

Questions from AAHAM

What is the best way to communicate with you on denied claims or questions regarding claims?

- We encourage providers to use CareFirst Direct to submit claim inquiries.
- Providers can submit corrected claims electronically.
- Once a claim is submitted electronically, there is a record of receipt.

Training webinars are offered that demonstrate how CareFirst Direct can be used to submit claim inquiries and how to submit corrected claims.

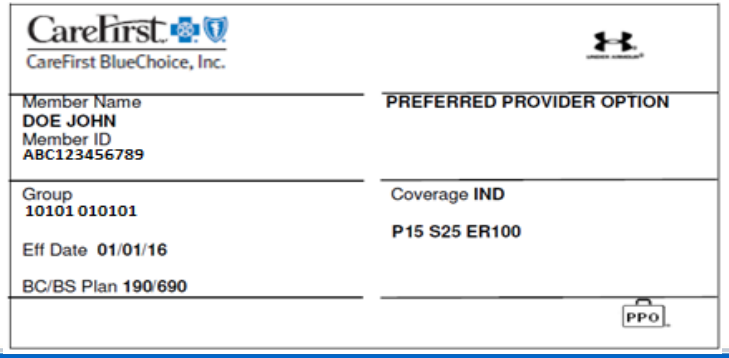
Questions from AAHAM

For Blue Choice plans with PPO overlay, what indicators are there for registration to determine when the service is Blue Choice and when it is covered under the PPO?

A BlueChoice Advantage product but with a Preferred Provider Option overlay.

How does it work?

- BlueChoice rules apply to the product overall.
- Difference:
  - Members have the flexibility to utilize PPO lab and radiology providers without the restrictions of the BlueChoice product.



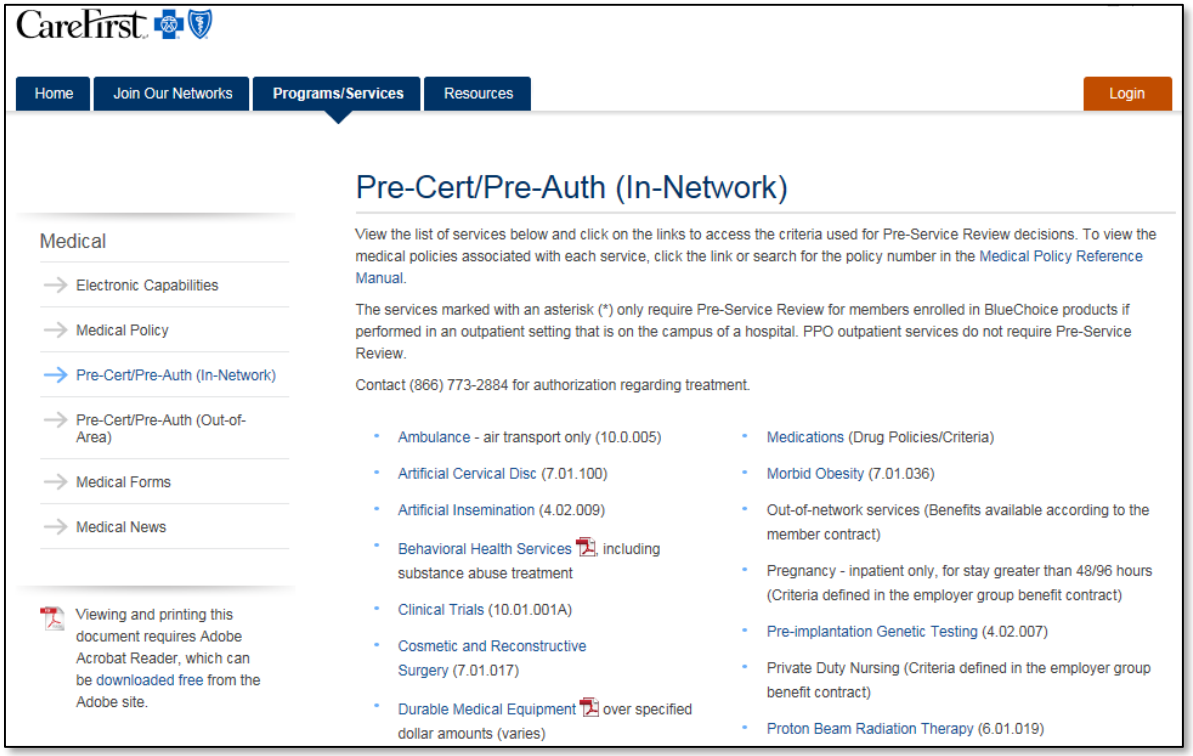
Questions from AAHAM

BlueChoice Products At-a-Glance								
	BlueChoice HMO	BlueChoice HMO Open Access	BlueChoice Opt-out Plus Open Access	BlueChoice Advantage	BlueChoice Advantage w/ PPO Overlay	BlueChoice HealthyBlue HMO	BlueChoice HealthyBlue Plus/2.0	BlueChoice HealthyBlue Advantage
PCP Selection Required	✓	✓	✓	X	X	✓	✓	✓
LabCorp Only for Laboratory Services	✓	✓	✓	✓	X	✓	✓	✓
Hospital Services must be Authorized	✓	✓	✓	✓ *(*only required for inpatient)*	✓ *(*only required for inpatient)*	✓	✓	✓
Written Referrals Required for Specialist Services	✓	X	X	X	X	X	X	X
Radiology Services Must be Rendered at an Approved Freestanding Facility (refer to Provider directory)	✓	✓	✓	✓	X	✓	✓	✓
In-Network Benefits Only	✓	✓	X	X	X	✓	X	X
Both In-Network and Out of Network Benefits Available *(*Members may see any provider – subject to deductible, coinsurance, balance billing)*	X	X	✓	✓	✓	X	✓	✓

Questions from AAHAM

Where can providers find written policies and directions on your pre-authorization requirements?

http://www.carefirst.com/preauth



Post-acute Placement Process

- The Hospital Transitions Coordinator (HTC) will collaborate with the facility discharge planner for all requests for a post-acute placement.
- The HTC will send an email to the Post-Acute Transitions of Care Team at CareFirst to request post-acute placement to include the facility contact information for both the requesting and receiving facilities to be notified of the decision.
- The Post-Acute Transitions of Care Team will verify the members benefit for the requested service.
- The Post-Acute Transitions of Care Team will give the requesting facility discharge planner a verbal approval for transfer.
- The Post-Acute Transitions of Care Team will create the authorization and notify the receiving facility of the authorization number and number of days approved.
- If there is no benefit or the clinical information does not meet medical necessity for the requested service, the Post-Acute Transitions of Care Team will notify the facility requestor, and discuss alternative options.

Questions?