Outpatient Evaluation Authorizations Frequently Asked Questions

What services require authorization for outpatient behavioral health?

As stated in PB 2021-26, registration requirements are reinstated for the following outpatient behavioral health services:

Psychiatric / Medical Diagnostic Evaluation 90791-90792
Interactive Complexity 90785
Intensive Outpatient Program (IOP) - MH S9480
Intensive Outpatient Program (IOP) - SA H0015
Partial Hospitalization Program (PHP) H0035
Extended Day Treatment (EDT) H2012
Other Behavioral Health Services (Targeted Case Management and Homebased Services) H2019 and T1017
Psychological & Neurological Testing 96116, 96121, 96130-96133, 96136-96137 – Psychological Testing 96136 TF and 96137 TF – Neuropsychological Testing Only
Methadone Maintenance H0020
Case Management T1016
Adult Day Treatment H2013
MRO Group Homes 2074Y

Who needs to obtain prior authorization for the above services?

Physicians, Advanced Practice Registered Nurses (APRN), Physician Assistants, Outpatient Hospitals , Outpatient Chronic Disease Hospitals (CDH), Freestanding Psychiatric Hospitals, Opioid Treatment Programs (Methadone Maintenance Clinics), Freestanding Behavioral Health Clinics, Enhanced Care Clinics, Medical Clinics (including School Based Health Centers), Federally Qualified Health Centers, Independent Behavioral Health Clinicians (Licensed Clinical Social Workers (LCSWs), Licensed Alcohol and Drug Counselors (LADCs), Licensed Marital and Family Therapists (LMFTs), Licensed Professional Counselors (LPC), and Licensed Psychologists)

What authorization changes resulted from reinstating registration?

Obtaining the 90-unit authorization for one (1) year is no longer required, as only the evaluation needs prior authorization. The evaluation results in a two (2)-unit authorization over six (6) months.

Any exceptions to the above change?

CMAP rehabilitation clinics and billing for the 90785 will still require the 90-unit authorization.

Are providers no longer able to obtain the 90-unit authorization?

The 90- unit authorization capability will remain in effect due to rehabilitation clinics and the use of the 90785 CPT code.

Is this change temporary?

There is no plan to return to the full use of the 90-unit authorization for all standard outpatient services.

Is Gainwell Technologies aware of these new requirements?

Yes. Gainwell has updated their billing procedures as well. More information on procedures codes requiring authorization can be found on the Provider Fee Schedule at www.ctdssmap.com.

Are concurrent reviews required on existing outpatient authorizations prior to May 21, 2021?

No, concurrent reviews are not needed for any existing authorizations, with the exception of rehabilitation clinics or the use of the 90785 CPT code.

Are concurrent reviews required for outpatient authorizations after May 21, 2021?

No, authorizations for standard outpatient services past 5/21/2021 are not required. Please bill standard outpatient services directly to Gainwell. No concurrent reviews are required for outpatient services.

There is a 90-unit authorization on file soon to expire. Can services continue without submitting for a new 90-unit authorization?

The 90-unit authorization may expire and providers can continue to bill the standard outpatient services.

If a provider completes an evaluation but obtained the 90 –unit authorization instead of the evaluation, does the provider need to request the evaluation?

If a standard 90-unit authorization was recently obtained, there is no need to re-submit for an evaluation. The 90 unit authorization parameters are still inclusive of the evaluation CPT billing codes.

Is an outpatient evaluation needed for all therapy units?

An outpatient evaluation is needed for only the 90791 - initial diagnostic evaluation and 90792 – initial medical evaluation CPT codes. All other standard outpatient office visits, individual, group and family therapy sessions can be billed directly to Gainwell.

What selection in ProviderConnect do I use for Type of Care?

Outpatient evaluation – outpatient services. Please note these requests are all Mental Health for type of service no matter what the primary diagnosis. This will not affect the authorization or claims payment.

Are providers notified when a new authorization is required?

It is the provider's responsibility to track the units and date range for any authorization, for any level of care.

What if there is no diagnosis code when submitting the evaluation?

ProviderConnect has the option of using code R69. General Symptoms and Signs, Description: Illness, unspecified.

Would an outpatient facility that bills under a hospital need to obtain the evaluation as well?

Yes. Providers with one Medicaid ID should obtain only one (1) 2 – unit outpatient evaluation to bill for the 90791 or 90792. For an Outpatient Clinic or Hospital, Providers with one Medicaid ID should obtain only one (1) 2-unit outpatient evaluation. However, clinics with multiple locations should obtain the evaluation based on where the services were rendered, as each location has their own ID.

A patient sees an LCSW for 90971 in one location and an MD for 90792 in another location. Does this require separate authorizations?

Yes. Practices that bill based on the specific licensure level should obtain separate evaluation authorizations as determined by the license of the clinician(s).

If a member transfers to a different licensure for care and a new intake is <u>not required,</u> is a new evaluation needed?

If a new evaluation is not required upon transfer and the diagnosis has not changed, there is no need to obtain a new evaluation.

When should providers submit outpatient evaluations? How often?

DSS Regulations state that only one diagnostic interview in a twelve-month period per licensed behavioral health clinician per client should be submitted. This means providers should only submit the evaluation once.

Members that leave treatment however, may need a new evaluation if their clinical presentation significantly differs from the first intake. To process such requests, members returning outside the 6-month span and both units have been exhausted will require providers to complete a new evaluation.

Members who return inside the 6-month span and both units are exhausted will require a request for an additional unit. Providers will submit a ProviderConnect Inquiry (PCI) via ProviderConnect and provide clinical rationale detailing the medical necessity of the request.

For more information on the PCI requirements, please contact Beacon Health Options

If there were a change in the rendering provider, would a new authorization be necessary for the evaluation?

Yes. A change in the rendering provider warrants a new evaluation.

How can a provider be sure an evaluation authorization submitted?

Before navigating away from the submission page, providers can print or download the authorization request. After that point, the authorization letter should generate within two (2) business days. Alternatively, a provider can see a listing of all the authorization in

ProviderConnect by clicking 'Authorization Listing'. You can find a video tutorial on our website here.

Is the evaluation authorization required every six (6) months?

No. The evaluation in most circumstances should be obtained once, as it equals the initial intake.