

Interactive Voice Registration (IVR) System Manual

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INTRODUCTION

The IVR is a telephonic system that permits providers to register units of care and check the status of claims over the phone. The system is available seven days a week between the hours of 7 a.m. and 9 p.m.

This system registers treatment in units rather than service codes, which allows the provider to have more flexibility in treatment planning. The IVR shifts greater control to the provider, eliminates paperwork, and accelerates the response time for authorizations.

The manual includes updated information on the IVR and menu choices. Please review the following materials carefully prior to using the IVR.

IVR INSTRUCTIONS

The IVR system guides the caller through a series of voice prompts. Refer to the section of the manual detailing the services requested through the IVR and to learn how to access requested services through the IVR.

Before you start using the IVR, you need to determine whether your client is eligible for MassHealth benefits. Check the Member's eligibility with MassHealth by using the eligibility options available through EDS, including the Eligibility Verification System (EVS), at (800) 554-0042. Once you have determined your client's eligibility, you should proceed as follows:

Access the IVR system at (888) 899-6277:

- Enter your 7-digit Medicaid Provider Identification number or your 9-digit National Provider Identification number.

Select the menu option for the desired level of service:

1. The IVR will verify the Member's eligibility at the date of request. Registrations entered during the expired eligibility period will not be accepted through IVR.
2. Enter the effective date of registration.
3. Enter the expiration date of the registration, if applicable. (*Most outpatient services are assigned an automatic end date.*)
4. Enter the number of units requested, if applicable.
5. Enter the DSM-IV/ICD9 Primary Diagnosis Code.
6. Enter the DSM-IV/ICD9 Secondary Diagnosis Code, if applicable.
7. Different levels of care may prompt additional questions; listen carefully and respond to all prompted questions.

The IVR system will generate an authorization number, and confirmation of this number is available to the provider via the ValueOptions online provider portal, Provider Connect, at www.valueoptions.com/pclogin.

CONTACT INFORMATION

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Health New England Be Healthy (MBHP/HNE BH)
100 High Street
3rd Floor
Boston, MA 02110

Phone: (800) 495-0086

Fax: (617) 790-4133

Web site: www.masspartnership.com, click on “HNE Be Healthy” button. At the provider login, enter your login name and password to access the provider-secure page.

Important Phone Numbers

- The IVR System: **(888) 899-6277**
- MBHP/HNE BH Clinical Access Line: **(800) 495-0086**
- MBHP/HNE BH Clinical Outpatient Line: **(617) 790-5634**
- MBHP/HNE BH Clinical Concurrent Review Line: **(617) 790-5620**
- Eligibility Verification System (EVS): **(800) 554-0042**

The EVS is one of many options available to verify a Member's MassHealth eligibility status.

IVR SELECTION OPTIONS

Because of the number of services that can be registered through IVR, the menu is extensive. To help you to navigate through the menu, the following is a listing of shortcuts that you can enter during your call:

Effective July 1, 2010

Registration for Non-Residential or Residential Outpatient Services, Medication visits, and Psychiatric Consults on a Medical Unit		Press 1
	Outpatient Services in a Nonresidential setting	Press 1
	Outpatient Services in a Residential setting	Press 2
	Outpatient Medication Visits	Press 3
	Psychiatric Consultations on a Medical Unit	Press 4
Registration for Substance Abuse Services, including ATS, CSS, and SOAP		Press 2
	Acute Treatment Services for Substance Abuse (ATS)	Press 1
	Clinical Support Services (CSS)	Press 2
	Structured Outpatient Addictions Treatment (SOAP)	Press 3
Registration for Specialized Outpatient Services		Press 3
	Psychiatric Day Treatment	Press 1
	Assessment for Safe and Appropriate Placement Services (ASAP)	Press 3

	Psychological Testing	Press 4
	Dialectical Behavioral Therapy (DBT)	Press 5
	Electroconvulsive Therapy	Press 6
	Community Support Program (CSP)	Press 7
Partial Hospitalization Program (PHP)		Press 5
Children's Behavioral Health Initiative		Press 6
	Therapeutic Mentoring	Press 1
	In-Home Behavioral Services	Press 2
	Family Support and Training	Press 3
	In-Home Therapy	Press 4
Claims Information		Press 7
To Enter a Different Medicaid Provider # or National Provider #		Press 8
Registration for Any Other Level of Care		Press 9
To Repeat These Options		Press #

OVERVIEW OF IVR REGISTRATION PARAMETERS

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Outpatient Services in a Nonresidential Setting	For Members under the age of 4	2 A unit equals 1 session.	365 days	28 days back 14 days forward	Telephonic review with an outpatient care manager for continued authorization
	For Members ages 4 and older	24 A unit equals 1 session.	365 days	28 days back 14 days forward	Provider submits EOTS after utilization of the 18 th unit
Outpatient Services in a Residential Setting	For Members ages 4-18	100 A unit equals 1 session.	365 days	28 days back 14 days forward	Provider submits EOTS after utilization of the 75 th unit
Outpatient Medication Visits	For Members ages 5 and older	24 A unit equals 1 session.	365 days	28 days back 14 days forward	Provider submits EOTS after utilization of 18th unit
	For Members under the age of 5	2 A unit equals 1 session	365 days	28 days back 14 days forward	Telephonic review with an outpatient care manager for continued authorization
Psychiatric Consultations on a Medical Unit	For Members of all ages	3 A unit equals 1 session.	120 days	28 days back 14 days forward	Telephonic review with an outpatient care manager after the initial three units

