Behavioral Health Authorization Training

EFFECTIVE JULY 1, 2025

PASSPORT BY MOLINA HEALTHCARE

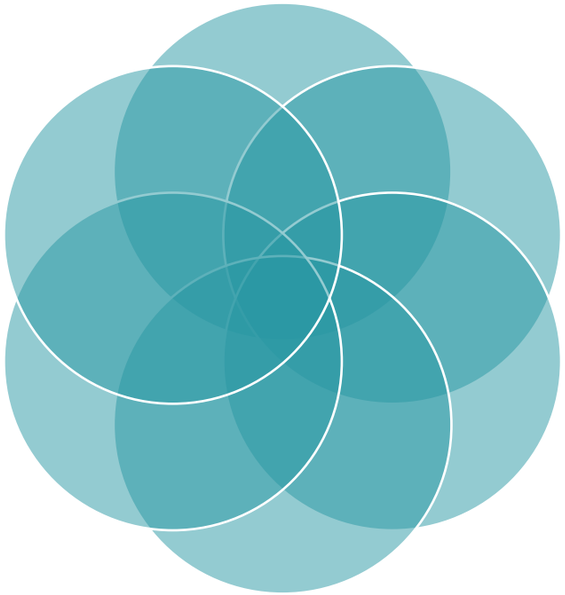
MHKY 2583 APP 05/27/2025 WZ 21097

Agenda

UM Program

Auth Determinations and TAT’s

Medical Necessity



How to Submit an Auth

Services Requiring Auth

When to Submit an Auth

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Passport by Molina Healthcare Recording Policy

Molina Healthcare, Inc. and its subsidiaries (collectively, “Molina” or “Company”) does not permit video or audio recordings (including transcriptions) of any person. Employees may not participate in video, audio or transcriptions of third-party meetings. The use of third-party recording/transcription software is expressly prohibited. Dissemination of recordings/transcriptions outside of Molina and/or recordings/transcriptions for personal purposes are expressly prohibited.

Participants on this call who use video or audio recordings will be immediately removed from this call.

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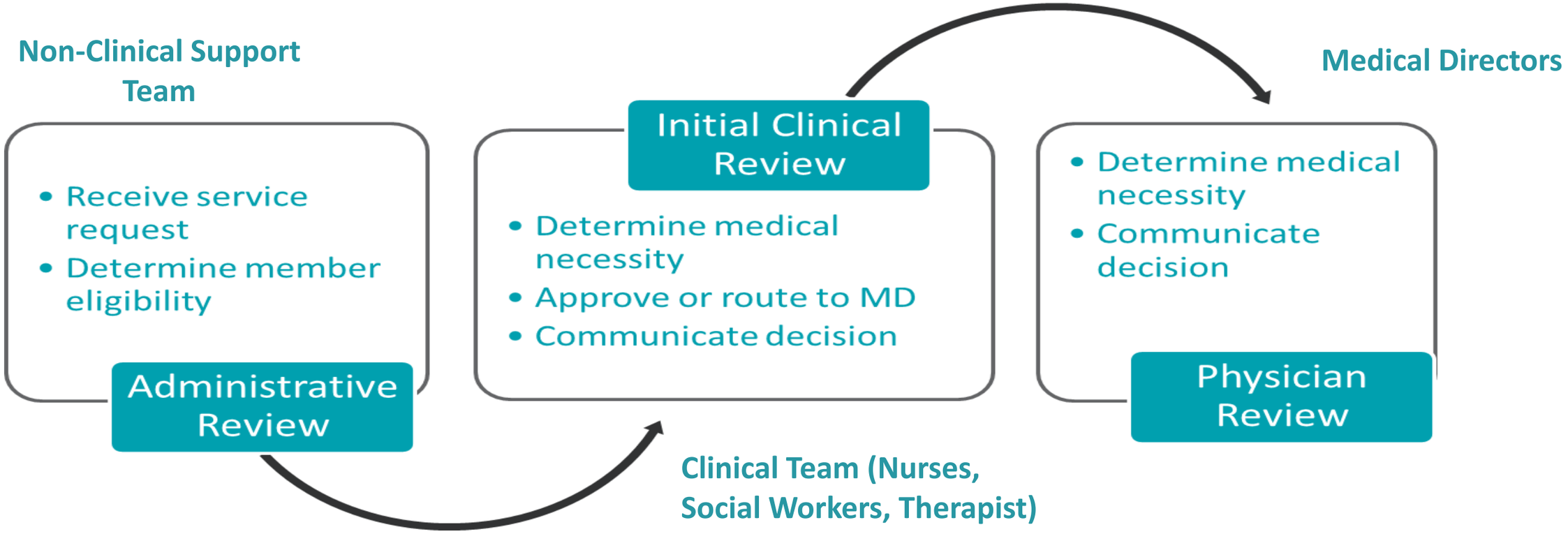
Passport's Utilization Management (UM) Program

