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INTRODUCTION

The Interactive Voice Registration (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 7:00 a.m. and 9:00 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.

This manual was revised in October 2015 and 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. To learn how to access requested services through the IVR, refer to the section of this manual detailing the services requested 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 1-800-554-0042. Once you have determined your client’s eligibility, you should proceed as follows:

**Access the IVR system at 1-888-899-6277:**

- Enter your 7-digit Medicaid Provider Identification number or your 10-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. *(All services are assigned an automatic end date.)*

4. Enter the number of units requested, if applicable.

5. Enter the DSM Primary Diagnosis Code.

6. 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 MBHP/HNE Be Healthy online provider portal, ProviderConnect, at [www.valueoptions.com/pcllogin](http://www.valueoptions.com/pcllogin).
CONTACT INFORMATION

Massachusetts Behavioral Health Partnership/
Health New England Be Healthy (MBHP/HNE BH)
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Phone: 1-800-495-0086

Web site: www.masspartnership.com; click on “HNE Be Healthy” button

Click on the “HNE Be Healthy IVR Manual.”

Important Phone Numbers

• The IVR System: 1-888-899-6277
• Community Relations: 1-800-495-0086
• MBHP/HNE BH Clinical Access Line: 1-800-495-0086
• MBHP/HNE BH Clinical Outpatient Line: (617) 790-5634
• MBHP/HNE BH Clinical Acute Services Concurrent Review Line: (617) 790-5620
• MassHealth’s Eligibility Verification System (EVS): 1-800-554-0042

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

Notices of new routine authorizations and the letters themselves will be available at the MBHP/HNE Be Healthy online provider portal ProviderConnect. Letters related to adverse actions or denials will continue to be sent through the mail.
**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:

<table>
<thead>
<tr>
<th>Registration for Non-Residential or Residential Outpatient Services, Medication visits, and Psychiatric Consults on a Medical Unit</th>
<th>Press 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services in a Nonresidential Setting</td>
<td>Press 1</td>
</tr>
<tr>
<td>Outpatient Services in a Residential Setting</td>
<td>Press 2</td>
</tr>
<tr>
<td>Outpatient Medication Visits</td>
<td>Press 3</td>
</tr>
<tr>
<td>Psychiatric Consultations on a Medical Unit</td>
<td>Press 4</td>
</tr>
</tbody>
</table>

**Registration for Substance Use Disorder Services, including ATS, CSS, and SOAP**

<table>
<thead>
<tr>
<th>Press 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Treatment Services for Substance Abuse (ATS)</td>
</tr>
<tr>
<td>Clinical Support Services (CSS)</td>
</tr>
<tr>
<td>Structured Outpatient Addictions Treatment (SOAP)</td>
</tr>
<tr>
<td>Level IV Inpatient Substance Use Disorder Services</td>
</tr>
</tbody>
</table>

**Registration for Specialized Outpatient Services**

<table>
<thead>
<tr>
<th>Press 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Day Treatment</td>
</tr>
<tr>
<td>Assessment for Safe and Appropriate Placement Services (ASAP)</td>
</tr>
<tr>
<td>Psychological Testing</td>
</tr>
<tr>
<td>Dialectical Behavioral Therapy (DBT)</td>
</tr>
<tr>
<td>Community Support Program (CSP)</td>
</tr>
</tbody>
</table>

**Partial Hospitalization Program (PHP)**

<table>
<thead>
<tr>
<th>Press 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Mental Health Partial</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eating Disorder Partial</td>
</tr>
<tr>
<td>Children’s Behavioral Health Initiative</td>
</tr>
<tr>
<td>Therapeutic Mentoring</td>
</tr>
<tr>
<td>In-Home Behavioral Services</td>
</tr>
<tr>
<td>Family Support and Training</td>
</tr>
<tr>
<td>In-Home Therapy</td>
</tr>
<tr>
<td>Claims Information</td>
</tr>
<tr>
<td>To Enter a Different Medicaid Provider # or National Provider #</td>
</tr>
<tr>
<td>Registration for Any Other Level of Care</td>
</tr>
<tr>
<td>To Repeat These Options</td>
</tr>
</tbody>
</table>
Overview of IVR Registration Parameters  
*For full description of parameters and exceptions to the parameters listed below, please refer to parameter page for each level of care.*

