Select Health of South Carolina DAODAS Provider Guide

Select Health of South Carolina

Healthy Connections

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Select Health of South Carolina DAODAS Provider Guide

CONTENTS

What services are covered by the MCO (Select Health of South Carolina)?

Services covered by Select Health and the prior authorization rule:

SERVICE TYPE	DESCRIPTION	SERVICE CODE	ASAM LEVEL	UNIT	PRIOR AUTHORIZATION RULE
Bundle 1	Social detox/inpatient	HOO10	3.2 D	1 day	All units require a prior authorization
Bundle 2	Medical detox/inpatient	HOO11	3.7 D	1 day	All units require a prior authorization
Bundle 3	Residential rehabilitation	HOO19	3.5 R	1 day	All units require a prior authorization
Bundle 4	Residential rehabilitation	HOO18 HOO18 HA	3.7 R 3.7 RA	1 day	All units require a prior authorization
Bundle 5	Partial hospitalization program (PHP)	H2O35	2.5	1 hour	All units require a prior authorization
Bundle 6	Intensive outpatient program (IOP)	HOO15	2.1	1 hour	All units require a prior authorization
Discrete	Outpatient (OPT)	Multiple – see appendix	1	Varies	See Discrete Services Table

What services are not covered by Select Health?

All codes below are covered by Medicaid Fee-for-Service; therefore, all prior authorization requests and claims should be directed to Medicaid Fee-for-Service.

SERVICE CODE	DESCRIPTION
T1O16	Targeted case management, telephone
T1O17	Targeted case management, face-to-face

What will happen if I submit one of these non-covered codes to Select Health?

If you submit a request for one of the above codes not covered by Select Health, the Behavioral Health Utilization Management (UM) department will issue an administrative denial for non-covered benefits. Denial letters are sent to the treating provider and the member.

How do I request a prior authorization?

SERVICE TYPE	DESCRIPTION	SERVICE CODE	REQUEST SUBMITTED:
Bundle 1	Social detox/inpatient	H0010	Telephonic or fax reviews permitted (see fax form below)
Bundle 2	Medical detox/inpatient	H0011	Telephonic or fax reviews permitted (see fax form below)
Bundle 3	Medically managed residential	H0019	Telephonic or fax reviews permitted (see fax form below)
Bundle 4	Clinically managed residential	H0018 H0018HA	Telephonic or fax reviews permitted (see fax form below)
Bundle 5	Partial hospitalization (PHP)	H2035	Telephonic or fax reviews permitted (see fax form below)
Bundle 6	Intensive outpatient program (IOP)	H0015	Fax only for initial and continued stay requests
Discrete	Level I (outpatient)	Multiple – see appendix	Fax only for initial and continued stay requests

What documentation is required to request an authorization?

All documentation below is required for authorizations and will be reviewed to determine medical necessity for services.

SERVICE TYPE	DESCRIPTION	SERVICE CODE	DOCUMENTATION REQUIRED
Bundle 1	Social detox/inpatient	H0010	Telephonic reviews: completed checklist for bundled services
			Faxed reviews: completed BH fax form
Bundle 2	Medical detox/inpatient	H0011	Telephonic reviews: completed checklist for bundled services
			Faxed reviews: completed BH fax form
Bundle 3	Medically managed residential	H0019	Telephonic reviews: completed checklist for bundled services
			Faxed reviews: completed BH fax form
Bundle 4	Clinically managed residential	H0018 H0018HA	Telephonic reviews: completed checklist for bundled services
			Faxed reviews: completed BH fax form
Bundle 5	Partial hospitalization (PHP)	H2035	Telephonic reviews: completed checklist for bundled services
			Faxed reviews: completed BH fax form
Bundle 6	Intensive outpatient program (IOP)	H0015	Initial requests: (1) Completed Clinical Assessment including member name, DOB, ID number, ASAM dimensions, diagnosis (2) Individual plan of care (IPOC) including services requested, frequency of services, start date, end date
			Continued stay requests: (1) Completed continued stay request including member name, DOB, ID number, ASAM dimensions, diagnosis (2) Updated IPOC (if services change) including services requested, frequency of services, start date, end date
Discrete	Level I (outpatient)	Multiple - see appendix	Initial requests: (1) Completed clinical assessment including member name, DOB, ID number, ASAM dimensions, diagnosis (2) Individual plan of care (IPOC) including services requested, frequency of services, start date, end date
			Continued stay requests: (1) Completed continued stay request including member name, DOB, ID number, ASAM dimensions, diagnosis (2) Updated IPOC (if services change) including services requested, frequency of services, start date, end date