Passport ensures the service delivered is ***Medically Necessary*** and demonstrates an appropriate use of resources based on the level of care needed for a Member. The UM program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs.

UM Program Responsibilities:

- Manages available benefits effectively and efficiently while ensuring quality care;
- Evaluates the Medical Necessity and efficiency of health care services across the continuum of care;
- Defines the review criteria, information sources, and processes that are used to review and approve the provision of items and services;
- Coordinates, directs, and monitors the quality and cost effectiveness of health care resource utilization;
- Implements comprehensive processes to monitor and control the utilization of health care resources;
- Ensures services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviews processes to ensure care is safe and accessible.

UM Process



The UM Team has dedicated Clinical Professionals for all Behavioral Health authorizations.
All authorizations are completed by a Team of Clinical Staff.
Only a Medical Director can issue an Adverse Benefit Determination.

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What is Medical Necessity?

In Kentucky Medicaid, "medically necessary" or "medical necessity" means a covered benefit is determined to be needed according to 907 KAR 3:130. This definition encompasses a service that is reasonable and required for the diagnosis, treatment, or prevention of a disease, illness, injury, or other medical condition. It must also be appropriate in terms of the service, amount, scope, and duration, and provided for medical reasons, not primarily for convenience or cosmetic reasons. Furthermore, the service should be provided in the most appropriate location, and if an emergency service, it must meet the "prudent layperson standard".

Clinical Criteria

The UM Department utilizes the following criteria for ***medical necessity*** determinations:

- MCG
- ASAM
- Medical Clinical Policy

If MCG does not cover a Behavioral Health Service, the following standardized tools are utilized for Medical Necessity Determinations:

- For adults: Level of Care Utilization System (LOCUS);
- For children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII)

Services Requiring Authorization (children, adolescents and adults)

SERVICE	NOTES
Non-participating (non-par) Providers	All Services require authorization for non-participating providers, excluding emergent
Inpatient Psychiatric Hospital (free standing and distinct part) including EPSDT Special Services in Extended Care Units (Revenue Codes 114, 124 and 128 – with a behavioral health diagnosis) (ESPDT Code T2048)	• Members who were admitted prior to 7/1/2025 will require notice of admission for payment; concurrent review (authorization) is required if the stay extends more than three (3) days after 7/1/2025, regardless of admission date • Members admitted on or after 7/1/2025 require authorization
Partial Hospitalization for Substance Use Disorder and Mental Health (CPT Code H0035)	• Members who were admitted prior to 7/1/2025 will require notice of admission for payment; concurrent review (authorization) is required if the stay extends more than three (3) days after 7/1/2025, regardless of admission date • Members admitted on or after 7/1/2025 require authorization
Psychiatric Residential Treatment Facilities (Revenue Code 1001)	All services for Residential Treatment on or after 7/1/2025 require authorization
Intensive Outpatient Program (CPT Codes S9480 and H0015)	• Authorization required after 16 visits per member per calendar year, beginning 1/1/25 • If member has already utilized 16 visits prior to 7/1/2025, prior authorization will be required for additional visits
Therapeutic Rehabilitation Program (CPT Codes H2019 and H2020)	Authorization will be required for the 2 associated codes on and after 7/1/2025

