The Health Plan
HEALTHPLAN.ORG

The right plan for you

Medicaid

Behavioral Health Provider/Practitioner Manual 2019

Mountain HEALTH TRUST

WV HEALTH BRIDGE
MY HEALTHCARE CONNECTION

The Health Plan
1110 Main Street
Wheeling, WV 26003-2704
1.877.221.9295
TTY: 711
healthplan.org

***** DISCLAIMER *****
For General Information and coverage guidelines, please consult The Health Plan Provider Procedural Manual or Contact The Health Plan at 1.800.624.6961.

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SECTION 1.1

Billing

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SECTION 1.1

The Health Plan Medicaid Billing Procedures

All claims should be submitted to:

The Health Plan – Wheeling
1110 Main Street
Wheeling, WV 26003

Claims must be completed in their entirety. The efficiency with which the claim form is completed directly affects the efficiency of claims processing for payment. Submission of a clean claim ensures timely and appropriate processing of payment. A clean claim is defined as one that can be processed without obtaining additional information from the provider/practitioner of the service or from a third party. It does not include a claim from a provider/practitioner who is under investigation for fraud, abuse, or a claim number review for medical necessity

The Health Plan requires that all claims are submitted with accurate and current CPT-4, HCPCS as well as, ICD-10 codes, as appropriate. For each procedure that is listed on the claim a diagnosis code (ICD-10) must support the services (listed in block 24D on the CMS 1500 form) to ensure expeditious and accurate processing of the claim. You must relate the diagnosis listed in block 21 to the individual service lines. You need ONLY to relate diagnosis A, B, C, or D, NOT the ICD-10 code in block 24E. THP encourages the use of Category II codes to respect performance measures. Use of Category II codes will decrease the need for medical record abstraction and chart review.

The Health Plan accepts the standard CMS 1500 forms and the UB-04 hospital billing forms.

When indicating the member ID number on the billing form, the entire number, including the nine digit The Health Plan ID number and two-digit suffixes should be indicated as shown on the ID card.

Patient ID number starts with a letter H, the remaining eight digits are numeric. The suffix identifies the family member. THP also accepts the Medicaid ID # for billing.

Example:	John Doe	H01234567-01 Subscriber
	Jane Doe	H01234567-02 Spouse
	Mary Doe	H01234567-03 Child

The Health Plan provider website offers a link to the National NPI Registry for referring providers/practitioners and facilities.

All services must be billed within to 365 days from the date of service.

Coordination of benefit (COB) claims (where another carrier has primary responsibility for making payment), must be submitted within 12 months from the date of service or three months from the date of the primary carrier's explanation of benefits (EOB). If you do not receive payment or rejection from the primary carrier and the 12-month time limit is approaching, you must bill The Health Plan before the 12-month deadline, whether or not you have received the EOB from the primary carrier. *Please refer to Section 11 of the Provider Procedural Manual for additional COB information.*

All claims are paid within 30 days from the date of receipt by The Health Plan or as otherwise required by prompt pay requirements. If a clean claim is not paid within the applicable time frame, appropriate interest will be applied to the claim when it is paid as required by state law, Medicare or Medicaid requirements. (For WV Medicaid services, interest will be paid to in-network providers/practitioners at 7% per annum calculated for the full period the claim remains unpaid beyond the 30 day clean claims payment deadline.)

- In-Network Services
    - The Health Plan will make timely payment within 30 calendar days for medically necessary, covered contract services rendered by in-network providers/practitioners when:
        - Services were rendered to treat a medical emergency
        - Services were rendered under the term of The Health Plan's contract with the provider/practitioner, or
        - Services were prior authorized
- Out-of-Network Services
    - The Health Plan will make timely payments to out-of-network providers/practitioners for medically necessary, covered services when:
        - Services were rendered to treat a medical emergency, or
        - Services were for family planning and sexually transmitted diseases, or
        - Services were prior authorized.

The Health Plan will reimburse at least 100 (one-hundred) percent of the current fee-for-service Medicaid fee schedule to in-network behavioral health providers/practitioners, unless such providers/practitioners agree to an alternate payment schedule.

Payment and payment vouchers are mailed bimonthly. *Please refer to Section 10 of the Provider Procedural Manual for information regarding electronic remittances.*

Questions concerning payment or denial must be submitted to The Health Plan within 180 days from the date of the payment voucher. *Please refer to Section 10 of the Provider Procedural Manual for additional information on claims resubmission procedures.*

When submitting a refund check to The Health Plan for overpayment (e.g., COB, workers' compensation, subrogation, etc.), include a copy of the payment voucher underlining or circling the claim and document the reason for the refund. If unsure of the voucher date for the paid

claim, you may contact the COB/refunds recovery representative. It is best to include detailed information such as:

a) Patient name
b) ID number
c) Date of service
d) Reason for the refund

The Health Plan members are NOT to be billed directly or balance billed for covered services.

Procedural Manuals will be supplied by The Health Plan to all participating providers/practitioners, upon request, to assist with The Health Plan guidelines and procedures. The manual can be found on The Health Plan secure website that can be accessed from the main website. Procedural Manuals are also available on CD.

The Health Plan will NOT reimburse providers/practitioners, nor can the member be billed, for the following services:

- Services not rendered
- Phone calls (including phone consults) except those related to covered targeted case management services
- Cancelled/missed appointments
- Making referrals
- Normal postoperative care
- Completion of paperwork except as set forth under behavioral health treatment planning services when covered
- Mileage
- Stat-charges
- Educational services
- Prescriptions (reimbursement is permitted for medication management services)
- False information/fraudulent billing
- Never Events and Avoidable Hospital Conditions
- Unnecessary services not indicated by diagnosis
- Provider/Practitioner Preventable Conditions

The Health Plan will comply with Ohio, West Virginia, Medicare and Medicaid prompt pay requirements. THP must adjust the reimbursement schedule to in-network behavioral provider within thirty (30) calendar days of the Department's notification of any changes in the fee-for-service Medicaid schedule.

Electronic Billing – Documentation Submission

The Health Plan allows for electronic submission of claims, as well as other HIPAA compliant transactions. *For detailed information, please refer to Section 11 of the Provider Procedural Manual.*

Behavioral health providers/practitioners may submit requests for authorization directly to The Health Plan utilizing the APS format or THP forms which are available on the THP website or the provider secure portal.

In the event that there is a need to supplement electronic information, providers/practitioners may fax supporting documentation to The Health Plan at **1.866.699.6163.**

Timelines of Claims Processing

The Health Plan utilizes the established state and federal guidelines for releasing of claims. The Health Plan's claim number houses the date of receipt of a claim and the claim will release before 30 days after receipt. This is the receipt of the claim and not the date of service. Health care providers/practitioners should allow 30 days from the date of submission to inquire about the outcome. The Health Plan's vouchers, either paper or electronic, will provide the status of the claim after the 30 days and should be used prior to inquiring on the claim(s).

Time limits for submitting claims were established by The Health Plan in its continuing efforts to better manage health care costs. The original claim must be received by The Health Plan 365 days from the date of service. In the event the claim requires resubmission, health care providers/practitioners have 180 days from the date of the original denial. Exceptions, if any, are noted in the agreement with The Health Plan.

The Health Plan provides tools to evaluate your claims during processing. We provide an in-process claims list on the payment vouchers, a secure website providing all claims status, and a customer service area to handle telephone inquiries.

Claims denied for timely filing must have an explanation for the delay as well as specific documentation.

- Member did not present The Health Plan's billing information at the time of service. This will require: a copy of the registration information provided by member on that day or prior; a copy of the other carrier billed in error and this should be received within one year of the date of service. In some cases, the billing information is received from other health care providers/practitioners and a copy of this information can be presented.
- Claims submitted electronically will require a copy of The Health Plan's acceptance report or the submitter/clearinghouse's acceptance report verifying claim sent to The Health Plan.
- Documentation not accepted as proof of receipt of claim from The Health Plan. This documentation is their own system base software and does not provide The Health Plan's acceptance details.

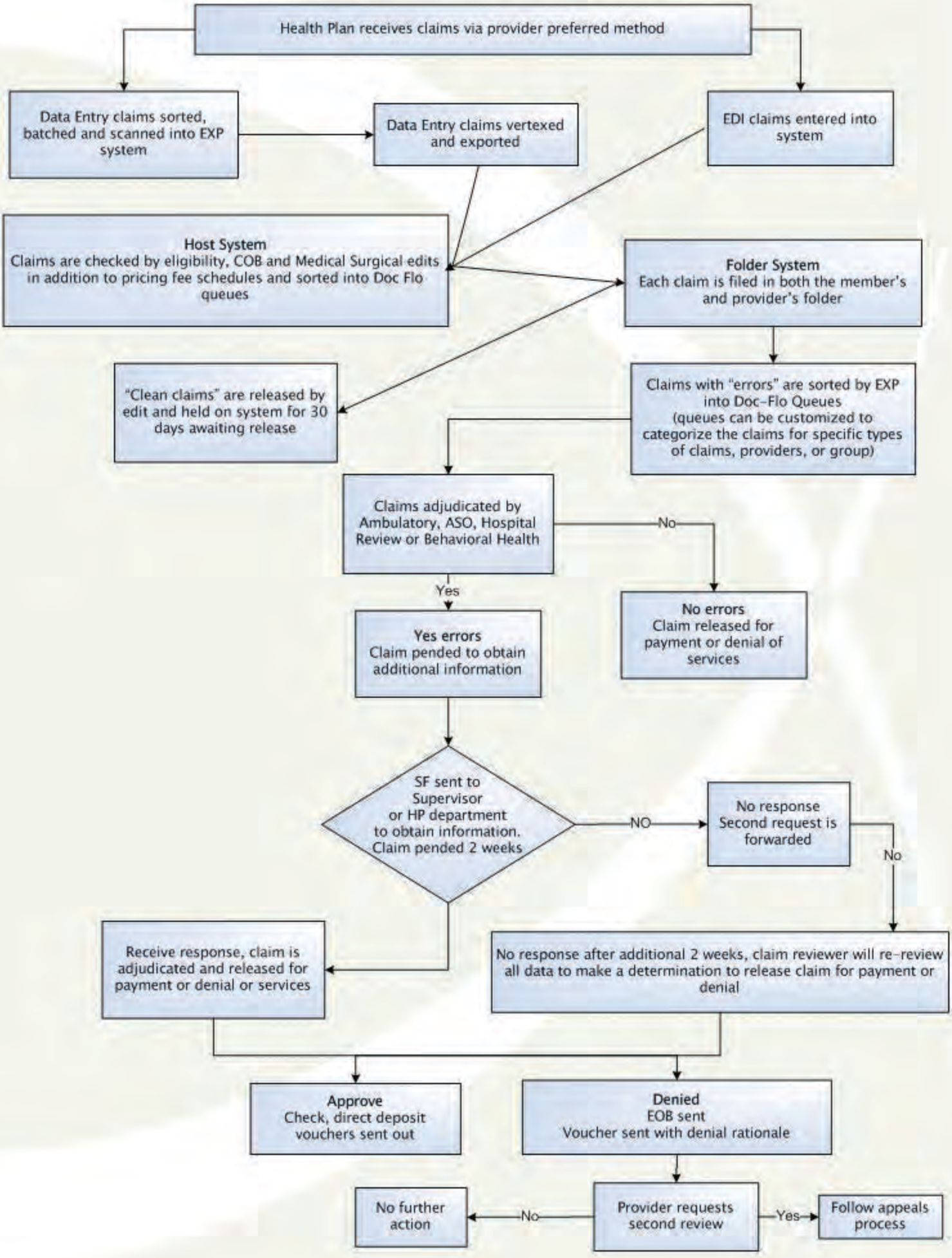
Resubmission of Claims Denied for Documentation

In order to expedite the processing of claims that are denied for additional documentation when the diagnosis does not support the level of service the following procedures have been implemented.

