2020 Behavioral Health Provider Services Reference Guide

	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF INITIAL AND CONTINUED STAY AUTHORIZATION ***Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent assessment is acceptable.***					
SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
ACUTE INPATIENT CARE – MENTAL HEALTH AND SUD • Acute Psychiatric Inpatient; Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Inpatient Acute Withdrawal (Detoxification) ASAM 4.0 * MEMBERS ADMITTED ON AN ITA ARE REVIEWED FOR CHANGE IN LEGAL STATUS, CONFIRMATION OF ACTIVE TREATMENT AND TRANSITION OF CARE NEEDS. **IF ITA, PLEASE ATTACH COURT DOCUMENTS.**	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days* *Initial and concurrent for ITAs is 14 days.*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days*	**No.** Emergent admissions require notification only within 1 business day followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** ** Initial and concurrent: 3-5 days*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Authorization length segments:** ** **Voluntary admissions** - Initial and continued stay: 3-5 days (or Medical Director discretion)* ** **ITA admissions** – Initial for 120 hours, then dependent on further commitment will authorize 14 days or to the next court date. Upon confirmation of 90-day commitment, will continue to authorize in 14-day increments (or at Medical Director discretion).*	**No.** Emergent Acute admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Whole Person Care/Health Home Care coordinator.** **Initial: 3-5 days*	

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SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
WITHDRAWAL MANAGEMENT (IN A RESIDENTIAL SETTING) • ASAM 3.7 • ASAM 3.2 * MEMBERS ADMITTED ON AN ITA ARE REVIEWED FOR CHANGE IN LEGAL STATUS, CONFIRMATION OF ACTIVE TREATMENT AND TRANSITION OF CARE NEEDS. **IF ITA FOR SECURE DETOX, PLEASE ATTACH COURT DOCUMENTS.**	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review. **Yes**, if planned – requires pre-service review and concurrent review. **Initial: 3-5 days* *Concurrent : 3 days*	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review. **Yes**, if planned – requires pre-service review and concurrent review. **Initial: 3-5 days*	**No,** if Emergent – requires notification only within 1 business day followed by concurrent review. **Yes**, if planned – requires pre-service review and concurrent review. ** Initial and concurrent: 3-5 days*	**No,** if Emergent –requires notification only within 24 hours followed by concurrent review. Yes, if planned – requires prior authorization and concurrent review. **Initial: 3-5 days depending on severity of detoxification and types of substances used* **Authorization length segments:** *For Secure Detox: * ITA admissions – Initial for 120 hours, then dependent on further commitment will authorize 7-day increments (or at Medical Director discretion).*	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review. **Yes**, if planned – requires pre-service review and concurrent review. **5 days*	
CRISIS STABILIZATION IN A RESIDENTIAL TREATMENT SETTING **IF LRA OR CR, PLEASE ATTACH COURT DOCUMENTS.**	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review.	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review.	**No,** if Emergent – requires notification only within 1 business day followed by concurrent review.	**No,** if Emergent –requires notification only within 24 hours followed by concurrent review.	**No,** if Emergent – requires notification only within 24 hours followed by concurrent review.	

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	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF INITIAL AND CONTINUED STAY AUTHORIZATION ***Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent assessment is acceptable.***					
SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
	Yes, if planned – requires pre-service review and concurrent review. **Initial and Concurrent: 3-5 days*	**Yes,** if planned – requires pre-service review and concurrent review. **Initial: 3-5 days* **If on ITA: 7 Days Initial, 14 days after*	** Initial and concurrent: 3-5 days*	**Yes,** if planned – requires prior authorization and concurrent review. **Authorization length segments:** **Initial: 3-5 days (or Medical Director discretion) Continued stay: Based on medical necessity and at Medical Director's discretion*	**Yes,** if planned – requires pre-service review and concurrent review. **Initial: 3-5 days*	
RESIDENTIAL TREATMENT – MENTAL HEALTH AND SUBSTANCE USE DISORDER **IF FOR SUD:** • **ASAM 3.5** • **ASAM 3.3** • **ASAM 3.1** **IF LRA OR CR, PLEASE ATTACH COURT DOCUMENTS.**	**Yes,** if planned – requires pre-service review and concurrent review. ***Initial and Concurrent: 14 days* *Long Term Concurrent: 30 days* **For long term MH RTF (H0019), authorization segments are 30 days for initial and concurrent review (or Medical Director discretion)*	**Yes,** if planned – requires pre-service review and concurrent review. **SUD Long term** ** 14 days* ***SUD Short Term*** *14 days **RTC SUD PPW** (Residential Treatment Substance Use Disorder for Pregnant or Parenting Women)	**Yes,** if planned – requires pre-service review and concurrent review. ** Initial and concurrent:* *7 to 14 days for ASAM 3.1 and 3.5* ***30 days for ASAM 3.3*** *14 days for short term* ***MH*** *30 days for long term* ***MH***	**Yes,** requires prior authorization and concurrent review. **Authorization length segments:** **Initial and Concurrent for ASAM 3.5 and short-term MH RTF (H0018):* *7 to 14 days (or Medical Director discretion)* **For ASAM 3.3 and 3.1, authorization segments are 30 days for initial and concurrent review (or*	**Yes,** if planned – requires pre-service review and concurrent review. **Initial 14-days for ASAM 3.5/SERI code H0018* **Initial 30 Days for ASAM 3.3/SERI code H0019* **Initial: 30 Days: ASAM 3.1/SERI code H2036* *All initial and concurrent reviews are	