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Acute Treatment Services (ATS) for Substance Abuse: DX 303.9 Alcohol Dependence	For Members ages 19 or older	4 A unit equals 1 day.	4 days	Within the initial date of the requested service Telephonic review with a care manager after the 6 th ATS request within 180 days per Member's auth history	Provider contacts concurrent review care manager within one business day of the authorization expiration
Acute Treatment Services (ATS) for Substance Abuse: DX 304.0 Opioid Dependence, 304.10 Sedative, Hypnotic, or Anxiolytic Dependence	For Members ages 19 or older	6 A unit equals 1 day.	6 days	Start date is equal to the date of the call. Telephonic review with a care manager after the 6 th ATS request within 180 days per Member's auth history	Provider contacts concurrent review care manager within one business day of the authorization expiration
Clinical Support Services for Substance Abuse	For Members ages 19 or older	10 A unit equals 1 day.	10 days	The authorization cannot overlap an existing CSS authorization. The call will be transferred to a care manager for telephonic review.	Provider submits CSS extension web form prior to the last covered day

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Structured Outpatient Addictions Program (SOAP)	For Members ages 13 or older	12 A unit equals ½ day.	28 days	7 days back 7 days forward	Provider submits SOAP extension 3 days prior to the use of the last covered unit of service
Psychiatric Day Treatment	For Members ages 4 or older	510 A unit equals 1 hour.	120 days	7 days back 7 days forward	Provider submits Explanation of Day Treatment (EODT) 30 days prior to the end of the third auth period
Assessment for Safe and Appropriate Placement (ASAP)	For Members younger than, or equal to, 19 years of age	40 A unit equals 15 minutes.	60 days	28 days back 14 days forward	Providers contact an outpatient care manager for a live telephonic review if an additional ASAP authorization is needed for further assessment purposes

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Psychological Testing	For Members ages 6 or older For school testing, Member must be under 19 years of age	Varies by type of testing – see IVR Provisions	90 days	28 days back or 14 days forward	Provider submits Psychological Evaluation Request (PER) Form
Dialectical Behavioral Therapy (DBT)	For Members ages 13 or older	120 A unit equals 1 day.	120 days	28 days back 14 days forward	Telephonic review with an outpatient care manager after 3 IVR auths, 30 days prior to the auth expiration
Inpatient and Outpatient Electroconvulsive Therapy	For Members ages 19 or older	20 A unit equals 1 day of service.	120 days	28 days back 14 days forward	Telephonic review with an outpatient care manager between 15 th and 20 th unit for units > 20 per year

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Community Support Programs (CSP)	For Members ages 18 or older	180 A unit equals 15 minutes.	42 days	7 days back 7 days forward	Provider contacts Clinical Access Line care manager for Members outside of age parameters Provider contacts specialized care managers for ongoing authorizations

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Partial Hospitalization Program (PHP)	For Members age 6 or older	12	21 days	4 days back 4 days forward	PHP providers contact the Clinical Access Line to complete a precertification for PHP authorizations. For extensions to existing authorizations, providers need to contact the CCR Dept one business day prior to the last unit.
Therapeutic Mentoring	For Members < 21 years of age	For ICC Members – # units are based on an existing ICP ¹ or Treatment Plan; a unit equals 15 minutes. For Non-ICC Members – 208 units	90 days	14 days back 14 days forward	Members not in ICC must have an active authorization for OP (RPS service type) or In-Home Therapy (claim type C7).

¹ ICP is an Individual Care Plan.

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
In-Home Behavioral Services	For Members < 21 years of age	For ICC Members – # units are based on an existing ICP ² or Treatment Plan; a unit equals 15 minutes.	30 days	14 days back 14 days forward	Members not in ICC must have an active authorization for OP (RPS service type) or In-Home Therapy (claim type C7).
Family Support & Training (FS&T)	For Members < 21 years of age	For ICC Members - # units are based on an existing ICP ³ or Treatment Plan; a unit equals 15 minutes.	90 days	14 days back 14 days forward	Members not in ICC must have an active authorization for OP (RPS service type) or In-Home Therapy (claim type C7).
In-Home Therapy	For Members < 21 years of age	For ICC Members – # units are based on an existing ICP ⁴ or Treatment Plan; a unit equals 15 minutes.	90 days	14 days back 14 days forward	Provider may obtain consecutive authorizations through the IVR

² ICP is an Individual Care Plan.

³ ICP is an Individual Care Plan.

⁴ ICP is an Individual Care Plan.

Type of Outpatient Service	Age Parameters	Maximum IVR Units	Max. Date Range	Min./Max. Window For Registration	Requests for Services beyond IVR Parameters
Claims Verification					Directions in the IVR Manual

Note: With the exception of ECT, all services are auto-assigned an end date by the IVR.

