A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

Under normal circumstances, to receive reimbursement from the Wisconsin Medical Assistance Program (WMAP), prior authorization must be obtained before services are performed. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed on an emergency basis, retroactive prior authorization may be obtained. Refer to Section III-G of this handbook and Section VIII of Part A of the WMAP Provider handbook for additional information on retroactive prior authorization.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Psychiatric Evaluations and Diagnostic Testing

Psychiatric evaluations and diagnostic testing are limited to six hours per recipient in a two year period. Evaluation services by any combination of psychotherapy providers count toward this limit. Psychiatric evaluations and diagnostic testing in excess of six hours in a two year period, which are billed as limitation-exceeded psychotherapy, are also subject to the 15 hour or $500 threshold beyond which prior authorization is required. Therefore, providers require prior authorization for these services when they exceed these limits or when a series of testing alone may exceed the six hour limit. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Providers requesting prior authorization for psychiatric evaluation and testing services must use the Prior Authorization Request Form (PA/RF) and Prior Authorization Evaluation and Testing Attachment (PA/ETA). Refer to Appendices 4 and 5c of this handbook for a sample PA/RF and completion instructions, to Appendices 12 and 13 of this handbook for a sample PA/ETA and completion instructions, and to Appendix 14 of this handbook for a summary of prior authorization guidelines.

Psychotherapy and AODA Treatment Services

Prior authorization is required for most mental health and Alcohol and Other Drug Abuse (AODA) treatment services after a recipient has accumulated 15 hours or $500 (whichever comes first) in allowed services in any calendar year. Appendix 3 of this handbook indicates outpatient psychotherapy services which accumulate toward this limit and which require prior authorization when services exceed 15 hours or $500 of allowed charges to an individual recipient in a calendar year. Outpatient hospital services for mental health or AODA treatment also accumulate towards this threshold. Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

The allowed dollar amount is calculated based upon the lesser of the billed amount or the maximum allowable fee for the service as established by the WMAP. Services reimbursed by any health insurance payer count toward this limit. Reimbursement to any outpatient psychotherapy or AODA provider is included when calculating the 15 hours or $500 of allowed service for each individual.

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

Providers requesting prior authorization for psychotherapy services must use the PA/RF and the Prior Authorization/Psychotherapy Attachment (PA/PSYA). Refer to Appendices 4 and 5a of this handbook for a sample PA/RF and completion instructions, to Appendices 6 and 7 of this handbook for a sample PA/PSYA and completion instructions, and to Appendix 8 of this handbook for a summary of prior authorization guidelines.

Providers requesting prior authorization for AODA treatment services must use the PA/RF and the Prior Authorization/AODA Attachment (PA/AA). Refer to Appendices 4 and 5b of this handbook for a sample PA/RF and completion instructions, to Appendices 9 and 10 of this handbook for a sample PA/AA and completion instructions, and to Appendix 11 of this handbook for a summary of prior authorization guidelines.

Emergency Psychotherapy

Although emergency psychotherapy may be provided without first obtaining prior authorization, as described in Section II-B of this handbook, claims for emergency psychotherapy require prior authorization before payment is made if the 15 hour/$500 limit for services in a calendar year has been exceeded. Claims submitted for emergency psychotherapy services which exceed the prior authorization threshold and which do not indicate a valid prior authorization number are denied. Providers should use the standard psychotherapy prior authorization request forms (refer to Appendices 5 and 7 of this handbook) to receive a prior authorization number for emergency services which have been provided. Up to eight hours of emergency psychotherapy in a two-week period may be authorized. The prior authorization request must be received by EDS within two weeks of performance of emergency psychotherapy, must request backdating, and must justify the need for emergency treatment.

Concurrent Mental Health/AODA Prior Authorizations

Prior authorization is normally only granted to one provider at a given time. However, concurrent prior authorizations may be approved for separate providers providing mental health and AODA services. Concurrent prior authorization requests must meet the following requirements:

- The prior authorization requests must clearly indicate that each provider is aware of the services being provided by the other, and that these services are being coordinated.
- Justification must be given for having services provided by separate providers.
- The overall intensity of service must be within the range ordinarily approved for outpatient mental health/AODA (e.g., intensive AODA outpatient treatment is generally not approved concurrently with one to two hours of family psychotherapy per week, but one 2-hour AODA group therapy session plus one 1-hour individual psychotherapy session may be approved).

Concurrent Outpatient Mental Health and Medical Day Treatment Services

Outpatient psychotherapy or AODA therapy may be provided concurrently with medical day treatment services which are considered medically necessary and appropriate when the following conditions are met:

1. the recipient's diagnosis is appropriate for both services (refer to the guidelines used to process prior authorization requests);
2. there is documentation that the providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the outpatient and day treatment services augment one another; and

B. SERVICES REQUIRING PRIOR AUTHORIZATION (continued)

3. when one of the following statements is true:

   a. there is a pre-existing relationship between the recipient and the outpatient provider;

   b. the recipient has appropriate day treatment needs, but the recipient also has a need for specialized intervention which the day treatment staff is not trained to provide; or

   c. the recipient is transitioning from day treatment to outpatient services.

