Overview:
Utilization Management for Fully Integrated Managed Care and Behavioral Health Services Only Apple Health Enrollees
Clark & Skamania Counties

Presented By:

Molina Healthcare
Community Health Plan of Washington

March 2\textsuperscript{nd}, 2016
Welcome!

- This session will provide you with information about referral and authorization processes.
- The first portion of the discussion is jointly facilitated by Community Health Plan of Washington (CHPW) & Molina Health Care and includes:
  - What’s Happening?
  - NCQA Accreditation
  - Key Definitions & Terms
  - Authorization Decision Time Frames
- The second section will have separate presentations by the two MCOs and includes:
  - Services Requiring a Referral or Authorization
  - Clinical Criteria Used for Authorization Decisions
  - How to Submit a Referral or Authorization Request
  - Key Contacts
  - Additional Training Sessions
What’s Happening...

• Mental health & substance use disorder services have been delivered in *isolation* of each other and of medical services

• The Health Care Authority is taking steps to *integrate* all of these services in Clark & Skamania Counties

• CHPW & Molina are the **Managed Care Organizations** selected to integrate these services
More of What’s Happening…

• The Counties & State have asked us to collaborate in delivery of this new model of managed care to achieve administrative simplification for enrollees and providers

• Our aim is to align as much as possible as we establish new relationships with you, our providers of care
First things first... **Mental Health Parity**

Washington state's Mental Health Parity Act requires coverage for medically necessary mental health services under the same terms and conditions as medical and surgical services.

- *Good News:* Parity supports better and equal coverage for behavioral health services
- *Tougher News:* More service requires stronger stewardship to ensure medical necessity
Shared Utilization Management Regulations

- FIMC/WrapAround Contracts
- WACs and RCWs
- HCA Provider Guide
- HCA Health Technology Assessment Committee
- NCQA Standards
NCQA Accreditation

• Both Community Health Plan of Washington & Molina Healthcare of Washington are required to be accredited by the National Committee for Quality Assurance (NCQA).

• An independent, not-for-profit organization who has developed quality standards for health plans.
  – Accredited health plans today face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn NCQA’s seal of approval.
  – Includes 14 UM specific standards.
Medical Necessity

- Medical Necessity

Washington State law defines medical necessity as

- A requested service that is intended to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that
  - endanger life,
  - cause suffering or pain, or
  - result in an illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction AND

- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.
Utilization Management

• NCQA Definition of **Utilization management**:

  Evaluating & determining coverage for and appropriateness of medical & behavioral health care services, as well as providing needed assistance to providers and patients, in cooperation with other parties, to ensure appropriate use of resources.
Types of UM Reviews

• **Pre-Service/Prior Authorization**
  
  Services in which authorization must be obtained *prior* to start of service

• **Concurrent**

  Services in which authorization is obtained during a course of care and prior to the end of the episode of care.

• **Retrospective/Post-Service**

  A review conducted after the service has occurred to determine if the services were medically necessary
Emergent Services

• **Psychiatric**
  A mental health condition in which the patient is a danger to themselves, others or is gravely disabled.

• **Medical**
  A medical condition that a prudent lay person might anticipate serious impairment to his or her health in an emergency situation.
  
  The American College of Emergency Physicians has long believed that anyone who seeks emergency care suffering from symptoms that appear to be an emergency, such as chest pain, should not be denied coverage if the final diagnosis does not turn out to be an emergency.
# UM Decision Time Frames

<table>
<thead>
<tr>
<th></th>
<th>Pre-Service</th>
<th>Concurrent</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard/Non-Urgent</td>
<td>Within 5 days of receipt of necessary information</td>
<td>Initial determination within 1 business day</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensions within 72 hours of request</td>
<td></td>
</tr>
<tr>
<td>Emergency/Urgent</td>
<td>Within 24 hours of request</td>
<td>Initial determination within 1 business day</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensions within 72 hours of request</td>
<td></td>
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</tbody>
</table>

Note: These time frames are the general requirement and assume that all information needed to make a decision has been received.
Prior Authorizations and Referrals
Behavioral Health Services
Requiring Authorization

• Our approach...
  – Remove barriers to accessing mental health and substance abuse services
  – Eliminate unnecessary administrative burden to providers
  – Identify those enrollees with complex, chronic conditions who may benefit from care coordination or intensive care management services
  – Ensure services received are medically necessary
Care Management Services

- **Case Management** assists members with acute, complex behavioral health and/or medical needs. The program offers
  - coordination between providers
  - education and support for enrollees and
  - connection to community services and programs.

