PROVIDER BULLETIN

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PRIOR AUTHORIZATION PROCESS – 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 (TFC) Services**

Effective date: July 1, 2023

- **PRIOR AUTHORIZATION REQUIRED**
- **INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION REQUESTS**
- **PROCEDURE CODES AND MODIFIERS**
- **REQUIRED DOCUMENTATION FOR INITIAL REQUESTS**
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PRIOR AUTHORIZATION REQUIRED

Prior authorization is required for TFC, Residential Treatment Level 2, Level 3, Level 4 and Above Level 4 Residential. Prior authorization is not required for Transition TFC or Residential Aftercare.

INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION REQUESTS

For fee-for-service covered participants, please submit the following via fax to (**573) 659-0207** up to 10 calendar days prior to the requested date of admission.

- Cover sheet with a return fax number
- Completed Prior Authorization Request
- Residential Care Screening Team (RCST) Approval document (This document is required effective October 1, 2023)
- Supporting documentation (see below)

Note: Participants receiving adoption or guardianship subsidy, must have an approved/signed subsidy amendment in place prior to admission to a residential facility.

Instructions for completing each section of the Prior Authorization Request are below:

- Section I – Complete entire section
- Section II – Leave blank
- Section III –
  - Enter procedure code (field 18) and modifiers (field 19) for service and level requested (see tables below)
  - Enter from (field 20) and through (field 21) dates requested
  - Leave Description (field 22) blank
  - Enter quantity of units (days) requested (field 23)
  - Leave Amount to be Charged (field 24) blank
- Section IV – Complete all fields
- Section V – Leave blank
- Section VI – For State Use Only

For additional information on what to enter in each field of the Prior Authorization Request, review page two of the form.

PROCEDURE CODES AND MODIFIERS

Residential Treatment Services

	Level 2	**Level 3**	**Level 4**	**Above Level 4**
IMD QRTP	H0019 HK	H0019 TF HK	H0019 TG HK	H0019 TJ HK
Non-IMD QRTP	**H0019 HE**	**H0019 TF HE**	**H0019 TG HE**	**H0019 TJ HE**
Non-QRTP	H0019 HA	H0019 TF HA	H0019 TG HA	H0019 TJ HA

Treatment Foster Care Services

	Traditional TFC	**Relative TFC**
Level 1	H2020	H2020 HA
Level 2	**H2020 HK**	**H2020 HK HA**

REQUIRED DOCUMENTATION FOR INITIAL REQUESTS

Providers must submit the below supporting documentation (if available):

- Referral information for admission – to include the independent assessment (which needs to include the Child and Adolescent Needs and Strengths (CANS) and/or the Childhood Severity of Psychiatric Illness (CSPI), Residential and Specialized Placement Referral (CS9), any relevant treating provider documentation, etc.
  - For subsidy population only: Daily Living Activities-20 (DLA-20)
- Child/youth psychiatric/behavioral health diagnosis (ICD-10 code)
- 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

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 Prior Authorization Request with supporting documentation by fax to (**573) 659-0207**. Please complete the Request as above and indicate "reauthorization" in field 1. Continued service requests may be submitted up to 10 calendar days prior to the last covered day.

The first continued service review must include the participant'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 participant'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.

MEDICAL NECESSITY DETERMINATION

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 to gather the additional information. Each determination and length of authorization will be based on individual medical necessity review and participant 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.

Failure to obtain authorization may result in administrative claim denials. Per 13 CSR 70-4.030(2), providers are prohibited from billing the participant for services for which payment was denied by MHD.

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.

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