| *PRIOR AUTHORIZATION REQUIRED?**LENGTH OF AUTHORIZATION?* |
| --- |
| **Service Type and Description** | **Coordinated Care** |
| **Acute Inpatient Care – Mental Health and Substance Use Disorder (SUD)*** Acute Psychiatric Inpatient; Evaluation and Treatment
* Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital
* Inpatient Acute Withdrawal (Detoxification) ASAM 4.0

\* Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs. | **No.** Emergent admissions require notification only within 1 business day followed by concurrent review.Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.***\* Initial: 3-5 days* |
| **WITHDRAWAL MANAGEMENT**(In a Residential setting)* ASAM 3.7
* ASAM 3.2

\* Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs. | **No,** ifEmergent –requires notification only within 1 business day followed by concurrent review.**Yes**, if planned – requires pre-service review and concurrent review.*\* Initial: 3-5 days* |
| **Crisis stabilization in a Residential Treatment setting** | **No,** requires notification only within 1 business day followed by concurrent review.*\* Initial: 3-5 days* |
| **Residential Treatment – mental Health and Substance Use Disorder*** **ASAM 3.5**
* **ASAM 3.3**
* **ASAM 3.1**
 | **Yes,** if planned – requires pre-service review and concurrent review.*\* Initial: 28 days*  |
| **Partial Hospitalization/Day Treatment*** **ASAM 2.5**
 | **Yes.***\*Initial: 7 days* |
| **Intensive Outpatient Psychotherapy Services*** **ASAM 2.1**
 | **No,** not for in network providers.**Yes**, if non network provider requests. |
| **Medication Evaluation and Management** | **No,** not for in network providers.**Yes,** if non network provider requests. |
| **Medication Assisted Therapy (MAT)** | **No**, not for in network providers.**Yes**, if non network provider requests.\*Managed by retail pharmacy |
| **Initial Assessment (MH and SUD/ASAM) and Outpatient Psychotherapy Services** | **No,** not for in network providers.**Yes,** if non network provider requests. |
| **High Intensity Outpatient/Community Based Services** | **Notification only,** followed by Concurrent Review.***\**** *Initial: 1 year for PACT and 6 months for WISe.* |
| **Applied Behavior Analysis (ABA)** | **Yes.** Pre-Service Authorization is required for ABA Therapy and Continued Treatment every 6 months. |
| **Electroconvulsive Therapy (ECT)** | **Yes.** Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment.*\*Initial: 10-12 sessions.* |
| **TRANSCRANIAL MAGNETIC STIMULATION (TMS)** | **Yes.** Pre-Service Authorization Required for Initial or Acute treatment. |
| **Psychological Testing** | **No** prior authorization required for first 2 units of service per client per lifetime.Up to 7 units without Prior Authorization when billed with UC Modifier. |
| **Neuropsychological Testing** | **No** prior authorization required. |
| **Telehealth/TelePsych** | **No,** not for in network providers.**Yes**, if non network provider requests. |
| **“Wrap-Around Services” – State General Fund Services** | **No.** Payment limited to GFS allocated amount identified in Provider contract. |
| **Clubhouse** | **No.** |
| **Respite Care** | **No.** |