Submitting Prior Authorization Requests for Outpatient Psychotherapy

NaviNet Provider Portal

Individual Psychotherapy Authorization Guidelines

Before you continue, take into consideration:

- How many times a month you will possibly be seeing your patient.
- How many months are left in the fiscal year (July – June).

When you enter your request, you will need to make the request for no more than 48 units:

- Only six sessions per month can be billed. If there are five months left in the fiscal year, you can only request 30 visits. You cannot request more than 48 total visits (only 72 visits are allowed per year, 6 × 12 = 72).
- If you are currently seeing the patient, enter a future end date.
- If the request is after the end of the fiscal year (June 30), you may have the end date in the past.
- If you are no longer seeing the patient, enter the end date of services as the last date you saw the member.

Authorization requests cannot not be amended, and only one request can be submitted per fiscal year (July to June).

Examples:

- If you are seeing a member weekly and you reach your 24th visit on November 30, you will need to submit an authorization for coverage of 4 visits × 6 months = 24 visits. You will ask for 24 visits from December 1 to June 30. You can ask for all visits to be for 90837. (Please see explanation above.)
- If you submit a visit on September 1, your end date will need to be no earlier than September 2.

If a request needs to be amended due to the change of a provider, call Utilization Management at **866-341-8765**.

If you are having difficulties getting registered with NaviNet, please reach out to your Account Executive who will guide you.

Select Health of South Carolina

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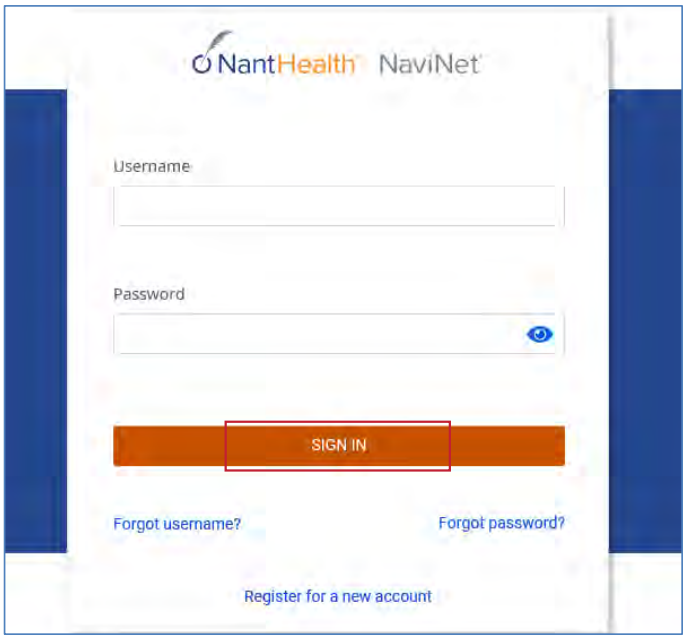
www.selecthealthofsc.com

1. Access NaviNet: https://navinet.navimedix.com

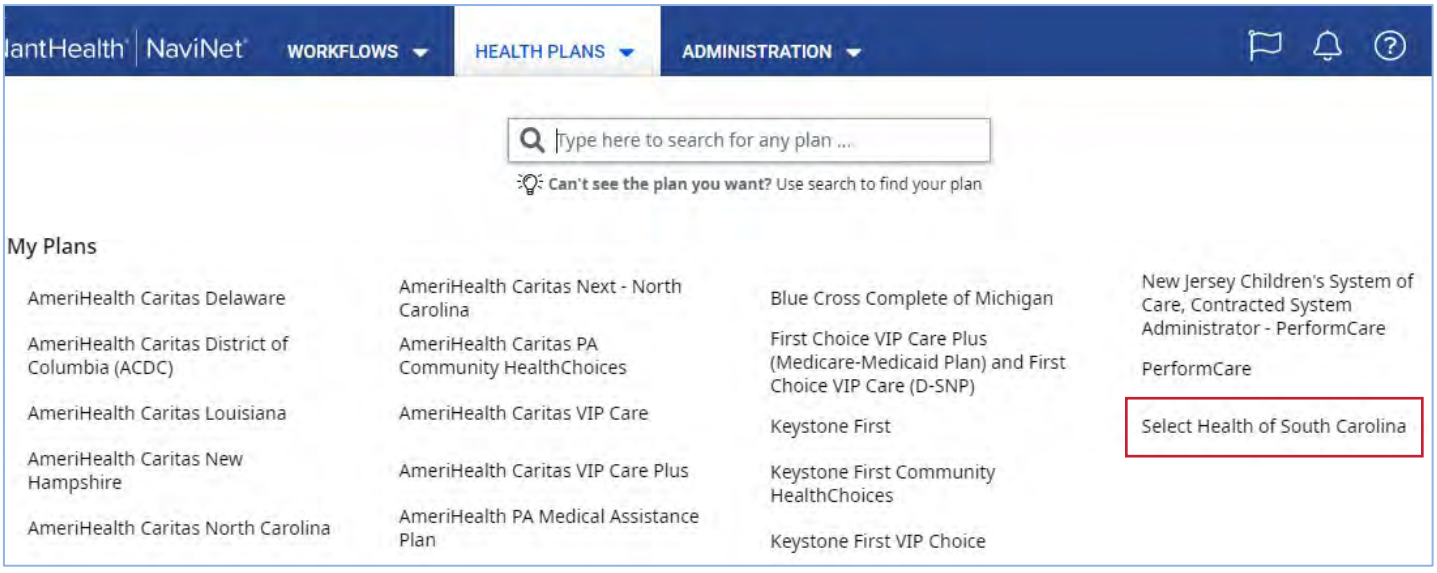
2. Enter log-in credentials to sign in.