EXTENDED OUTPATIENT TREATMENT SCREENS (EOTS)

The Extended Outpatient Treatment Screens (EOTS) were developed for providers who request units beyond the maximum number allowed by the IVR for a particular authorization period. These screens are utilized for outpatient residential treatment, outpatient nonresidential treatment, and medication visit requests. Both adult and child/adolescent (under age 19) screens are available. In addition, an Extended Outpatient Day Treatment (EODT) screen was developed for day treatment providers to request services beyond the initial units provided by the IVR.

Providers can submit the EOTS and EODT forms to MBHP/HNE BH via MBHP's secure web site at www.masspartnership.com.

An MBHP/HNE BH outpatient care manager or an MBHP/HNE BH outpatient physician advisor will review the EOTS and EODT. If the information provided on the Extension Screens is sufficient to approve additional units, the MBHP/HNE BH outpatient care manager will enter the authorization. A confirmation email will be sent out to the provider within five (5) business days if an authorization is approved.

If the information is not sufficient, the outpatient care manager will call the provider to request a telephonic review.

Notices of new routine authorizations, and the letters themselves, will be available at the ValueOptions online provider portal, ProviderConnect. Letters related to adverse actions or denials will continue to be sent through the mail.

Information on the Extension Screens must be documented in the Member's chart and will be reviewed in conjunction with future record reviews.

Note: Over guideline requests for Psychological Testing will require submission of a Psychological Evaluation Request (PER) form in writing to MBHP/HNE BH.

INSTRUCTIONS FOR USING THE EXTENDED OUTPATIENT TREATMENT SCREENS (EOTS)

The EOTS and EODT should be completed by the Member's outpatient clinician and are designed to be submitted to MBHP/HNE BH via the web site at www.masspartnership.com.

Providers should adhere to the following timelines for submitting EOTS:

- EOTS for traditional outpatient nonresidential treatment should be submitted to MBHP/HNE BH after utilization of the 18th unit of an IVR authorization.
- EOTS for traditional outpatient residential treatment should be submitted to MBHP/HNE BH after utilization of the 75th unit of an IVR authorization.
- EOTS for medication visit units should be submitted to MBHP/HNE BH after utilization of the 18th unit of an IVR authorization.
- EODT for psychiatric day treatment should be submitted 30 days prior to the end of the current authorization period.

Note 1: If the EOTS form is submitted after the initial IVR units have been exhausted or the end date of the authorization has expired, the MBHP/HNE BH outpatient care manager will only authorize the appropriate number of units from two days prior to receipt of the EOTS form.

Note 2: The "start date" on the EOTS should be the date the provider will need the additional units to begin (that is, after the initial units have been exhausted).

All items on the form should be completed. Providers need to ensure proper, completed submission on the web screen. Any incomplete form will be returned to the provider. Incomplete forms will not be considered an official request, and the corrected EOTS/EODT form will be considered the first submission.

A ***NO*** response to the following questions on the EOTS/EODT forms will generate a telephone review with an outpatient care manager. A ***YES*** response must be documented in the Member's medical record.

Child, Adolescent, and Adult EOTS:

- Is there documented evidence of ongoing communication between the prescriber and program staff?
- Has a documented discussion taken place with the Member about whether he or she feels that treatment is effective and that he or she is making progress?
- Does a goal-oriented treatment plan exist?

Psychiatric Day Treatment EODTS:

- Is there documented evidence of ongoing communication between the prescriber and program staff?
- Has a documented discussion taken place with the Member about whether he or she feels that treatment is effective and that he or she is making progress?
- Does a documented discharge plan exist?
- Is the Member referred to, or participating in, other community-based activities or programs?

**SUBSTANCE ABUSE SERVICES WEB SCREENS FOR CLINICAL SUPPORT
SERVICES (CSS) AND STRUCTURED OUTPATIENT ADDICTION PROGRAMS
(SOAP)**

The following web-based screens were developed for substance abuse services.

- The SOAP Case Registration form is for programs that currently have initial requests for treatment that are contracted with MBHP/HNE BH for units beyond the maximum number allowed by the IVR for a particular authorization period. *All other programs are to utilize the Interactive Voice Registration System (IVR) for initial treatment authorizations.*
- The CSS/SOAP Extension form is for requests of an extension of units to current CSS/SOAP treatment and/or end-date extensions for a current authorization period.

Providers can submit the web-based forms to MBHP/HNE BH via MBHP's secure web site at www.masspartnership.com.

An MBHP/HNE BH outpatient care manager will review the CSS/SOAP screen. If the information provided on the screen is sufficient to approve the request, the MBHP/HNE BH outpatient care manager will complete the authorization needs appropriately. If the information is not sufficient, the outpatient care manager will contact the provider to request a telephonic review to gather additional information.

Notices of new routine authorizations, and the letters themselves, will be available at the ValueOptions online provider portal, ProviderConnect. Letters related to adverse actions or denials will continue to be sent through the mail.

Information on the screens must be documented in the Member's chart and will be reviewed in conjunction with future record reviews.

INSTRUCTIONS FOR USING SUBSTANCE ABUSE SERVICES WEB SCREENS

The substance abuse services web screens should be completed by the Member's clinician and are designed to be submitted to MBHP/HNE BH via the web site at www.masspartnership.com.