Initially, the claim will be reviewed and if it is determined that the diagnosis does not support the level of service, the claim will be denied with the more descriptive denial codes. The providers/practitioners at this time will need to resubmit the claim with the appropriate level of service or submit appropriate documentation such as, office notes, progress notes, etc. to support the level for service **180 days from the date of the payment voucher.**

Once The Health Plan receives the additional documentation to support the level of services, it will be sent to the Claims Department for review by a different claims reviewer. If the documentation supports the level of services, the claim will be reprocessed and depending on the review date will show on your next voucher as either paid or denied. If the documentation does not support the level of service, the claim will continue to deny. At this time, the provider/practitioner can correct the claim with the appropriate level of service.

CLAIMS SUBMISSION PROCESS



SECTION 2.1

Credentialing

SECTION 2.1

Credentialing Behavioral Health Providers/Practitioners

The Health Plan is a state and federally qualified HMO and is required to comply with Quality Assurance standards on credentialing. Additionally, The Health Plan is required to comply with the State of West Virginia, State of Ohio, CMS, Ohio HB 125 Credentialing Guidelines and West Virginia Bureau of Medical Services (BMS) credentialing guidelines. The Health Plan has formulated written policies and procedures for credentialing potential behavioral health providers/practitioners and facilities (including MD, DO, and licensed non-physician behavioral health providers/practitioners).

The credentialing process includes:

- Providers/Practitioner Application
- A site visit is required to be performed for non-accredited comprehensive facilities that are identified by DHHS in West Virginia:
  - In lieu of a site visit, a copy of CMS or state review or Office of Health Facilities Licensing and Certification performed within the last two years is required
- Medical Record Review

Copies and verification of:

- Licensure(s)
- Clinical privileges
- DEA Registration (if applicable)
- Complete malpractice history
- Board Certification of MD, DO (if not board certified, education and training)
- Education and/or training (for all licensed non-physicians)

The Health Plan is able to credential licensed centers as a group entity. In such cases, the center will need to either submit a copy of their CARF accreditation (or other acceptable accreditation). If the center is NOT accredited by an outside entity, then the center may submit the following items that will be reviewed by the Credentialing staff and forwarded to Executive Management for final approval:

- Copy of State Behavioral Health Application or completed application

  (State of Ohio and/or West Virginia Standardized Application)
- Copy of State License
- Copy of most recent state review and any corrective actions incorporated as a result of the state review
- List of all licensed and/or non-licensed staff (including their titles, services they provide, social security number, birth date, license number if applicable and supervisor)
- Copy of Professional Liability Coverage Information

As any license, DEA, liability, or certifications expire, a letter will be generated requesting a copy of the renewal.

It is imperative that we receive this information as soon as possible.

The provider/practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

The March 2016 federal rule on Medicaid managed care included a requirement that any provider/practitioner that is a member of an MCO network must enroll with the State Agency if they wish to provide services to WV Medicaid enrollees:

- Federal rule stated Medicaid has ultimate responsibility for screening, enrolling and periodically revalidating all Medicaid MCO network providers/practitioners.
- State Medicaid agencies must be in compliance by July 1, 2018.

Recredentialing Behavioral Health Providers/Practitioners

The Health Plan recredentials behavioral health providers/practitioners every three years.

The recredentialing process includes primary verification of:

- Licensure(s)
- Clinical Privileges (if applicable)
- DEA (if applicable)
- Board Certification and/or Facility Accreditation
- Professional Liability claims history
- Reappointment Application (MD, DO, and licensure of non-physician providers/practitioners)
- Verifying the information contained on the Reappointment Application

Credentialed licensed centers are not required to complete a reappointment application but are required to provide the following items for primary verification:

- Copy of current license
- Most current survey and findings from the state with any corrective actions
- Copy of professional liability coverage information
- Current staff roster listing the name, title, birth date, social security number, NPI Number, license number if applicable, services they provide, and their supervisor

As any license, DEA, liability, or certifications expire, a letter will be generated requesting a copy of the renewal.

Providers/Practitioners Rights

- Provider/Practitioner has the right to correct missing and/or erroneous information.
- Provider/Practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application.
- Provider/Practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

WV Practitioners: The mandatory State of WV Credentialing and Recredentialing applications are available through West Virginia Offices of the Insurance Commissioner website at **http://www.wvinsurance.gov/Uniform-Credentialing** or through CAQH, if you are a member of CAQH.

OH Practitioners: The Health Care Simplification Act, as indicated in ORC-3963.05 Standard Provider Credentialing Application and Form, requires all Ohio physicians to submit the CAQH Form. The Health Plan subscribes to CAQH; therefore, can retrieve the practitioner's application from the CAQH website. If the practitioner has not yet completed their initial application through CAQH, they may access the application electronically through CAQH at **http://caqh.org/**.

OH Ancillary Providers:
http://insurance.ohio.gov/Forms/Pages/FormsDetail.aspx?FID=1108.

If the provider is unable to obtain these forms electronically, please contact Provider Relations at **1.800.624.6961** and these forms will be provided.

SECTION 2.2

Standards for Participation

To become a provider/practitioner with The Health Plan a physician must be credentialed and meet the standards of participation as developed by The Health Plan in association with participating physicians. A physician must have the following credentials:

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA.
- Professional Liability - Minimum amount of $1 million, any amount below minimum will be reviewed by the Credentials Committee.
- Admitting privileges at a participating hospital.
- Clear report from the National Data Bank.
- Board Certified or Board Eligible. If not Board Certified or Board Eligible, the physician must demonstrate appropriate training for specialty listed.
- Facility Accreditation.
- Signed and dated agreement.
- Site surveys are conducted on Primary Care Physicians, (PCP), OB/GYN and High Volume specialist offices who participate in WV Medicaid.
- Proof of current medical license(s).
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN number (if applicable)
- Completed Application

Standards for Participation, cont.

Providers/practitioners and facilities must meet certain requirements to be a participating provider/practitioner with The Health Plan. Please contact our Network Development Department or Provider/Practitioner Relations Department for specific requirements.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the provider/practitioner has been approved for participation.

Notification of acceptance and/or rejection will be sent in written form within 60 days of the decision.

The Health Plan will complete the credentialing process within 90 days of receipt of the application or within 180 days from the date of signature on the attestation statement of the application.

In addition to the above credentials The Health Plan Quality Improvement Committee have identified the following behaviors and expectations for The Health Plan physicians, who should:

- Have 24-hour availability, seven days a week, with backup coverage.
- Accept members of any or all of The Health Plan products, as required by The Health Plan. In order to participate in WV Medicaid, providers must be enrolled with Molina prior to credentialing.
- Admit The Health Plan patients to participating hospitals/mental health facilities.
- Accept and support The Health Plan policies.
- Allow medical records and office to be reviewed as part of collaborative quality program.
- Have records and office meet criteria established by The Health Plan and participating physician.
- Refrain from discriminating against The Health Plan patients or "demarket" The Health Plan.
- Admit under own service to participating hospitals if patients condition is within physician's range of expertise and scope of privileges.
- Meet the CME requirement that is required for state licensure.

SITE SURVEY OF STANDARDS (AUDIT) • *BEHAVIORAL HEALTH*

Revised: 05/99, 02/00, 03/02, 10/03, 08/04, 07/08, 12/08, 08/09, 10/22/2013, 01/29/2014, 01/20/2015, 03/18, 05/18
Reviewed: 04/10, 04/11, 04/12, 04/13, 04/14

(Please Print)

Provider Name:		**Specialty:**	
Provider Street Address:		**Provider Number:**	
City:	**State:**	**ZIP Code:**	**Date:**

STD NBR	STANDARD	DOES NOT APPLY	MET	NOT MET
1	All offices will be clearly marked.	☐	☐	☐
2	All office complexes will have wheelchair & handicapped access - single offices would not need to provide handicapped access.	☐	☐	☐
3	All exits, if different from the main office entrance, will be marked and plainly visible.	☐	☐	☐
4	All offices shall have adequate parking with handicapped spaces marked. ☐ Street ☐Lot	☐	☐	☐
5	A. All waiting rooms shall have adequate clean comfortable seating. B. All waiting rooms shall have adequate lighting. C. All waiting rooms shall have office hours posted.	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
6	All examination rooms will be private and clean.	☐	☐	☐
7	All pharmaceutical will reflect the following: A. Stored in a locked cupboard or accessible only to appropriate personnel. B. Controlled substances shall be stored in a double locked cupboard and logged. C. Drugs requiring refrigeration will be kept on a shelf separately. D. All needles/syringes will be disposed in a "sharps" container & incinerated or collected by a special medical waste refuse company. E. All pharmaceutical, stock, meds, vaccines, anesthetic agents, ointments, and samples will be checked routinely for expiration dates. The office will have specific time intervals to check dates. F. Syringes not accessible to patients. G. Prescription pads not accessible to patients.	 ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐
8	All suboxone/methadone providers located at least 10 minutes from a hospital will have the following emergency equipment: A. Adrenalin B. Narcan/Naloxone	 ☐ ☐	 ☐ ☐	 ☐ ☐
9	Patients' Rights. A. Patient greeted promptly, courteously, professionally. ☐ Yes ☐ No B. Complaint/concerns handled by whom? C. Privacy is maintained. ☐ Yes ☐ No D. Patient education. ☐ Video ☐ Written ☐ Brochures	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐
10	Emergency/After hour coverage: A. Answering service or device to instruct patients after hours. B. 24 hour life threatening emergency coverage.	 ☐ ☐	 ☐ ☐	 ☐ ☐

SITE SURVEY OF STANDARDS (AUDIT) • *BEHAVIORAL HEALTH*

STD NBR	STANDARD	DOES NOT APPLY	MET	NOT MET
11	Provider Accessibility			
	A. Routine office within 10 working days as clinically indicated _____	☐	☐	☐
	Other _____	☐	☐	☐
	B. Urgent care within 48 hrs. _____ Same Day _____ Other _____	☐	☐	☐
	C. Non-life-threatening emergency within 6 hrs. _____ Same Day _____	☐	☐	☐
	D. Emergency services immediately.	☐	☐	☐
	E. Average waiting time within 45 minutes	☐	☐	☐
	Number of patients scheduled per hour _____	☐	☐	☐
12	All offices with x-ray and lab facilities will:			
	A. Have trained & qualified personnel	☐	☐	☐
	B. Submit the qualification of personnel performing testing.	☐	☐	☐
	C. Have all equipment inspected on a regularly scheduled basis.	☐	☐	☐
13	All offices will have a fire extinguisher that is inspected and reviewed regularly.	☐	☐	☐
14	All offices having more than one story or more than one suite of offices shall have a written fire exit plan.	☐	☐	☐
15	Confidentiality:			
	A. There should be a written policy assuring confidentiality of personal health information (PHI) in accordance with the HIPAA guidelines.	☐	☐	☐
	B. Office policy regarding release of information and records.	☐	☐	☐
	C. Storage of records in a confidential manner.	☐	☐	☐
	D. Disposal of records in a confidential manner	☐	☐	☐
16	A signature log is maintained (example in Provider Manual). Identifying 1st initial, last name, and credentials (MD, DO, DC, DMD, DPM, PA, C-NP, OD, PO, LSW, LPPC, etc).	☐	☐	☐

SITE SURVEY OF STANDARDS (AUDIT) • *BEHAVIORAL HEALTH*

STD NBR	STANDARD	DOES NOT APPLY	MET	NOT MET
17	All offices will maintain records in a current, detailed, organized, and comprehensive manner in accordance with the following Health Plan Standards for Patient Records. The medical record should be organized with the various types of information placed in a consistent location to enable easy access for reviewing the chart. (A minimum of 3 records reviewed)			
	A. PATIENT ID — Each and every page in the record contains the patient's name or ID number and birthdate.	☐	☐	☐
	B. BIOGRAPHICAL / PERSONAL DATA — Personal/biographical data includes address, employer, home and work telephone numbers, marital status, tobacco use, and drug/alcohol use.	☐	☐	☐
	C. PROVIDER IDENTIFICATION — All entries in the medical record contain author identification. Initials may be used only if there is a signature log identifying 1st initial, last name & credentials. Electronic signatures are acceptable.	☐	☐	☐
	D. DATED ENTRIES — All entries are dated.	☐	☐	☐
	E. LEGIBILITY — The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.	☐	☐	☐
	F. PROBLEM AND MEDICATION LIST	☐	☐	☐
	G. ALLERGIES — Medication allergies and adverse reactions are prominently noted in the record. Absence of allergies should be recorded as NKA. The documentation for allergies should be in a consistent location in all charts.	☐	☐	☐
	H. RETURN VISIT/FOLLOW-UP — Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or PRN.	☐	☐	☐
	I. REVIEW SIGNIFICATION — Consultation, lab and x-ray reports filed in chart are initialed by the ordering physician to signify review.	☐	☐	☐
	J. IMMUNIZATION RECORD — For pediatric (ages 10 and under) records, there is a completed immunization record or a notation that "immunizations are up to date".	☐	☐	☐
	K. PREVENTIVE SERVICES — There is evidence that preventive screening and services are offered.	☐	☐	☐
	L. HEALTH PLAN ID — It is recommended that patients should be identified as Health Plan patients. This evidence will assist in obtaining authorization and referrals when necessary.	☐	☐	☐
	M. ADVANCE DIRECTIVE — There is evidence that information regarding advance directives was provided to Health Plan member age 18 and over.	☐	☐	☐

Additional Surveyor's Comments	
Survey Performed By:	**Date:**

SECTION 3.1

Service Guidelines

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SECTION 3.1

Service Guidelines

Behavioral Health Department Accessibility

There is always access to a nurse to assist providers/practitioners regarding information about the utilization management process and authorization of care.