3. If you are not registered for a NaviNet account, click on the **Register for a new account** link and complete the online registration.



4. After signing in, the NaviNet homepage will be displayed.

5. Click on **HEALTH PLANS** in the top menu and choose **Select Health of South Carolina** from the drop-down list.

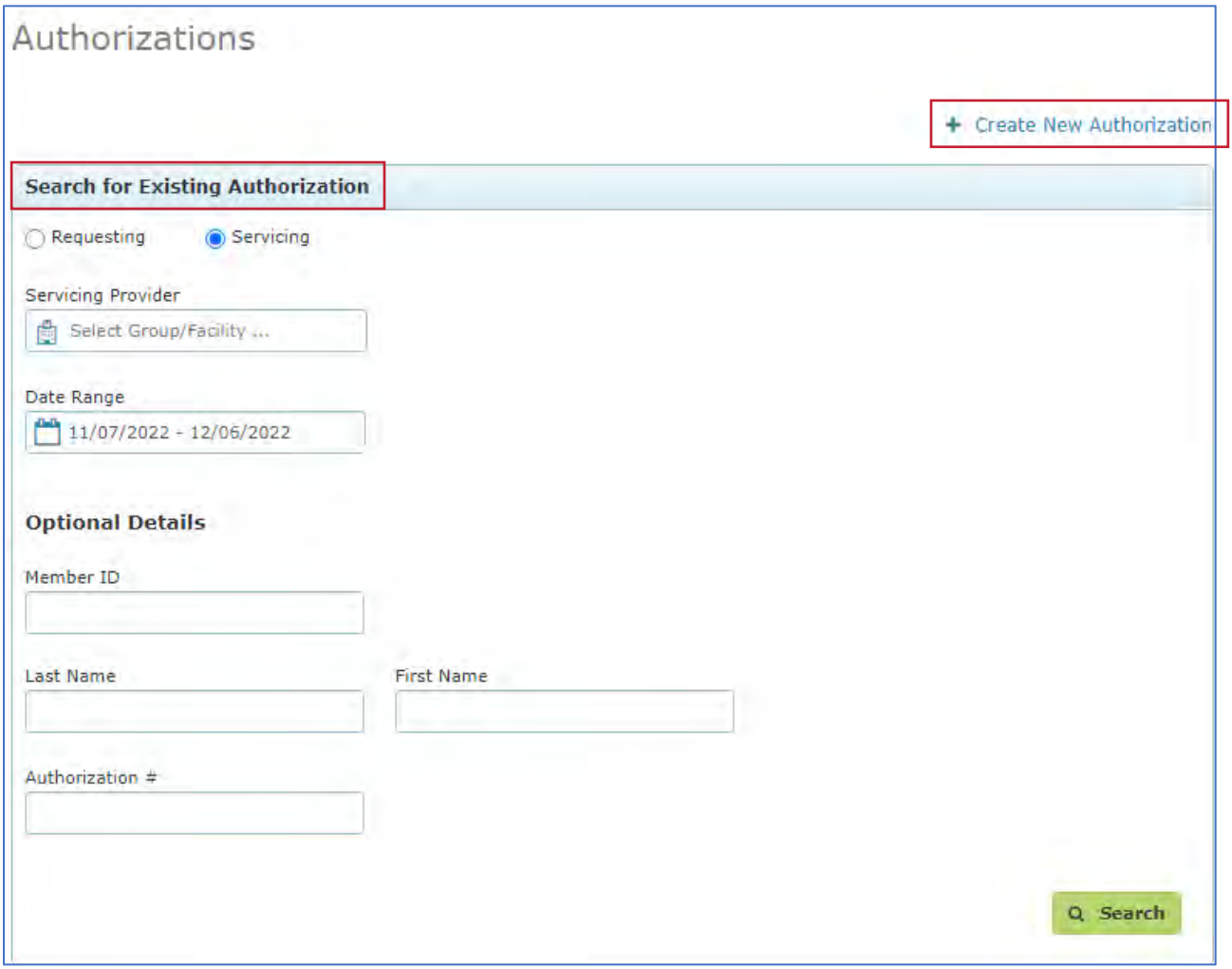


