



Gateway Health Plan *Medicare Assured*SM Mental Health and Substance Abuse Outpatient Authorization Request Instructions

Effective 1/1/07

Mental Health Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*SM no longer requires par (in-network) providers to complete the Mental Health Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*SM, the par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

a. **Initial Request**

MH outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for MH services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. **Ongoing Services/ Reauthorization Requests**

Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for MH services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

SA Outpatient Treatment Registration

Gateway Health Plan *Medicare Assured*SM no longer requires par (in-network) providers to complete the Substance Abuse Outpatient Treatment Registration Form. However, psychological testing, neuropsychological testing and outpatient ECT must be pre-certified using a separate form.

The Outpatient Treatment Registration form is required for all outpatient non-par providers. Remember in order to be eligible for Gateway Health Plan *Medicare Assured*SM, the par and non-par providers must have a Medicare number. If the provider does not have a Medicare number, the provider will get an administrative denial of their request. Eligible non-par providers must do the following:

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a. **Initial Request**

SA outpatient services should be requested within 10 business days from the time a Provider sees a Member using the Outpatient Treatment Request form for SA services (i.e. individual, family, group therapy; psychiatric evaluations and medication management).

The provider will receive a phone call to enter the network. If the provider agrees to be credentialed, the service will be authorized for 90 days.

If the provider does not wish to enter the network, the provider will be asked for a clinical reason why the member cannot go to an in-network provider. If clinical appropriate, the provider will be given a 90 day authorization in order to transition the member to an in-network provider. Any services provided after the 90 day period will be denied and the provider may not seek reimbursement from the Member.

b. **Ongoing Services**

Only those non-par providers that choose to enter the network will receive continuation authorizations provided that their credentialing application is in process with CBHNP. Continued authorization is based on Member meeting American Society of Addiction Medicine (ASAM) criteria. Reauthorizations will be limited to an additional 90 day period. Reauthorization should be requested using the Outpatient Treatment Request form for SA services, which is the same form used for initial authorization requests. Providers may submit a reauthorization request up to two weeks prior to the requested authorization start date or up to ten (10) business days after the requested start date of the authorization.

All current authorization request forms are available at our website, www.cbhnp.org. Please print and copy these forms.

In an effort to process provider requests for changes, corrections, or revisions to OP authorizations more efficiently, Gateway Health Plan *Medicare Assured*SM has developed an OP Revision/Correction Form. Providers will need to utilize the attached form when seeking revisions or corrections to submitted OP treatment requests or existing authorizations. Providers have up to 30 days from the original occurrence (the date faxed, the date authorization was issued, etc.) to request changes, corrections or revisions. The OP Revision/Correction form will be processed and faxed back to the provider indicating the action taken. Revised/corrected authorization letters will be mailed to the provider as appropriate. Any changes, revisions or corrections that are over the 30-day period will need to be sought through the Administrative Appeal process.

Authorizations cannot span calendar years. Authorizations will be issued until the end of the calendar year. Providers will need to request a new authorization for the next calendar year

Completion of Treatment Requests:

- Please review requests prior to submission to make certain the information is accurate and reflects the number and type of session, start date, etc. that you seek to have authorized.
- The Member Status Block must be completed on each request. Choose the appropriate selection (one of the top three items OR one of the lower two items).
- The Three Dates - These dates are needed for either of the lower two selections in the Member Status block (1st Appointment or New Service)

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- i. **Member Requested Services:** This date field reflects the date the Member first contacted your office to initiate this treatment episode or when a new service is discussed with or requested by a Member. For example, a Member in individual therapy who is going to start family therapy would not need the three dates reported as this is not considered a new service (as the Member currently has therapy services). A Member going from MH to SA, SA to MH, therapy to psychiatric services, or psychiatry to therapy, these would all require the three dates to be reported. The three dates must be completed on every 90801 request.
 - ii. **Services 1st Offered:** This date field reflects the first available appointment date offered to the Member, even if the Member declines or accepts and then needs to reschedule.
 - iii. **First Seen:** This date reflects the Member's actual first appointment.
- Providers are required to track and document the above three dates on each Member's treatment record. Audits will be conducted to assure compliance.

- e. The OP Treatment request forms have been revised and have the date 6/1/06 at the bottom left hand corner. These forms may be accessed on the Gateway Health Plan *Medicare Assured*SM website. The "Number of sessions used in previous authorization period, total sessions used to date, and frequency of services" have been removed from the form. Added to the forms are spaces for the CBHNP OP Department to complete. These areas are for the start date and end date of the authorization and the number of sessions authorized.

A. General Information

1. Authorization of Initial Diagnostic Interviews

This initial session must be billed using the CPT code 90801. For all 90801 requests, the printed name and degree of the person performing the service must be listed on the request form. Signatures are not required on the request forms.