The Behavioral Health Services Department can be reached by calling toll free 1.877.221.9295 24 hours a day.

Referrals

Referrals for Behavioral Health Services are not needed. Members are afforded direct access to Behavioral Health providers/practitioners.

Preauthorization Submission

Preauthorization requests will be accepted in the following formats:

- BMS standard behavioral service authorization format
  - In addition to accepting the standard behavioral service authorization format, the format can be changed at the request of the MCO provider/practitioner
- HIPAA transaction format
- The Health Plan Authorization Forms located on The Health Plan Provider website
- Preauthorization requirements are listed individually for each code in this section
- Electronic Submission

Emergent and urgent treatment do not require preauthorization. Non-urgent treatment, whether concurrent or initial and non-urgent pre-authorizations will be processed and the decision returned to the requesting provider/practitioner within the BMS timeframes.

Providers/practitioners shall be informed of service and authorization requirement changes (including site of service changes) no less than 30 days prior to the implementation of such changes

Covered Services

The Health Plan is responsible for the following services, when meeting medical necessity criteria:

1. The Health Plan is responsible for all claims incurred within the inpatient behavioral health treatment settings covered by managed care; (Adult)
2. The Health Plan is responsible for any claims incurred during involuntary inpatient facility stays.
3. Court ordered treatment is a covered service as long as medically necessary criteria is met;
4. The Health Plan is responsible for all claims incurred within the inpatient behavioral health or psychiatric treatment setting covered by managed care; (Children)
5. The Health Plan is required to reimburse providers/practitioners for court-ordered treatment services that are covered by The Health Plan under the Medicaid State Plan; the court order will serve as a binding determination of medical necessity
6. Behavioral Health Outpatient services, including a follow-up session immediately following the discharge from a facility;
7. Psychological Services
8. Hospital Services, Inpatient – Behavioral Health and Substance Use Disorder Stays
9. Behavioral Health Rehabilitation for individuals under age 21; PRTF
10. Inpatient Psychiatric Services for Individuals under age 21 (MHT only)
11. Notwithstanding any of the provisions of Article III, Section 10.6, The Health Plan is responsible for any claims incurred during an involuntary inpatient facility stay.
12. Drug screening as it relates to laboratory service to screen for presence of one or more drugs of abuse per BMS guidelines.

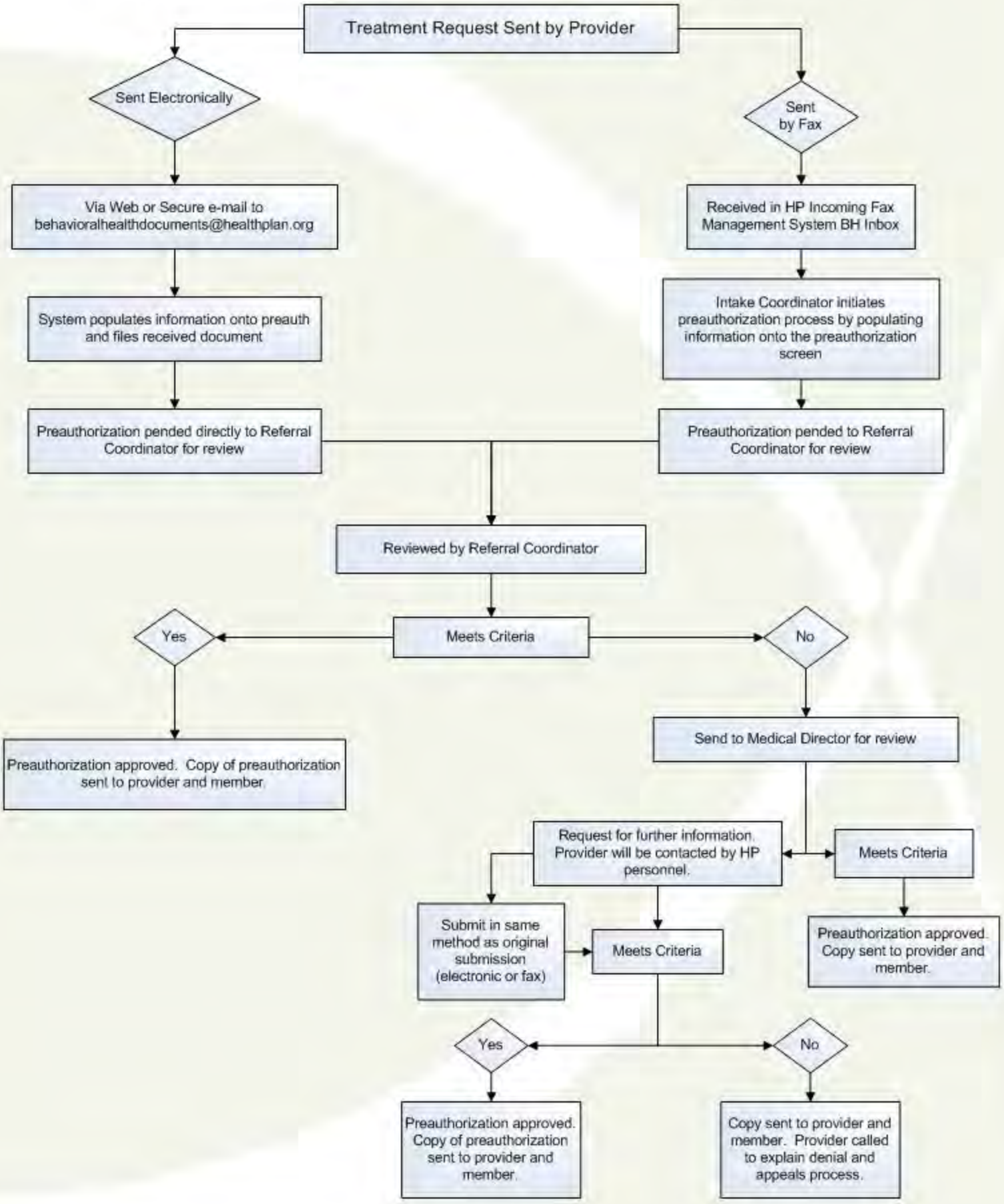
Non-covered Services

Behavioral Health Services that are not the responsibility of The Health Plan:

1. Services provided to individuals under age 21 performed in a Children's Residential Treatment facility;
2. Services provided in certain alcohol and drug addiction community-based residential treatment facilities to individuals between the ages of 22 and 64 for facilities of 17 beds or more. As restricted per Title XIX of the Social Security Act addressing Medicaid reimbursements to Institutions for Mental Disease (IMD) [42USC 1396d].
3. Any payments for inpatient behavioral health services that are covered by fee-for-service; (Adult and Children)
4. Claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a fee-for-service member; (Adult)

5. Claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a member of another MCO; (Adult)
6. Claims incurred during a residential treatment stay for members 21 years of age or older; (Adult)
7. Claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a fee-for-service member (Children)
8. Claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a member of another MCO (Children)
9. All opioid treatment program services provided under the October 2017 Substance Use Disorder (SUD) waiver. The Health Plan will be responsible for making all reasonable attempts to assure members are appropriately referred to opioid treatment program services and subsequent care coordination, as required by contract.

The Health Plan BH Preauthorization Flow Sheet



Service Guidelines

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
H0031	Mental Health Assessment by non-physician	Yes	BMS	None	Assessments allowed following BMS criteria
H0031AJ	Behavioral Health Counseling, Professional, associated with Non-Methadone Medication Assisted Treatment	Yes	BMS	None	Assessments allowed following BMS criteria
96101	Psychological testing with interpretation and report	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format
90791	Psychiatric Diagnostic Interview Evaluation without medical services	Yes	None	None	Must have a valid BH diagnosis
90792	Psychiatric Diagnostic Interview Evaluation with medical services	Yes	None	None	Must have a valid BH diagnosis
T1023HE	Screening by Licensed Psychologist	Yes	None	None	N/A
96110	Developmental testing, limited	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format
96111	Developmental testing, extended	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
96116	Neurobehavioral Status Exam with Interpretation and Report	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format
96118	Neuropsychological Testing Battery with Interpretation and Report	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format
96119		No			
96120	Neuropsychological Testing by Computer	Yes	InterQual	Preauthorization is required	THP psychological testing form available or may use BMS format
90899	Special evaluation services	Yes	InterQual or BMS	Preauthorization is required	Criteria is dependent on the procedure requested
H0032	Mental health service plan development	Yes	BMS	None, unless evaluation is more often than every 90 days	Assessments allowed following BMS criteria
H0032AH	Mental Health Service Plan Development by Psychologist	Yes	BMS	None, unless evaluation is more often than every 90 days	Assessments allowed following BMS criteria
G9008	Physician coordinated care oversight services	Yes	BMS	None, unless evaluation is more often than every 90 days	Assessments allowed following BMS criteria
90832	Psychotherapy, 30 minutes	Yes	None	None	
90832AJ	Psychotherapy, 30 minutes (MSW or Licensed Counselor)	Yes	None	None	
90833	Psychotherapy, 30 minutes, with Medical Evaluation and Management	Yes	None	None	No authorization needed for this add-on service

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
90834	Psychotherapy, 45 minutes	Yes	None	None	
90834AJ	Psychotherapy, 45 minutes (MSW or Licensed Counselor)	Yes	None	None	
90836	Psychotherapy, 45 minutes, with Medical Evaluation and Management	Yes	None	None	No authorization needed for this add-on service
90837	Psychotherapy, 60 minutes	Yes	None	None	
90838		No			
90846	Family Psychotherapy without patient present	Yes	None	None	
90847	Family Psychotherapy with patient present	Yes	None	None	
90847AJ	Family Psychotherapy with patient present (MSW or Licensed Counselor)	Yes	None	None	
90853	Group psychotherapy	Yes	None	None	
90853AJ	Group Psychotherapy (MSW or Licensed Counselor)	Yes	None	None	

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
90875	Individual Psychotherapy Biofeedback 20-30 minutes	Yes	BMS	Preauthorization is required	Not allowed as a stand alone intervention, must be part of a therapeutic process/psychotherapy service
90876	Individual Psychotherapy Biofeedback 45-50 minutes	Yes	BMS	Preauthorization is required	Not allowed as a stand alone intervention, must be part of a therapeutic process/psychotherapy service
99201-99215	Evaluation and Management Visits	Yes	InterQual	None	Must have a valid BH diagnosis
90839, 90840, H2011	Crisis intervention	Yes	BMS	None	Crisis Encounter form should be submitted to guarantee payment without request for documentation
90899		No			
90887	Case consultation	Yes	BMS	None	Documentation will be requested to support this code
H0004HO	Behavioral Health Counseling, Professional	Yes	BMS	Preauthorization needed only when associated with an IS program	Services are preauthorized for a maximum of 30 days and may be extended with additional, timely documentation which continue to meet criteria.
H0004HOHQ	Behavioral Health Counseling, Professional, group	Yes	BMS	Preauthorization needed only when associated with an IS program	Services are preauthorized for a maximum of 30 days and may be extended with additional, timely documentation which continue to meet criteria.
H0004	Behavioral health counseling, supportive, individual	Yes	BMS	Preauthorization needed only when associated with an IS program	Services are preauthorized for a maximum of 30 days and may be extended with additional, timely documentation which continue to meet criteria.
H0004HQ	Behavioral health counseling, supportive, group	Yes	BMS	Preauthorization needed only when associated with an IS program	Services are preauthorized for a maximum of 30 days and may be extended with additional, timely documentation which continue to meet criteria.