6. The Select Health Plan central page will be displayed.

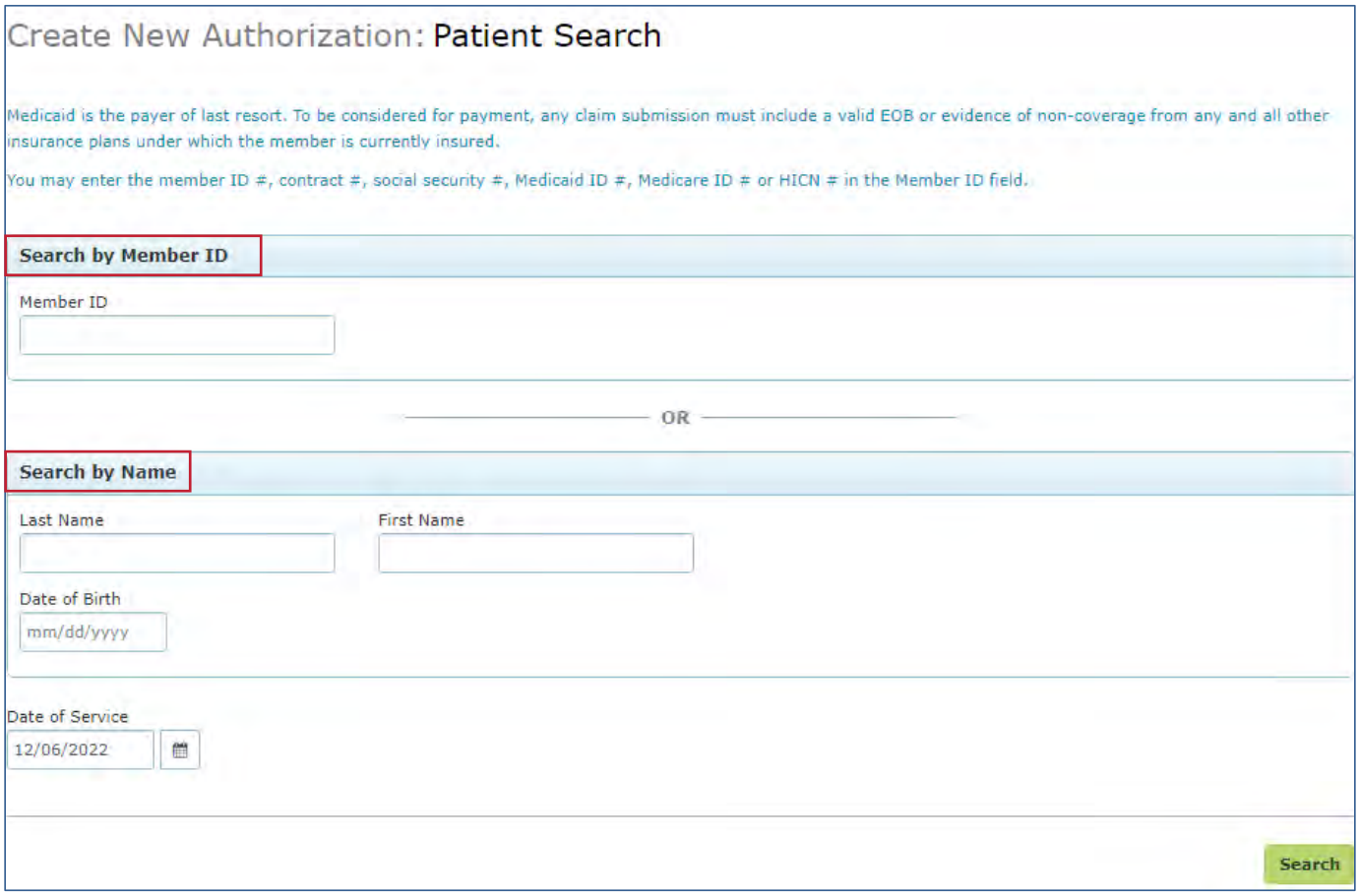
7. Go to **Workflows for this Plan** on the left side of the screen and click on the **Medical Authorizations** link.

8. The Authorizations screen will be displayed. Here you can search for an existing authorization or create a new authorization.

