June 28, 2018

Provider Memorandum

Partial Hospitalization Program (PHP) vs Intensive Outpatient Program (IOP) authorization requirements

Molina Healthcare of Illinois (Molina) requires prior authorization for psychiatric partial hospitalization services when using revenue code 912 or 913 for HealthChoice Illinois members. Molina does not require prior authorization for intensive outpatient psychiatric services when billing HCPCS code S9480 alone. When intensive outpatient psychiatric services are billed in combination with psychiatric partial hospital revenue codes 912 or 913, the full stay does require an approved authorization prior to rendering services.

Claims billed for intensive outpatient psychiatric services with HCPCS S9480 that include partial hospitalization revenue codes 912 or 913 without an approved authorization will be denied. This memo is not a change from existing authorization requirements but seeks to provide additional clarity on current authorization requirements.

Service	Revenue Code or HCPCS	Authorization Requirement
Partial Hospitalization *Psychiatric clinic type B service*	912	Authorization is required
Partial Hospitalization – Intensive Treatment *Psychiatric clinic type B service*	913	Authorization is required
Intensive outpatient psychiatric services *Psychiatric clinic type B service*	S9480	No authorization required when billed alone

Requests for prior authorizations for behavioral health services must be faxed to (866) 617-4971, using the attached Behavioral Health Prior Authorization Form.

If you have questions, please contact your Provider Network Manager or the Provider Network Management department via email at MHILProviderNetworkManagement@MolinaHealthcare.com.

For help locating your respective Provider Network Manager, please visit Molina's Service Area page at http://www.molinahealthcare.com/providers/il/medicaid/contacts/Pages/servicearea.aspx.

Molina Healthcare of Illinois
Behavioral Health Prior Authorization Form
Phone Number: (855) 866-5462
Inpatient Requests: Fax Number: (866) 617-4971
****Outpatient MMP Requests: Fax Number: (844) 251-1450**

Member Information

Plan: ☐ Medicaid ☐ Molina Dual Options Date of Request: _____Admit Date: _____

Request Type: ☐ Initial ☐ Concurrent

Member Name: _____ DOB: _____

Member ID#:_____ Member Phone: _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

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

Provider Information

Treatment Provider/Facility/Clinic Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Attending Psychiatrist Name: _____

UR Contact Name: _____ UR Phone#/Fax#: _____

Facility Status: ☐PAR ☐Non-PAR Member Court Ordered? ☐Yes ☐No ☐In Process Court Date:

Service Type Requested

Service is for: ☐ Mental Health ☐ Substance Use

☐ Inpatient Psychiatric Hospitalization ☐ Involuntary ☐Voluntary ☐ Subacute Detoxification ☐ Involuntary ☐Voluntary If Involuntary, Court Date:	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Day Program	☐ **Electroconvulsive Therapy (ECT) ☐ **Psychological/Neuropsychological Testing ☐ ** Applied Behavior Analysis ☐ **PAR & Non-PAR Outpatient Services ☐ Other – Describe:

Procedure Code(s) and Description Requested: _____

Length of Stay Requested: _____

Dates of Service Requested: _____

Primary Diagnosis Code for Treatment (including Provisional Diagnosis)	
Additional Diagnoses (including any known Medical Diagnoses/Conditions)	
Psychosocial Barriers (formerly Axis IV)	

For Molina Use Only:

Molina Healthcare of Illinois
Behavioral Health Prior Authorization Form
Phone Number: (855) 866-5462
Fax Number: (866) 617-4971

Clinical Review - Initial and Concurrent

Functioning: Presenting/Current Symptoms that Necessitate Treatment (or Continued Treatment)
* Denotes Documentation of Safety Plan Completed under Additional Information

☐ *Suicidal ideations/plan/attempt
☐ *Homicidal ideations/plan/attempt
☐ *History of Suicidal/Homicidal
☐ Hallucinations/Delusions/Paranoia
☐ Self-Mutilation (ex. cutting/burning
☐ Mood Lability
☐ Anxiety
☐ Sleep disturbances
☐ Appetite Changes
☐ Significant Weight Gain/Loss
☐ Panic Attacks
☐ Poor Motivation
☐ Cognitive Deficits
☐ Somatic Complaints
☐ Anger Outbursts/Aggressiveness
☐ Inattention
☐ Impulsivity
☐ Legal Issues
☐ Problems with Performing ADL's
☐ Poor Treatment Compliance
☐ Social Support Problems
☐ Learning/School/Work Issues
☐ Substance Use Interfering with Functioning