Services Requiring Authorization Continued (children, adolescents and adults)

Service	Notes
Applied Behavior Analysis (CPT Codes 97153, 97154, 97155, 97156, 97157, 97158)	Prior authorization required after 48 units, for any combination of CPT Codes listed, per member per calendar year, visit count beginning 1/1/25
Day Treatment (CPT Code H2012)	Authorization will be required for the associated codes on and after 7/1/2025
Peer Support Services (CPT Code H0038)	Prior authorization required for services exceeding 200 units (units measured in 15-minute increments) per member per calendar year, beginning 1/1/25
Psychoeducation (CPT Code H2027)	Prior authorization required for services exceeding 100 units (units measured in 15-minute increments) per member per calendar year, beginning 1/1/25
Targeted Case Management (CPT Code T2023)	Authorization will be required for the associated codes on and after 7/1/2025
Comprehensive Community Supports (CPT Code H2015)	Authorization will be required for the associated codes on and after 7/1/2025
Assertive Community Treatment (CPT Code H0040)	Authorization will be required for the associated codes on and after 7/1/2025

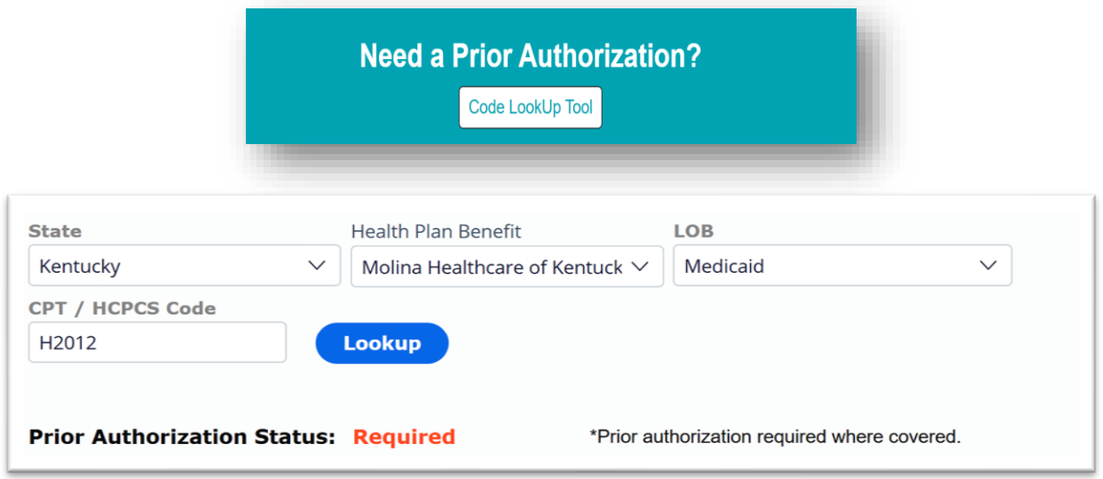
How to Determine if a Service/Code Requires Authorization

All Inpatient Services and Out of Network providers require an Authorization.

Online tools are available to determine if a service/code requires an authorization

Prior Auth Lookup Tool

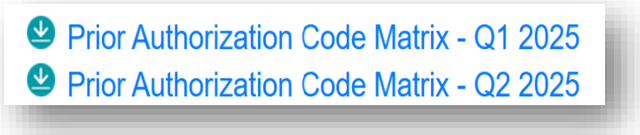
This tool allows providers to enter a CPT or HCPCS code to determine authorization requirements in real time.



To access to the lookup tool visit our website.