- **Disease Management** is available for adults with diabetes, congestive heart failure, depression, COPD and children with asthma. The program offers
  - education and support to members to help them understand and manage their conditions
Care Management Services, Continued

- Multichronic Care Management (MCCM) is available for high-risk enrollees with multiple chronic conditions exacerbated by behavioral comorbidities & psychosocial challenges. MCCM focuses on
  - physical, psychological, & social drivers of maladaptive behavior.
  - helping members increase motivation, adhere to treatment and achieve their personal health goals.
Care Management Referrals

• Who may be appropriate for these services?
  – Patients with complex, chronic behavioral health conditions
  – Patients with co-morbid medical conditions
  – Patients needing assistance with basic needs such as transportation, shelter, food, etc.
How to Refer for Care Management Services

- Referrals can be made by calling our case management department at **1-800-251-4506**, Mon- Friday 8:00 AM- 5:00 PM

- You can also go to CHPW’s web site, [http://chpw.org](http://chpw.org)
  Click on “For Providers” and select “Forms and Tools” to access a case management referral form to fax to us.
# Outpatient Behavioral Health Services

## Requirement Authorization

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description of Services</th>
<th>Notification Required?</th>
<th>Authorization Required?</th>
<th>Type of Authorization</th>
<th>Additional Requirements</th>
</tr>
</thead>
</table>
| **Initial Assessment & Outpatient Therapy & Counseling Services** | For Psychiatric AND SUD Treatment | No | Yes, based on threshold | Concurrent review | **Threshold:** 12 or more outpatient sessions in 3 months  
• Refer for intensive care management  
• Medical necessity review as needed |
| **High Intensity Outpatient Programs** | • IOP  
• PHP  
• Day Treatment Program  
• WISE Program  
• PACT Program | Yes | Yes | Pre-Service authorization for Admission  
Concurrent review | |  
• Refer for intensive care management |
| **Community Support Services** | • SUD Recovery Services  
• Psychosocial Case Mgmt  
• Psychosocial Rehab  
• Peer Supports | No | Yes, based on threshold | Pre-Service authorization when threshold met | Pre-services authorization is required when **threshold** of 16 hours or more of services per month for 2 consecutive months has been met. |
# Outpatient Behavioral Health Services
## Requiring Authorization, Continued

<table>
<thead>
<tr>
<th>Service Type</th>
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<th>Authorization Required?</th>
<th>Type of Authorization</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA Therapy, ECT, Neuropsych Testing, Repetitive Transcranial Magnetic Stimulation (rTMS)</td>
<td>Special outpatient services</td>
<td>N</td>
<td>Y</td>
<td>Pre-Service authorization required</td>
<td></td>
</tr>
</tbody>
</table>
| Psychological Testing                       | Psychological Testing                    | No                     | Yes, based on threshold | Pre-Service authorization required for additional units of service beyond benefit limit (2 units per lifetime) | First 2 units (hours) of service in a lifetime do not require pre-service authorization.  
**Threshold:** Hours beyond 2 hours in a lifetime require a request for benefit limit exception |
Inpatient & Other Behavioral Health, Facility-Based Care Requiring Authorization

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description of Services</th>
<th>Notification Required?</th>
<th>Authorization Required?</th>
<th>Type of Authorization</th>
<th>Additional Requirements</th>
</tr>
</thead>
</table>
| Inpatient, psychiatric or substance use disorders | • Acute Psychiatric Inpatient Care  
• Evaluation & Treatment Admission  
• Inpatient Acute Withdrawal (Detoxification)  
• Crisis Stabilization in residential setting  
• Inpatient                                               | Yes, within 24 hours of admission                     | Yes                      | Pre-service authorization for non-emergency admissions        | Concurrent review for emergency admission                     |
# Behavioral Health Medical Necessity Criteria

You can request a copy of criteria used for a determination by calling **800-336-5231, select option 1**

