Behavioral Health Auth Frequently Asked Questions

Submission Portal & Access:

- Which portal should we use to submit prior authorizations (PAs)?
  - Providers may submit requests through the Availity portal.
- How can we set up portal access for each provider?
  - Contracted providers can create a login on the Availity Essentials Portal. The Training & Resources tab on the Passport website has additional information and links to use Availity.

Required Forms & Documentation:

- Is the universal prior authorization form accepted?
- Yes. Providers may submit requests using the universal form. All forms are located here:https://www.molinahealthcare.com/providers/ky/medicaid/forms/fuf.aspx
- What additional documentation is required for each service besides the OTR?
  - The Initial requests should include a copy of the assessment and the plan of care. The assessment and plan of care should follow the guidelines outlined in Department for Medicaid Services (DMS) regulations.

Authorization Requirements by Service:

- Are authorizations required for CSA's, PSS, or additional support staff?
  - Prior authorizations are required for services, not specific staff. Comprehensive Community Supports (H2015) requires prior authorization and Peer Support Services (H0038) requires prior authorization after 200 units per member per calendar year, based on the current published policy.
- Is a prior authorization needed for inpatient behavioral health at a freestanding psychiatric facility or psychiatric hospital?
  - Yes
- Do units still roll over from month to month for T2023?
  - T2023 is adjudicated on a calendar month. For example, if an authorization is given on July 5, all contacts for the first month must be made by July 31.
- Are there any limitations on the number of hours for psychoeducation services?
  - Passport allows 100 units of H2027 (Psychoeducation) before an authorization is required. There is no benefit limit on psychoeducation, but PA will be required after 100 units.

Authorization Duration & Units:

- Will the PA for Therapeutic Rehabilitation cover a 3-month period, as it did prior to COVID?
  - The duration of the authorization for Therapeutic Rehabilitation (H2019/H2020) will match the individual needs of the member and the request submitted. Providers should request the services which they believe are needed to provide treatment to the members and restore their level of functioning.
- How many units can be requested for CPT codes like H0015, T2023, and H0038?
  - Providers should request the number of units necessary to implement the treatment plan and address the members' needs. Per DMS regulations, the time frame for treatment plan review varies based on the services received and the member's condition, it should occur at least every six months.
- Is there a date limit for progress reports required for behavioral health authorizations?
  - Concurrent reviews should be conducted prior to the expiration of the existing auth if additional services are needed. If this is a first-time request for a service and the member has been receiving services prior to 7/1, Passport UM recommends including the last 3 months of progress notes with the request for authorization. After an authorization has been provided, upon the next review, the UM Department will need progress notes from during the time the auth was granted and to the next review date

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Targeted Case Management (TCM) Specifics

Authorization Timing & Requirements:

- Is a PA required for both adults and children for TCM services?
  - All TCM (T2023) requires PA.
- If a client is currently receiving TCM, is a PA needed by 7/1/25, or is it required 3 months after that date?
  - All TCM requires a PA effective 7/1/25 regardless of whether the member has received the service in the past or not.
- What is the duration for a TCM authorization—calendar month or rolling month?
  - Calendar month.
- Will billing for TCM be done on a month-to-month basis (e.g., 5/1/2025 - 5/31/2025) or on a rolling month basis (e.g., 5/15/2025 - 6/15/2025)?
  - Calendar month.

Submission Process:

- Where and how do we submit the PA for TCM services?
  - Requests for TCM are sent to UM as any other request, Portal, phone, fax
- How soon can we submit a PA prior to the services needed?
  - PA requests may be submitted beginning July 1, 2025.
- What is the process for submitting a PA for a new client versus an ongoing client?
  - Please indicate on your request if this is new or existing client and the start of care. The process is the same for both new and existing clients.

Assessment Tools & Requirements:

- Is there a standardized assessment tool required for TCM PAs?
  - No.
- Is the TCM assessment & treatment plan or the actual clinical assessment needed for PA submission?
  - Information sufficient to demonstrate the need for TCM should be submitted. Usually, this will require the assessment and the plan of care along the goals for the TCM referral (for initial requests) and the TCM care plan (for concurrent reviews).

Authorization Validity & Backdating:

- Will the PA backdate the date of assessment if inpatient treatment is determined?
  - An authorization may be backdated but is unique to the individual case.
- If a member presents for intake, how many sessions can be provided before a PA is required to develop the treatment plan and conduct screenings?
  - No PA is required for screenings or assessments. Specific codes requiring an authorization can be found by using the code lookup tool on the website.

Behavioral Health Services

Authorization Requirements:

- Is a PA necessary for regular outpatient therapy (e.g., 90837)?
  - PA is not required for individual outpatient therapy, e.g. 90832, 90834, and 90837.
- Will the PA for Therapeutic Rehabilitation cover a 3-month period, as it did prior to COVID?
  - The length of the PA for Therapeutic Rehabilitation (H2019/H2020) will match the needs of the member. Providers should request the services which

they believe are needed to provide treatment to the member and restore their level of functioning.