**Medication Administration Document can be submitted in lieu of completing the below*

Medication Name	Dosage/Frequenc	New from Admit?	Date Current Dose	Compliant?	Lab/Plasma Level?
		☐New		☐Yes ☐No	
		☐New		☐Yes ☐No	
		☐New		☐Yes ☐No	
		☐New		☐Yes ☐No	
		☐New		☐Yes ☐No	

Additional Information (explanation of any checked symptoms or other pertinent information):
For Inpatient, RTC, and Partial Hospitalization/Day Treatment - Please submit current (within the last 48 hours) Medical Progress Notes for Clinical Review
For ECT, Psychological/Neuropsych Testing-Applied Behavior Analysis, and non-Par OP Requests – see page 3 for additional information required for review

Aftercare Plan/Follow-up Appointment

Expected Discharge Date: _____

Follow-Up Appointment Scheduled: ☐YES ☐NO
(Complete if Member is in Inpatient Hospitalization)

**NOTE: First follow-up apt must be scheduled within 7 (seven) days of discharge.*

Provider Type	Provider Name	Telephone Number	Date of Appointment	Time of Appointment

Is treatment being coordinated with the Psychiatrist or Behavioral Health Practitioner? ☐Yes ☐No
If Yes, Name of Provider: _____ Last Contact Date with Provider: _____
If No, please explain: _____

NOTE: Level of Care coverage is subject to State Contract Specific Covered Services. Please refer to the State Specific Provider Handbook for a list of covered levels of care. Authorization of services does not guarantee payment. Payments for services are pending eligibility at the time of service and benefit coverage.

By requesting prior authorization, the out-of-network provider is affirming that the services are medically necessary, a covered benefit under the Medicare and/or Medicaid Program(s), and the servicing provider is enrolled in those programs as eligible for reimbursement. As a condition of authorization, for services that are primary to Medicare, the servicing provider agrees to accept no more than 100% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the Date(s) of Service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member was enrolled in the Medicare Fee-For-Service Program. If the service is primary to Medicaid, Provider agrees to accept no more than the amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of Illinois in effect on the Date(s) of Service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Molina Healthcare will not reimburse providers for services that are not deemed medically necessary. Servicing providers also recognize that Molina Healthcare members are not to be balanced billed for any uncollected monies for covered services pursuant to Medicare and Medicaid billing guidelines.

Clinical Information

Please provide the following information with the request for review:

Neuropsychological/Psychological Testing: *as covered per benefit package

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of symptoms and impairment
- Member and Family psych /medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and # of hours requested, over how many visits and any past psych testing results
- What question will testing answer and what action will be taken/How will treatment plan be affected by results

Electroconvulsive Therapy (ECT):

Acute/Short-Term: *as covered per benefit package

- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- ECT indications (acute symptoms refractory to medication or medication contraindication)
- Informed consent from patient/guardian (needed for both Acute and Continuation)
- Personal and family medical history (update needed for Continuation)
- Personal and family psychiatric history (update needed for Continuation)
- Medication review (update needed for Continuation)
- Review of systems and Baseline BP (update needed for Continuation)
- Evaluation by anesthesia provider (update needed for Continuation)
- Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- Any additional workups completed due to potential medical complications

Continuation/Maintenance: *as covered per benefit package

- Information updates as indicated above
- Documentation of positive response to acute/short-term ECT
- Indications for continuation/maintenance

Applied Behavior Analysis: *as covered per benefit package

- Diagnosis (suspected or demonstrated)
- Assessment/Clinical Tool used for diagnosis
- Member presenting symptoms and behaviors
- Parent or Caregiver involvement and training
- Provider Qualifications (experience with Autism Spectrum Disorder)
- Treatment plan including measurable goals and outcomes

Non-PAR Outpatient Services

Initial:

- Rationale for utilizing Out of Network provider
- Known or Provisional Diagnosis

Concurrent/Ongoing:

- Rationale for utilizing Out of Network provider
- Personal and family psychiatric medical history (comprehensive assessment/History and Physical are acceptable)
- Medication review
- Known barriers to treatment and other psychosocial needs identified
- Treatment plan including ELOS and discharge plan
- Additional supports needed to implement discharge plan