<table>
<thead>
<tr>
<th>Criteria Sets for Behavioral Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>WA State Health Care Authority Health Technology Assessments</strong></td>
</tr>
<tr>
<td>• <strong>CMS National and Local Coverage Determination criteria</strong> for Dual Eligible Medicare/Medicaid members</td>
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<tr>
<td>• <strong>CHPW Clinical Coverage Criteria</strong> for ABA Services, ECT, rTMS, neuropsychological testing</td>
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<tr>
<td>• Mental Health Services - <strong>LOCUS/CA_LOCUS Crosswalk</strong> – The same crosswalk that used by Southwest Behavioral Health RSN</td>
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<tr>
<td>• Substance Use Disorder Services - The <strong>ASAM Criteria</strong>; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions</td>
</tr>
<tr>
<td>• <strong>MCG Guidelines</strong> for Psychological Testing</td>
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</table>
How to Request a Referral or Authorization

• You can either fax Behavioral Health and Medical Referral and Authorization requests or you can submit using the CHPW Medical Management Portal.

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<th>CHPW Medicaid Fax Numbers</th>
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<tr>
<td>Fax Queue</td>
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<tr>
<td>Prior Authorization Request (Inpatient/ Outpatient)</td>
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<tr>
<td>Appeals Fax</td>
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*If you have questions about an authorization request, you may call us at 800-336-5231, select option 1.*
The Jiva Provider Portal

• The medical management portal is a real timesaver for getting authorization letters, submitting requests and looking up info.

• We can set you and your staff up on the CHPW the medical management provider portal.
  – Submit a request by phone at 1 (800) 440-1561 or send an email to portal.support@chpw.org.
  – Let us know if morning or evenings work best for training.
  – Training is available by phone or Web Ex.
The Jiva Provider Portal

Health Information Portal (HIP)

Registered users have access to the following information:

• Eligibility and Benefit Details
• Member Rosters
• View Referrals & Authorizations
• View Claim Status

Once registered, providers can access HIP through a single sign-in at:

• OneHealthPort, or
• https://hip.chpw.org/login.asp

Support Phone Number: 1 (800) 440-1561
The Jiva Provider Portal, Continued

• When making a request, include the information below:

<table>
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<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Contact Number</th>
<th>Fax Number</th>
<th>Email Address</th>
<th>Company Name</th>
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Prior Authorizations and Referrals
Pre-Service Authorization Requests

• Prior Authorization/Pre-Service Review Guide is located at
  http://www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
  • CLICK – Frequently Used Forms from the Forms dropdown menu
  • Specialty service specific information also available here for Residential Inpatient Treatment

• Molina Prior Authorization by CPT Code Guide
  • Provides prior authorization requirements based on specific procedure code, place of service, etc.

• Molina Behavioral Health Prior Authorization Guide
  • Located within the Provider Web Portal
  • Provided high-level guidance re: services in need of PA
  • https://provider.molinahealthcare.com/provider/login
Pre-Service Authorization Request Form

Molina Healthcare of Washington
Behavioral Health Prior Authorization Form
Phone: (800) 849-9191
Fax: (800) 747-7165

MEMBER INFORMATION

Plan: [ ] Medicaid [ ] Medicare [ ] Marketplace

Date of Request: ____________________________

Admit Date: ____________________________

Request Type: [ ] Initial [ ] Concurrent

Member Name: ____________________________

DOB: __________

Member ID: ____________________________

Member Phone: ____________________________

Service Info: [ ] Revise/Revision [ ] Expedited Urgent

*Definition of Urgent: Expedited service request designation is given when the treatment requested is required to prevent serious deterioration in the member's health, or could precipitate the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine non-urgent.

PROVIDER INFORMATION

Treat/App: [ ] Facility Name: ____________________________

Provider Name: ____________________________

Provider Tax ID: __________

Provider Phone: ____________________________

Primary Payer: ____________________________

 REFERRAL/Service Type Requested

[ ] Inpatient Non-Operative

[ ] Inpatient Operative

[ ] Home Health Care

[ ] Rehabilitation

[ ] Individual Therapy (IPT)

[ ] Physical Therapy (PT)

[ ] Occupational Therapy (OT)

[ ] Other Therapy Services

Procedures Code(s) and Description Requested: ____________________________

Length of Stay Requested: ____________________________

Date of Service Requested: ____________________________

Primary Diagnosis: ____________________________

(Include Medical Diagnosis, Including any laboratory, imaging or other testing results)

Additional Diagnoses: ____________________________

(Include any nonzero Medical Diagnosis/Conditions)

Unrelated Services: ____________________________

ONLY COMPLETE THIS SECTION IF MEMBER IS IN PATIENT:

Expected Discharge Date: ____________________________

Follow-Up Appointment Scheduled: ____________________________

(Complete if member is in Inpatient Hosp). Consultation

*NOTICE: Test follow up appt must be scheduled within 7 days of discharge.