2. Medication Management

Most medication services are provided using CPT code 90862. If you plan to use another CPT code for medication management, indicate the code with a description and unit on the request form.

3. Treatment Plans

Providers are not required to submit treatment plans with reauthorization requests for therapy but must continue to develop treatment plans in compliance with all applicable regulations. The treatment plans will be reviewed during annual treatment record reviews and regular site visits.

4. Forms

The outpatient treatment authorization request forms are available in a pdf. format, which will allow providers to complete the forms electronically. Providers may obtain the new forms directly from the Gateway Health Plan *Medicare Assured*SM website. These forms must be faxed to CBHNP at 717-540-1146.

B. Guidelines

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Please review requests prior to submission to make certain they reflect the number and type of session, start date, etc. that you seek to have authorized.

1. Faxed Requests

Faxed requests must be received by 4:00 pm. Faxes received after 4:00 pm will begin processing the next business day. The CBHNP fax number is 717-540-1146 and is listed on the request forms.

2. Provider Staff Resources

There should be at least one provider staff with knowledge of and experience with the Gateway Health Plan *Medicare Assured*SM requirements and request forms. Gateway Health Plan *Medicare Assured*SM expects that training and information regarding completing forms, the managed care system and Gateway Health Plan *Medicare Assured*SM would be part of new employee orientation. Please take advantage of your provider resources by contacting that individual, your billing personnel or your immediate supervisor before contacting Gateway Health Plan *Medicare Assured*SM with questions regarding the outpatient request forms.

3. Codes

You may use any procedure codes permitted under Medicare. If you are requesting an outpatient procedure with a CPT or HCPCS Code not listed on the request form, be sure to clearly indicate the code as well as brief title and unit.

4. Request Submission & Authorization Start Date Timeframes

Mental Health and Substance Abuse outpatient treatment requests are due within ten calendar days of the first date of service. For example, if a Member receives services on 7/10/06, the authorization request is due to CBHNP on or before 7/20/06. Requests will not be issued with a start date more than ten calendar days prior to receipt of the request. If a request is submitted more than ten calendar days after the initial session, the authorization will be issued with the start date being the date the request form was received by Gateway Health Plan *Medicare Assured*SM. A start date should be listed for each service requested.

5. Submission of Requests

A. Gateway Health Plan *Medicare Assured*SM expects that requests will be clear, complete and correct upon initial submission. If requests cannot be processed due to the need for clarity or information, a notice will be faxed to the submitting provider office. The provider has up to 30 calendar days after the date of the faxed notice to resubmit the request and have it processed with the original start date.

B. Changes cannot be made or authorizations issued by the outpatient department after 30 days from the original date the authorization was issued or requested to be issued. All requests received after 30 calendar days will be referred to the Administrative Appeals process as covered in the Gateway Health Plan *Medicare Assured*SM Provider News Brief of December 2007.

6. Psychological Testing

Psychological testing should not be requested using the outpatient request forms. Psychological testing requests require prior authorization. The form will be available on the Gateway Health Plan *Medicare Assured*SM website or from a Provider Relations Representative.

7. Neuropsychological Testing

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Neuropsychological testing should not be requested using the outpatient request forms. Neuropsychological testing requests require prior authorization. A copy of this form will be available on the Gateway Health Plan *Medicare Assured*SM website or from a Provider Relations Representative.

8. ECT

Requests for ECT should not be submitted on the OP Request form. These requests should be made by calling CBHNP at 1-866-755-7299 and request to speak with a Clinical Care Manager.

9. Eligibility Verification

It is the Provider's responsibility to verify eligibility. Member eligibility can be checked by contacting the DIVA Member Eligibility Line at 1-800-642-3515. The line is available 24 hours per day, seven (7) days per week. Members will have a Gateway Health Plan *Medicare Assured*SM Card. Providers should not request authorization for a person who is not yet an eligible Member.

10. Documentation of Faxed Request

Keep a copy of the fax transmittal sheet to document the date and time that a request was faxed. Verify that the fax was successfully transmitted. The fax cutoff deadline is 3:59 p.m. daily. Requests received at or after 4:00 p.m. will be processed on the next business day. Your transmittal sheet is the only record of successful transmittal.

11. Appropriate Use of Authorization Request Forms

This form cannot be used as a referral document. It is only used to authorize outpatient sessions and should be submitted by the service provider. Information on request forms should apply only to the current treatments being requested.