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
H2014U4	Skills Training and Development 1:1 by paraprofessional	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2014U1	Skills Training and Development 1: 2-4 by paraprofessional	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2014HNU4	Skills Training and Development 1:1 by Professional	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2014HNU1	Skills Training and Development 1:2-4 by Professional	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2019	Therapeutic behavioral services - implementation	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2019HO	Therapeutic behavioral services - development	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2010	Comprehensive medication services, mental health	Yes	None	no preauthorization is required	
H0040	Assertive community treatment (act)	Yes	BMS	Preauthorization is required	THP ACT form available or may use BMS format
H2012	Day treatment	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2015U1	Comprehensive community support services, ratio 1:12	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format
H2015U2	Comprehensive community support services, ratio 1:8	Yes	BMS	Preauthorization is required	Must meet BMS criteria, may submit THP treatment request form or BMS format

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
H0036	Community psychiatric support treatment/ crisis residential	Yes	BMS	No, considered emergent service	Per BMS regulation, the initial 72 hours do not require preauthorization or review, concurrent review and discharge clinicals are required. Days 3-5 approved with any form of documentation. This includes information required to demonstrate medical necessity. Days 5-8 requires chart documentation* (progress notes, nurse's notes, etc.) for approval. Days 8-10 requires chart documentation* (progress notes, nurse's notes, etc.) for approval. On day 8, a Grand Rounds will be scheduled to take place on day 10** between the facility and Health Plan medical staff to evaluate the member's progress, current needs and discharge planning. *** All documentation submitted must demonstrate medical necessity for continuing level of care.** **** If day 10 is not a business day, the Grand Rounds will be scheduled to take place on the next business day.** If day 10 is a Saturday, the grand rounds will occur on the following Monday. Sunday will not be authorized until after grand rounds have occurred. Authorization beyond day 10 will be dependent on the determination of medical necessity during grand rounds.

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
A0120 DD HE	Non-emergency Transportation by Vehicle other than Ambulance	Yes	BMS	No preauthorization is required	Transportation must meet BMS stipulations for programming.
A0160 DD HE	Non-emergency Transportation; per mile	Yes	BMS	No preauthorization is required	Transportation must meet BMS stipulations for programming and mileage limitations
T1017	Targeted case management	Yes	BMS	Preauthorization is required	4 units per month are billable without prior authorization; 36 units allowed over 3 months with preauthorization
H0035	Partial hospitalization	Yes	BMS	Preauthorization is required	Services are preauthorized for a maximum of 30 days, may be extended with additional, timely documentation which continues to meet criteria
H0015	Intensive outpatient treatment	Yes	BMS	Preauthorization is required	Services are preauthorized for a maximum of 30 days, may be extended with additional, timely documentation which continues to meet criteria
Q3014	Telehealth - originating site fee	Yes	BMS	No preauthorization is required	Follows BMS listing of eligible services.
80305 - 80307	Laboratory services	Yes	BMS	Preauthorization per BMS policy	Modifiers and service limits per BMS rules
G0659	Laboratory services	Yes	BMS	Preauthorization per BMS policy	Modifiers and service limits per BMS rules
90785		No			
G0480 - G0483	Laboratory services	Yes	BMS	Preauthorization per BMS policy	Modifiers and service limits per BMS rules
PRTF coverage		Yes	BMS	Preauthorization per BMS policy	Age restriction. Covered for members requiring service prior to age 21 and ending when he/she no longer requires service or the date he/she reaches the age of 22

CODE	CODE DESCRIPTION	COVERED	CRITERIA	PREAUTHORIZATION REQUIREMENTS	SPECIAL REMARKS
Acute Inpatient Care (Mental Health and Substance Use Disorder diagnosis)		Yes	InterQual	Only elective admissions require preauthorization.	All admissions should be reported with clinical review on the day of admission or first business day after admission; concurrent and discharge clinical also required.
Subacute admission (LP002)	Inpatient Psychiatric Hospitalization, Sub-Acute	Yes	BMS	Preauthorization per BMS policy	All admissions will require concurrent review for continued coverage
Observation		Yes	InterQual	No	Observation admissions should be reported with clinical review on the day of admission or first business day after admission; authorization will be determined by InterQual criteria
Residential Services		No	N/A	N/A	N/A
Medication Assisted Treatment		Yes	BMS criteria	According to BMS program guideline and individual code guideline	Program guidelines available in BMS manual
ABA	Applied Behavior Analysis	Yes	BMS	Preauthorization per BMS policy	Modifiers and service limits per BMS rules

SECTION 4.1

Inpatient Review

The right plan for you

SECTION 4.1

Review for Inpatient, Detoxification, Crisis Stabilization and Observation

Reviews for inpatient services require admission, concurrent and discharge review by The Health Plan.

Information may be provided to The Health Plan electronically or telephonically. Faxes should be sent to **1.866.616.6255**, telephonic reviews should be called to **1.877.221.9295**.

Information may also be submitted via the web. This information will be accessed by Behavioral Health Services personnel only.

Reviews are expected on the day of admission. When the admission is approved, the date for concurrent review will be established and conveyed to the provider/practitioner.

If the information submitted does not meet review criteria for admission or continued stay, The Health Plan nurse navigator will forward the clinical information for review to a physician for evaluation. The physician will provide a clinical review of the case and provide a medical appropriateness determination. The provider/practitioner will be notified when a determination is made and, if there is an adverse decision, will be provided an opportunity for appeal and further review.

Attached are admission, concurrent review, and discharge forms for use in providing review information to The Health Plan. These forms are also available on the behavioral health page of The Health Plan website, **healthplan.org**. The Health Plan will also accept assessment completed on facility forms.

FACILITY CLAIMS

Facility claims are typically billed on a UB-04 and refer to services and programs such as:

- Emergency Room Visits
- Observations
- Residential Services
- Inpatient Services

Observation

Observation is a facility-based treatment providing a level of service lower than inpatient, however providing a safe environment to stabilize the member's condition in an emergency situation. After the observation period has expired, if the member is not ready for discharge, he/she will be transitioned to another level of care.

Observation stays for Medicaid members will be authorized up to 48 hours if the clinical information submitted meets InterQual criteria. Facilities are expected to call or electronically submit admission demographics and clinicals to The Health Plan within the first 24 hours of the observation stay and an update/discharge for a second 24 hours. The second clinical should include discharge or alternate level of care information.

Crisis Encounter/Intervention

This service refers to a short, face-to-face, intervention dealing with an emergent event with the member. The service could take place in any setting.

Crisis service does not require a preauthorization, but should be reported within 48 hours, utilizing a Crisis Encounter Report Form, found on the web. Submission of the Crisis Encounter Form will provide contact information for claims payment. This will prevent the claim from being denied for clinical, supporting documentation.

Crisis Residential

Community Psychiatric Support Treatment is an organized program of services designed to stabilize the condition of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs or symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate episode.)

This physician driven service is intended for members whose condition can be stabilized with short-term, intensive, services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community. Services are episodic and, therefore, must be rendered on consecutive days of service. Treatment programs must be available seven days a week to anyone who meets admission criteria.

The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders, and/or treatment at all times.

The following elements are required components of Community Psychiatric Supportive Treatment:

- Must be authorized by a physician/psychiatrist
- A written order must be provided
- Each member must have a psychiatric evaluation
- History and description of the present illness
- Past psychiatric and general medical history
- Daily psychiatric review and examination
- Ongoing medication evaluation and administration
- Intensive supervision, if ordered by the physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan
- Discharge planning
- Psychological/functional evaluations, when appropriate
- Family intervention, when appropriate

Facility Expectations:

- Submit admission and concurrent information to The Health Plan after the initial 72 hours of admission.
- The admission will be certified by meeting InterQual criteria.
- If InterQual criteria are met, the nurse navigator will certify the stay.
- The nurse navigator will inform the facility of the date that the next review will be due.
- Follow-up and discharge or transfer reviews should be telephonically or electronically submitted in the same manner as the initial review.
- If the information is incomplete, the facility will be contacted by the nurse navigator.
- The nurse navigator will be able to assist with transportation to an alternate level of care.
- If the reviews do not meet InterQual criteria, the information submitted by the facility will be sent for physician review prior to denial of services.

Inpatient Psychiatric, Detoxification, Substance Use Disorder or Eating Disorder Services

Inpatient services are acute care services delivered in a psychiatric, detoxification, substance use disorder or eating disorder unit of a general hospital, free-standing psychiatric facility, or a state hospital. The acute care services provided include assessment, individual and group therapies, medication management, attention to medical problems, with all care coordinated by the physician. Inpatient hospitalization is usually short-term, stabilization and treatment of an acute episode of behavioral health problems.

The Health Plan does not cover stays for members aged 22-64 admitted for inpatient treatment at an IMD. An IMD is defined as “an institution for mental disease such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care and related services.

Facilities are expected:

- To telephonically or electronically submit admission demographics and clinicals to The Health Plan on the date of admission.
- The admission will be certified by meeting InterQual criteria for initial review.
- The nurse navigator will certify the stay for the appropriate number of days, according to admission diagnosis and inform the facility of the date that a concurrent review will be due.
- Concurrent reviews should be telephonically or electronically submitted in the same manner as the initial review.
- If the stay meets InterQual criteria for continued stay, the nurse navigator will continue to allow the admission and inform the facility of the date when the next concurrent review is due. This will continue through until discharge.
- If the information received is incomplete, the nurse navigator will contact the facility.
- Discharge clinicals shall be submitted in the same manner.
- If the reviews do not meet InterQual criteria, the information submitted by the facility will be sent for physician review prior to denial of services.

FAX AND PHONE NUMBERS:

Behavioral health secure FAX: **1.866.616.6255**

Toll-free behavioral health phone: **1.877.221.9295**

SECTION 5.1

Coordination

The right plan for you

SECTION 5.1

The Health Plan Mission Statement

The Health Plan developed the following mission statement to reflect our view of the role of our program.

"Established as a community health organization, The Health Plan delivers a clinically driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community. "

In keeping with our mission, we have identified members' rights along with their responsibilities, which are clearly indicated in the member's handbook.

As a participating provider/practitioner with The Health Plan, it is imperative that you be aware of these rights and responsibilities. You are expected to assist our members by making them aware of their rights and by supporting these within your practice.

SECTION 5.2

The Health Plan Medical and Behavioral Health Management Program

Social Work Services

Social Work Services are available to assist The Health Plan members and their families with socio-economic, psychosocial, personal, and environmental issues, which can predispose them illness or interfere with obtaining the maximum benefit from medical care.

The behavioral health social workers coordinate with health care providers/practitioners and The Health Plan Medical Department staff to identify community resources that will support individuals to live a meaningful, healthy life in the community of their choice.

Services provided by The Health Plan social worker may include:

- Financial counseling
- Assisting in applying for financial aid programs
- Educating members on resources available to them and their families
- Coordinating referrals to ancillary support, personal care, and nursing home placement
- Referral to local workforce agencies
- Linkage to available community supports

Providers/practitioners identifying social-economic needs of a The Health Plan member may contact the social worker to discuss possible assistance programs and support services.

SECTION 5.3

Behavioral Health Services

The goal of Behavioral Health Services is to ensure that highest quality of care for our members. To that end, we will work with providers/practitioners and members to coordinate care. Our staff will work directly with providers/practitioners and members to make known available resources within both the provider/practitioner and community networks. Our nurse navigators, disease management navigators, complex case navigators and pre-authorization navigators are available to assist providers/practitioners and members in obtaining and locating needed services.

