

Mental Health Prior Authorization Outpatient and/or Chemical Dependency Treatment Plan INSTRUCTION SHEET

No prior authorization is required for the **first fifteen (15) hours** of outpatient mental health (MH) psychotherapy services. This is applicable to AlohaCare members who are new to your practice or for members who are returning to you with a new spell of illness (typically described as a new treatment episode following a break in care of 60 days or longer after a previous treatment episode). Prior authorization will commence if you determine that your AlohaCare patient **requires medically necessary** outpatient services that exceed the initial 15 hours.

No prior authorization is required for QUEST-ACE, QUEST-NET and Basic Health Hawaii. Behavioral Health (BH) benefits are processed on a “first in, first out” basis until benefits are exhausted.

Prior authorization **is required** for psychological and neuropsychological testing, substance abuse treatment, any facility-based service (e.g., IOP, LIOP, day treatment), electroconvulsive therapy (ECT) and for individual psychotherapy sessions in excess of one hour per day, which include CPT codes: 90808, 90809, 90814 and 90815.

Additionally, the full-benefit QUEST BH benefit limits (i.e., maximum 24 hours of outpatient treatment and 30 inpatient days) were eliminated to comply with the federal mental health parity act and QUEST program requirements. This change also eliminated the “2-for-1” exchange provision and subsumes the provisions of the Hawaii mental health parity act.

Section ①:

- In the upper right-hand corner check box for Mental Health (MH), Chemical Dependence (CD) or Dual Diagnosis service
- Check box if this is an initial (new to treatment) or continuing request (already has an auth with you)
- Complete provider name and contact information
- Check all specialties that apply
- If working in a group practice or facility, list facility name. If working independently under own name, disregard this field
- Complete member information

Section ②:

- Complete Axis I-V information (DSM codes only for Axis I and II)
- Fax supporting documentation for any changes to Axis I
- Provide Current and Highest Past Year GAF **or** CAFAS (Child and Adolescent Functional Assessment Scales) scores, as appropriate based on the member’s age.
- Fax CAFAS scores, if appropriate based on the member’s age

Section ③:

- Complete Current Severity of Symptoms to reflect current functioning
- Complete current ASAM Dimensions **only if** Chemically Dependent or Dual Dx; or check N/A box
- Check if living in a structured environment (e.g., TLP, C&S housing, group or care home, etc.)

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Section ④:

- Check if psychiatric consultation has been completed
- Check 'No' if member is not on psychotropic medication
- Check box if member refused medication, and submit explanation
- List all current *psychiatric* medications, dose and start date, as well as identify the prescriber and specialty (e.g. psychiatrists, APRN-Rx, PCP, etc.)

Section ⑤:

- Check level of care (refer to Provider Manual, Section 8 for complete description of each level of care)
- For Outpatient Mental Health: Check all outpatient therapy modalities that apply. If checking Family, please note that Marital or Couples therapy is not a QUEST plan benefit and is excluded from benefit coverage
- If requesting interpreter service, check box and identify language
- Enter number of hours requested, along with the expected begin date and end date of service.
- New Spell of Illness – Check **YES** (if no services have been provided in the past 60 days). Check **NO** (if services have been provided within the last 60 days)
- Indicate the date of first visit **and** the date of last visit
- Indicate the percentage of improvement that has taken place since date of first treatment session
- Check if requesting referral to a BH Specialty Program:
BHPP-SMI Serious Mental Illness or **SEBD**/Support for Emotional and Behavioral Development Program

Section ⑥:

- **a. Outpatient Mental Health:** Please submit adequate documentation to support medical necessity, including an approach, plan, current symptoms and treatment frequency for the type of service being provided. What is the percentage of improvement since treatment began?
- **b. Chemical Dependency:** Submit treatment summary, Relapse Prevention Plan, UA results, Behavioral Contract and Support System
- Check Care Coordination Box: If checking "Yes," please indicate what additional support your patient requires from an AlohaCare Care Coordinator
- Credentialed provider of service signs and dates appropriate section of form