2019 Prior Authorization List and Utilization Guidelines Behavioral Services

Effective: January 1, 2019

COMMUNITY HEALTH PLAN of Washington™

Community HealthFirst® Medicare Advantage Plans

Washington Apple Health

Services for a specific program may not be a covered benefit; please call Customer Service to verify benefits and coverage or verify online by clicking on this link at hip.chpw.org

NOTIFICATION REQUIREMENTS

INPATIENT HOSPITALIZATION

PSYCHIATRIC & SUBSTANCE USE DISORDER (SUD) INPATIENT SERVICES

Types of Services:

- Acute Psychiatric Inpatient Care
- Evaluation &Treatment Admission
- Inpatient Acute Withdrawal (Detoxification)
- Crisis Stabilization in residential setting
- Inpatient Rehab, Substance Use Disorder (SUD)
- Inpatient residential treatment center, psychiatric
- Inpatient residential treatment center, SUD
- Any facility based service providing 24 hours/day and 7days/week services.

HIGH INTENSITY OUTPATIENT PROGRAMS

Notification required for initial 6 months, followed by ongoing concurrent review and authorization to extend past the 6 months.

Types of Services:

- Partial Hospitalization Program (PHP)
- Day Treatment Program
- WISe Program
- PACT Program
- COMET Program

AUTHORIZATION REQUIREMENTS

GENERAL REQUIREMENTS

- All clinical trials require prior authorization
- All inpatient and outpatient substance use disorder treatment for Medicare patients requires prior authorization
- All unlisted codes with a charge greater than $500 require a prior authorization

APPLIED BEHAVIORAL ANALYSIS (ABA) FOR AUTISM SPECTRUM DISORDER

Treatment provided to members diagnosed with Autism Spectrum Disorder and other Developmental Disorders between the ages of 0-21.

MENTAL HEALTH SERVICES

Types of Services:

- Elective Inpatient Psychiatric Services (Integrated Managed Care/BHSO)
- Electroconvulsive Therapy (Washington Apple Health/Integrated Managed Care/ BHSO)
- Repetitive Transcranial Magnetic Stimulation (rTMS) (Washington Apple Health/Integrated Managed Care/BHSO)
- Neuropsychological Testing and Psychological Testing

DOCUMENTATION REQUIRED TO SUPPORT DECISION-MAKING

Please provide documentation wit the request to support medical necessity. Examples of appropriate documents include:

- Current (within 6 months, or more recent depending on condition) history and/or physician examination notes that address the problem and need for services requested
- Relevant lab and/or radiology results
- Relevant specialty consultation notes
- Other pertinent information

REFERRAL POLICY

Referrals to Network Providers:
The Plan requires use of in-network providers whenever possible. If a request is received from the member's assigned Primary Care Physician (PCP) for an in-network provider, no Plan authorization is required.

Referrals to Out-of-Network Providers:
When circumstances arise that require a referral to an out-of-network specialist, authorization from the Plan is required.

PCP to PCP Referrals:
If you are the member's assigned PCP or group, an authorization to provide primary care is required from the Plan.

INPATIENT HOSPITALIZATION

CHPW requires notification of all inpatient admissions, planned and urgent, within 24 hours or next business day.

All planned admissions also require prior authorization.

BENEFIT and COVERAGE LIMITATIONS

This PA list is not all-inclusive. Please refer to the HCA Provider Billing Guidelines Manual and/or Fee Schedule. For Medicare coverage, limitations, please refer to the National Coverage Guidelines and/or Local Coverage Guidelines. Failure to obtain the required prior authorization may result in a denied claim. Services are subject to benefit coverage, limitations and exclusions as described in plan coverage guidelines.

Please refer to the PA Code Lookup Tool for additional details on services listed.