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

Effective 10/1/2015
Overview of IVR Registration Parameters

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<th>Requests for Services beyond Max Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Treatment Services (ATS) for Substance Use Disorders: Alcohol Withdrawal</td>
<td>No age parameter</td>
<td>4 A unit equals 1 day.</td>
<td>4 days</td>
<td>2 days back</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
</tr>
<tr>
<td>Acute Treatment Services (ATS) for Substance Use Disorders: Opioid Dependence, Sedative, Hypnotic, or Anxiolytic Withdrawal</td>
<td>No age parameter</td>
<td>6 A unit equals 1 day.</td>
<td>6 days</td>
<td>2 days back</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Level IV Inpatient Substance Use Disorder Services for Alcohol Withdrawal</td>
<td>No age parameter</td>
<td>4 A unit equals 1 day</td>
<td>4 days</td>
<td>2 days back</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provider contacts concurrent review dept. on last covered day</td>
</tr>
<tr>
<td>Level IV Inpatient Substance Use Disorder Services for Opioid Withdrawal, Sedative, Hypnotic, or Anxiolytic Withdrawal</td>
<td>No age parameter</td>
<td>6 A unit equals 1 day</td>
<td>6 days</td>
<td>2 days back</td>
<td>Provider contacts concurrent review dept. on last covered day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services for Substance Use Disorders</td>
<td>No age parameter</td>
<td>10 A unit equals 1 day.</td>
<td>10 days</td>
<td>2 days back</td>
<td>Provider submits request via ProviderConnect prior to the last covered day</td>
<td>Provider submits request via ProviderConnect prior to the last covered day</td>
</tr>
</tbody>
</table>
Overview of IVR Registration Parameters
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</tr>
</thead>
<tbody>
<tr>
<td>Structured Outpatient Addictions Program (SOAP)</td>
<td>For Members age 13 or older</td>
<td>12 A unit equals ½ day.</td>
<td>28 days</td>
<td>7 days back, 7 days forward</td>
<td>Provider submits Substance Use Disorder web extension 3 days prior to the use of the last covered unit of service</td>
<td>Provider submits a Substance Use Disorder web extension prior to auth expiration date</td>
</tr>
<tr>
<td>Psychiatric Day Treatment</td>
<td>For Members age 4 or older</td>
<td>510 A unit equals 1 hour.</td>
<td>120 days</td>
<td>7 days back, 7 days forward</td>
<td>Provider submits Extended Day Treatment Screen (EODT) prior to using last unit</td>
<td>Provider may obtain up to 3 consecutive authorizations through the IVR; Provider submits an EODT to request a 4th consecutive authorization</td>
</tr>
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Overview of IVR Registration Parameters

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</tr>
</thead>
<tbody>
<tr>
<td>Assessment for Safe and Appropriate Placement (ASAP)</td>
<td>For Members younger than, or equal to, 19 years of age</td>
<td>40 A unit equals 15 minutes.</td>
<td>60 days</td>
<td>28 days back, 14 days forward</td>
<td>Providers contact an outpatient care manager for a live telephonic review if additional units are needed</td>
<td>Providers contact an outpatient care manager for a live telephonic review if an additional ASAP authorization is needed for further assessment purposes.</td>
</tr>
</tbody>
</table>
## Overview of IVR Registration Parameters

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</tr>
</thead>
<tbody>
<tr>
<td>Psychological Testing</td>
<td>For Members age 6 or older&lt;br&gt;For school testing, Member must be under 19 years of age</td>
<td>Varies by type of testing – see IVR Provisions</td>
<td>90 days</td>
<td>28 days back, or 14 days forward</td>
<td>Provider submits Psychological Evaluation Request (PER) Form</td>
<td>To extend an authorization end date, provider calls the outpatient dept. prior to the authorization expiration date.</td>
</tr>
</tbody>
</table>
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</tr>
</thead>
<tbody>
<tr>
<td>Dialectical Behavioral Therapy (DBT)</td>
<td>For Members age 13 or older</td>
<td>120 A unit equals 1 day.</td>
<td>120 days</td>
<td>28 days back, 14 days forward</td>
<td>Not applicable</td>
<td>Provider may obtain 3 consecutive authorizations through the IVR; To request a 4th consecutive authorization, provider calls the outpatient dept. for a telephonic review</td>
</tr>
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</table>
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<th>Requests for Services beyond Max Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support Programs (CSP)</td>
<td>For Members age 18 or older</td>
<td>180 A unit equals 15 minutes.</td>
<td>90 days</td>
<td>7 days back, 7 days forward</td>
<td>Providers contact a Clinical Access Line care manager for a telephonic review if additional units are needed in the current authorization period</td>
<td>Provider may obtain 2 consecutive authorizations through the IVR; To request a 3rd consecutive authorization, provider calls the Clinical Access Line for a telephonic review. Refer to complete list of parameters</td>
</tr>
</tbody>
</table>
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<th>Requests for Services beyond Max Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization Program (PHP)</td>
<td>For Members age 6 or older</td>
<td>12</td>
<td>21 days</td>
<td>4 days back, 4 days forward</td>
<td>For additional units providers contact the concurrent review dept. for a telephonic review on the last covered day.</td>
<td></td>
</tr>
</tbody>
</table>
Overview of IVR Registration Parameters