Telephonic Review for Bundled Services 1–5 (Inpatient Only)

When completing a telephonic review, please check the DAODAS prior authorization checklist (found in the appendix) before starting the telephonic review to ensure you have all needed information available. Each question on the checklist will be asked by the UM reviewer during the telephonic review.

THE DAODAS PRIOR AUTHORIZATION CHECKLIST FOR BUNDLED SERVICES IS INCLUDED IN THIS PROVIDER GUIDE.

Faxed Review for Bundled Services 1–5 (Inpatient/Residential Only)

The Behavioral Health Fax Form: INPATIENT/RESIDENTIAL SERVICES

Below is an explanation and overview of the Behavioral Health Fax Form to be used for the bundled services 1–5. The Behavioral Fax Form can be found in the appendix.

ONLY IF YOU ARE FAXING THE REQUEST
▼ EXAMPLE IS INCLUDED BELOW ▼

Today's Date: *insert the date you are completing the form.*

State date of admission/service: *insert the date the member is being admitted or will start the service.*

Type of Review:	**Type of Admission:**	**Admission Status:**	**Estimated Length of Stay:** *insert the estimated length of stay for the member.*
☐ Precertification ☐ Continued stay ☐ Discharge **TIP:** *Check the box for the type of review.*	☐ IOP ☐ MH-IP ☐ PHP/day treatment ***Substance Abuse*** ☐ Detox ☐ Rehab **TIP:** *Check the box for the service you are requesting.*	☐ Voluntary commitment ☐ Involuntary commitment **TIP:** *Check the box for the voluntary or involuntary status of the member.*	***Re-admission within 30 days?*** *Check yes or no if the member has been readmitted to this same level of care within the past 30 days.*

Member information section: complete all fields. Select Health needs all information in this box to complete the authorization request and verify the member's identity and eligibility status.

Provider information section: complete all fields. Select Health needs all information in this box to complete the authorization request and ensure the correct provider is assigned to the authorization. DSM-5 diagnosis is also required in this section.

Medications section: complete all fields as applicable.

Presenting problem section: complete this section with all relevant clinical information about the member. Be sure to include if the member has current suicidal or homicidal ideations, psychotic symptoms, presenting problem, reason for admission, mental status exam (including mood/affect, sleep problems, appetite, etc.) and current withdrawal symptoms if applicable.

Treatment history and current treatment participation section:

- **Previous MH/SA inpatient, rehab or detox:** insert if the member has had any previous admission to an MH/SA inpatient treatment, SA rehab or SA detox.
- **Outpatient treatment history:** insert if the member has had any previous outpatient treatment (mental health or substance abuse).
- **Is the member attending therapy and groups? *Check Yes or No;*** If yes, insert what type of therapy and group sessions the member is attending.
- **Explain clinical treatment plan:** insert the member's treatment plan while the member is inpatient.
- **Family involvement and/or support system:** insert if the member has any family involvement and/or support systems while inpatient.

Substance Abuse Section: Check yes or no if the member has substance abuse.