Providers should adhere to the following timelines for submitting web screens:

- **SOAP Case Registration Form**
All requests must be submitted to MBHP/HNE BH *within seven days of the admission date*.
- **SOAP Extension Form**
All requests for changes to an existing authorization's expiration date and/or the number of treatment units must be submitted *no later than three (3) business days* prior to the last covered day of the existing authorization to avoid loss of reimbursement for days not authorized.
- **CSS Extension Form**
All requests for changes to an existing authorization's expiration date and/or the number of treatment units must be submitted prior to the last covered day of the existing authorization to avoid loss of reimbursement for days not authorized.

Note: If the CSS/SOAP web screen forms are submitted later than the parameter dates listed, the MBHP/HNE BH care manager needs to modify the request accordingly.

All items on the form should be completed. Providers need to ensure proper, completed submission on the web screen. Incomplete forms will not be considered an official request, and the corrected CSS/SOAP form will be considered the first submission.

IVR AUTHORIZATION PARAMETERS

MBHP/HNE BH has developed authorization parameters for each level of outpatient service.

Before registering units of care through the IVR, providers must ensure that they comply with the provisions that are outlined on the following pages for each level of care.

If you require units exceeding the approved parameters, follow the procedures (described below) for each level of service.

OUTPATIENT TREATMENT IN A NONRESIDENTIAL SETTING

Definition: *Traditional outpatient mental health services provided in an ambulatory care setting (i.e., mental health clinic, hospital outpatient department, community mental health center, or private practitioner office)*

Member

- For all Members enrolled in the MBHP/HNE BH H001 or H002 Benefits packages as of the requested effective date of the authorization

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 364 days.

Unit parameters

- Registration parameters for Members under the age of 4: The IVR will automatically assign two units for diagnostic services for the initial authorization.
- Registration parameters for Members ages 4 through 18: The provider can enter a maximum of 24 units.
- Registration parameters for Members ages 19 and older: The provider can enter a maximum of 24 units.
- One unit = one session

Authorization overlap

- A new authorization cannot overlap an existing outpatient residential or nonresidential authorization for the same provider.

Over guideline request

- The provider should submit an Extended Outpatient Treatment Screen (EOTS) for either adults or child/adolescents (ages 4 through 18) prior to utilization of the 18th unit/session.
- For children under age 4, the provider must call a MBHP/HNE BH outpatient care manager for a live telephonic review prior to initiating treatment beyond the initial two diagnostic units.

Diagnoses Restrictions

For all Members ages 5 and under

- If the registered diagnosis is a bipolar disorder code (codes in the range of 296.00 through 296.90), two units will be auto-assigned if there are no previous authorizations registered in the Member's record. Otherwise, the call will be transferred to a MBHP/HNE BH outpatient care manager for a full clinical review.

For all Members over age 22

- The provider can request one outpatient authorization using the following primary diagnostic codes. The second authorization request will require a telephonic review with a MBHP/HNE BH care manager.

Adjustment Disorders:

309.0 Adjustment with Depressed Mood

309.24 Adjustment with Anxiety

309.28 Adjustment with Mixed Anxiety and Depressed Mood

309.3 Adjustment with Disturbance in Conduct

309.4 Adjustment with Disturbance in Emotions and Conduct

309.9 Adjustment Disorder Unspecified

For all Members

- If the registered diagnosis is an eating disorder code (307.1 and 307.51) or dissociative identity disorder code (300.14 and 300.15), the call will be transferred to a MBHP/HNE BH outpatient care manager for a full clinical review.

OUTPATIENT SERVICES IN A RESIDENTIAL SETTING

Definition: *Traditional outpatient mental health services provided in a residential setting*

Provider

- Only providers credentialed by MBHP/HNE BH to provide outpatient services to residential treatment programs may access this section of the IVR.

Member

- The Member must be older than, or equal to, 4 years and less than 19 years of age.
- The Member must be living in a 24-hour residential setting.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 364 days.

Unit

- The provider can enter a maximum of 100 units.
- One unit = one session

Authorization overlap

- A new authorization cannot overlap an existing outpatient residential or nonresidential authorization for the same provider.

Over guideline requests

- The provider should submit an Extended Outpatient Treatment Screen (EOTS) form for child/adolescent prior to utilization of the 75th unit/session.

OUTPATIENT MEDICATION VISITS

Definition: *Medication evaluation and medication-monitoring services*

Provider

- The provider must have the appropriate licensure levels for the provision of medication services.

Member

- The Member must be older than, or equal to, 5 years of age.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 364 days.

Unit

- The provider can enter a maximum of 24 units for Members ages 5 or older.
- The IVR automatically assigns two units for children under age 5 for the initial authorization.
- One unit = one session

Authorization overlap

- A new authorization cannot overlap an existing Outpatient Medication Visits authorization for the same provider.
- Overlapping authorizations are allowed for up to two different providers at any given time.

Over guideline request

- The provider should submit an Extended Outpatient Treatment Screen (EOTS) prior to utilization of the 18th unit/session.
- For children under age 5, the provider must call a MBHP/HNE BH outpatient care manager for a live telephonic review prior to initiating treatment beyond the initial two diagnostic units.