- How many units can be requested for CPT codes like H0015, T2023, and H0038?
  - Providers should request the number of units necessary to implement the treatment plan and address the members' needs. Per DMS regulations the time frame for treatment plan review varies based on the services received and the member's condition, it should occur at least every six months. See the eNews for specific requirements related to each of these codes.
- Is there a date limit for progress reports required for behavioral health authorizations?
  - Concurrent reviews should be conducted prior to the expiration of the existing auth if additional services will be needed. If this is a first-time requesting for a service and the member has been receiving services prior to 7/1, the UM Department would like to see the last 3 months of progress notes. After an authorization has been provided, upon the next review, the UM Department would need progress notes from during the time the auth was granted and to the next review date

Inpatient Services:

- If a client is receiving inpatient services and then transitions to outpatient services, do they need a new PA?
  - If the member is transitioning to a service which requires PA, then a PA should be obtained. The authorization is associated to the specific CPT code and member.
- Will clients who are still inpatient on 7/1/25 also require a PA, or only new admits?
  - Members who were admitted prior to 7/1/2025 will require notice of admission for payment; concurrent review (prior authorization) is required if the stay extends more than three (3) days after 7/1/2025, regardless of admission date.

Authorization Timing & Retroactive Requests

Submission Timing:

- How early can we submit a PA prior to the services needed?
  - 7/1
- Will PAs in place prior to 7/1/25 continue under waiver, or will they need to be resubmitted post 7/1/25?

        - Refer to PA requirements; For SUD services that required PA prior to 7/1, there is no change
    - Can we start submitting outpatient treatment requests prior to the 7/1 start date?
        - No

Retroactive Authorizations:

- Are retroactive authorizations allowed? If so, how is that request submitted, and what's the timeframe to submit a retro-dated authorization?
    - Utilization management suggests sending the retro request in prior to claims submission. Passport does not retroactively authorize services that require PA, as mentioned in the Provider Manual.
- How far can we backdate an authorization request?
    - For retro eligible members only, a request should be sent as soon as the provider is aware that the member obtained Medicaid retrospective eligibility
- Can we submit a retro authorization request on Availity?
    - Yes

Availity PA Submissions

Submission Process:

- How do we submit a PA in Availity?
    - Training materials for submitting an authorization using Availity are published on the website. Once the training link under Provider Portal Materials is selected, the link will open Availity and require a login.
- What supporting documentation is required for PA submissions?
    - Forms for select services are located here: https://www.molinahealthcare.com/providers/ky/medicaid/forms/fuf.aspx. These forms are not required but are intended to assist in documenting the information needed. In general, for initial requests, a copy of the assessment and a copy of the plan of care as outlined in Department for Medicaid Services (DMS) regulations. Targeted case management is covered in the scheduled training for prior authorization.
- When an authorization has been sent, will it indicate how many units the patient has left?
    - Providers are responsible for tracking the number of units that they have used on an authorization.

Approval Notifications:

- Will approvals show on Availity?
    - Yes
- Once a PA is submitted, how and when will we know the outcome?
    - The UM Department will notify the provider telephonically and via fax of the review determination.

Specific Code Questions

Authorization Requirements by Code:

- Is prior authorization necessary for H2027 over 100 units? How will that be determined?
    - Prior authorization is required for H2027 over 100 units per member per calendar year. If you are unsure how many units a member has used, request a PA.
- Does H2015 need authorization?
    - Comprehensive Community Supports will require a PA effective July 1, 2025.

Timing & Grace Periods

Authorization Timing:

- Are you going to ask for clinical information for the first authorizations in July, or just the request?
    - Providers are encouraged to submit clinical information to demonstrate medical necessity with their first request. Including the clinical documents will prevent delays and mitigate potential denials.
- Another MCO stated they would state the authorization was required starting with services on 7/1. How early can we submit for prior authorization?
    - July 1, 2025
- The PowerPoint shared during the training mentioned PAs being needed before services start. Are we going to be able to request services 14 days prior to and 14 days before the next PA is due?
    - Non-urgent requests should be submitted prior to the start of care. Providers may submit a request when it is determined that the member will require the service; UM will accept a request at any time prior to the start of a new service. For the 7/1 Go live, we realize the start of care may be on (or close to) 7/1 and for the month of July 2025, UM may allow late notification. For

concurrent review, UM will provide the date range for approval with the NRD (Next Review Date). Providers should submit several days prior to the NRD, on the NRD or one day after (but not 14 days in advance)

ASAM 4th Edition Implementation and Training

- Will the ASAM 4th Edition be utilized for adults in Kentucky, and how does this align with current Kentucky DMS regulations?
  - DMS regulations state that "the most recent" or "the most current" edition of ASAM should be used. For adults, ASAM, 4th Edition will be used. For adolescents, ASAM, 3rd Edition will be used on July 1, 2025. This is consistent with the DMS regulation.
- Where can providers access the ASAM 4th Edition criteria, and are there any available crosswalks or guidance documents to assist in implementation?
  - The American Society of Addiction Medicine (ASAM) has training materials and information on the 4th Edition of their criteria. Their website is https://www.asam.org/.

ABA Services and Authorization Requirements

- Where can providers find the required forms and documentation for ABA service submissions, and are there specific guidelines regarding diagnostic reports for new authorizations effective July 1, 2025?
  - Providers may submit requests using the Kentucky Medicaid Therapy Prior Authorization Request Form (See above). In general, for initial requests, a copy of the assessment and a copy of the plan of care as outlined in Department for Medicaid Services (DMS) regulations.
- How are evaluation units counted towards the initial 48 units for ABA services, and does this apply to multiple therapists working with the same child on the same day?
  - The first 48 units do not require an authorization and may be any combination of the following codes: 97153, 97154, 97155, 97156, 97157, or 97158. Prior authorization is not required for 97151 or 07152.
- Will the initial 48 units for ABA services commence on July 1, 2025, and what documentation is required for service requests?
  - The count of units begins January 1, 2025. The 48 units without authorization are per member per calendar year.

- Note: ABA codes 97151 and 97152 have been removed from requiring authorization.