Provider Type: ____________________________

Provider Name: ____________________________

Telephone Number: ____________________________

Date of Appointment: ____________________________

Time of Appointment: ____________________________

*Together with this form, please forward medical documentation to include medical/administration documents.

*For Inpatient PT, OT, and Home Health Care Requests: Please submit medical records to the MTM for Inpatient Program (CPT).

NOTE: Level of care coverage may require state Contract Services Coverage. Please refer to the state-specific Provider Handbook for a list of covered levels of care. Authorization of services does not guarantee payment. Payment for services are pending eligibility to the terms of service and benefit coverage.
Behavioral Health Prior Authorization Guide

All billed services must meet medical necessity requirements regardless of authorization requirements. "Medically Necessary Services" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

Emergent services are defined as a medical [behavioral health] condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a). Emergent services do not require Pre-Service authorization; see below for notification and clinical review requirements.

All non-emergent Out-of-Network services require authorization.
Definitions of medical necessity review and authorization types:
• Pre-Service (Prior): authorization must be obtained prior to start of service
• Concurrent: authorization is obtained after service has occurred but prior to end of episode of care
• Post-Service (Retro): medical necessity review conducted after service has occurred
# Behavioral Health Prior Authorization Guide

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>DESCRIPTION OF SERVICES</th>
<th>NOTIFICATION REQUIRED?</th>
<th>AUTHORIZATION REQUIRED?</th>
<th>TYPE OF AUTHORIZATION</th>
<th>ADDITIONAL REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE INPATIENT CARE – MENTAL HEALTH AND SUD</strong></td>
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<tr>
<td></td>
<td>Acute Psychiatric Inpatient; Evaluation and Treatment</td>
<td>Yes within 24 hours of admission</td>
<td>Yes</td>
<td>Emergent – concurrent review following notification</td>
<td></td>
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<tr>
<td></td>
<td>Inpatient Acute Withdrawal (Detoxification)</td>
<td></td>
<td></td>
<td>Planned – pre-service review</td>
<td></td>
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<td></td>
<td>Crisis Stabilization in residential setting</td>
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<tr>
<td><strong>INPATIENT REHABILITATION/SUBACUTE DETOXIFICATION/RESIDENTIAL TREATMENT</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Rehabilitation and SubAcute Detox for Substance Use Disorder</td>
<td></td>
<td>Yes</td>
<td>Emergent – concurrent review following notification w/in 24 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Treatment Services for Psychiatric and Substance Use Disorder</td>
<td></td>
<td>Yes</td>
<td>Planned – pre-service review; concurrent review as determined by Medical Director, UM Nurse</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Coordinate with Transitions of Care/Health Home Care coordinator</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description of Services</td>
<td>Notification Required?</td>
<td>Authorization Required?</td>
<td>Type of Authorization</td>
<td>Additional Requirements</td>
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</tr>
<tr>
<td><strong>Partial Hospitalization/Day Treatment</strong></td>
<td>Add description</td>
<td>Yes</td>
<td>Yes</td>
<td>Emergent – concurrent review following notification w/in 24 hours</td>
<td>Referral to Molina Case Management for members who utilize more than 6 weeks of PHP or Day Treatment program services within a rolling year</td>
</tr>
<tr>
<td><strong>Medication Evaluation and Management</strong></td>
<td>Prescriber (MD and ARNP) office visits</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK providers</td>
<td></td>
</tr>
<tr>
<td><strong>Medication Assisted Therapy</strong></td>
<td>Suboxone, Vivitrol</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK providers</td>
<td>Consider referral to MCO Case Management</td>
</tr>
</tbody>
</table>
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<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Assessment (MH and SUD/ASAM) and Outpatient Psychotherapy Services</strong></td>
<td>For Psychiatric AND Substance Use Disorder Treatment</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK provider.</td>