Behavioral Health Services will work directly with other departments at The Health Plan to address behavioral health related concerns. This will integrate behavioral components with disease management, primary care, specialty care and behavioral providers/practitioners.

Our 24-hour phone number, **1.877.221.9295** is available to members and providers/practitioners.

You may fax requests and reports to **1.866.616.6255**. This is a dedicated computer fax that is available only to Behavioral Health Services personnel.

SECTION 5.4

Continuity and Coordination of Care Between Behavioral Health Care and Primary Care Providers/Practitioners

Continuity and coordination of care between behavioral and physical health care providers/practitioners is an important aspect in the delivery of quality health care as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical health care providers/practitioners whenever clinically appropriate.

Providers/practitioners must treat all information that is obtained through the performance of services as confidential information to the extent that confidential treatment is provided under State and Federal laws, rules and regulations.

The Health Plan's Continuity of Care Consultation Sheet is a useful form to use in sharing information and can be accessed through the provider web page.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO PRIMARY CARE PHYSICIAN

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization.

Patient Authorization

☐ I agree to release any applicable mental health/substance use disorder information to my PCP.

My primary care physician is _____

Address _____

Telephone Number _____

☐ I agree to release only medication information to the PCP.

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving behavioral health services and I direct you NOT to notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I, therefore, WAIVE NOTIFICATION of a PCP that I am seeking or receiving behavioral health services.

This authorization will expire on ___/___/_____. If no date entered by patient, this authorization will expire one year from the date of signature below.

_____

Patient Signature Date

Patient Rights

- You can end this authorization (permission to use or disclose information at any time by contacting _____
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep it for your records.
- You do not have to agree to this request to use or disclose information.

Provider/practitioner: Please send a copy of this signed form to the PCP with the Continuity of Care Consultation Sheet and keep the original in the treatment record.

Communication between behavioral health providers/practitioners and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. There are circumstances when your behavioral health condition and/or medications will influence treatment of your physical conditions. Many times behavioral health and physical health share a connection. This form will allow your behavioral health provider/practitioner to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI will only include diagnosis, treatment plan and medication, if necessary. Information relating to any psychotherapy notes or conversations will not be shared.

REVIEWED 08/23/2018

SECTION 5.6

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Substance use disorder is a widespread problem. Many times, the primary care physician (PCP) is the first professional to encounter a patient with alcohol or other substance use disorder issues.

The Health Plan suggests a few points for providers/practitioners to consider when encountering patients who may be experiencing problems with alcohol and other substance dependence.

What PCPs Can Do:

- Carefully ask about alcohol and other drug use and screen for problem use.
- Make sure the diagnosis is listed in the patient chart and on your claims.
- Follow-up with the patient. Schedule a follow-up appointment or schedule an appointment with a qualified behavioral health clinician. Make sure that a substance use disorder diagnosis is included on each follow-up visit. Patients may want to minimize their substance use disorder, so due diligence is expected in keeping substance use at the forefront of the patient's care.
- Encourage the patient to follow through. Express interest in his/her progress.
- Discuss health concerns regarding ongoing use and ask patient if he/she would be willing to be referred to a Behavioral Health clinician for assistance.
- Consult The Health Plan Substance Use Disorder Guidelines which includes various screening tools.

Providers/practitioners need to be mindful that substance use disorder can co-occur with other behavioral health problems such as major depression or anxiety disorder, which can make treating substance use disorder or diagnosing a behavioral health disorder more difficult. In instances like this, referral to a behavioral health provider/practitioner is prudent. Providers/practitioners looking to refer a patient for behavioral health services or to facilitate coordination of services may refer to The Health Plan website for a list of participating providers and facilities or call Behavioral Health Services at 1.877.221.9295 for assistance. Additional resources on substance use disorder can be found at **nida.nih.gov**.

SECTION 5.7

Follow-Up Care after Behavioral Health Admissions

It is very important in the care of those with behavioral health conditions, to receive timely follow-up care after discharge from an inpatient stay.

The Health Plan is asking for your cooperation and assistance to achieve the important goal of a follow up visit for these patients within seven days of discharge. We would appreciate you facilitating this by:

- Communicating to the hospital discharge planners that follow-up appointments should be scheduled within seven days of discharge.
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within seven days of discharge.
- When The Health Plan is aware of an eminent discharge, the nurse navigator will alert the Comprehensive Center so that a bridge visit can be scheduled prior to the member's discharge.
- When The Health Plan is aware of an eminent discharge, the nurse navigator will alert the Comprehensive Center so that a visit can be scheduled.

SECTION 6.1

Standards & Guidelines of Care

The right plan for you

SECTION 6.1

Guidelines

The Health Plan has adopted nationally recognized guidelines to assist our providers/practitioners in providing care to our members. These guidelines address the treatment of depression, the treatment of substance use disorder and guidelines for the diagnosis, evaluation and treatment of ADHD in children and adolescents. Links to these guidelines are posted on The Health Plan website, Behavioral Health page.

These guidelines have been approved by The Health Plan's Physician Advisory Committee, Medical Director Oversight Committee and the Executive Management Team.

For a copy of the current guideline or questions related to the guideline, call the Quality Improvement department of The Health Plan at 1.800.624.6961, ext. 7586.

SECTION 6.2

Behavioral Health Services

Access to Care

To comply with NCQA standards, The Health Plan holds to the following standards for access to care for behavioral health cases:

- Providers/practitioners should provide care to our members and see them within 6 hours for emergency care that is not life-threatening or send them to the nearest emergency room.
- Providers/practitioners should provide care within 48 hours of a request for service when the need is urgent.
- Providers/practitioners should provide follow-up appointment within seven days of discharge from an inpatient facility.
- Providers/practitioners should provide a routine office visit within 10 days of request.
- Follow-up visits should be scheduled within 30 days of an initial visit for a specific condition with a prescriber and within 20 days with a non-prescriber.

If the provider/practitioner is not available, the member should be made aware of how to access care. This would apply to after-hours and weekend coverage as well as other situations.

SECTION 6.3

Medical Record Audit

For more information, reference our Provider Procedural Manual regarding:

- Medical Records and Confidentiality Statement
- Signature Log
- Signature Log Form

The right plan for you

SECTION 7.1

Complaints, Appeals & Grievances

The right plan for you

SECTION 7.1

Complaints

The Health Plan reviews and evaluates all complaints from its' providers/practitioners. To submit a complaint:

Call Medicaid Customer Service at 1.888.613.8385.

Write to: The Health Plan
ATTN: Medicaid Appeals Coordinator
1110 Main Street
Wheeling, WV 26003

SECTION 7.1

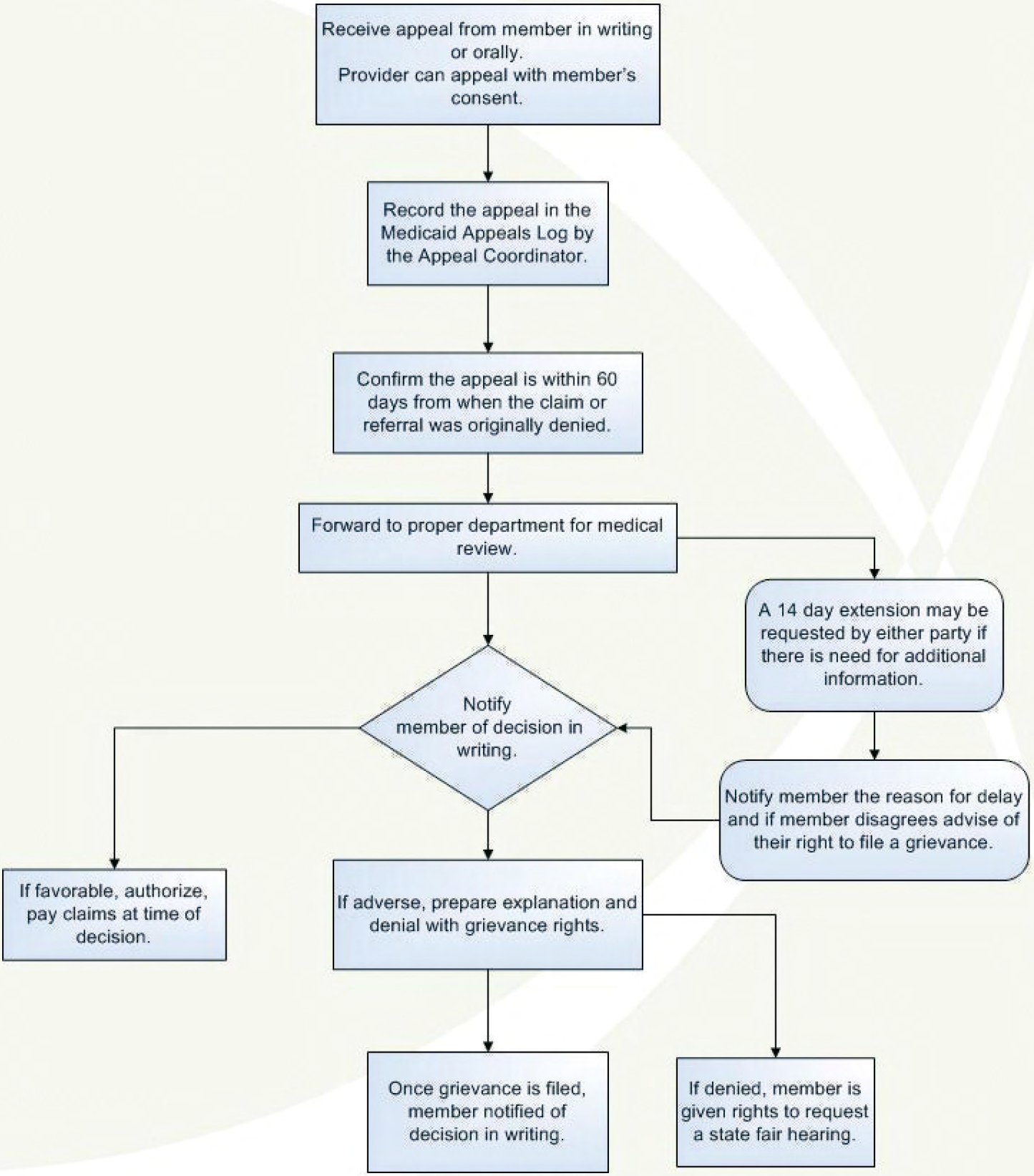
Complaints, Appeals & Grievances

For more information, reference our Provider Procedural Manual regarding:

- Appeals and Grievances

The right plan for you

MHT APPEALS PROCESS



SECTION 8.1

Behavioral Health Services Forms

The right plan for you

BEHAVIORAL HEALTH UNIT FAX COVER SHEET — FAX TO: 1.866.616.6255

Today's Date: _____

To: _____

Provider's Name: _____

Your Name: _____

Phone Number: _____

Company Fax: _____

Pages Including This Cover Sheet: _____

PLEASE COMPLETE EACH SECTION TO ENSURE YOUR DOCUMENT WILL BE ROUTED CORRECTLY

MEMBER ID#: _____ – _____

(MUST INCLUDE MEMBER SUFFIX)

DATE OF SERVICE: _____

DOCUMENT TYPE BEHAVIORAL HEALTH UNIT RECORDS

DOCUMENT DESCRIPTION (*PLEASE INDICATE ONE OF THE FOLLOWING…*)	
☐ ER TREATMENT	☐ THERAPY NOTES
☐ OFFICE/CLINCAL NOTES	☐ ADMISSION/CONCURRENT D/C CLINICAL
☐ PHYSICIAN ORDERS	☐ OTHER

CONFIDENTIALITY NOTE

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS CONFIDENTIAL INFORMATION INTENDED FOR THE USER OR THE INDIVIDUAL ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEARBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION IS STRICTLY PROHIBITED.

