

## PROVIDER BULLETIN

Volume 45 Number 34

<http://dss.mo.gov/mhd/>

March 16, 2023

### RESIDENTIAL TREATMENT AND TREATMENT FOSTER CARE

#### Applies to:

- Qualified Residential Treatment Programs (QRTP)
- Residential Treatment Agencies for Children and Youth
- Child Placing Agencies Delivering Treatment Foster Care Services

Effective date: January 1, 2023

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- **PRIOR AUTHORIZATION REQUIRED**
  - **INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION REQUESTS**
  - **PROCEDURE CODES AND MODIFIERS**
  - **CONTINUED SERVICE REVIEWS**
  - **RESPONSE TIMELINE**
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#### **PRIOR AUTHORIZATION REQUIRED**

Prior authorization is required for Treatment Foster Care (TFC), Transition TFC, and Residential Treatment Level 2, Level 3, Level 4, Above Level Residential. Prior authorization is not required for Residential Aftercare Treatment.

#### **INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION REQUESTS**

For fee-for-service covered participants, please submit a cover sheet with return fax number, completed [Prior Authorization Request](#) form, and supporting documentation via fax to **(573) 659-0207** up to 10 business days prior to the requested date of admission.

Instructions for completing each section of the form are below:

- Section I – Complete fields 2-5; 7 and 8;
- Section II – Leave blank;
- Section III
  - Enter procedure code and modifiers for service and level requested (fields 17-18 – see tables below);
  - Enter from and through dates requested (fields 19-20);
  - Leave field 21 blank;
  - Enter number of units (days) requested in 22.

- Leave fields 23 and 24 blank.
- Submit also the below supporting documentation (as available):
  - Referral information for admission -to include the independent assessment (which needs to include the CANS and/or CSPI), CS9, DLA 20, etc.;
  - Most recent psychiatric evaluation completed by psychiatrist, psychologist, or advanced practice psychiatric nurse if available;
  - Rationale for admission to requested level of care;
  - Documentation of previous treatment history and outcome of treatment if applicable;
  - Guardian contact information;
  - Discharge Plan –starts at admission and will develop throughout continued stay;
  - Discharge Planner Information
- Section IV – Complete all fields;
- Section V – Leave blank.

**PROCEDURE CODES AND MODIFIERS**

**Residential Treatment Services**

	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Above Level 4</i>
<b>QRTP</b>	H0019 HK	H0019 TF HK	H0019 TG HK	H0019 TJ HK
<b>Non- QRTP</b>	H0019 HA	H0019 TF HA	H0019 TG HA	H0019 TJ HA

**Treatment Foster Care Services**

<b>Treatment Foster Care</b>	<i>H2020</i>
<b>Transition TFC</b>	H2022 HE

**CONTINUED SERVICE REVIEWS**

Continued service reviews are required and will be determined based on continued medical necessity for treatment. The treating provider/agency must submit continued service requests via the above [form](#) with supporting documentation by fax to **(573) 659-0207**. Please complete form as above and indicate “continued service request” in field 1. Continued service requests may be submitted up to 10 days prior to the last covered day.

The first continued service review must include the member’s plan of care. All continued service requests must include evidence that clearly supports the need for ongoing treatment at the requested level of care and must clearly identify why the member’s treatment needs can’t be treated at a lower level of care. Documentation to be submitted at concurrent review may include:

- Plan of care since last review;

- Psychiatrist/treatment team progress notes;
- Individual therapy progress notes since last review period;
- Family therapy progress notes since last review period. If not applicable, documentation must clearly indicate why family therapy sessions are not occurring;
- Any updates to the participant's diagnoses;
- Discharge Plan – to include any details currently available including any established outpatient providers, appointment dates and times, recommended treatment level of care, etc.

### **RESPONSE TIMELINE**

MO HealthNet Division (MHD) will provide a medical necessity determination via fax to the provider. If MHD requires additional information to determine medical necessity, MHD will contact the provider who submitted the request to gather additional information. Each determination and length of authorization will be based on individual medical necessity review and member needs.

PLEASE NOTE: An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Provider Communications Management option in [eMOMED](#) (preferred) or by calling the Interactive Voice Response (IVR) System at (573) 751-2896.

### **APPLICABILITY**

The information in this bulletin applies to the MO HealthNet (MHD) fee-for-service program and may apply to the MHD managed care program, as well. MHD's fee-for-service policies set the basic coverage policies for benefits and limitations in the managed care program. The managed care health plans have additional flexibilities in operating their respective programs such as determining which services require prior authorization, and details required for claims submission. Certain services, such as pharmacy, are "carved out" of managed care and will be paid through the fee-for-service program. To ensure your understanding of this bulletin's applicability to each managed care health plan, please contact your health plan directly, or contact [MHD.MCCommunications@dss.mo.gov](mailto:MHD.MCCommunications@dss.mo.gov).

[Provider Bulletins](#) are available on the [MO HealthNet Division \(MHD\) website](#). Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletins page.

Providers and other interested parties are urged to [subscribe](#) to the electronic **MO HealthNet News** mailing list to receive automatic notifications of [provider bulletins](#), [provider hot tips](#), provider manual updates, and other official MO HealthNet communications via email.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- MO HealthNet Managed Care

Before delivering a service, please check the patient's eligibility status by swiping their MO HealthNet card, calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and choosing Option One or using the Participant Eligibility option in [eMOMED](#). Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan.

[MHD Education and Training](#) offers schedules for interactive web based trainings for providers and general and program specific educational resources.

**Provider Communications**  
**573-751-2896**