Note: *A Procedure Code, 99404, Medication Diagnostic Evaluation 50-90 minutes, is to be utilized for claims when submitting for a diagnostic evaluation, previously billed as 90801. This service will be covered in the medication (MEV) authorization.*

PSYCHIATRIC CONSULTATION ON A MEDICAL UNIT

Definition: *Psychiatric consultations on a medical floor of a general hospital*

Provider

- To register for this level of care, providers must be an in-network facility/practice and limited to psychiatry in most cases.
- In-network psychologists may use this function on the IVR but only if they are seeing an MBHP/HNE BH Member who is under the age of 22.
- Out-of-network psychiatrists, please see *Alert* Vol. 6, #13.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 119 days.

Unit

- One unit = one session
- Provider enters the number of units up to a maximum of three units

Authorization overlap

- The new authorization request cannot overlap an existing psychiatric consultation on a medical unit authorization for the same provider.
- The new authorization request may overlap an existing psychiatric consultation on a medical unit authorization for a different provider.

Over guideline request

- If additional units are needed, telephonic review with a MBHP/HNE BH outpatient care manager is required after the initial three units have been used but before the use of any additional units.

ACUTE TREATMENT SERVICES (ATS) FOR SUBSTANCE ABUSE

Definition: *Inpatient, 24-hour, medically-monitored evaluation, care, and treatment for Members with a physical dependency on alcohol, opioids, sedatives, hypnotics, or anxiolytics*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide Acute Treatment Services (ATS) for Substance Abuse.

Member

- Members must be older than, or equal to, 19 years of age to be registered for this level of care via the IVR.
- Members under the age of 19 must be registered via telephonic review with a MBHP/HNE BH care manager.
- Members who are pregnant must be registered via telephonic review with a MBHP/HNE BH care manager, and a referral will be made for ICM services.

Effective date

- The effective date of the authorization must be the date of the call.

Unit

- The IVR automatically assigns an expiration date based on the primary diagnosis.
- One unit = one day of service
- Alcohol Dependency, 303.90, the IVR assigns four units
- Opiate dependency, 304.00, the IVR assigns six units
- Sedative, hypnotic, or anxiolytic dependency, the IVR assigns six units

Authorization history

- A Member who has had six or more ATS authorizations within the past 180 calendar days cannot be authorized for ATS through the IVR.

For Members who meet these criteria, the provider will be transferred from the IVR to the Clinical Access Line for telephonic review.

Over guideline requests

- For care beyond the four or six units authorized via the IVR or by telephonic review, the provider can contact the MBHP/HNE BH Concurrent Review Department to request additional units for a current authorization.

CLINICAL SUPPORT SERVICES FOR SUBSTANCE ABUSE (CSS)

Definition: *Program that provides a short-term, therapeutic, 24-hour living situation with moderate levels of supervision, structure, restriction, and intensity of substance abuse treatment*

Member

- Members must be older than, or equal to, 19 years of age to be registered for this level of care via the IVR.
- Members under the age of 19 must be registered via telephonic review with a MBHP/HNE BH care manager.

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide Clinical Support Services for Substance Abuse.

Effective/Expiration date

- The effective date of the authorization can be no more than one day prior to the date of the call.

Unit

- One unit = one day of service
- The provider can enter a maximum of 10 units.

Authorization history

- A Member who has had a CSS authorization within the past 30 calendar days cannot be authorized for CSS through the IVR

For Members who meet these criteria, the provider will be transferred from the IVR to the Clinical Access Line for telephonic review.

Over guideline requests

- Providers submit a CSS extension form prior to the last covered day.

STRUCTURED OUTPATIENT ADDICTIONS PROGRAM (SOAP)

Definition: *Structured, multi-modal, outpatient substance abuse treatment programs to help Members sustain recovery*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide SOAP services.

Member

- The Member must be older than, or equal to, 13 years of age.

Effective date

- The effective date of the authorization can be no more than seven days prior to the date of the call to the IVR, or seven days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 27 days.

Unit

- One unit = ½ day of service
- The provider can enter a maximum of 12 units.

Authorization overlap

- A new authorization cannot overlap an existing SOAP or DBT authorization.

Authorization history

- The effective date of the new authorization must be greater than 30 days from the end date of any previous SOAP authorization.

For Members who meet these criteria, the provider will be transferred from the IVR to the Outpatient Department for telephonic review.

Over guideline request

- The provider should submit a SOAP extension form three days prior to use of the last approved unit.

PSYCHIATRIC DAY TREATMENT PROGRAM

Definition: *A structured, clinical program for individuals who have restrictive functioning on a daily basis and who require intensive rehabilitation and treatment services*

Provider

- The provider must be an MBHP/HNE BH in-network provider contracted to provide Psychiatric Day Treatment services.

Member

- The Member must be older than, or equal to, 4 years of age.

Effective date

- The effective date of the authorization can be no more than seven days prior to the date of the call to the IVR, or seven days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 119 days.

Unit

- One unit = one hour of service
- The provider can enter a maximum of 510 units.

Authorization overlap

- A new authorization cannot overlap an existing Psychiatric Day Treatment authorization.

Authorization history

- The provider can request up to three, 120-day authorizations through the IVR in a 365-day period.

Continuing care requests

- The provider should submit the Extended Outpatient Day Treatment (EODT) Form 30 days prior to the expiration of the current authorization.