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SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
		*30 days if Parenting, 60 days if Pregnant **RESIDENTIAL TREATMENT – MENTAL HEALTH** * *DAYS AUTHORIZED- BASED ON CLINICAL ASSESSMENT*		*Medical Director discretion)* **For long term MH RTF (H0019), authorization segments are 30 days for initial and concurrent review (or Medical Director discretion)*	subject to medical director discretion.	
PARTIAL HOSPITAL PROGRAM **(Mental Health)**	**Yes.** *Initial: 10 days*	**Yes.** *Initial: 10 days*	**Yes.** *Initial and concurrent: 7 business days	**Yes,** requires prior authorization and concurrent review **Authorization length segments:** *Initial: 5 to 10 days* *Continued stay: Based on request and medical necessity*	**Yes.** *Initial: 4 days*	
INTENSIVE OUTPATIENT SERVICES/PROGRAM **ASAM 2.1**	**No**, not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers and non-network providers	**No,** not for in network providers and non-network providers.	**No**, not for in network providers. **Yes**, if non network provider requests. Outlier monitoring with concurrent and post-service medical necessity	**No,** for Code: 96153 **Yes**, if non network provider requests. *Initial: Less than or equal to 12 visits based on Authorization / Notification Rules and*	

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	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF INITIAL AND CONTINUED STAY AUTHORIZATION ***Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent assessment is acceptable.***					
SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
				reviews.	*Outlier Monitoring*	
MEDICATION EVALUATION AND MANAGEMENT	**No,** not for in network providers. **Yes,** if non network provider requests.	**No,** not for in network providers and non-network providers	**No,** not for in network providers and non-network providers.	**No,** not for in network providers. **Yes,** if non network provider requests.	**No,** not for in network providers. **Yes,** if non network provider requests.	
MEDICATION ASSISTED TREATMENT	**No,** not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers and non-network providers For all providers: Buprenorphine monotherapy AND non-preferred medication require prior authorization	**No**, not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers. **Yes**, if non network provider requests. For all providers: Buprenorphine monotherapy AND non-preferred medication require prior authorization	**No,** not for in network providers. **Yes**, if non network provider requests.	

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PRIOR AUTHORIZATION REQUIRED? ***LENGTH OF INITIAL AND CONTINUED STAY AUTHORIZATION***

Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent assessment is acceptable.

SERVICE TYPE AND DESCRIPTION	AMERIGROUP	CHPW	COORDINATED CARE	MOLINA	UNITED	LEFT BLANK INTENTIONALLY
INITIAL ASSESSMENT (MH AND SUD/ASAM) AND OUTPATIENT PSYCHOTHERAPY SERVICES	**No,** not for in network providers. **Yes,** if non network provider requests. Outlier monitoring with concurrent and post-service medical necessity reviews.	**No,** not for in network providers and non-network providers	**No,** not for in network providers and non-network providers.	**No,** not for in network providers. **Yes,** if non network provider requests. Outlier monitoring with concurrent and post-service medical necessity reviews.	**No,** not for in network providers. **Yes,** if non network provider requests. Outlier monitoring with concurrent and post-service medical necessity reviews.	
HIGH INTENSITY OUTPATIENT/COMMUNITY BASED SERVICES (WISE, PACT)	**Notification only.** Members in WISe/PACT are case managed by AMG case manager and participate in case conferences. **WiSe- Notification** Required for Adverse Benefits Determination **Only**	**WiSe- Notification** Required for Adverse Benefits Determination **Only** WiSe members are assigned a BH or Regional CM – **PACT** – Notification Followed by ongoing concurrent review after 12 months	**Notification only.**	**Notification only.** Notification referral to Molina CM only.	**Yes:** MH IOP S9480 **WISe requires Notification only**	
APPLIED BEHAVIOR ANALYSIS	**No.** ABA services do not require a Pre-Service Authorization.	**Yes.** Pre-Service Authorization is required for ABA Therapy and Continued Treatment	**Yes.** Pre-Service Authorization is required for ABA Therapy and Continued Treatment every 6 months.	**Yes.** Beginning 5/12/2020 the following codes require PA:	**Yes.** Pre-Service Authorization is required for ABA Therapy and Continued Treatment	