9. To start an authorization request, click **Create New Authorization** in the upper-right corner.



10. The **Create New Authorization: Patient Search** screen will be displayed.



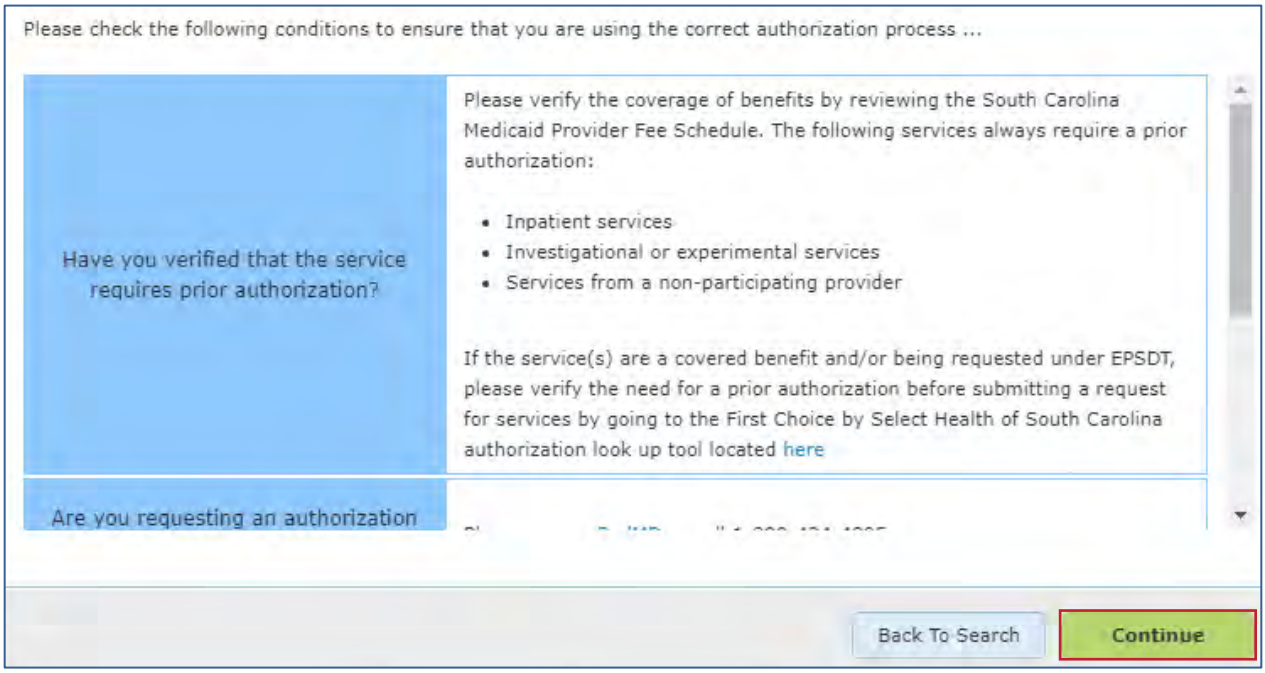
11. Enter patient search criteria information; you can search by Member ID (First Choice member ID or 10-digit Medicaid ID) or by Name.

    - If searching by name, the member's first name, last name, and date of birth (DOB) are required.

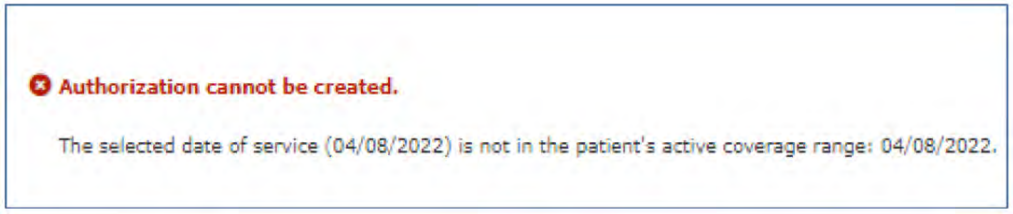
12. Click **Search**.

    Note: If you enter an incorrect/invalid member ID, you will receive the following message:

13. The **New Authorization Prescreening Questions** pop up will be displayed. Click **Continue**.

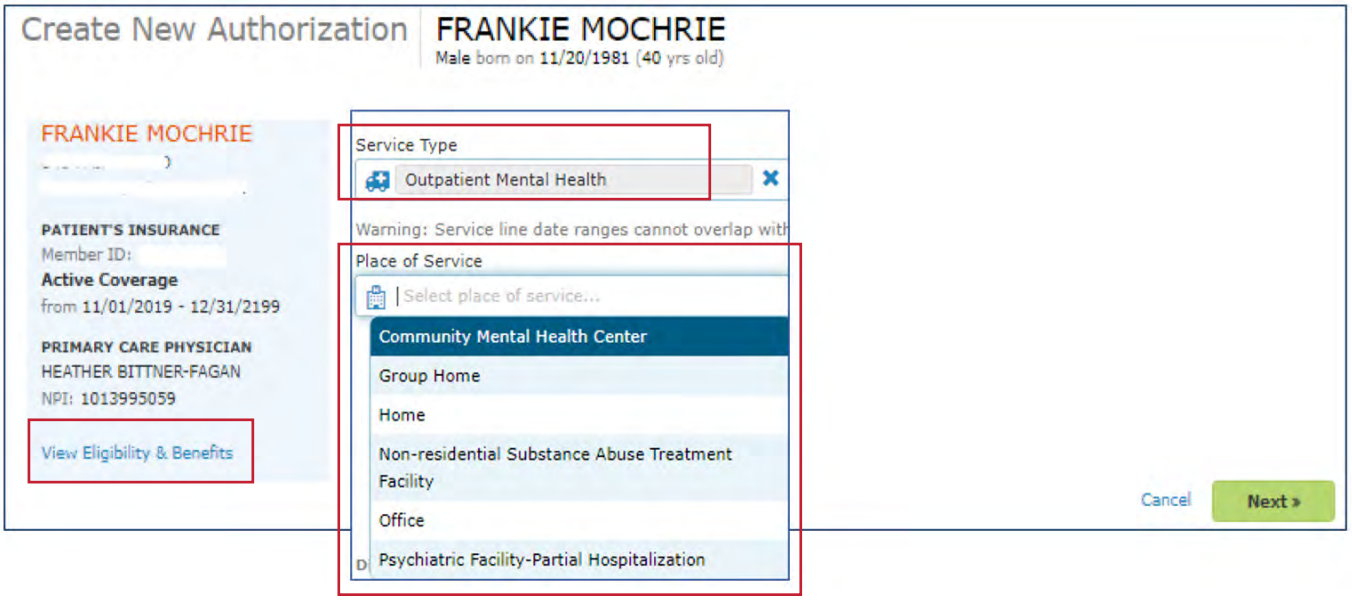


Note: If you enter a member who is not active with the health plan, you will not be advanced to the prescreening questions. You will receive the following message:



14. If you enter a member who is active, the **Authorization Service Type** screen will be displayed.

- **Note: View Eligibility & Benefits** is available to view under the member's demographic information.



15. Select the **Service Type: Outpatient Mental Health** from the drop-down list.

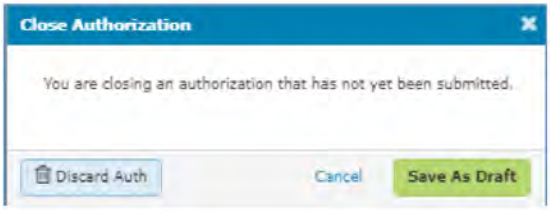
16. Select **Place of Service**. Use the most appropriate place of service.

17. Click **Next**.

Note: While creating an authorization, you can close or save the request.

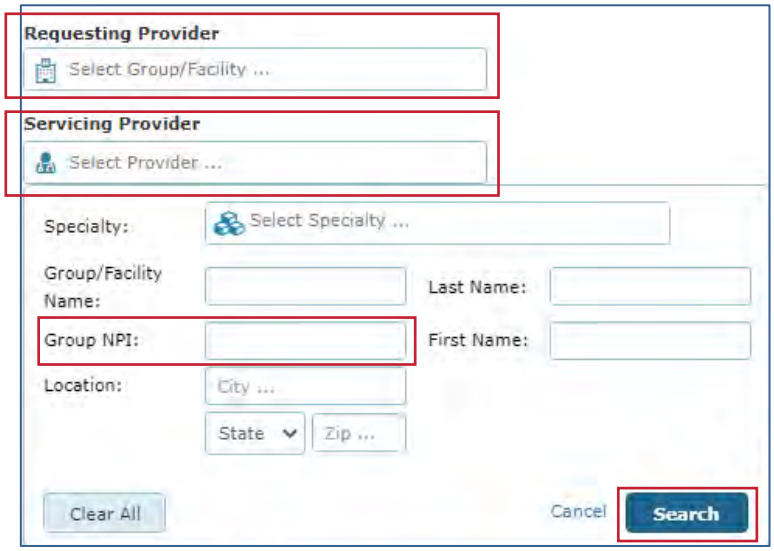
Select ✖ Close/Save , which allows you to:

- Discard auth — Delete the request.
- Cancel — Continue with the request.
- Save as draft — Come back and complete the request later.



18. Complete information on the request screen:

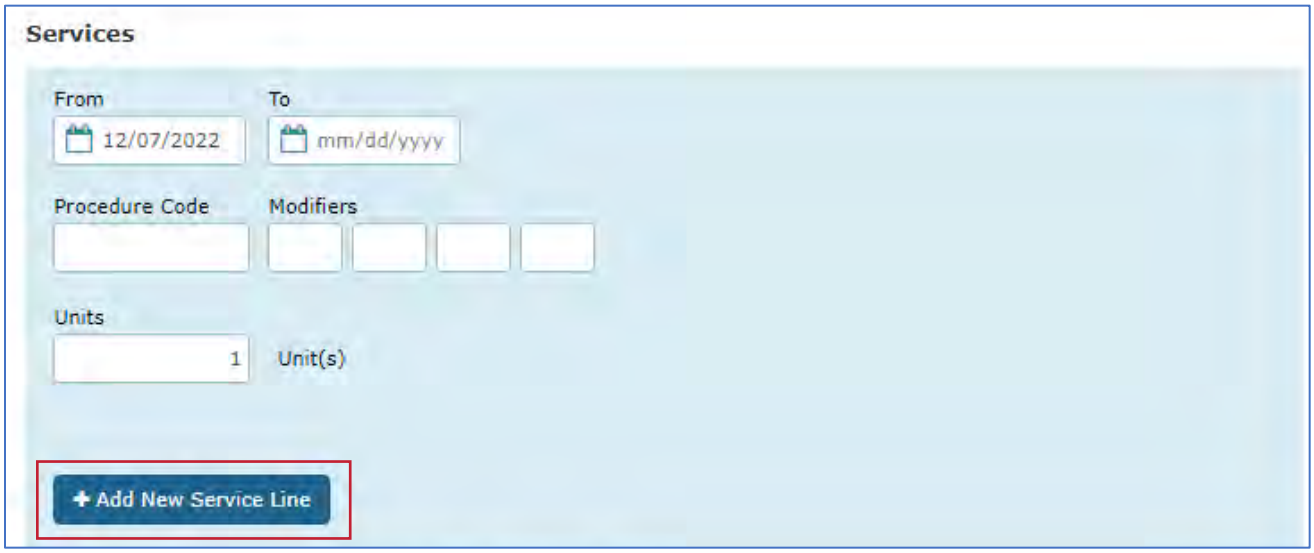
- **Date of service** — defaults to current date.
- **Level of Service** — Choose **Elective**.
- **Requesting Provider** — provider requesting the service.
  - Your provider/group information will automatically populate here.