ASSESSMENT FOR SAFE AND APPROPRIATE PLACEMENT (ASAP)

Definition: *An assessment to evaluate Members who are in the care or custody of the Department of Children and Families (DCF) for fire-setting and/or sexually-offending behaviors*

Provider

- The provider must be contracted as one of the lead agencies for Qualified Diagnosticians.

Member

- The Member must be younger than, or equal to, 19 years of age.
- The Member must be in the care or custody of the Department of Children and Families (DCF).

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 59 days.

Unit

- One unit = 15 minutes
- The provider can enter a maximum of 40 units.

Over guideline request

- Providers contact a MBHP/HNE BH outpatient care manager for a live telephonic review if an additional ASAP authorization is needed for further assessment purposes. Please see the provider manual for multiple criteria.

PSYCHOLOGICAL TESTING

Definition: *An assessment of a Member's cognitive, emotional, behavioral, and psychological functioning*

Provider

- Providers must have an appropriate licensure level for the provision of psychological testing.

Member

- The Member must be at least 6 years of age.
- For school testing also known as Educational Achievement Testing, the Member must be younger than, or equal to, 19 years of age.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date is automatically assigned by the IVR and is the effective date plus 89 days.

Category

The IVR will prompt the caller to choose the category of psychological testing:

- General Psychological Testing
- Medically Driven Psychological Testing
- Developmentally Driven Psychological Testing
- Chapter 766 Psychological Testing also known as Educational Testing

Unit

- One unit = 1 hour of testing
- Based on the type and combination of testing requested, the IVR allows the following maximum number of units:

Educational Achievement Testing = 1

Intelligence = 2

Personality = 3

Intelligence and Personality = 6

Neuropsychological testing = 5

Combined intelligence, personality, and

neuropsychological testing or a full Neuropsychological battery = 11

Note 2: Pre- and Post-Psychological Testing Counseling units will no longer be automatically authorized. Providers will be able to bill two pre- and two post-testing counseling unit (99402), authorization-free, per Member for a rolling twelve-month period.

Restrictions

- Any selection of Mental Retardation diagnoses (DSM-IV codes 317.0, 318.0, 318.1, 318.2, 319.0) requires submission of the PER (Psychological Evaluation Request) Form.
- IVR registration for Psychological Testing requires the entry of a DSM-IV diagnosis code. The IVR will accept the V71.09 diagnosis code.
- Psychological testing **not** requested as a result of referral from a behavioral health provider or a medical specialist will require the PER form and will no longer be available through the IVR.
- School testing not requested as a result of referral from a special education administrator will require a PER form and will no longer be available through the IVR.

Authorization overlap

- A new authorization cannot overlap an existing psychological testing authorization.

Authorization history

- The start date of the new authorization must be greater than 180 days from the end date of any previous authorization for any level of care that is inclusive of psychological testing.
- The start date of any new authorization for Chapter 766 Psychological Testing must be greater than three years from the end date of any prior such authorization.
- The start date of any new authorization for general, medically driven, and developmentally driven psychological testing must be greater than one year from the end date of any prior such authorization.

Over guideline request

- The provider submits the Psychological Evaluation Request (PER) Form to MBHP/HNE BH for testing outside of date range, children younger than 6, or a Member with primary or secondary DSM-IV diagnosis of Mental Retardation.

DIALECTICAL BEHAVIORAL THERAPY (DBT)

Definition: *A manual-directed outpatient treatment program that combines strategies from behavioral, cognitive, and other supportive psychotherapies*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide DBT services.
- The provider is a facility or group practice provider.

Member

- The Member must be older than, or equal to, 13 years of age.
- The Member meets DSM IV criteria for Borderline Personality Disorder.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 119 days.

Unit

- The IVR automatically assigns 120 units to the authorization.
- One unit = one day of Member enrollment in DBT (includes one DBT individual therapy, one DBT skills group, telephonic therapeutic consultation, clinical consultation team meeting per week)

Authorization overlap

- A new authorization cannot overlap existing IVR authorizations for SOAP and DBT.
- New authorizations can overlap existing medication authorizations.

Over guideline request

- The IVR allows three consecutive 120-day authorization periods. For subsequent DBT services, the provider contacts the MBHP/HNE BH outpatient care manager for a live telephonic review within 30 days of the expiration of the last IVR authorization.

INPATIENT AND OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT)

Definition: *Medically necessary electroconvulsive therapy provided on an inpatient or outpatient basis*

Provider

- The provider must be an MBHP/HNE BH in-network provider contracted to provide ECT services.

Member

- The Member must meet clinical specifications (refer to MBHP/HNE BH Provider Policies and Procedures Manual) for ECT.
- The Member must be older than, or equal to, 19 years of age.

Effective date

- The effective date of the authorization can be no more than 28 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- The expiration date must be less than, or equal to, 119 days from the effective date.

Unit

- One unit = one session
- The provider can enter between one and 20 units per registration period. Units cannot exceed 20 per 365 days.

Authorization overlap

- A new authorization cannot overlap an existing ECT authorization for the same or different provider.

Over guideline request

- The provider contacts a MBHP/HNE BH outpatient care manager for a live telephonic review if units exceed 20 in a calendar year.
- The provider contacts MBHP/HNE BH outpatient care manager between the 15th and 20th unit of service.

