

BEHAVIORAL HEALTH PRIOR AUTHORIZATION REFERENCE GUIDE



SERVICE TYPE AND DESCRIPTION	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF AUTHORIZATION
<p>ACUTE INPATIENT CARE – MENTAL HEALTH AND SUBSTANCE USE DISORDER (SUD)</p> <ul style="list-style-type: none"> Acute Psychiatric Inpatient; Evaluation and Treatment Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital Inpatient Acute Withdrawal (Detoxification) ASAM 4.0 <p>* Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs.</p>	<p>No. Emergent admissions require notification only within 1 business day followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission.</p> <p>Coordinate with Transitions of Care/Health Home Care coordinator. * <i>Initial: 3-5 days</i></p>
<p>WITHDRAWAL MANAGEMENT (IN A RESIDENTIAL SETTING)</p> <ul style="list-style-type: none"> ASAM 3.7 ASAM 3.2 <p>* Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs.</p>	<p>No, if <u>Emergent</u> –requires notification only within 1 business day followed by concurrent review. Yes, if <u>planned</u> – requires pre-service review and concurrent review. * <i>Initial: 3-5 days</i></p>
<p>CRISIS STABILIZATION IN A RESIDENTIAL TREATMENT SETTING</p>	<p>No, requires notification only within 1 business day followed by concurrent review. * <i>Initial: 3-5 days</i></p>
<p>RESIDENTIAL TREATMENT – MENTAL HEALTH AND SUBSTANCE USE DISORDER</p> <ul style="list-style-type: none"> ASAM 3.5 ASAM 3.3 ASAM 3.1 	<p>Yes, if <u>planned</u> – requires pre-service review and concurrent review. * <i>Initial: 14 days</i></p>
<p>PARTIAL HOSPITALIZATION/DAY TREATMENT</p> <ul style="list-style-type: none"> ASAM 2.5 	<p>Yes. *<i>Initial: 7 days</i></p>
<p>INTENSIVE OUTPATIENT PSYCHOTHERAPY SERVICES</p> <ul style="list-style-type: none"> ASAM 2.1 	<p>No, not for in-network providers. Yes, if non network provider requests.</p>
<p>MEDICATION EVALUATION AND MANAGEMENT</p>	<p>No, not for in-network providers. Yes, if non network provider requests.</p>
<p>MEDICATION ASSISTED THERAPY (MAT)</p>	<p>No, not for in-network providers. Yes, if non network provider requests. *Managed by retail pharmacy</p>

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INITIAL ASSESSMENT (MH AND SUD/ASAM) AND OUTPATIENT PSYCHOTHERAPY SERVICES	No , not for in-network providers. Yes , if non network provider requests.
HIGH INTENSITY OUTPATIENT/COMMUNITY BASED SERVICES	Notification only , then CCW will build the provider approved service into our system for tracking and care coordination referral. <i>* Initial: 1 year for PACT and 6 months for WISe.</i>
APPLIED BEHAVIOR ANALYSIS (ABA)	Yes . Pre-Service Authorization is required for ABA Therapy and Continued Treatment every 6 months.
ELECTROCONVULSIVE THERAPY (ECT)	Yes . Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. <i>*Initial: 10-12 sessions.</i>
TRANSCRANIAL MAGNETIC STIMULATION (TMS)	Yes . Pre-Service Authorization Required for Initial or Acute treatment.
PSYCHOLOGICAL TESTING	No prior authorization required for <u>first 2 units of service</u> per client per lifetime. Up to 7 units without Prior Authorization when billed with UC Modifier.
NEUROPSYCHOLOGICAL TESTING	No prior authorization required.
TELEHEALTH/TELEPSYCH	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.
CLUBHOUSE	No .
RESPIRE CARE	Yes .