Behavioral Health Prior Authorization Reference Guide

SERVICE TYPE AND DESCRIPTION	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF AUTHORIZATION
ACUTE INPATIENT CARE – MENTAL HEALTH AND SUBSTANCE USE DISORDER (SUD) • Acute Psychiatric Inpatient; Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Inpatient Acute Withdrawal (Detoxification)	**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*
SUBACUTE DETOXIFICATION (IN A RESIDENTIAL SETTING)	**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*
CRISIS STABILIZATION IN A RESIDENTIAL TREATMENT SETTING	**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*
RESIDENTIAL TREATMENT	**Yes**, If planned –requires pre-service review and concurrent review. ** Initial authorization of 28 days*
PARTIAL HOSPITALIZATION/DAY TREATMENT	**Yes.** ***Initial 7 days**

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Intensive Outpatient Psychotherapy Services	**No**, not for in-network providers. **Yes**, if non-network provider requests.
Medication Evaluation and Management	**No**, not for in-network providers. **Yes**, if non-network provider requests.
Medication Assisted Therapy	**No**, not for in-network providers. **Yes**, if non-network provider requests.
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**, followed by concurrent review. ***** Initial authorization of 1 year for PACT and 6 months for WISe.
Applied Behavior Analysis (ABA)	**Yes.** Pre-service authorization is required for ABA therapy and continued treatment every 6 months.
Electroconvulsive Therapy **TMS (Transcranial magnetic stimulation)**	**Yes.** Pre-service authorization is required for Initiation, Continuation and Maintenance treatment. *Initial authorization for 10-12 sessions. **Yes.** Pre-service authorization is required for Initial or Acute treatment.

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PSYCHOLOGICAL TESTING	**No** prior authorization required for first 2 units of service 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**
RESPITE CARE	**No**