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic Mentoring (TM)</strong></td>
<td>For Members &lt; 21 years of age</td>
<td>For ICC Members: # units are based on an existing ICP or Treatment Plan on record; For Non-ICC Members: 208 units A unit equals 15 minutes.</td>
<td>90 days</td>
<td>14 days back, 14 days forward</td>
<td>Provider submits fax form</td>
<td>Consecutive authorizations may be obtained through the IVR. Refer to complete list of parameters</td>
</tr>
<tr>
<td><strong>In-Home Behavioral Services (IHBS)</strong></td>
<td>For Members &lt; 21 years of age</td>
<td>240 units A unit equals 15 minutes.</td>
<td>60 days</td>
<td>14 days back, 14 days forward</td>
<td>Provider submits fax</td>
<td>Consecutive authorizations may be obtained through the IVR. Refer to complete list of parameters</td>
</tr>
</tbody>
</table>

---

1 ICP is an Individual Care Plan.
Overview of IVR Registration Parameters

For full description of parameters and exceptions to the parameters listed below, please refer to parameter page for each level of care.

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</tr>
</thead>
<tbody>
<tr>
<td>Family Support and Training (FS&amp;T)</td>
<td>For Members &lt; 21 years of age</td>
<td>For ICC Members: # units are based on an existing ICP(^2) or Treatment Plan on record; For Non ICC Members: 208 units A unit equals 15 minutes.</td>
<td>90 days</td>
<td>14 days back, 14 days forward</td>
<td>Provider submits fax form</td>
<td>Consecutive authorizations may be obtained through the IVR. Refer to complete list of parameters</td>
</tr>
</tbody>
</table>

\(^2\) ICP is an Individual Care Plan.
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<tbody>
<tr>
<td>In-Home Therapy (IHT)</td>
<td>For Members &lt; 21 years of age</td>
<td>For ICC Members: # units are based on an existing ICP⁴ or Treatment Plan on record; For Non ICC Members: 360 units</td>
<td>90 days</td>
<td>14 days back, 14 days forward</td>
<td>Provider submits fax form</td>
<td>Consecutive authorizations may be obtained through the IVR. Refer to complete list of parameters</td>
</tr>
</tbody>
</table>

**Note:** All services are auto-assigned an end date by the IVR.

---

⁴ ICP is an Individual Care Plan.
EXTENDED OUTPATIENT TREATMENT SCREENS (EOTS AND EODT)

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 the age of 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. Forms are under the menu For Behavioral Health Providers > Provider Information > Service Authorizations.

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, MBHP/HNE BH will update the authorization. Provider can use the tracking function on the web page to monitor the status of EOTS and EODT requests.

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 MBHP/HNE BH 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 record and will be reviewed in conjunction with future record reviews.
INSTRUCTIONS FOR USING THE EXTENDED OUTPATIENT TREATMENT SCREENS (EOTS AND EODT)

The EOTS and EODT should be completed by the Member’s outpatient clinician and are designed to be submitted on the MBHP/HNE BH 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).

Note 3: If the authorization end date has expired, provider should not use the EOTS but rather obtain a new authorization through the IVR.

All items on the form should be completed. Providers need to ensure proper, completed submission on the web screen. Any incomplete form will be marked as an error. 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 USE DISORDER SERVICES WEB SCREENS FOR STRUCTURED OUTPATIENT ADDICTION PROGRAMS (SOAP)

The SOAP Extension form is for requests of an extension of units to a current SOAP authorization and/or end date extension for a current authorization period.

Providers can submit the web-based forms via MBHP’s secure web site at www.masspartnership.com. Forms are under the menu For Behavioral Health Providers > Provider Information > Service Authorizations.