Prior Auth Matrix

This document allows providers to search for services to determine authorization requirements



The PA Matrix is updated quarterly; historical codes are also located on our Web as a reference.

To access the PA Auth Matrix, visit our website.

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When to Submit an Authorization

Urgent Request

- Requests should be submitted within **2 Business Days** of the service.
- *From Kentucky Medicaid, "urgent" generally means a situation where a medical condition has a significant impact on the health of the member and requires immediate attention. This is often related to situations where the absence of immediate medical attention could lead to serious health risks, impairment, or dysfunction.*
- Urgent request example: Inpatient admissions from the ER / Direct Admission;
- Providers should submit the clinical information with the authorization request;
- Once an urgent request is received, the Passport UM Team has **1 Calendar day** in which to render a decision.

Inpatient Concurrent Review

- Requests should be submitted by the first open day or Next Review Date (NRD).
- Inpatient authorizations, the Passport UM Team will fax the authorization to the provider with the NRD.

Standard (Non-Urgent) Request

- Request should be submitted **prior** to the service being rendered.
- Standard request example: Outpatient Services;
- Once a non urgent request is received, the Passport UM Team has **5 Calendar days** in which to render a decision.

Retrospective Authorization Request

A medical necessity review is required only for **inpatient services** provided to a retrospective-eligible member.

Providers should submit clinical records to meet medical necessity prior to claims submission:

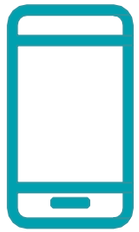
- Retrospective eligibility is coverage of Medicaid benefits for an applicant that may be back-dated for a full three months prior to the month in which the application for Medicaid is filed.
    - Requests should be submitted prior to a claim being submitted.
- Once a retrospective request is received, the Passport UM Team has **5 Calendar** days in which to render a decision.

Submitting Prior Authorization Requests

Providers may submit **medical and behavioral health** prior authorization requests to Passport's Utilization Management department in a variety of convenient ways:

Online
Passport Provider Portal,
Availity Essentials
availity.com

Mail
Passport by Molina Healthcare
Attn: Utilization Management
2028 W. Broadway Louisville, KY
40203



Phone
Medical and Behavioral Health
(800) 578-0775 – option 4

Fax
(833) 454-0641

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Submitting Authorizations - Availity Essentials

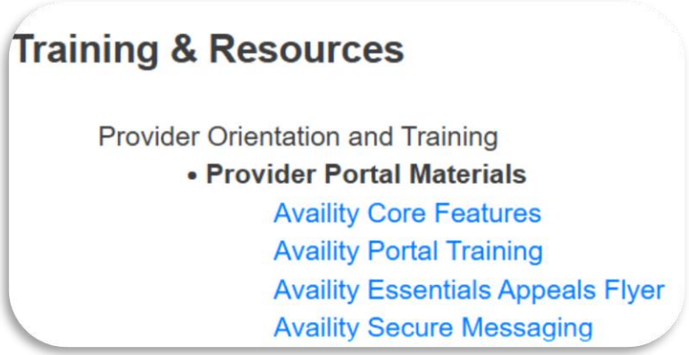
Availity Essentials is our official secure provider portal for providers. Some of the core features available:

- Eligibility & benefits, attachments, claim status, Smart claims, Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute);
- Claims correction feature;
- Dispute resolution;
- MCG Cite for Care Guideline

How to register

- Visit Availity.com/MolinaHealthcare and click the Register button.
- For registration issues, call Availity Client Services at (800) AVAILITY (282-4548).
  - Assistance is available Monday-Friday 8 a.m. to 8 p.m. EST.
- Once you have your Availity Essentials account, you can learn more about the features and functionality
  - Simply log in > go to Help & Training > Get Trained to register for a webinar.

Additional provider portal materials are available here.