- **Servicing Provider** — provider rendering the service.
  - This section does not automatically populate.
  - Enter your NPI to pull up your provider/group.
  - Click **Search**.
  - Click on the provider to add to the request.

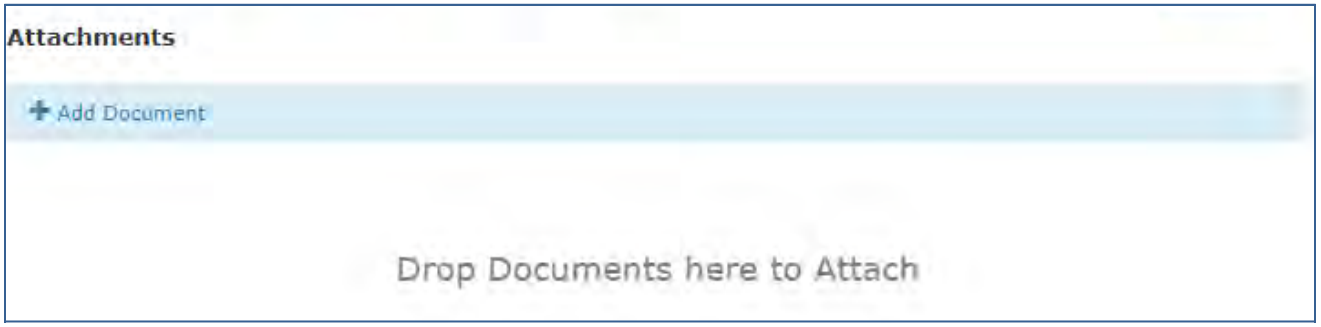
- **Note: Requesting and Servicing providers can be the same.**
  - If the Servicing Provider is different from the Requesting, you can search by specialty, name, or NPI.
- **Diagnoses** — Enter DX code. This is a look-up field. There is a 12-code maximum.
- **Services:**
  - Enter: **From** and **To** dates — **REMEMBER you can request services through June 30 each year. The 24-visit-with-no-authorization count starts over the first of every fiscal year, July 1.**
  - **Procedure codes** — Any combination of the individual psychotherapy codes — 90832, 90834, and 90837. Modifiers are not required, but you can enter them if you like.
  - **Units** — Enter the number of units being requested. **REMEMBER the six-visit/month limit still applies.**

19. **Add New Service Line:** Enter the CPT codes for the services you are providing. After entering each service line, click **Add New Service Line** to save the service line you just entered and to add additional services.

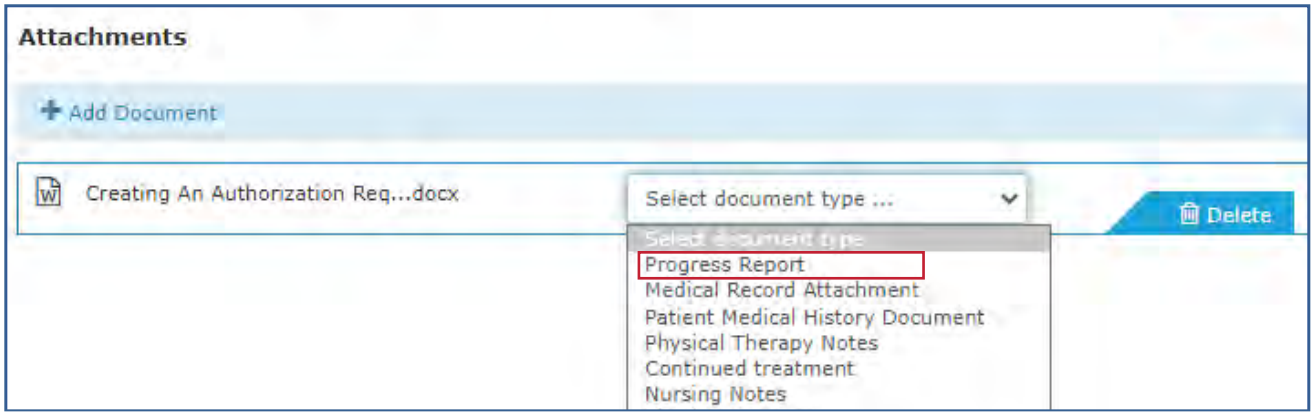


20. Attach supporting clinical documentation (supported document types: PDF, docx, xml, csv, png, gif).

- Attach documents by clicking + Add Document , or drag and drop your file.