12. Reauthorization Requests

Authorizations are limited by the number of sessions and/or the authorization expiration date. As authorizations cannot cross calendar years, 12/31 is also a valid expiration date for authorizations. Reauthorization requests are needed when either the number of authorized sessions has been exhausted prior to the expiration date or the authorization expiration date has been reached. Authorizations cannot be extended. Providers may submit a reauthorization request up to one month prior to the requested authorization start date or up to ten calendar days after the requested start date of the authorization.

13. Incomplete Requests

Your request may not be approved if:

- A. Information is missing or is unclear
- B. Information is not legible
- C. Services requested are not listed in your provider profile
- D. The address or service site is not listed in the provider profile
- E. The individual is not a Member
- F. Identifying information on Member does not match Gateway Health Plan *Medicare Assured*SM Member records
- G. An incorrect form was used

14. Authorization Process

Requests are authorized as quickly as possible, and most requests are reviewed and an authorization made within two (2) business days after receipt of a fully completed request form. If you choose to call for an

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authorization number, please allow three (3) days from the date the request was faxed in order for the request to have been fully processed and for the authorization number to appear in the Gateway Health Plan *Medicare Assured*SM computer system.

If you are unsure whether a request was received successfully, please re-fax the request – marking it as a “Re-fax” on the request itself. We strongly advise that you review the fax confirmation coversheet to assure that the request transmitted properly. CBHNP is unable to search for individual requests prior to the entry of the authorization.

15. Corrections and/or Revisions

a. Corrections and revisions can be made by the OP Department if they are requested within 30 calendar days of the original applicable date (the date the authorization was issued, the date the request was submitted, the date faxed, etc).

b. Retroactive authorization requests more than 30 calendar days old **MUST** be sought through the Administrative Appeal process as covered in the Gateway Health Plan *Medicare Assured*SM Provider News Brief of December 2007.

c. Corrected/revised authorization letters will be faxed to the Provider within 2 business days.

Treatment Request Form - Request Fields and Definitions

- MEMBER NAME AND MEMBER SOCIAL SECURITY NUMBER.**
- MEMBER GATEWAY HEALTH PLAN *MEDICARE ASSURED*SM ID NUMBER AND MEMBER DATE OF BIRTH.**
- MEMBER ADDRESS AND MEMBER PHONE NUMBER.**

PROVIDER NAME AND ID: Entity or Organization Name to appear on the authorization, as it should appear on the authorization. This should also be the person/entity to which the payment will be made for the services rendered.

PROVIDER ADDRESS: (STREET) AND CONTACT PERSON: (address of place where service is being rendered and as it should appear on authorization). A legible address label or stamp may be used.

PROVIDER (CITY) ADDRESS, PHONE NUMBER & FAX NUMBER: **This should be the address where services are provided.**

MEMBER STATUS: CHECK EITHER INITIAL REQUEST OR CONTINUED SERVICE REQUEST.

DSM - IV Multiaxial Diagnosis:

As requests do not need to be submitted until after a Member is seen, this information should be available. If you do not have this information, please include a diagnostic impression and rule outs. A diagnosis must be included on each request. A primary MH diagnosis is required for any MH request and a primary SA diagnosis is required for any SA request. V-codes are not acceptable on requests as a primary diagnosis.

Treatment Code:

Please request the CPT code that coordinates with the service you are providing. If you do not know the appropriate CPT code, ask the person responsible for billing at your provider office.

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If you wish to use a CPT code not identified on the form, you may place the CPT code(s) with a description and unit in the blank boxes at the very bottom of the Treatment Code column.

Once you select the code(s) please write the following information on the Treatment Request Line(s) - beside the code(s) selected:

- a. Start date of requested authorization:** The date that the authorization for the *current* request/treatment episode should begin. For initial requests the requested start date should reflect the first session. The request must be faxed to CBHNP within ten calendar days of the start of services in order to be dated as requested. Requests received after ten calendar days will be given a start date of the date the request was received at CBHNP.
- b. Description and unit:** This section provides a description of the treatment code.
- c. Number of Sessions requested:** Indicate the number of sessions you are requesting. Providers should reference “Service Increments” above for information specific to number of sessions authorized.
- d. For Substance Abuse (SA) requests:** ASAM is utilized for Members. The level of care should reflect the level of care as per the evaluation for each dimension. The criteria indicated will reflect the letters of the criteria as per the evaluation for each dimension. Dimension status or progress comments may be listed.

Comments: Utilize as necessary to explain request or provide additional information. Please use the *comment* section (and not the fax cover page) for any notes or additional information.

For 90801: (Initial diagnostic interview requests) the printed name and degree of the professional performing the evaluation must be included in the “Name and Degree...” portion of the Treatment Request line.

Provider response to a request for more information: If a faxed notice requesting further information/clarification about a request is sent to your office, the request must be resubmitted and received within 30 business days in order for the originally requested authorization start date to be approved.

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