- **If yes, MH services only, please explain how substance abuse is being treated**. DAODAS providers would not complete this section.
- **If yes, please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/day treatment, SA detox and SA rehab**. Complete this entire section to indicate the member's current ASAM dimensions. **Required.**

DIMENSION RATING	CURRENT ASAM DIMENSIONS ARE REQUIRED			
Dimension 1: acute intoxication and/or withdrawal potential **Rating:** *Insert the rating 0–4*	**Substances used (pattern, route, last used):** *Insert the substances used by member including pattern, route and last use*	**Tox screen completed?** ☐ Yes ☐ No **If Yes, Results:** *Check yes or no; insert results if yes*	**History of withdrawal symptoms:** *Insert the member's history of withdrawal symptoms*	**Current withdrawal symptoms:** *Insert the member's current withdrawal symptoms, if applicable*
Dimension 2: biomedical conditions and complications **Rating:** *Insert the rating 0–4*	**Vital signs:** *Insert the member's current vital signs (medically managed treatment types)*	**Is member under doctor care?** ☐ Yes ☐ No *Check yes or no* **Current medical conditions:** *Insert the member's current medical conditions, if applicable*		**History of seizures?** ☐ Yes ☐ No *Check yes or no*
Dimension 3: emotional, behavioral or cognitive conditions and complications **Rating:** *Insert the rating 0–4*	**MH diagnosis:** *Insert the member's mental health diagnosis (if applicable)*	**Cognitive Limits?** ☐ Yes ☐ No *Check yes or no if the member has cognitive limits*	**Psych medications and dosages:** *Insert the member's psychiatric medications and dosages (if applicable)*	**Current risk factors (SI, HI, psychotic symptoms, etc.):** *Insert if the member is currently having suicidal/homicidal ideations or psychotic symptoms*
Dimension 4: Readiness to Change **Rating:** *Insert the rating 0–4*	**Awareness/commitment to change:** *Insert the member's current awareness for the need for change*	**Internal or external motivation:** *insert the internal and external motivations for the member to be in treatment*	**Stage of change, if known:** *Insert the member's stage of change*	**Legal problems/ probation officer:** *Insert if the member has current legal problems or on probation/parole*
Dimension 5: relapse, continued use or continued problem potential **Rating:** *Insert the rating 0–4*	**Relapse prevention skills:** *Insert the member's current relapse prevention skills*	**Current assessed relapse risk level:** ☐ High ☐ Moderate ☐ Low *Check the member's current relapse risk level*		**Longest period of sobriety:** *Insert the member's longest period of sobriety*
Dimension 6: recovery/ living environment **Rating:** *Insert the rating 0–4*	**Living situation:** *Insert the member's current living situation (prior to admission)*	**Sober support system:** *Insert the member's sober support system*	**Attendance at support group:** *Insert if the member was attending support groups prior to admission*	**Issues that impede recovery:** *Insert any issues/barriers that would impede the member's recovery*

Discharge Planning Section: complete the entire section with every review. **Required.**

- **Discharge planner name:** *insert the name of the person responsible for helping the member with discharge planning.*
- **Discharge planner phone:** *insert the phone number of the discharge planner.*
- **Residence address upon discharge:** *insert the member's residence address once discharged.*
- **Treatment setting upon discharge:** *insert the level of treatment/program the member will be attending once discharged.*
- **Has a post-discharge 7-day follow-up appointment been scheduled?** *Check yes or no.*
  - *If no, insert the reason.*
  - *If yes, insert the treatment provider's name with a date/time of the scheduled appointment.*

SEE APPENDIX FOR EXAMPLE OF BH FAX FORM FOR INPATIENT, DETOX AND RESIDENTIAL REQUESTS.

Authorization Request for IOP or Level I (Discrete) Services

When completing an authorization request for Intensive Outpatient Program (IOP) or Level I Services, fax in the following documentation:

Initial requests: current clinical assessment, current individual plan of care (IPOC).

Continued stay requests: current continued stay request form, updated IPOC (if services being requested have changed).

Fax the documents to 1-888-796-5521.

What discrete services have state-specific criteria?