REVIEWED 08/23/2018

1110 Main Street, Wheeling, WV 26003-2704 • P: 1.800.624.6961

healthplan.org

The HealthPlan

ADMISSION REVIEW INFORMATION

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

ADMISSION REVIEW INFORMATION	
Today's Date:	
Patient Name:	
ID #:	Date of Birth:
Referring Physician:	
Admitting Physician:	

UTILIZATION REVIEW CONTACT	
Name:	Phone Number:
Information Submitted By:	
Fax:	Date of Review:
Facility Name:	
Admission Date:	Time:

TYPE OF ADMISSION	
☐ Emergency Room	☐ Urgent Admission
☐ Elective Admission	☐ Transfer from Another Unit
☐ Outpatient/Office	
Room Number:	

ASSESSMENT	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

Psychosocial Stressors

Please indicate the severity of current Psychosocial Stressors:

☐ None ☐ Mild ☐ Moderate ☐ Severe

GAF Score Highest Past Year: Current:

ADMISSION CHIEF COMPLAINT:

PRECIPITATING FACTORS:

ACTIVE PSYCHIATRIC SYMPTOMS:

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

PERTINENT LAB RESULTS:

OTHER PERTINENT LAB RESULTS:

MENTAL STATUS:

CURRENT PSYCHOTROPIC HOME MEDICATIONS:

CURRENT BEHAVIORAL HEALTH SERVICES & PROVIDERS

ADLS (EX: AMBULATION, SLEEP, APPETITE):

SUBSTANCE USE DISORDER ISSUES:

LEGAL ISSUES:

REQUESTED LEVEL OF CARE:	
☐ Observation	☐ Crisis Stabilization
☐ Chemical Dependency Intensive Outpatient	☐ Inpatient
☐ Partial Hospitalization	☐ Inpatient Rehab Program
☐ Detox	☐ Intensive Outpatient

EDUCATIONAL AND FAMILY/SUPPORT COMPONENTS:

REVIEWED 08/23/2018

CONCURRENT AUTHORIZATION FOR ABA/BEHAVIORAL SERVICES

Member Name: _____

Member ID#: _____ Date of Birth: _____

Requesting Provider: _____

Phone Number: _____ NPI #: _____

Provider Address: _____

Date of Initial Evaluation:			
Services Requested:			
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	

INDICATIONS FOR CONTINUED TREATMENT:	
Treatment Initiated in last 5 months	☐ Yes ☐ No
A) At least 80% of behavioral targets achieved/expected to be achieved by goal date	☐ Yes ☐ No
1) Parent/Caregiver Training attendance at least 80% of planned parent sessions	☐ Yes ☐ No
B) 50% to 79% of behavioral targets achieved/expected to be achieved by goal date & treatment plan revised for unattained targets	☐ Yes ☐ No
1) Increased time/frequency working on targets	☐ Yes ☐ No
2) Change in treatment techniques	☐ Yes ☐ No
3) Increased parent/caregiver Training	☐ Yes ☐ No
4) Identification & resolution of barriers to treatment effectiveness	☐ Yes ☐ No
5) Goals reconsidered	☐ Yes ☐ No
a) Goals modified/removed	☐ Yes ☐ No
b) Parents/Caregivers agree to changes	☐ Yes ☐ No

INDICATIONS FOR CONTINUED TREATMENT (continued):	
C) 25-49% of behavioral targets achieved/expected to be achieved by goal date	☐ Yes ☐ No
Co-occurring disorder newly identified & treatment plan revised	☐ Yes ☐ No
1) Intellectual disability	☐ Yes ☐ No
2) Anxiety disorder	☐ Yes ☐ No
3) Mood disorder	☐ Yes ☐ No
4) Psychotic disorder	☐ Yes ☐ No
D) Family/Provider scheduling difficulties	☐ Yes ☐ No
1) Resulted in inadequate treatment intensity	☐ Yes ☐ No
2) Have now been resolved	☐ Yes ☐ No
E) Achieved greater than 50% of behavioral targets for last 3 months	☐ Yes ☐ No
Has some verbal expression	☐ Yes ☐ No
1) Functioning	☐ Yes ☐ No
Treatment initiated w/in last 12 months	☐ Yes ☐ No
Treatment initiated over 12 months ago	☐ Yes ☐ No
a) Patient able to communicate requests nonverbally/verbally	☐ Yes ☐ No
b) Patient able to follow one-step directions	☐ Yes ☐ No
2) Progress from baseline demonstrated on repeated assessments	☐ Yes ☐ No
a) Structured parent/caregiver interview	☐ Yes ☐ No
b) Direct behavioral observation	☐ Yes ☐ No
c) Checklist/Rating Scale for Symptoms of ASD	☐ Yes ☐ No
d) Expressive/Receptive Language Measure	☐ Yes ☐ No
e) Measure of cognitive function	☐ Yes ☐ No

PARENT CAREGIVER TRAINING	
A) Occurring greater than one time/week	☐ Yes ☐ No
B) Occurring greater than one time x/ 3 weeks and parent/caregiver attendance is at least 80% of planned sessions	☐ Yes ☐ No
Coordination with other service providers	
A) Behavior analyst has updated information from other treatment providers/school within the last 12 months	☐ Yes ☐ No
B) Patient not receiving other therapeutic services	☐ Yes ☐ No
Treatment duration	
A) ABA initialed w/I last 36 months	☐ Yes ☐ No
B) ABA initialed over 36 months ago and less than 20 hrs/wk of ABA planned	☐ Yes ☐ No

TREATMENT PLAN	
Current Targets Address Safety/Functioning	☐ Yes ☐ No
A) Communication/Language	☐ Yes ☐ No
B) Social/Family Interaction	☐ Yes ☐ No

REPETITIVE/RESTRICTIVE BEHAVIORS	
A) Behavior interferes with functioning/relationships	☐ Yes ☐ No
B) Potential to harm self/others	☐ Yes ☐ No
C) ADLs/ADOLs	☐ Yes ☐ No
D) Disruptive/Aggressive/Self-injurious Behavior	☐ Yes ☐ No

PROVIDER QUALIFICATIONS	
Case supervised by state-licensed BCBC/BCBA-D	☐ Yes ☐ No
Planned supervision of case	
1) Greater than 4 supervision sessions/month	☐ Yes ☐ No
2) Greater than 1 hour of supervision per 15th hour of direct treatment	☐ Yes ☐ No
Direct/Video-based supervision planned	
1) Greater than 1 time in two weeks	☐ Yes ☐ No
2) Greater than 1 hour per 30 hours of direct treatment	☐ Yes ☐ No
Direct treatment providers:	
A) All direct treatment providers are credentialed for independent practice of ABA	☐ Yes ☐ No
1) BCBA/BCBA-D	☐ Yes ☐ No
2) Licensed behavior analyst by state statute	☐ Yes ☐ No

SERVICES:
Treatment Intensity
Select one of the following
☐ 1) Attends full days of school/preschool/EI & up to 15 hours/week of direct ABA treatment
☐ 2) Attends half days of school/preschool/EI & up to 25 hours/week of direct ABA treatment
☐ 3) Not enrolled in school/preschool
☐ 4) Less than 6 years of age
☐ 5) Up to 30 hours/week of direct ABA treatment
Select one of the following
☐ 1) Up to 2 hours of supervision per 10th hour of direct treatment
☐ 2) Up to 3 hours/week of parent/caregiver training
☐ 3) Up to 12 hours per year of consultation with other providers/agencies/school personnel

TREATMENT PLAN
*Plan must be child-centered, strength-based, family focused, community-based, multisystem, and culturally-competent. Parental training must be involved so they can provide additional hours of intervention. Complete this page or attach treatment plan.
Goal 1:
Objective:
As Evidenced By:
Objective:
As Evidenced By:
Objective:
As Evidenced By:
Goal 2:
Objective:
As Evidenced By:
Objective:
As Evidenced By:
Objective:
As Evidenced By:
Goal 3:
Objective:
As Evidenced By:
Objective:
As Evidenced By:
Objective:
As Evidenced By:

IF APPLICABLE, WAS THE PLAN SUBMITTED AND APPROVED BY THE HUMAN RIGHTS COMMITTEE?
☐ Yes ☐ No

Signature: _____

Date: _____

REVIEWED 08/23/2018

CONCURRENT OR DISCHARGE REVIEW INFORMATION

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

Today's Date:	
Patient Name:	
ID #:	Date of Birth:
Referring Physician:	
Admitting Physician:	

UTILIZATION REVIEW CONTACT	
Name:	Phone Number:
Information Submitted By:	
Fax:	Date of Review:
Facility Name:	
Admission Date:	Room Number:

ASSESSMENT	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

Psychosocial Stressors

Please indicate the severity of current Psychosocial Stressors:

☐ None ☐ Mild ☐ Moderate ☐ Severe

GAF Score Highest Past Year: Current:

CHANGES IN MEDICATION:

CURRENT TREATMENT/SERVICES:

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

MENTAL STATUS:

SYMPTOMS/BEHAVIORS:

PROGRESS MADE IN THE PROGRAM:

Anticipated Discharge Date (if applicable):			
Follow-Up Appointment(s) Scheduled:			
Discharge Address:			
Discharge Phone:			

DISCHARGE GOALS:

BARRIERS TO DISCHARGE:

OTHER INFORMATION:

HAS THE MEMBER CREATED A TAKE HOME RECOVERY PLAN FOR SUPPORT UPON DISCHARGE?
☐ Yes ☐ No

REVIEWED 08/23/2018

CONTINUITY OF CARE CONSULTATION SHEET

This form is provided to facilitate communication between behavioral health and primary care physicians to enhance continuity and coordination of care. Please complete the information below and forward to the appropriate practitioner.

MEMBER INFORMATION	
Member Name:	
Date of Birth:	ID #:

BEHAVIORAL HEALTH	PRIMARY CARE PROVIDER
Provider Name:	Provider Name:
Provider ID/NPI:	Provider ID/NPI:
Provider Phone Number:	Provider Phone Number:

TREATMENT UPDATES
Date/Reason for Behavioral Health visit: *(check one):*
☐ Initial Evaluation ☐ Continuation of Treatment ☐ Re-evaluation ☐ Crisis ☐ Testing
Date/Reason for PCP visit:
Diagnosis:

CURRENT MEDICATION LIST: *(Please include long-term and newly prescribed medications)*

RECOMMENDATIONS FOR CONTINUED TREATMENT REGIMEN:

Please feel free to contact the office with any questions and/or concerns. **Do not forget to download and sign the Authorization to Disclose Health Information to PCP Form from our website**. Thank you.