<td>Outlier monitoring with concurrent and post-service medical necessity reviews</td>
</tr>
<tr>
<td></td>
<td>Includes counseling/psychotherapy for Individual, family, group, and activities to treatment behavioral health conditions</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Intensive Outpatient Psychotherapy Services</strong></td>
<td>For Psychiatric AND Substance Use Disorder Treatment</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK provider.</td>
<td>Outlier monitoring with concurrent and post-service medical necessity reviews</td>
</tr>
<tr>
<td></td>
<td>Includes Psychotherapies for Individual, family, group, and activities to treatment mental health (definition)</td>
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<th>Additional Requirements</th>
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<tbody>
<tr>
<td><strong>High Intensity Outpatient/Community Based Services</strong></td>
<td>PACT</td>
<td>Yes – referral to Molina case management</td>
<td>No</td>
<td>Notification and referral to Molina CM only</td>
<td>Members in WISe/PACT are case managed by Molina case manager and participate in case conferences</td>
</tr>
<tr>
<td></td>
<td>WISe</td>
<td></td>
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</tr>
<tr>
<td><strong>Community Based Services</strong></td>
<td>Includes SUD Recovery Services, Psychosocial Case Management, Psychosocial Rehabilitation, Peer Supports</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK provider.</td>
<td>Outlier monitoring with concurrent and post-service medical necessity reviews</td>
</tr>
<tr>
<td><strong>Applied Behavioral Analysis for Autism Spectrum Disorder</strong></td>
<td>Treatment provided to beneficiaries diagnosed with ASD between the ages of 0-21.</td>
<td>Yes</td>
<td>Yes</td>
<td>Initial evaluation and treatment planning through a COE (Center of Excellence) does NOT require authorization for IN-NETWORK COEs</td>
<td>7 hours of psych testing covered for ABA evaluation for 0-21 – notification only required</td>
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<td></td>
<td></td>
<td>Pre-Service Authorization is REQUIRED for ABA Therapy and Concurrent Authorization every 6 months</td>
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</tbody>
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<th>Type of Authorization</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electroconvulsive Therapy</strong></td>
<td>Covered - 90870</td>
<td>Yes</td>
<td>Yes</td>
<td>Pre-Service Authorization Required</td>
<td>7 units of psych testing covered for ABA evaluation performed by a COE – notification only required for Autism COEs; other qualified providers require pre-service authorization for additional 5 units of testing</td>
</tr>
<tr>
<td><strong>Psychological Testing</strong></td>
<td>Covered at 2 Units of Service per lifetime. For ASD evaluation, covered at 7 Units of Service per lifetime.</td>
<td>No for first 2 units.</td>
<td>Yes - for additional Units of Service (limitation exception) Exception: Autism COEs – notification only prior to service</td>
<td>Pre-Service Authorization required for additional units of service Notification Only required for COEs for ASD evaluation</td>
<td></td>
</tr>
<tr>
<td><strong>Neuropsychological Testing</strong></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Pre-Service authorization required</td>
<td></td>
</tr>
<tr>
<td><strong>Telehealth/TelePsych</strong></td>
<td>All covered behavioral health services may be delivered through telehealth with appropriate telehealth modifier.</td>
<td>No</td>
<td>No</td>
<td>No Authorization Required for IN-NETWORK provider.</td>
<td></td>
</tr>
<tr>
<td>“Wrap-Around Services” – State General Fund Services</td>
<td>Defined in Behavioral Health Wrap-Around Contract</td>
<td>No</td>
<td>No</td>
<td>Payment limited to SGF allocated amount identified in Provider contract</td>
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</tbody>
</table>
Behavioral Health Prior Authorization

• For most efficient processing, all requests should include, if applicable:
  • Appropriate service location (inpatient residential, etc.)
  • Planned date of service/service date range
  • ICD-10 diagnosis code(s)
  • CPT, HCPCS or revenue code(s)

• No authorization required for most outpatient services with in-network specialists.
Behavioral Health Prior Authorization

• Routine requests – are to be processed and completed within 5 business days according to state guidelines unless additional information is needed to complete the review.
  • Current average turnaround time is 1-2 business days.
• Urgent requests – Processed within 24 hours unless additional information is needed.

“Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member’s health or could jeopardize the enrollee’s ability to regain maximum function.”
Behavioral Health Prior Authorization

• Reconsideration requests – If a coverage denial is issued, a request to re-consider the determination will be made if received within 14 days and additional clinical information is submitted.
Behavioral Health Prior Authorization

**Frequently Used Numbers**

To request an authorization or check the status of a request:
Provider Web Portal
Healthcare Services (Prior Authorization): (800) 869-7175

To fax in a request for services:
Prior Authorization Fax: (800) 767-7188 or (505) 924-8284

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact the supervisors:

- Donna Jeter-Francis (425) 424-1175 (Authorization process)
- Matt Ryerson (425) 398-2615 (Clinical)
- Tim Reitz (888) 562-5442 ext. 142635 (Manager)
Behavioral Health Prior Authorization

REMINDER –

No PCP Referral is needed for access to Behavioral Health or Substance Use Disorder related Services.

Members can self-refer for treatment.
Inpatient Authorizations

• Planned admissions require prior authorization

• For those admitted via the emergency room or direct admit:
  – Notification within 24 hours or next business day of admission of all admissions
    • Already accomplished for most facilities using electronic processes

• Molina will request and review clinical information supporting the admission using InterQual medical necessity criteria

• A decision will be provided within 24 hours of receipt of the complete clinical information

• Continued stay reviews follow in a 2-4 day cycle
Inpatient Denials

- Following the review of clinical information by the review nurse, the clinical information is sent to the Molina medical director (M.D.)
- The facility will be notified of the medical director’s finding by the review nurse.
- For Medicaid members, peer to peer is available to the MD
- The nurse reviewers do not make adverse decisions or denials - all are reviewed by a MD.
- More details available on the Molina website
- Provider Services can help with this process
Inpatient Denials

• Peer to Peer:
  • 425-398-2603
  • 800-869-7175 ext. 142603

• To appeal post-service denials, please contact Provider Services at:
  • 888-858-5414
  • MHWProviderServicesInternalRep@MolinaHealthCare.Com
Molina reviews each service based on Medical Necessity of treatment per individual members.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>CA/LOCUS Level &amp; Score</th>
<th>MCO Clinical Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery, Resiliency and Health Maintenance</td>
<td>1 Score - 10 thru 13</td>
<td>Maintenance Stage of Support; usually a step down requiring only minimal contact and coordination of services to sustain recovery.</td>
</tr>
<tr>
<td>Outpatient Services (Individual/Group/Family)</td>
<td>2 Score - 14 thru 16</td>
<td>Mild to moderate clinical symptoms, behaviors, and/or functional impairment and/or deterioration due to a diagnosed psychiatric illness. Demonstrated capacity and willingness to engage in treatment and/or has responded positively to more intensive treatment and this level offers ongoing treatment to maintain gains. (Typical routine outpatient services)</td>
</tr>
<tr>
<td>Psychological/Neuropsychological Testing</td>
<td>n/a</td>
<td>This service addresses specific clinical questions; or to ascertain another course of action when current treatment is unsuccessful; or to rule out psychological factors complicating conditions such as chronic pain and morbid obesity. Testing is not considered usual or routine and is never an emergency procedure.</td>
</tr>
<tr>
<td>Intensive Outpatient Services</td>
<td>3 Score - 17 thru 19</td>
<td>Multiple and/or significant symptoms and functional impairments, or deterioration in more than one life domain due to a diagnosed psychiatric illness; individual requires more focused, intensive treatment and service coordination. Services are provided in either a clinic or community setting.</td>
</tr>
<tr>
<td>Medically Monitored Community Based Services (includes PACT and WISe)</td>
<td>4 Score - 20 thru 22</td>
<td>Acute or chronic impairment due to psychiatric illness and/or deterioration in psych condition, such that member requires frequent monitoring without the need for 24 hour structured care; associated with the likelihood of requiring acute inpatient care if member does not benefit from intervention at this level; member may have experienced frequent hospitalizations, crisis interventions, or criminal justice system involvement.</td>
</tr>
<tr>
<td>Medically Monitored, Residential/ Hospital Diversion Services (includes Residential, Partial Hospitalization and Day Treatment)</td>
<td>5 or 6 Score - 23+</td>
<td>When presenting signs/symptoms of a psychiatric illness clearly demonstrate the need for 24/hr structure, supervision and active treatment; member’s support system is either non-existent or has been proven to lack stability and less acute treatment or non-community based setting is likely unsuccessful at this time; or where there history of multiple, recent hospitalizations and a period of structured supervision is needed at this level to return member to a lower level of care.</td>
</tr>
<tr>
<td>Medically Managed Detoxification and Psychiatric Inpatient Services</td>
<td>n/a</td>
<td><strong>Detoxification &amp; Psychiatric Inpatient:</strong> Based on medical necessity and admission criteria, and are NOT dependent on member’s CA/LOCUS level. Current Symptoms indicate an imminent threat to self or others; severe emotional deterioration requiring 24 Hour Supervision and medication management</td>
</tr>
</tbody>
</table>
Outlier Review

