



Behavioral Health Pre-Authorization and Notification Requirements

Below is a list of services that require notification, pre- authorization and/or medical appropriateness review by all physicians and non- physician practitioners.

PLEASE NOTE: There are additional procedures that require pre- authorization for Self- Funded Employer Groups. Please contact The Health Plan Behavioral Health Services at 1.877.221.9295 for assistance on handling of authorization for Self- Funded Employer Groups.

Additional procedures for Medicaid groups may also require pre- authorization. Please reference the Medicaid Behavioral Health Practitioner Procedural Manual or call The Health Plan Behavioral Health Services at 1.877.221.9295.

Out of Network Care

- All out-of-network care per plan design

Tertiary Care

- All services require pre-authorization

Inpatient Care

- All elective inpatient care.
- Admission notification of urgent and emergent admission is expected within 48 hours or as soon as reasonably possible
- Substance abuse rehabilitation
- Residential Adult Services for Substance Use Disorder Waiver: ASAM Level 3.1 (H2036U1HF), ASAM Level 3.3 (H2036U3HF), ASAM Level 3.5 (H2036U5HF) and ASAM Level 3.7 (H2036U7HF) after three days

Diagnostic Testing and Studies

- Psychological testing after a certain number of units (see manual)
- Neuropsychological testing
- Outpatient ECT
- Transcranial magnetic stimulation for depression
- Urine Drug Testing:
 - Medicaid member - definitive urine drug testing (G0483, G0659) for all services.
 - Medicaid member - all other urine definitive and presumptive codes have service limits. Prior authorization for medical necessity is required beyond established limits.
 - All other lines of business member - urine definitive drug testing (G0481-G0483, G0659) for all services.
 - All other lines of business member - urine definitive and presumptive codes have service limits. Prior authorization for medical necessity is required beyond established limits.



Behavioral Health Pre-Authorization and Notification Requirements

Ambulatory Services

- Partial hospitalization after 30 units/days
- Intensive outpatient services after 30 units/days
- Assertive Community Treatment
- All genetic, genomic, pharmacogenetic, pharmacogenomic, and pharmacodynamic testing
- Peer Recovery Support (H0038) after 400 units
- Crisis Stabilization Unit (Community Psychiatric Supportive Treatment) after 144 units (Applies to WV Medicaid members only)

Ancillary Providers and Services

- Ambulance/ambulette–non-emergent
- Applied Behavioral Analysis for Autism

New Technology

It is imperative that providers contact The Health Plan to verify coverage of all new technology. Investigational services are not covered. Pre- authorization is required for these services.



Behavioral Health Pre-Authorization Options

Behavioral Health Services:

Admissions: Notification of urgent and emergent admissions to participating facilities (in-plan) available 24 hours a day/7 days a week; Reverts to voice mail notification after regular business hours: **1.800.304.9101**

Secure fax: To submit clinical information for review: **1.888.329.8471**

For referrals, care coordination, and continuing behavioral health services:

Toll-free (24 hours/day, 7 days/week): **1.877.221.9295**

Secure fax: **1.866.616.6255**

Physician Access Line:

For all EMERGENCY ISSUES, URGENT/EMERGENT TRANSFERS to TERTIARY FACILITIES, and contacting the medical director after hours, call **1.866.NURSEHP (1.866.687.7347)**. Available 24 hours a day/7 days a week – physician access only

Provider Websites:

myplan.healthplan.org - open website; link to password secure provider website for pre-authorization submission, eligibility, claims, reference materials and provider support information.

ADDITIONAL SERVICES MAY REQUIRE PRE- AUTHORIZATION.

Due to changes in medical technology, the accessibility of diagnostic equipment and services in an office/outpatient setting, as well as updated methods of performing procedures, there may be additional services that will require pre-authorization. Please contact The Health Plan prior to performing services related to new technology. Periodic review of provider utilization data may eliminate or require the need for medical appropriateness review and pre-authorization of additional services and diagnostic studies.