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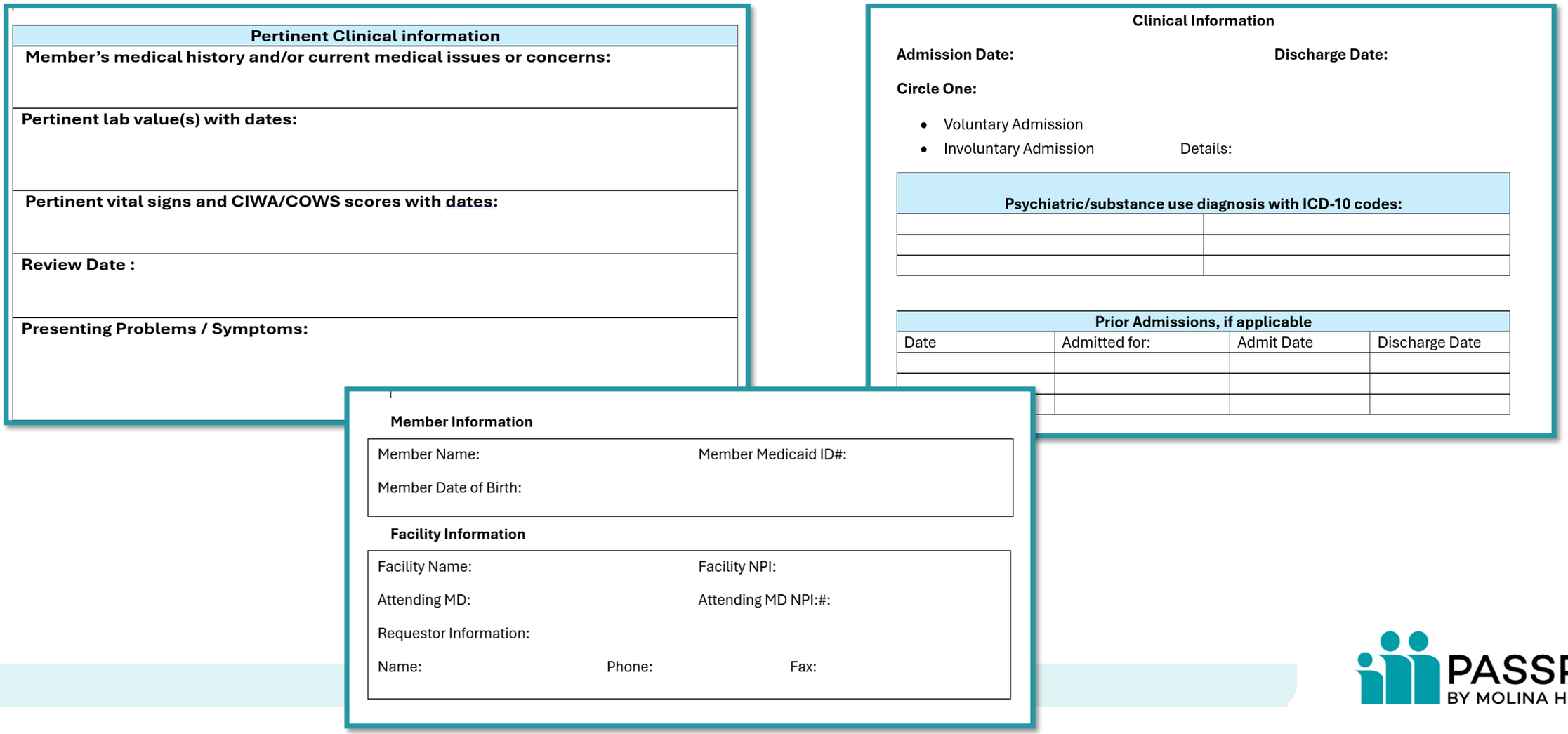
What to Submit with an Authorization Request

- Information required for review is dependent on the type of review.
- The UM Department will develop forms / guides with the elements required for review and these will be posted on our web.



