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.

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
- Out-of-network/out-of-area care
- Partial hospitalization
- Intensive outpatient services
- 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)

Diagnostic Testing and Studies

- Psychological testing
- 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.

Ambulatory Services

- All genetic, genomic, pharmocogenetic, pharmacogenomic, and pharmacodynamic testing
- Peer Recovery Support (H0038)
- Out-of-network/out-of-area care

Periodic retrospective review will be completed to assure compliance with standards of care and medical appropriateness guidelines. Effective July 1, 2019.

Behavioral Health Pre-Authorization and Notification Requirements

Ancillary Providers and Services

- Ambulance/ambulette–non-emergent
- Speech therapy–all visits; PT/OT after 20 visits for Autism diagnosis

Behavioral Health Services

Care coordinated through The Health Plan Behavioral Health Services Department

Addictionology	**Outpatient Mental Health**
Counselor/Therapist	**Psychiatry**
Inpatient Mental Health	**Psychology**

- Pre-authorization not required for crisis visits
- Crisis encounter forms requested within 48 hours of crisis intervention
- Pre-authorization required for ABA and all services related to autism
- Health and behavior assessment (CPT 96150, 96151, 96152)

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.

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Behavioral Health Pre-Authorization Options

Behavioral Health Services:

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, EMERGENT BEHAVIORAL HEALTH ISSUES** and contacting the **medical director after hours**, call **1.877.221.9295**. Available 24 hours a day, 7 days a week.

Provider Websites:

www.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 prior 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.

Periodic retrospective review will be completed to assure compliance with standards of care and medical appropriateness guidelines. Effective July 1, 2019.