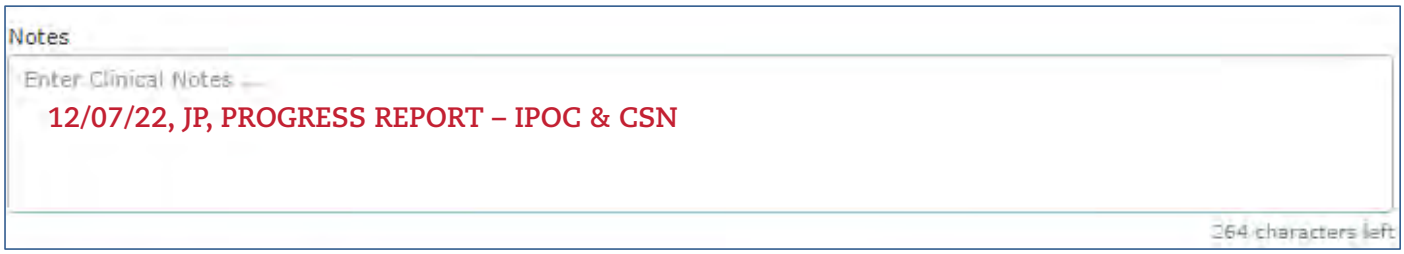


  - **Attach all documents as one file.**
  - Identify the document type using the drop-down list.
    - Choose: **PROGRESS REPORT only.**

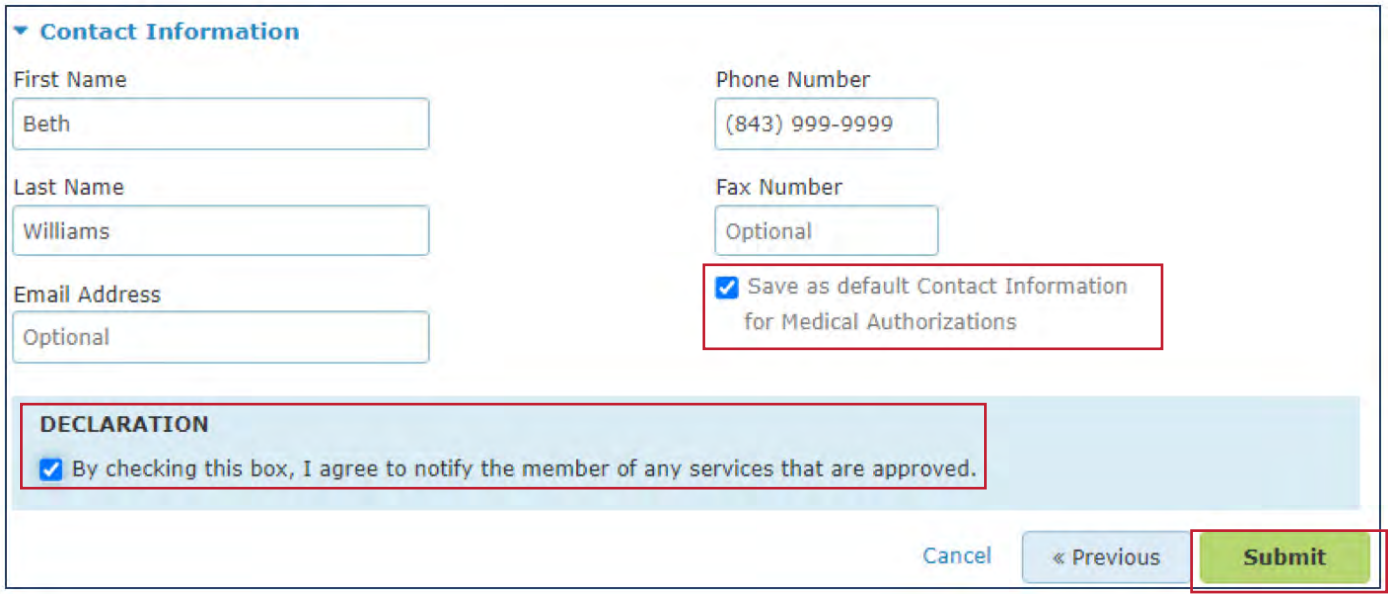


21. Enter the following in the Notes section:

    - Date of notes, Member's initials, PROGRESS REPORT
    - Document Description: IPOC, CSN, Treatment plan (whichever is applicable)



22. **Contact Information:** Enter your contact information. First name, last name, and phone number are required fields. Fax number and email address are optional. The Declaration check box must be checked to submit the request.