The day treatment provider is required to request prior authorization for any day treatment services requested for a recipient who is also receiving outpatient services.

In general, a recipient who is able to benefit from outpatient services does not require as high a level of day treatment services and the consultant may modify the hours requested based on clinical judgement.

HealthCheck "Other Services"
All requests for services under the HealthCheck "Other Services" benefit require prior authorization. Providers should submit a PA/RF indicating the description of the service (but leaving blank the section requesting the procedure code, as one is assigned by EDS) and the number of hours of service requested. To expedite processing of the request, write "HealthCheck Other Services" or "HOS" in red ink at the top of the PA/RF. The provider must submit documentation that the recipient received a comprehensive HealthCheck screening in the past year. A physician's prescription for the particular treatment service is required. Additional information documenting the recipient's need for the service and the appropriateness of the service being delivered must be supplied by the provider.

C. WHEN TO REQUEST PRIOR AUTHORIZATION

Because a provider may have no way of knowing whether or not a recipient has received services from another provider and has, therefore, reached the prior authorization threshold, providers are encouraged to request prior authorization as soon as possible when providing psychotherapy or AODA services. Because the WMAP ordinarily grants prior authorization to only one psychotherapy/AODA provider at a time, making the prior authorization request helps protect the provider against potential denial of services.

Any part of the 15 hours or $500 of services which may be reimbursed without prior authorization that is not used, remains available for use by the recipient for the remainder of the calendar year.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility and recipient eligibility on the date of service, as well as all other WMAP requirements must be met prior to payment of the claim.

Non-billing performing providers (master's degree psychotherapists or AODA counselors) requesting prior authorization must indicate the group or clinic provider name and number as the billing provider on the Prior Authorization Request Form (PA/RF).

D. PRIOR AUTHORIZATION CRITERIA

Appendices 8, 11, and 14 of this handbook summarize the criteria which are used to process prior authorization requests for psychotherapy, AODA, and psychiatric evaluations and testing. A copy of the complete guidelines used to process prior authorization requests may be obtained by writing to:

D. PRIOR AUTHORIZATION CRITERIA (continued)

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing, Room 250
Division of Health
Post Office Box 309
Madison, WI 53701

Prior authorization requests may be returned to providers for additional information when the initial request does not contain adequate information to process the prior authorization request. Returned requests are not denials. Providers are responsible for providing adequate, updated, information to allow the mental health/AODA consultants to determine the appropriateness of the service being requested. The additional information must be added to the returned request and resubmitted to EDS. Do not complete a new PA/RF.

E. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

The appropriate prior authorization request forms and attachments along with their completion and submittal instructions are given in Appendices 4, 5, 6, 7, 9, 10, 12 and 13 of this handbook.

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms may be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

F. SERVICE INTERRUPTIONS

If a provider is unable to utilize all prior authorized services during the prior authorization grant period due to unforeseeable interruptions in service (e.g., recipient illness or vacation), the provider may request an extension of the grant period. The provider should write a letter indicating the change requested and the reason and attach it to a copy of the PA/RF and send these to the EDS Prior Authorization Unit. Gaps in service exceeding one month require special justification.

If a recipient transfers to another mental health or AODA provider before the expiration of a prior authorization period, the provider should notify the EDS Prior Authorization Unit of the exact date care is terminated so that a new prior authorization may be granted.

G. GRANT DATES AND BACKDATING FOR PRIOR AUTHORIZATIONS

Determination of Grant Dates

The prior authorization grant date (i.e., the first date of service which may be reimbursed under the authorization), is the date the prior authorization request is reviewed by the WMAP mental health consultant, or the date the request is first received by EDS if this date is deemed appropriate for continuity of care reasons by the WMAP mental health consultant. See Section VIII of Part A of the WMAP Provider Handbook.

Procedures for Backdating Prior Authorization Requests

Backdating of prior authorization requests up to two weeks prior to the date the prior authorization request is received at EDS may be allowed at the discretion of the WMAP mental health consultant. The provider must request backdating and must indicate the clinical rationale for the request on the prior authorization attachment or in a narrative submitted with the prior authorization request.

Backdating for Services by Multiple Providers Exceeding the Prior Authorization Threshold

Providers may request backdating of prior authorizations to cover services which are denied because they exceeded the prior authorization threshold. In these cases, authorization may be granted for services provided more than two weeks prior to the receipt of the prior authorization request at EDS. Requests for backdating prior authorization are considered if the following conditions are met:

- More than one provider must have provided service during the period for which backdating is requested;
- The provider must document an inability to obtain information from the recipient or other provider which would have allowed the provider to determine that prior authorization would have been required.