For services not requiring prior authorization, Molina will monitor service activity via claims data. Providers that meet ANY criteria below as indicated through data set identified by Molina claims review:

- Top 25% in a utilization across all outpatient services, including Community Based Services (i.e. PACT/WISe)
- Top 25% of providers who submitted claims where primary diagnosis code of an adjustment disorder or other Molina plan focused diagnostic code (i.e. ASD, ADHD)
Case Management Referral Process

- Providers can call the Member and Provider Contact Center (1-800-869-7165) and request that the member be referred to Case Management.

- Members can self-refer by calling the Member and Provider Contact Center (1-800-869-7165).

- Providers can also fax in a request for Case Management services by completing the attached form.

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Molina of Washington Care Management Referral Form

Fax: (800) 767-7198
Phone: (800) 869-7165

Date: ________________

Referral Source Information:
Person Making Referral: ____________________________ Office Name: ____________________________
Phone Number: ____________________________
Referring Provider: ____________________________ Specialty: ____________________________
Telephone Number: ____________________________ Diagnoses: ____________________________

Patient Information:
Name: ____________________________ Date: ____________________________
Address: ____________________________
Telephone Number: ____________________________
Patient’s Current Location if Other Than Residence: ____________________________
Molina Member ID #: ____________________________ OR Provider One ID #: ____________________________

Reason for Referral:
Member needs support with the following areas (check all that apply):
* Please attach clinical notes if available.

- Catastrophic medical or trauma related
- Chronic condition or recurring medical problems
- Functional or emotional impairment
- Pediatric/Neonatal
- Mentally, physically handicapped or developmentally disabled

- Housing Assistance
- Assistance with obtaining food
- POP/Specialist Appointment Set up
- Smoking Cessation Services

- Transportation
- Community Resources
- Understanding health care benefits

Member needs assistance managing one or more of the following chronic conditions:

- Asthma
- CHF
- COPD
- Diabetes
- Depression
- Obesity
- Prediabetes
- Other

Other (please specify): ____________________________

TO BETTER SERVE YOUR PATIENT PLEASE LET THEM KNOW YOU WILL BE REFERRING THEM TO US FOR SERVICES.
Data and Reporting Requirements
Data Collection – Behavioral Health Non Encounter Transactions

Overview

• Planned Approach
  – Standardize across all MCOs

• Implementation Status
  – Timeline

• Inventory of Provider capabilities
  – Avitar
  – EMS Systems Extracts
  – Stop Gap Measures

• Q&A
# Data Collection – Behavioral Health Contact Guide

<table>
<thead>
<tr>
<th>Corey Cerise</th>
<th>Howard Chilcott</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Analyst II, Encounter Data &amp; Reporting</td>
<td>Director, Infrastructure and Data Management Services</td>
</tr>
<tr>
<td>Molina Healthcare of Washington</td>
<td>Community Health Plan of Washington</td>
</tr>
<tr>
<td>Phone: (425) 424-1140</td>
<td>Phone: (206) 613.5021</td>
</tr>
<tr>
<td>Email: <a href="mailto:Corey.Cerise@molinahealthcare.com">Corey.Cerise@molinahealthcare.com</a></td>
<td>Email: <a href="mailto:Howard.Chilcott@chpw.org">Howard.Chilcott@chpw.org</a></td>
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Thank you!