An MBHP/HNE BH outpatient care manager will review the SOAP screen. If the information provided on the screen is sufficient to approve the request, the outpatient care manager will complete the authorization. If the information is not sufficient, the outpatient care manager will contact the provider to request a telephonic review to gather additional information. Providers can use the tracking function on the web page to monitor the status of requests.

Notices of new routine authorizations and the letters themselves will be available at the MBHP/HNE BH 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 record and will be reviewed in conjunction with future record reviews.
INSTRUCTIONS FOR USING SUBSTANCE USE DISORDER SERVICES WEB SCREENS

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

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

- **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.

*Note: If the SOAP web screen forms are submitted later than the parameter dates listed, the MBHP/HNE BH care manager will administratively 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 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)

Provider
- The provider should be an in-network provider contracted to provide Outpatient Services in a Nonresidential Setting.

Member
- For Members enrolled in the HNE Be Healthy Benefits package 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.
- Registration parameters for Members age 4 and up: 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 max unit request
- The provider should submit an Extended Outpatient Treatment Screen (EOTS) for either adults or child/adolescents (age 4 through 18) prior to utilization of the 18th unit/session.
- For children under age 4, the provider must call an MBHP/HNE BH outpatient care manager for a live telephonic review prior to initiating treatment beyond the initial two diagnostic units. Contact the Outpatient Department.
Diagnoses Restrictions

For all Members age 5 and under

- If the registered diagnosis is a bipolar disorder code (codes in the range of F31.xx), 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 an 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 an MBHP/HNE BH care manager.

  Adjustment Disorders:
  - F43.21 Adjustment with Depressed Mood
  - F43.22 Adjustment with Anxiety
  - F43.23 Adjustment with Mixed Anxiety and Depressed Mood
  - F43.24 Adjustment with Disturbance in Conduct
  - F43.25 Adjustment with Disturbance in Emotions and Conduct
  - F43.20 Adjustment Disorder Unspecified

For all Members

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

  - F50.01 and F50.02 Eating Disorders
  - F44.81 and F44.9 Dissociative Identity Disorder

Continued authorization

- Outpatient authorizations have a set date range. For continued authorization beyond the 365 days, provider obtains a new authorization through the IVR. Any remaining unused units under the prior authorization will expire.
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 of age and less than 19 years of age.
- The Member must be living in a 24-hour residential setting.
- For Members enrolled in the HNE Be Healthy Benefits package 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
- 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 max unit requests
- The provider should submit an Extended Outpatient Treatment Screen (EOTS) form for child/adolescent prior to utilization of the 75\textsuperscript{th} unit/session.

Continued authorization
- Outpatient authorizations have a set date range. For continued authorization beyond the 365 days, provider obtains a new authorization through the IVR. Any remaining unused units under the prior authorization will expire.
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
- For Members enrolled in the HNE Be Healthy Benefits package 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
- The provider can enter a maximum of 24 units for Members age 5 or older.
- The IVR automatically assigns 2 units for children under the age of 5.
- One unit = one session

Authorization overlap
- A new authorization cannot overlap an existing Outpatient Medication Visits authorization for the same provider.
- Overlapping medication authorizations are allowed for up to two different providers. The third provider attempting to get an authorization will be automatically assigned two units.

Over max unit request
- The provider should submit an Extended Outpatient Treatment Screen (EOTS) prior to utilization of the 18th unit/session.
- For children under the age of 5, the provider must call an MBHP/HNE BH outpatient care manager for a live telephonic review prior to initiating treatment beyond the initial two diagnostic units.
- For the third overlapping medication provider, the provider should call the OP Department to clarify the Member’s ongoing treatment needs.
**Continued authorization**

- Medication authorizations have a set date range. For continued authorization beyond the 365 days, the provider obtains a new authorization through the IVR. Any remaining unused units under the prior authorization will expire.
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 contact the Outpatient Department for telephonic review.

Member
- For Members enrolled in the HNE Be Healthy Benefits package 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 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 may enter 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 max unit request
- If additional units are needed, telephonic review with an 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 USE DISORDERS

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 an MBHP/HNE BH in-network provider contracted to provide Acute Treatment Services (ATS) for Substance Use Disorders.

Member
- For Members enrolled in the HNE Be Healthy Benefits package as of the requested effective date of the authorization

Effective date
- The effective date of the authorization can be no more than 2 days prior to the date of the call to the IVR.