Note: If you check the Save as default box, the system will save your contact information so you won't have to enter it every time.

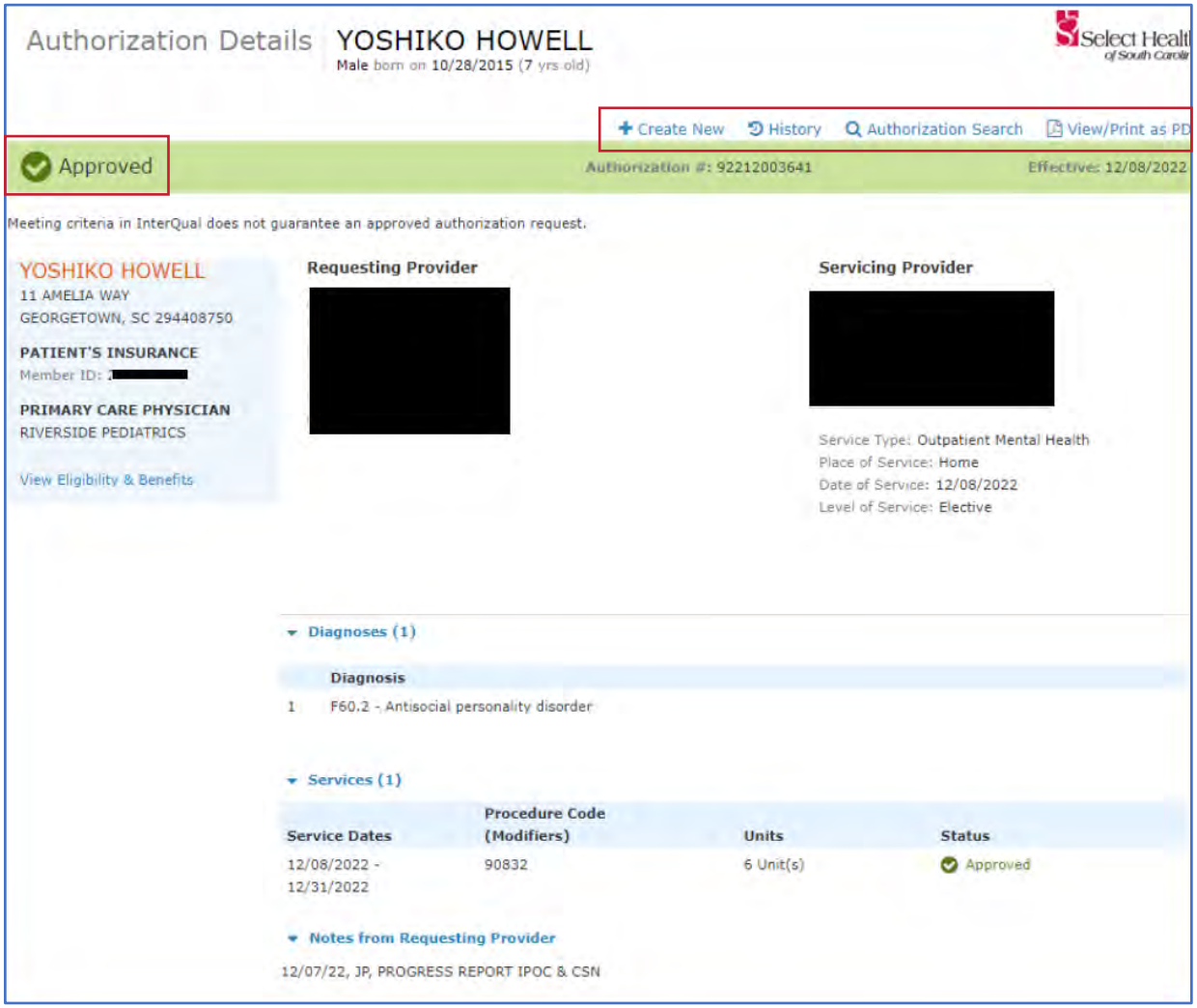
23. Click **Submit**.

24. You will see the following message as the system runs the Interqual criteria (clinical guidelines) check:

25. Once the Interqual criteria check is complete, you will receive approval of your request.

- From this screen you can:
  - Choose **Create New** if you need to submit another request for this same member, or you can submit a request for another member by clicking on Search.
  - Look at the **History** for this request.
  - Go to the **Authorization Search** function to look up authorizations.
  - Go to **View/Print as PDF** to produce a copy of the authorization to place in the member's file.

Note: Only fictitious member information and redacted provider information are used in the images in this document.



If you have questions or need assistance with completing your request, **Medical Authorization** videos are available on the NaviNet Plan Central page, or you can contact your Provider Account Executive.

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