COMMUNITY SUPPORT PROGRAM (CSP)

Definition: *Provides an array of services delivered by a community-based, mobile, multidisciplinary team including services of outreach and supportive services, delivered in a community setting*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide CSP services.

Member

- The Member must be older than, or equal to, 18 years of age.

Effective date

- The effective date of the authorization can be no more than seven days prior to the date of the call to the IVR, or seven days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 41 days.

Unit

- The provider can enter a maximum of 180 units.
- One unit = 15 minutes of service

Authorization overlap

- A new authorization cannot overlap an existing IHT or TM, authorization.

Over guideline request

- Provider contacts the Clinical Access Line care manager for Members outside of age parameters

THERAPEUTIC MENTORING (TM)

Definition: *Services provided to youth (under the age of 21) that offer structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social and communication needs. Therapeutic Mentoring services include supporting, coaching and training.*

Provider

- The provider must be an MBHP/HNE BH in-network provider contracted to provide Therapeutic Mentoring services.

Member

- The Member must be less than 21 years of age within the timeframe of the authorization request.
- Members must be enrolled in the MBHP/HNE BH H001 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the MBHP/HNE BH H001 Benefits package are restricted from access to this service.

BRL – Family Assistance without DMH	840012
BRH – Family Assistance without DMH	840006
BRM – Family Assistance with DMH	840013
BRI – Family Assistance with DMH	840007
BRR – Essential without DMH	840020
BRS – Essential with DMH	840021
BRG – Basic without DMH	840017
BRO – Basic with DMH	840019
BRF – Basic + Limited without DMH	840016
BRN – Basic + Limited with DMH	840018

Effective date

- The effective date of the authorization can be no more than 14 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 89 days.

Unit

- One unit = 15 minutes

Unit Restrictions

- For ICC Members, providers can obtain the number of units listed for Therapeutic Mentoring as registered in the Member's ICP.
- For Non-ICC Members, the provider can enter a maximum of 208 units for a 90-day period.

Authorization Restrictions

- Members with active ICC flags must have an active ICP date no older than 100 days from the date of the call to the IVR.
or
- Members must have an active Outpatient authorization (service class RPS) or In-Home Therapy authorization (claim type C7).

Authorization overlap

For ICC Members

- A new authorization cannot overlap an existing Therapeutic Mentoring authorization for the same or different provider.

For non-ICC Members

- A new authorization cannot overlap an existing Therapeutic Mentoring authorization for the same provider.
- A maximum of two providers may have open authorizations for Therapeutic Mentoring at a given time.

Authorization history restrictions

- The provider may obtain consecutive authorizations through the IVR.

IN-HOME BEHAVIORAL SERVICES (IHBS)

Definition: *Services that are delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary Behavioral Management Therapy and Behavioral Monitoring. Behavioral Management Therapy includes a behavioral assessment, development of a highly specific behavior treatment plan, supervision and coordination of interventions, and training other interveners to address specific behavioral objectives and performance goals. Behavioral Monitoring includes implementation of the behavioral treatment plan, monitoring the youth's behaviors, reinforcing implementation of the treatment plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the treatment plan and progress toward behavioral objectives or performance goals.*

Provider

- The provider must be an MBHP/HNE BH in-network provider contracted to provide In-Home Behavioral Services.

Member

- The Member must be less than 21 years of age within the timeframe of the authorization request.
- Members must be enrolled in the MBHP/HNE BH H001 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the MBHP/HNE BH H001 Benefits package are restricted from access to this service.

BRL – Family Assistance without DMH	840012
BRH – Family Assistance without DMH	840006
BRM – Family Assistance with DMH	840013
BRI – Family Assistance with DMH	840007
BRR – Essential without DMH	840020
BRS – Essential with DMH	840021
BRG – Basic without DMH	840017
BRO – Basic with DMH	840019
BRF – Basic + Limited without DMH	840016
BRN – Basic + Limited with DMH	840018

Effective date

- The effective date of the authorization can be no more than 14 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 29 days.

Unit

- One unit = 15 minutes

Unit Restrictions

- For ICC Members, providers can obtain the number of units listed for In-Home Behavioral Services as registered in the Member's ICP.
- For non-ICC Members, the provider can enter a maximum of 120 units for a 30-day period.

Authorization Restrictions

- Members with active ICC flags must have an active ICP date no older than 100 days from the current date of the call to the IVR, or
- Members must have an active Outpatient authorization (service class RPS) or In-Home Therapy authorization (claim type C7).

Authorization overlap

For ICC Members

- A new authorization cannot overlap an existing In-Home Behavioral Services authorization for the same or different provider.

For non-ICC Members

- A new authorization cannot overlap an existing In-Home Behavioral Services authorization for the same provider.
- A maximum of two providers may have open authorizations for In-Home Behavioral Services at a given time.

Authorization history restrictions

- The provider may obtain consecutive authorizations through the IVR.

FAMILY SUPPORT & TRAINING (FS&T)

Definition: Services that are provided to the parent/caregiver of a youth (under the age of 21), in any setting where the youth resides, that provide a structured, one-to-one, strength-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for ICC Members.