Unit
- The IVR automatically assigns an expiration date based on the primary diagnosis.
- One unit = one day of service
- Alcohol Withdrawal the IVR assigns four units
- Opioid Withdrawal the IVR assigns six units
- Sedative, Hypnotic, or Anxiolytic Withdrawal, the IVR assigns six units

Authorization overlap
- New authorization request cannot overlap with existing ATS authorization for same provider.

Authorization history
- Not applicable

Over max unit requests
- For care beyond the four or six units authorized via the IVR or by telephonic request, the provider can contact the MBHP/HNE BH Concurrent Review Department to request additional units for a current authorization.
LEVEL IV INPATIENT SUBSTANCE USE DISORDER SERVICES

Definition: Inpatient, 24-hour, medically managed evaluation, care, and treatment for Members with a physical dependency on alcohol, opioids, sedatives, hypnotics, or anxiolytics and are experiencing severe withdrawal symptoms and/or have acute biomedical complications

Provider
- The provider must be an MBHP/HNE Be Healthy in-network provider contracted to provide Level IV Inpatient Substance Use Disorder Services.

Member
- For HNE Be Healthy Members eligible as of the requested effective date of the authorization

Effective date
- The effective date of the authorization can be no more than 2 days prior to the date of the call to the IVR.

Unit
- The IVR automatically assigns an expiration date based on the primary diagnosis.
  - One unit = one day of service
  - Alcohol Withdrawal the IVR assigns four units
  - Opioid Withdrawal, the IVR assigns six units
  - Sedative, Hypnotic, or Anxiolytic Withdrawal, the IVR assigns six units

Authorization overlap
- New authorization request cannot overlap with existing Level IV Inpatient Substance Use Disorder Services authorization for same provider.

Authorization history
Not applicable

Over max unit requests
- For care beyond the four or six units authorized via the IVR or by telephonic request, the provider can contact the MBHP/HNE BH Concurrent Review Department to request additional units for a current authorization.
**CLINICAL SUPPORT SERVICES FOR SUBSTANCE USE DISORDERS (CSS)**

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

**Member**
- For Members enrolled in the HNE Be Healthy Benefits package as of the requested effective date of the authorization

**Provider**
- The provider must be an MBHP/HNE BH in-network provider contracted to provide CSS.

**Effective date**
- The effective date of the authorization can be no more than 2 days prior to the date of the call.

**Expiration date**
- The expiration date is equal to the number of units.

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

**Authorization overlap**
- New authorization request cannot overlap with existing CSS authorization for same provider.

**Authorization history**
- Not applicable

**Over max unit requests**
- Providers submit a CSS extension request via ProviderConnect prior to the last covered day.
STRUCTURED OUTPATIENT ADDICTIONS PROGRAM (SOAP)

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

Provider
- The provider must be an 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.
- For Members enrolled in the HNE Be Healthy Benefits package as of the requested effective date of the authorization

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.
- A new SOAP authorization request cannot overlap existing SOAP authorization for the same or different provider.

Authorization history
- The effective date of the new authorization must be greater than 15 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 max unit 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.
- For Members enrolled in the HNE Be Healthy Benefits package as of the requested effective date of the authorization.

**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 authorization**
- Provider may obtain up to three consecutive authorizations through the IVR. Provider submits an EODT to request the 4th and subsequent consecutive authorizations.
**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).
- For Members enrolled in the HNE Be Healthy Benefits package 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 59 days.

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

**Over max unit request**
- Providers contact an MBHP/HNE BH outpatient care manager for a live telephonic review if an additional ASAP authorization is needed for further assessment purposes.
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.
- Provider must be an MBHP/HNE BH in-network provider.

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.
- For Members enrolled in the HNE Be Healthy Benefits package 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 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 12-month period.

**Restrictions**
- Any selection of Intellectual Disability diagnoses (DSM codes F70, F71, F73, F79) requires submission of the PER (Psychological Evaluation Request) Form.
- IVR registration for Psychological Testing requires the entry of a DSM diagnosis code. A provisional code may be used. Psychological testing not requested as a result of referral from a behavioral health provider or a medical specialist will require a 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.
- Psychological testing requests for Members under the age of 6 requires submission of a PER Form.