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	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF INITIAL AND CONTINUED STAY AUTHORIZATION ***Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent assessment is acceptable.***					
SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
		Authorization every 6 months.		97153, 97154, 97155, 97158 Effective 8/1/2020 these codes will require PA: 0373T H2020 -After the initial 48 service days 97151 Limitation Extension requests will be required for > 28 units per assessment, 2 assessments per year 0362T Limitation Extension requests will be required for > 8 units (2 hours of assessment), 3 assessments per year	Authorization every 6 months.	
ECT - ELECTROCONVULSIVE THERAPY	**Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. **Initial: 6-10 sessions.*	**Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. **Initial: 6 sessions. Beyond 6 sessions is subject to MD review (for initial and ongoing/ maintenance)*	**Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. **Initial and concurrent: 10-12 sessions*	**Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. **Initial: 6 sessions (or at Medical Director discretion) for acute/initiation requests.*	**Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. **6-12 initial visits*	

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SERVICE TYPE AND DESCRIPTION	**AMERIGROUP**	**CHPW**	**COORDINATED CARE**	**MOLINA**	**UNITED**	**LEFT BLANK INTENTIONALLY**
				**Continuation: 6 sessions (or at Medical Director discretion)*		
TMS – TRANSCRANIAL MAGNETIC STIMULATION	**Yes.** Pre-Service Authorization Required for Initial or Acute treatment.	**Yes.** Pre-Service Authorization Required for Initial or Acute treatment.	**Yes.** Pre-Service Authorization Required for Initial or Acute treatment.	**Yes.** Pre-Service Authorization Required for Initial or Acute treatment. **Authorization details:** **Initial: Up to 36 treatments over 1-year period*	**Yes.** Pre-Service Authorization Required for Initial or Acute treatment.	
PSYCHOLOGICAL TESTING	**No** prior authorization required for first 2 units of service per client per lifetime. **Yes,** Prior Authorization required for additional units of service. Notification Only required for COEs if	**No** prior authorization required for first 2 units of service per client per lifetime. **Yes,** Prior Authorization required for additional units of service. 7 units of psych testing covered for ABA for clients age 20 or younger when evaluation	**No** prior authorization required	**No** prior authorization required for first 9 units of service per client per lifetime. **Yes.** Prior Authorization required for additional units of service and for all non-par providers.	**No** prior authorization required for first 12 units of service per client per lifetime. **Yes,** Prior Authorization required for additional units of service.	

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	purpose of evaluation is for ABA services.	performed by a COE – notification only. Other qualified providers require pre-service authorization for ABA evaluation for more than 2 units of testing, up to 4.				
NEUROPSYCHOLOGICAL TESTING	**Yes.** Prior-Authorization required except for neurobehavioral status examination.	**Yes.** Prior Authorization required.	**No** prior authorization required.	**Yes.** Prior Authorization required.	**No** prior authorization required.	
TELEHEALTH/TELEPSYCH	**No,** not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers and non-network providers.	**No,** not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers. **Yes**, if non network provider requests.	**No,** not for in network providers. **Yes**, if non network provider requests.	
"WRAP-AROUND SERVICES" – STATE GENERAL FUND SERVICES	**No.** Payment limited to GFS allocated amount identified in Provider contract.	**No**. *Payment limited to GFS allocation*	**No.** Payment limited to GFS allocated amount identified in Provider contract.	**No.** Payment limited to GFS allocated amount identified in Provider contract.	**No.** Payment limited to GFS allocated amount identified in Provider contract.	
CLUBHOUSE /DAY SUPPORT	**Clubhouse- No.** Covered under Procedure Code H2031 **Day Support- No.**	**No.**	**No.**	**No.**	**No.** Payment limited to GFS allocations and agreement in Provider Contract	
RESPITE CARE	**No.** Registration/ Notification only.	**No.**	**No.**	**No.**	**No.** Payment limited to GFS allocations and	

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	Covered under Procedure Codes H0045, S9125, T1005.				agreement in Provider Contract	

You may find this information on our individual websites:

Community Health Plan of Washington – CHPW

https://www.chpw.org/for-providers/prior-authorization-and-medical-review/

Coordinated Care of Washington -CCW

https://www.coordinatedcarehealth.com/content/dam/centene/Coordinated%20Care/provider/PDFs/BehavioralHealthForms/508-PriorAuth-Quick-Reference-Guide-IMC-BHSO.pdf

Molina Healthcare of WA - MHW

https://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/1344-2001_2020%20Medicaid%20MHW%20PA%20BH%20Provider%20Services%20Reference%20Guide_508.pdf

United

https://www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home/wa-cp-prior-auth.html

"Notification Only"

Emergent, unplanned admissions to acute inpatient BH facilities (such as E & T or acute inpatient detoxification) do not require prior authorization but do require notification of the admission by means of electronic file, fax or phone call within 24 hours of that admission. Clinical information shall be provided for medical necessity determination, known as concurrent review, following this notification. This can apply to lower level services as well.