Pertinent Clinical information
Member's medical history and/or current medical issues or concerns:
Pertinent lab value(s) with dates:
Pertinent vital signs and CIWA/COWS scores with dates:
Review Date :
Presenting Problems / Symptoms:

Clinical Information

Admission Date: **Discharge Date:**

Circle One:

- Voluntary Admission
- Involuntary Admission Details:

Psychiatric/substance use diagnosis with ICD-10 codes:	

Prior Admissions, if applicable			
Date	Admitted for:	Admit Date	Discharge Date

Member Information

Member Name: Member Medicaid ID#:

Member Date of Birth:

Facility Information

Facility Name: Facility NPI:

Attending MD: Attending MD NPI:#:

Requestor Information:

Name: Phone: Fax:

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UM Decisions and Timeframes

An organizational determination is any decision made by Passport or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to delay, modify, or deny authorization or payment of request (adverse determination).

Passport must render a decision on an authorization request:

Review Type	Decision Turn Around Time
Urgent	1 Calendar Day
Non-Urgent (Standard)	5 Calendar Days
Retrospective	5 Calendar Days

Communication of Determinations

Provider notification of the review determination

- The Passport UM Team will notify the provider of a review determination via fax and telephonically; Providers may also view the determination on the Passport Provider Portal, Availity.
- The fax notification will contain the case number; review status (approved, partially approved, denied), Peer to Peer information and for inpatient services the Next Review Date.
- In the event an adverse benefit determination is rendered, a letter is sent to both the member and provider.

Below is an overview of information contained in the UM notification:

Determination	Authorization Number	Approved Date Span	Approved Services	Denial Notification	Appeal Rights
Approved	✓	✓	✓		
Denied				✓	✓
Partial	✓	✓	✓	✓	✓

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Adverse Benefit Determinations (Denials)

If a request for service is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the provider by telephone, fax or electronic notification.

Providers and members can request a copy of the criteria used to review requests for medical services by calling: Phone: (800) 578-0775 or faxing to (833) 454-0641.

Passport has full-time Medical Directors who are available to discuss medical necessity decisions (Peer-to-Peer Review) by calling (800) 578-0775 within five (5) business days of the denial.

Peer to Peer Review

Peer to Peer (P2P): a conversation between the provider directing the care of the member and the Passport Medical Director to re-evaluate the denied decision. The requesting provider may share **NEW** clinical information to support the approval of the requested services. If no new clinical information is noted, the denial will be upheld.

This conversation can occur for inpatient or PA requests.

The requesting provider has five **(5) business days** from the verbal notification of the denial to request a P2P. Upon request, a P2P is scheduled. A P2P is generally scheduled within 5 business days of the P2P request.

Provider eNEWS

NEWS FOR THE NETWORK

Supporting Our Provider Partners Through Communication and Collaboration

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Assertive Community Treatment (CPT Code H0040)	· Prior authorization required

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AVAILABLE RESOURCES	
Behavioral Health Tool Kit Designed for Providers to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting.	https://www.molinahealthcare.com/providers/common/bh_toolkit/bh_toolkit.aspx
Enews	https://www.molinahealthcare.com/providers/ky/medicaid/comm/news.aspx
Training Guides	https://www.molinahealthcare.com/providers/ky/medicaid/comm/training.aspx
PA Look up Tools	https://www.molinahealthcare.com/members/ky/en-us/health-care-professionals/home.aspx https://www.molinahealthcare.com/providers/ky/medicaid/forms/fuf.aspx
Forms	https://www.molinahealthcare.com/providers/ky/medicaid/forms/fuf.aspx
Claim Forms	https://www.molinahealthcare.com/providers/ky/medicaid/comm/training.aspx
Provider Manual	https://www.molinahealthcare.com/providers/ky/medicaid/manual/medical.aspx

Please refer to the appropriate Regulation within 907 KAR for specific Regulatory requirements.

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