**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. Requests that do not meet this criteria require submission of a PER Form.
- 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. Requests that do not meet this criteria require submission of a PER Form.
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 an 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 current DSM criteria for Borderline Personality Disorder.
- For Members enrolled in the HNE Be Healthy Benefits package 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**
- 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, and clinical consultation team meeting per week)

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

**Continued authorization**
- 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.
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 an 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. The provider contacts the Clinical Access Line to request authorization for Members under the age of 18.
- For Members enrolled in the HNE Be Healthy Benefits package as of the requested effective date of the authorization

**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 89 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.
- Overlapping CSP authorizations are allowed for up to two different providers. The third provider attempting to get a CSP authorization will be transferred to a care manager.

**Authorization history**
- The start date of any new authorization must be within 6 months of an admission to a 24-hour behavioral health inpatient/diversionary level of care.
Continued authorization

- The provider may obtain up to two consecutive authorizations through the IVR. The IVR will transfer the provider to a Clinical Access Line Care Manager for the 3rd and subsequent consecutive authorizations.
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 HNE BH H001/HEA1 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the HNE BH H001/HEA1 Benefits package are restricted from access to this service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units</th>
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<tbody>
<tr>
<td>BRL</td>
<td>Family Assistance without DMH</td>
<td>840012</td>
</tr>
<tr>
<td>BRH</td>
<td>Family Assistance without DMH</td>
<td>840006</td>
</tr>
<tr>
<td>BRM</td>
<td>Family Assistance with DMH</td>
<td>840013</td>
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<td>BRI</td>
<td>Family Assistance with DMH</td>
<td>840007</td>
</tr>
<tr>
<td>BRV</td>
<td>Care Plus Direct Coverage</td>
<td>840026</td>
</tr>
<tr>
<td>BRW</td>
<td>Care Plus Direct Coverage plus EADC</td>
<td>840027</td>
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</tbody>
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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 services 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.
- A new authorization cannot overlap an existing CSP authorization.

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.
- A new authorization cannot overlap an existing CSP authorization.

Over max units requests
- The provider submits a fax form five days prior to using the last unit.

Continued authorization
- Authorizations have a set date range. For continued authorization beyond the 90 days, providers may obtain consecutive authorizations through the IVR. Any remaining unused units under the previous authorization will expire.
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 HNE BH H001/HEA1 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the HNE BH H001/HEA1 Benefits package are restricted from access to this service.

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<td>BRW</td>
<td>Care Plus Direct Coverage plus EADC</td>
<td>840027</td>
</tr>
</tbody>
</table>

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 all Members (regardless of ICC involvement), the provider can enter a maximum of 240 units for a 60-day period.

**Authorization Restrictions**
- Members with active ICC services 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.

**Over max unit request**
- The provider submits a fax form five days prior to using the last unit.

**Continued authorization**
- Authorizations have a set date range. For continued authorization beyond the 30 days, provider may obtain consecutive authorizations through the IVR. Any remaining unused units under the previous authorization will expire.
FAMILY SUPPORT AND 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 an MBHP/HNE BH in-network provider contracted to provide FS&T 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 HNE BH H001/HEA1 Benefits package as of the requested effective date of the authorization. Exclusionary group codes under the HNE BH H001/HEA1 Benefits package are restricted from access to this service
  
<table>
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</table>

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

Effective 10/1/2015
Unit Restrictions
- For ICC Members, providers can obtain the number of units listed for FS&T 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 FS&T authorization for the same or different provider.

- For non-ICC Members
  - A new authorization cannot overlap an existing FS&T authorization for the same provider.
  - A maximum of two providers may have open authorizations for FS&T at a given time.

Over max unit request
- The provider submits a fax form five days prior to using the last unit.

Continued authorization
- Authorizations have a set date range. For continued authorization beyond the 90 days, provider may obtain consecutive authorizations through the IVR. Any remaining unused units under the previous authorization will expire.
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 an 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 HNE BH H001/HEA1 or HEA2 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.

Over max unit request
- The provider submits a fax form five days prior to using the last unit.

Continued authorization
- Authorizations have a set date range. For continued authorization beyond the 90 days, provider may obtain consecutive authorizations through the IVR. Any remaining unused units under the previous authorization will expire.
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 an MBHP/HNE BH in-network provider contracted to provide PHP services.

Member
- The Member must be greater than 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 max unit 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 1-888-899-6277.
2. Enter your 10-digit National Provider ID or 7-digit Medicaid Provider ID 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 1-800-495-0086 (press 1 for the English menu or 2 for the Spanish menu, then 4, then 1 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.”