| *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.** |