- Peer support services (H0038)
- Rehabilitative psychosocial services (H2017)
- Family support services (S9482)
- Medication training and support (H0034)
- Crisis intervention (H2011)

Problems and Troubleshooting:

1. **My request for authorization was pended; what happens now?**
   - Select Health Behavioral Health Utilization Management (BH UM) will send it back to you requesting the information we need and a date that the clinical information is due. The sooner the clinical documentation issubmitted, the sooner an authorization can be processed.
   - The request will remain as a pending authorization until the information is received.
   - Select Health BH UM will pend the authorization request for no longer than 28 days from the initial date the request was received.
   - On the date specified, the authorization request will be reviewed for a possible denial of service(s) if the clinical documentation has not been received.
2. **Possible reasons for pending an authorization request:**
   - The clinical information is missing.
   - The clinical information is not legible.
   - The address or service site is not listed in the provider profile.
   - The individual is not an active member, or the member's identity cannot be verified.
   - The identifying information on the member does match Select Health records.
   - A clinical assessment, IPOC or continued stay request is required but was not sent with the request or is not current.

3. **It's been 15 days or longer since I submitted my request for Intensive Outpatient Program or Level I/discrete therapy services, and I have not received any information. What should I do?**
   - Contact the BH UM staff on the 15th day or after, between 8 a.m. – 4:30 p.m., Monday–Friday.
4. **It's been longer than 24 hours since I submitted my request for inpatient services (bundled services 1–4), and I have not received any information. What should I do?**
   - Contact the BH UM staff once 24 hours have passed, between 8 a.m. – 4:30 p.m., Monday–Friday.
5. **My authorization dates do not match what I requested:**
   - Check to ensure you are not requesting a backdating of services.
   - Contact the BH UM department for further clarification.
   - Resubmit the request with proof of prior submission for backdating of services.
6. **I received an administrative denial notification that the member is no longer eligible with First Choice by Select Health. What is the next step?**
   - Check with South Carolina Healthy Connections for guidance on the member's current eligibility.
7. **I received notification that Select Health BH could not verify the member's identity. What do I do now?**
   - Resubmit all documentation initially submitted.
   - Be sure to include two of the following:
     - *Member name and date of birth.*
     - *Healthy Connections (Medicaid) ID number.*
     - *First Choice by Select Health ID number*
     - *Social Security number.*
8. **What will my authorization look like?**
   - If you completed a telephonic review for a bundled service 1–5, you will receive your authorization via telephone.
   - If you faxed your authorization request, the authorizations are faxed to the provider at the given fax number. The next page has an example of an authorization fax. Please remember to read all of the information on the fax cover sheet.

SEE APPENDIX FOR EXAMPLE OF FAX AUTHORIZATION.

Adverse Determinations

I received a denial. What does this mean, and what can I do?

An administrative denial: issued when Select Health policies and procedures related to timely notification, benefits, precertification, billing and other contractual obligations are not met.

A medical necessity denial: issued when a Select Health medical director and/or psychologist determine the clinical information submitted for the member does not meet medical necessity criteria for the service being requested.

Once a denial is issued, the provider and the member receive a denial letter. If you receive a denial, please inform your patient of the denial and the member appeal rights outlined below and in the denial letter.

1. **I received a denial for a member's service indicating that the service does not meet medical necessity.**
   This is a denial from a Select Health medical director that indicates the clinical information submitted for the member does not meet medical necessity criteria per ASAM criteria.

What can I do? If you receive a medical necessity denial, you can do one or any of the following:

- Discuss the denial with your patient and explain member appeal rights.
- Request a peer-to-peer review. A peer-to-peer review is a telephonic conversation with the medical Director or psychologist who issued the denial. *See section on how to request a peer-to-peer review below.*
- If the service being denied will result in the member's life or health being seriously jeopardized or jeopardize the member's ability to regain maximum functioning, the member can request an expedited appeal while still in services. *See section on how to submit an expedited appeal.*
- Send in a provider dispute for the denial. *See section on how to dispute a denial.*

2. **I received a denial for a member's service indicating that the service does not meet medical necessity due to insufficient clinical information.**
   This is a denial from a Select Health medical director that indicates the clinical information submitted was not sufficient in providing enough information to determine medical necessity per ASAM criteria.