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide Family Support & Training services.

Member

- The Member must be less than 21 years of age within the timeframe of the authorization request.
- Members must be enrolled in the MBHP/HNE BH H001 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the MBHP/HNE BH H001 Benefits package are restricted from access to this service

BRL – Family Assistance without DMH	840012
BRH – Family Assistance without DMH	840006
BRM – Family Assistance with DMH	840013
BRI – Family Assistance with DMH	840007
BRR – Essential without DMH	840020
BRS – Essential with DMH	840021
BRG – Basic without DMH	840017
BRO – Basic with DMH	840019
BRF – Basic + Limited without DMH	840016
BRN – Basic + Limited with DMH	840018

Effective date

- The effective date of the authorization can be no more than 14 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 89 days.

Unit

- One unit = 15 minutes

Unit Restrictions

- For ICC Members, providers can obtain the number of units listed for Family Support and Training as registered in the Member's ICP.
- For non-ICC Members, the provider can enter a maximum of 208 units for a 90-day period.

Restrictions

- Members with active ICC flags must have an active ICP date no older than 100 days from the date of the call to the IVR,
or
- Members must have an active Outpatient authorization (service class RPS) or In-Home Therapy authorization (claim type C7).

Authorization overlap

For ICC Members

- A new authorization cannot overlap an existing Family Support & Training authorization for the same or different provider.

For non-ICC Members

- A new authorization cannot overlap an existing Family Support & Training authorization for the same provider.
- A maximum of two providers may have open authorizations for Family Support & Training at a given time.

Authorization history restrictions

- The provider may obtain consecutive authorizations through the IVR.

IN-HOME THERAPY (IHT)

Definition: *This service is delivered by one or more members of a team consisting of professional and paraprofessional staff for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. The In-Home Therapy team develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains.*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide In-Home Therapy.

Member

- The Member must be less than 21 years of age within the timeframe of the authorization request.
- Members must be enrolled in the MBHP/HNE BH H001 Benefits package as of the requested effective date of the authorization.

Effective date

- The effective date of the authorization can be no more than 14 days prior to the date of the call to the IVR, or 14 days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 89 days.

Unit

- One unit = 15 minutes

Unit Restrictions

- For ICC Members, providers can obtain the number of units listed for In-Home Therapy as registered in the Member's ICP.

- For non-ICC Members, the provider can enter a maximum of 360 units for a 90-day period.

Restrictions

- Members with active ICC flags must have an active ICP date no older than 100 days from the current date of the call to the IVR.

Authorization overlap

For ICC Members –

- A new authorization cannot overlap an existing In-Home Therapy authorization for the same or different provider.

For non-ICC Members -

- A new authorization cannot overlap an existing In-Home Therapy authorization for the same provider.
- A maximum of two providers may have open authorizations for In-Home Therapy at any given time.

Authorization history restrictions

- The provider may obtain consecutive authorizations through the IVR.

PARTIAL HOSPITALIZATION PROGRAM (PHP)

Definition: *A short-term, day mental health service that provides therapeutically intensive acute treatment within a stable therapeutic milieu; includes daily psychiatric management, and is seen as an alternative to inpatient level of care*

Provider

- The provider must be a MBHP/HNE BH in-network provider contracted to provide PHP services.

Member

- The Member must be greater than, to or equal to, 6 years of age.

Effective date

- The effective date of the authorization can be no more than four days prior to the date of the call to the IVR, or four days forward from the date of the call to the IVR.

Expiration date

- An expiration date is automatically assigned by the IVR and is the effective date plus 20 days.

Unit

- The IVR automatically assigns 12 units to the authorization.
- One unit = one half day of treatment

Authorization overlap

- A new authorization cannot overlap an existing PHP authorization.

Authorization history restrictions

- The effective date of the new authorization must be greater than 30 days from the end date of any previous PHP authorization.

For Members who meet this criterion, the provider will be transferred from the IVR to the Clinical Access Line for a telephonic review.

Over guideline requests

- For care beyond the initial units authorized via IVR or by telephonic review, the provider should contact the MBHP/HNE BH Concurrent Review Department prior to use of the last covered unit, to request additional units for the current authorization.

CLAIMS VERIFICATION

To verify the status of a claims payment, follow these instructions:

1. Call the IVR at (888) 899-6277.
2. Enter your 7-digit Medicaid Provider ID number or 9 digit NPI number.
3. Select “Claims Information” from the menu.
4. Enter the date of service (example; May 15, 1999 is entered 05151999).
5. The IVR will provide claims information for up to 20 transactions per call.
6. For any questions, please call the MBHP/HNE BH Community Relations Department at (800) 495-0086 (press 1 for the English menu or 2 for the Spanish menu, then 4, then 2 to skip prompts).

Troubleshooting Tips

- If the claim is “Adjudicated” or “Open,” the message will indicate: “This claim is in process.”
- If the claim status is posted and payment has been issued, the message will indicate: “...was paid on (date) with check number ___.”
- If the claim status is posted, and there is a paid date, but no check number, the message will indicate: “...see remittance advice dated (date) for an explanation of payment.”
- If the claim status is posted, and there are no paid date and no check number, the message will indicate: “...this claim is in process.”