Name of Person Completing Form:	
Provider Name:	Date:

REVIEWED 08/23/2018

CRISIS ENCOUNTERS REPORT FORM

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

Provider Name:	
Provider Address:	
Call Date:	
Member Name:	
Member ID #:	
Caller Name:	
Contact Phone #:	
Crisis Date:	
Crisis Time:	

DESCRIPTION AND OUTCOME OF EVENT:

Recorder Name: _____ Date: _____

FOLLOW-UP NOTES:

REVIEWED 08/23/2018

The HealthPlan

INITIAL AUTHORIZATION FOR ABA/BEHAVIORAL SERVICES

Member Name: _____

Member ID#: _____ Date of Birth: _____

Requesting Provider: _____

Phone Number: _____ NPI #: _____

Provider Address: _____

Date of Initial Evaluation:	
Services Requested:	
CPT _____	Hours Per Week: _____
CPT _____	Hours Per Week: _____
CPT _____	Hours Per Week: _____
CPT _____	Hours Per Week: _____
CPT	Hours Per Week:

DIAGNOSIS AND CARE COORDINATION:	
Member diagnosed with ASD	☐ Yes ☐ No
Age of member when diagnosis confirmed	
Diagnosis supported by*: Structured parent/caregiver interview	☐ Yes ☐ No
Direct behavioral observation	☐ Yes ☐ No
*Provider may submit all evidence based screening and scaling results used in determining the diagnosis with this form.	
Communication and social interaction deficits exhibited in at least 2 different settings	☐ Yes ☐ No
Repetitive/Restrictive behaviors evident	☐ Yes ☐ No
Suspicion of severe/profound intellectual disability	☐ Yes ☐ No
Estimated IQ greater than 35	☐ Yes ☐ No
Blind and/or deaf	☐ Yes ☐ No

SCHOOL/PRESCHOOL / EARLY INTERVENTION SERVICES PROVIDED:	
School/preschool/early intervention services provided	☐ Yes ☐ No
Types of services/Number of hours of each service provided	
1	
2	
3	
4	
5	
Behaviors Targeted:	
1	
2	
3	
4	
5	

COORDINATION WITH OTHER THERAPY PROVIDERS:	
BCBA Coordinating treatment with all other allied health services & has obtained specific info	
1) Types of therapy provided and hours per week	
a)	
b)	
c)	
d)	
e)	
2) Behaviors/Deficits targeted	
a)	
b)	
c)	
d)	
e)	
3) Coordination not achieved with at least 1 other provider despite at least 3 attempts	☐ Yes ☐ No
4) Other therapy services provided to patient	☐ Yes ☐ No
5) Up to 12 hours per year of consultation with other providers/agencies/school personnel	☐ Yes ☐ No

TREATMENT PLAN	
Focused on specific behavioral targets	
A) Communication/Language	☐ Yes ☐ No
B) Social/Family Interactions	☐ Yes ☐ No
C) Repetitive/Restrictive Behaviors	
1) Behaviors interfere with functioning/relationships	☐ Yes ☐ No
2) Potential to harm self/others	☐ Yes ☐ No
3) ADLs/IADLS	☐ Yes ☐ No
4) Disruptive/Aggressive/Self-Injurious behaviors	☐ Yes ☐ No
5) Behavioral targets defined by objective measurements	☐ Yes ☐ No
6) Procedure in place for data collection & analysis- Describe:	
7) Strategies planned to promote generalization- Describe:	
8) Parent/Caregiver Training Scheduled	☐ Yes ☐ No
9) Use of mechanical restraint not expected	☐ Yes ☐ No

PROVIDER QUALIFICATIONS	
Case Supervised by state licensed/BCBA/BCBA-D	☐ Yes ☐ No
A) Supervisor experienced in ASD	☐ Yes ☐ No
Planned Supervision of case	
1) Greater than 4 supervision session/month	☐ Yes ☐ No
2) Greater than 1 hour of supervision per 15 hours of direct treatment	☐ Yes ☐ No
Direct/Video-based supervision planned	
1) Greater than 1 time in two weeks	☐ Yes ☐ No
2) Greater than 1 hour per 30 hours of direct treatment	☐ Yes ☐ No
Direct treatment providers:	
B) All direct treatment providers are credentialed for independent practice of ABA	☐ Yes ☐ No
1) BCBA/BCBA-D	☐ Yes ☐ No
2) Licensed behavior analyst by state statute	☐ Yes ☐ No

TREATMENT PLAN:	
*Plan must be child-centered, strength-based, family focused, community-based, multisystem, and culturally-competent. Parental training must be involved so they can provide additional hours of intervention.	
Goal 1:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 2:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 3:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:

The HealthPlan

RISK ASSESSMENT*:
Past Attempts to Harm Self or Others: ☐ None ☐ Self ☐ Others
Comments:
Current Risk of Harm to Self: ☐ None ☐ Low ☐ Moderate ☐ High
Comments:
Current Risk of Harm to Others: ☐ None ☐ Low ☐ Moderate ☐ High
Comments:
Functional Impairment (only indicate the impairments that are present) Social Interaction * If potentially harmful behaviors exist, please submit full risk assessment and crisis plan.

TARGETED INTERVENTIONS AIMED AT SPECIFIC BEHAVIORS:	
Intervention 1:	a.) description of intervention:
	b.) risk analysis:
Intervention 2:	a.) description of intervention:
	b.) risk analysis:
Intervention 3:	a.) description of intervention:
	b.) risk analysis:
Intervention 4:	a.) description of intervention:
	b.) risk analysis:

ADDITIONAL INTERVENTIONS:

IF APPLICABLE, WAS THE PLAN SUBMITTED AND APPROVED BY THE HUMAN RIGHTS COMMITTEE?
☐ Yes ☐ No

Signature:

Date:

REVIEWED 08/23/2018

DEFINITIVE/PRESUMPTIVE DRUG TESTING PRIOR AUTHORIZATION FORM

Date: _____

Member Name: _____ Date of Birth: _____

Member ID#: _____

Diagnosis: _____

Provider: _____ Tax ID#: _____

Provider Phone #: _____

Laboratory Completing Request: _____

Laboratory Tax ID#: _____

What phase of treatment is the patient currently in?

☐ Initiation (0 – 8 weeks) ☐ Stabilization (9 – 16 weeks) ☐ Maintenance (16 + weeks)

Requested Code	Code Description	Presumptive Result and Date	Expected Result	Result Disputed by Patient	Treatment Impact
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

If requesting testing for more substances than patient disputed the results of, please provide specific substances that you wish to be tested and rationale for testing additional substances.

Substance	Rationale

REVIEWED 08/23/2018

The HealthPlan

INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION REQUEST FORM

Member Name: _____	Date of Request: _____
Member ID: _____	Date of Birth: _____
Provider/Facility Name: _____	
Program Name: _____	Contact Phone Number: _____
Address: _____	
_____	
Physician Overseer: _____	
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Date of Last Inpatient Admission: _____	Expected Adherence to the Program: _____ %
Potential For Non-Adherence: ☐ Y ☐ N	Present Adherence to the Program: _____ %
Available Support System: ☐ Y ☐ N	Adequate Support System: ☐ Y ☐ N
Transportation Available: ☐ Y ☐ N	

SYMPTOMS:	Present	Resolved	N/A
Self-destructive behavior	☐	☐	☐
Recklessness	☐	☐	☐
Impulsive behavior	☐	☐	☐
Compulsive behavior	☐	☐	☐
SI/HI w/o plan or intent	☐	☐	☐
Medication resistant	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Thought disturbances	☐	☐	☐

SYMPTOMS: (cont.)	Present	Resolved	N/A
Self-injurious behavior	☐	☐	☐
Severe cravings	☐	☐	☐
Preoccupied with substance use disorder	☐	☐	☐
Preoccupied with substance use disorder experience	☐	☐	☐
Guilt/remorse	☐	☐	☐
Drug seeking behavior	☐	☐	☐
Drug induced psychosis	☐	☐	☐
Altered mood	☐	☐	☐
Withdrawal symptoms	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

PROBLEMS:	Present	Resolved	N/A
Anger outbursts	☐	☐	☐
Withdrawn	☐	☐	☐
Nutrition	☐	☐	☐
Hygiene	☐	☐	☐
Crisis within the last 7 days	☐	☐	☐
Arrest within last 7 days	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

SERVICES PROVIDED:	Yes	No	N/A
Individual therapy	☐	☐	☐
Group therapy	☐	☐	☐
Family therapy	☐	☐	☐
Medication evaluation	☐	☐	☐

SERVICES PROVIDED:	No	N/A	Yes
Crisis planning	☐	☐	☐
Recovery based activities	☐	☐	☐
Identification of goals/triggers	☐	☐	☐
Personal recovery plan	☐	☐	☐

ADDITIONAL INFORMATION (PLEASE LIMIT TO 600 CHARACTERS):

REVIEWED 08/23/2018

PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUEST FORM*
BEHAVIORAL HEALTH SERVICES

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

*****All sections must be completed for timely pre-authorization consideration.*

Today's Date:	Member's ID#:
Member's Name:	Date of Birth:

Referring Provider:	Phone Number:
Address:	

Testing Provider:	Phone Number:
Address:	

Has a diagnostic interview been conducted by the requesting practitioner? ☐ Yes ☐ No

Date of review? _____ Was rating scales and/or inventories completed? ☐ Yes ☐ No

If so, please list:

DIAGNOSIS CODES	CPT
CODE	TESTS REQUESTED / HOURS
1)	
2)	
3)	
4)	

INFORMATION CONTINUED for Member: _____

WHAT IS SPECIFIC QUESTION(S) TO BE ANSWERED BY TESTING?

Is testing related to the diagnosis of ADHD? ☐ Yes ☐ No

If IQ testing is requested, please provide the reason for this testing.

WHAT ARE THE CURRENT SYMPTOMS THE CLIENT IS EXHIBITING?

HOW WILL THE RESULTS OF THE TESTING AFFECT THE TREATMENT PLAN?

WHAT TREATMENT(S) HAS/HAVE ALREADY BEEN RENDERED TO THE CLIENT?

ARE THERE ANY FACTORS THAT COULD AFFECT THE OUTCOME OF THE TEST (I.E. SUBSTANCE USE DISORDER, ILLITERATE)?

INFORMATION CONTINUED for Member: _____

WHAT IS TESTING PLAN:
Determine diagnosis? ☐ Yes ☐ No Lack of expected progress in treatment? ☐ Yes ☐ No

RELEVANT MEDICAL/PSYCHIATRIC HISTORY.

DESCRIBE ANY HISTORY OBTAINED FROM FAMILY/SCHOOL, SIGNIFICANT OTHERS.

DESCRIBE ANY HISTORY OBTAINED FROM CURRENT AND FORMER BH PROVIDERS OR TREATMENT.

IF UNABLE TO OBTAIN INFORMATION FROM FAMILY OR PROVIDERS, PLEASE EXPLAIN ATTEMPTS OR REASON.

_____ _____

Provider Signature Request Date

REVIEWED 08/23/2018

The HealthPlan

REQUEST FOR ACT PROGRAMMING

Member Name:	Date of Request:
Member ID:	Date of Birth:
Provider/Facility Name:	
Program Name:	Contact Phone Number:
Address:	
Physician Overseer:	
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
CPT Code Requested:	

HISTORY OF HOSPITALIZATION FOR PSYCHIATRIC REASONS IN THE LAST 24 MONTHS:

Admit date:	Discharge date
Admit date:	Discharge date
Admit date:	Discharge date
Admit date:	Discharge date
Admit date:	Discharge date

HISTORY OF LAST 5 ER AND/OR CSU VISITS FOR PSYCHIATRIC REASONS, IF APPLICABLE:

Admit date:
Admit date:
Admit date:
Admit date:
Admit date:

HISTORY:	Yes	No	N/A
Partial Hospitalization in past year	☐	☐	☐
IOP in the past year	☐	☐	☐
Substance use disorder history	☐	☐	☐

NEEDS LIST:	Yes	No	N/A
Homelessness	☐	☐	☐
	☐	☐	☐
Risk of homelessness	☐	☐	☐
Needs assistance for successful outcome to perform ADLs independently	☐	☐	☐
Needs assistance for successful outcome to maintain support system	☐	☐	☐

NEEDS LIST:	Yes	No	N/A
Needs assistance for successful outcome with outpatient services	☐	☐	☐
	☐	☐	☐
Needs assistance for successful outcome to take prescribed medications	☐	☐	☐
Needs assistance for successful outcome to structure daytime hours independently	☐	☐	☐

REVIEWED 08/23/2018

The HealthPlan

REQUEST FOR CFT PROGRAMMING

Member Name:	Date of Request:
Member ID:	Date of Birth:
Provider/Facility Name:	
Program Name:	Contact Phone Number:
Address:	
Physician Overseer:	
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
CPT Code Requested:	

NEEDS LIST:	Yes	No	N/A
Master Plan completed	☐	☐	☐
Symptoms Mild	☐	☐	☐
Symptoms Moderate	☐	☐	☐
Symptoms Severe	☐	☐	☐

NEEDS LIST:	Yes	No	N/A
Inadequate support system	☐	☐	☐
Needs assistance for successful outcome to perform ADLs without structure	☐	☐	☐
Inappropriate for day treatment program	☐	☐	☐
Efforts made to link to natural supports/activities/services in the community	☐	☐	☐

LIST IDENTIFIED GOALS:

PROGRESS TOWARD PROGRAM OBJECTIVES AND FUTURE PLANNING:

NEWLY IDENTIFIED AREAS OF NEED:

REVIEWED 08/23/2018

The HealthPlan

REQUEST FOR OUTPATIENT ECT/TMS

Please fax to: Behavioral Health Services Toll Free: 1.866.616.6255

All sections must be completed for timely approval

Member Name: _____

Member ID: _____ Date of Birth: _____

Provider Name: _____

Provider Phone Number: _____ NPI #: _____

Provider Address: _____

_____

Location of Treatment: _____

Diagnosis (ICD-10): _____

Number of treatments requested: _____ Timeframe requested: _____

REQUEST FOR ECT TREATMENT:	REQUEST FOR TMS TREATMENT:
☐ Initial ☐ Continuation ☐ Maintenance	☐ Initial ☐ Continuation

Symptoms:

Depression	☐ Yes	☐ No	Neuroleptic malignant syndrome	☐ Yes	☐ No
Suicidal ideations	☐ Yes	☐ No	Acute or chronic psychosis	☐ Yes	☐ No
Suicidal intent	☐ Yes	☐ No	Dementia	☐ Yes	☐ No
Delusions	☐ Yes	☐ No	Seizure disorder	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No	Substance use disorder	☐ Yes	☐ No
Disorganized thinking/speech	☐ Yes	☐ No	Other symptoms:	☐ Yes	☐ No
Racing thoughts	☐ Yes	☐ No			
Flight of ideas	☐ Yes	☐ No			
Catatonia not due to a medical condition	☐ Yes	☐ No	History of non-compliance to treatment	☐ Yes	☐ No

TREATMENT HISTORY (ALL TREATMENT):	
Last ECT treatment:	Last TMS Treatment:

DESCRIBE CURRENT/PAST MEDICATION TRIALS:

DESCRIBE CURRENT/PAST SUPPORTIVE MEDICAL TREATMENT:

ECT/TMS HISTORY AND RESPONSE:

OTHER TREATMENTS:
Implanted or embedded magnetic – sensitive metals in member head or neck ☐ Yes ☐ No Informed consent obtained ☐ Yes ☐ No

PRE-ECT WORKUP:	
Completed ☐ Yes ☐ No	Clearance given ☐ Yes ☐ No
Additional information, if applicable:	

Requested by: _____ Date: _____

REVIEWED 08/23/2018

The HealthPlan

TREATMENT CONTINUATION REQUEST FORM

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255
*All Sections must be completed for timely approval

Patient Name:	
Member ID:	Date of Birth:

Provider Name:	
Phone Number:	NPI#:
Address:	

Date of Evaluation Visit for current Episode of Care: _____ Is this request urgent? ☐ Yes ☐ No

ASSESSMENT:	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

Psychosocial Stressors

Please indicate the severity of current Psychosocial Stressors:

☐ None ☐ Mild ☐ Moderate ☐ Severe

GAF Score Highest Past Year: Current:

CURRENT MEDICATIONS:			
☐ Anti-psychotic	☐ Anti-Anxiety	☐ Anti-Depressant	☐ None
☐ Hypnotic	☐ Mood Stabilizer	☐ Medical	
☐ Psycho-Stimulant	☐ Other/Comments:		

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

The HealthPlan

SYMPTOMS: (IF PRESENT, CHECK DEGREE)							
	Mild	Moderate	Severe		Mild	Moderate	Severe
Depressed Mood	☐	☐	☐	Anxiety	☐	☐	☐
Anhedonia	☐	☐	☐	Panic Attacks	☐	☐	☐
Low Energy	☐	☐	☐	Inattention	☐	☐	☐
Hopelessness	☐	☐	☐	Impulsive	☐	☐	☐
Somatoform/	☐	☐	☐	Bingeing/Purging	☐	☐	☐
Factitious Problems	☐	☐	☐	Restricting Food Intake	☐	☐	☐
Social Isolation	☐	☐	☐	Hyperactive	☐	☐	☐
Self Mutilation	☐	☐	☐	Hallucination	☐	☐	☐
Sleep Disturbance	☐	☐	☐	Delusions	☐	☐	☐
Mood Swings	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐	No Symptoms	☐	☐	☐

SUBSTANCE USE DISORDER		
☐ Active Drug Use	☐ Guilt/Remorse/Shame	☐ Use Disorder in Remission
☐ Cravings	☐ Preoccupation with getting high	☐ None
☐ Drug Seeking Behavior	☐ Preoccupation with Gambling	

Is this patient on mental health or chemical dependency disability? ☐ Yes ☐ No

Have you contacted the patient's PCP? ☐ Yes ☐ No

Have you contacted any other health care provider? ☐ Yes ☐ No

If "Yes", list who? _____

Other Provider: _____

INTERVENTIONS & GOALS USED IN TREATMENT:				
1.				
Time Frame to Complete:	☐ 1 Month	☐ 2 Months	☐ 3 Months	☐ Other
2.				
Time Frame to Complete:	☐ 1 Month	☐ 2 Months	☐ 3 Months	☐ Other
3.				
Time Frame to Complete:	☐ 1 Month	☐ 2 Months	☐ 3 Months	☐ Other

The HealthPlan

SPECIFIC SERVICES REQUESTED AND NUMBER OF SERVICES REQUESTED:					
Code:	No. of Services	Code:	No. of Services	Code:	No. of Services
90791		90833		90846	
90792		90836		90847	
90832		90838		90853	
90834		90785			
90837					
E&M Code:		No. of Services:			

SPECIFIC SERVICES NUMBER OF UNITS:					
Code:	No. of Units	Code:	No. of Units	Code:	No. of Units
H0004		H2014 U4		H2019	
H0004 HO		H2014 U1		H2019 HO	
H0004 HO HQ		H2014 HN U4		H2015 U1	
H0004 HQ		H2014 HN U1		H2015 U2	
T1017		Other			

FREQUENCY OF APPOINTMENTS SCHEDULE:

☐ Weekly ☐ 2 x a month ☐ Monthly ☐ Other:

LEVEL OF IMPROVEMENT TO DATE:

☐ None ☐ Minor ☐ Moderate ☐ Major

ADDITIONAL SYMPTOMS, FUNCTIONING LEVEL AND COMMENTS:

Provider Signature: _____ Date: _____

* Please Note: Only evaluation sessions and crisis encounters will be reimbursed prior to authorization requests.

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The HealthPlan

SUBSTANCE USE DISORDER ADMISSION REVIEW INFORMATION

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

ADMISSION REVIEW INFORMATION	
Today's Date:	
Patient Name:	
ID #:	Date of Birth:
Referring Physician:	
Admitting Physician:	

UTILIZATION REVIEW CONTACT	
Name:	
Phone Number:	Fax:
Information Submitted By:	
Date of Review:	
Facility Name:	
Admission Date:	Time:

TYPE OF ADMISSION	
☐ Emergency Room	☐ Urgent Admission
☐ Elective Admission	☐ Transfer From Another Unit
☐ Outpatient/Office	Room Number:

ASSESSMENT	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

ASSESSMENT (cont.)
Psychosocial Stressors Please indicate the severity of current Psychosocial Stressors: ☐ None ☐ Mild ☐ Moderate ☐ Severe GAF Score Highest Past Year: Current:

ADMISSION CHIEF COMPLAINT/CURRENT SUBSTANCE USE DISORDER/HISTORY OF SUBSTANCE USE DISORDER:

PRECIPITATING FACTORS/TRIGGERS:

ACTIVE PSYCHIATRIC SYMPTOMS/BEHAVIORAL HEALTH HISTORY IF APPLICABLE:

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

PERTINENT LAB RESULTS (ROUTINE/ABNORMALS); (U-TOX RESULTS AND DATES):

OTHER PERTINENT DIAGNOSTIC RESULTS, FOR EXAMPLE: SUBSTANCE USE DISORDER SCALES/SCORES (COWS, CEWA, ASAM DIMENSIONS, ETC.):

MENTAL STATUS:

CURRENT PSYCHOTROPIC HOME MEDICATIONS:

DETOX ONLY VITAL SIGNS:				
Date: _____	BP: _____	P: _____	R: _____	T: _____
Date: _____	BP: _____	P: _____	R: _____	T: _____
Date: _____	BP: _____	P: _____	R: _____	T: _____
Date: _____	BP: _____	P: _____	R: _____	T: _____
Date: _____	BP: _____	P: _____	R: _____	T: _____
Date:	BP:	P:	R:	T:

CURRENT SUBSTANCE USE DISORDER & PROVIDERS/PAST SUBSTANCE USE DISORDER TREATMENT:

ADLS (EX: AMBULATION, SLEEP, APPETITE):

SUBSTANCE USE DISORDER ISSUES/ACUTE/POST ACUTE SYMPTOMS:

LEGAL ISSUES:

INITIAL ORDERS/TREATMENT:

REQUESTED LEVEL OF CARE:	
☐ Medically managed Intensive Inpatient Services	☐ Medically monitored Intensive Inpatient Services
☐ Clinically managed High-Intensity Residential Services	☐ Clinically managed Population specific high-intensity residential services
☐ Clinically managed low-intensity Residential services	☐ Partial hospitalization
☐ Intensive Outpatient Treatment	☐ Chemical Dependency Intensive Outpatient Treatment
☐ Outpatient Services	☐ Early intervention
☐ Observation	

EDUCATIONAL AND FAMILY/SUPPORT COMPONENTS:

REVIEWED 08/23/2018

SUBSTANCE USE DISORDER CONCURRENT/DISCHARGE REVIEW INFORMATION

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

Today's Date:	
Patient Name:	
ID #:	Date of Birth:
Referring Physician:	
Admitting Physician:	

UTILIZATION REVIEW CONTACT	
Name:	Phone Number:
Information Submitted By:	
Fax:	Date of Review:
Facility Name:	
Admission Date:	Room Number:

ASSESSMENT	
Clinical Disorders/Syndromes	Diagnoses Code:
Personality Disorders/Intellectual Disabilities	Diagnoses Code:

Relevant Medical Issues/Physical Problems

Does the patient have a current medical condition linked to the Axis 1 or 2 diagnoses?

☐ Yes ☐ No Describe:

Psychosocial Stressors

Please indicate the severity of current Psychosocial Stressors:

☐ None ☐ Mild ☐ Moderate ☐ Severe

GAF Score Highest Past Year: Current:

CHANGES IN MEDICATION:

CURRENT TREATMENT/SERVICES/TRANSITION IN PROGRAM/NUMBER DAYS OR SESSIONS PER WEEK:

RISK ASSESSMENT:				
Suicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None
Homicidal Ideation	☐ Ideation	☐ Plan	☐ Intent	☐ None

MENTAL STATUS:

SYMPTOMS/BEHAVIORS/ASAM DIMENSION SUMMARY (SCALES/SCORES IF APPROPRIATE):

ADHERENCE TO PROGRAM/DAYS ATTENDED IN THIS REVIEW PERIOD/TOTAL DAYS ATTENDED AT DISCHARGE:

Anticipated Discharge Date (if applicable):			
Follow-Up Appointment(s) Scheduled:			
Discharge Address:			
Discharge Phone:			

DISCHARGE GOALS/PROGRESS IN PROGRAM:

BARRIERS TO DISCHARGE:

OTHER INFORMATION:

REVIEWED 08/23/2018

SECTION 9.1

EDI Guide

The right plan for you

SECTION 9.1

EDI Guide

For more information, reference our Provider Procedural Manual regarding:

- Introduction

SECTION 10.1

Fraud and Abuse Laws

The right plan for you

SECTION 10.1

Fraud and Abuse Laws

For more information, reference our Provider Procedural Manual regarding:

- Fraud, Waste and Abuse Regulations and Guidelines
- Compliance Through Training
- HIPAA Privacy and Security
- Fraud, Waste and Abuse Poster

SECTION 11.1

Appendix

The right plan for you

SECTION 11.1

Appendix

For more information, reference our Provider Procedural Manual regarding:

- Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) (WV Medicaid Programs)
- Mountain Health Trust ID Cards
- WV Health Bridge ID Cards
- Medicaid Benefits and Exclusions at a Glance
- EPSDT
- Payment to Out-of-Network
- Prescription Benefit
- Family Planning
- Local Health Departments
- Staffing
- West Virginia Prenatal Risk Screening Instrument
- Women's Access to Health Care
- Smoking Cessation
- Diabetes
- Adult Dental
- Children's Dental
- Immunization Registry
- MHT / WVHB Members' Rights and Responsibilities Statement
- Marketing Guidelines