What can I do? If services are denied due to insufficient clinical information, you can do one or any of the following:

- Resubmit the request with the clinical information requested in the denial letter.
- Request a peer-to-peer. *See section on how to request a peer-to-peer review below.*
- Send in a provider dispute for the denial. *See section on how to dispute a denial.*

3. **I received a denial for a member's service indicating the service is denied because the member already has an authorization in place for the requested services.**
   This is a denial indicating the clinical information submitted did not support medical necessity for the member receiving the same services from different providers. The member already has a current authorization for the service being requested with another provider.

What can I do?

- Confirm with the member that he or she is receiving the same services from another provider. If the member is and you have clinical information that it is medically necessary for the member to receive the same services from two different providers, request a peer-to-peer review and/or submit a provider dispute.
- If the member is not receiving the same services from a different provider and this has been confirmed, resubmit the request and indicate the member is no longer receiving services from the other provider, request a peer-to-peer review and/or submit a provider dispute.

4. **I received a denial for a member's service indicating that no prior authorization was obtained before continuing the admission.**
   This is a denial for lack of prior authorization for services. Services cannot be backdated, and if a prior authorization is not obtained prior to admission (or within 24 hours of admission), those days are denied for coverage.

What can I do? If services are denied due to no prior authorization you can do one or all of the following:

- Discuss the denial with your patient and explain member appeal rights.
- Send in a provider dispute for the denial. *See section on how to dispute a denial.*

5. **I received a denial for a member's service indicating the service is a non-covered benefit:**
   This is a denial indicating the service being requested is not a covered service under managed care at this time. Services can be requested by Medicaid Fee-for-Service.

What can I do? If services are denied due to no prior authorization, you can do one or all of the following:

- Contact the South Carolina Department of Health and Human Services (SCDHHS) and/or Medicaid Fee-for-Service to determine if the service is a covered benefit by Medicaid Fee for Service. If the service is a covered benefit by Fee-for-Service, then you can request authorization via Fee-for-Service.
- Discuss the denial with your patient and explain member appeal rights.
- Send in a provider dispute for the denial. *See section on how to dispute a denial.*

6. **I received a denial for a member's service indicating the member is no longer eligible with First Choice by Select Health.**
   This is a denial because according to Select Health's records, the member is no longer eligible for coverage. The member's eligibility status should be confirmed by SCDHHS.

What can I do? If services are denied due to the member no longer being eligible with First Choice by Select Health, you can:

- Contact SCDHHS to determine the member's eligibility.
- Once member's eligibility if confirmed, you can submit the authorization request to Medicaid Fee-for-Service, the covering MCO or insurance plan.
- Always verify a member's eligibility on the date a service is being provided to ensure accurate information.

7. **I received a denial for a member's service indicating the services are not medically necessary due to no substance use disorder risk factors.**
   This is a denial from a Select Health psychologist that indicates the clinical information submitted did not meet medical necessity guidelines for a member with a primary mental health diagnosis to receive substance use disorder services based on AOD risk factors. *See section on AOD Risk Factors.*

What can I do? If you received a medical necessity denial for a member due to no AOD risk factors, the psychologist reviewed the clinical information submitted and determined the member does not meet medical necessity criteria for AOD risk factors per ASAM and the DAODAS risk factors guidelines. You can do one of the following:

- If the member does not meet criteria for AOD risk factors, these services can be submitted for authorization request to Medicaid Fee-for-Service.
- If the clinical information does support the member meeting criteria for AOD risk factors, you can:
  - *Request a peer-to-peer review. Review the clinical information during the peer-to-peer review to show medical necessity criteria for AOD risk factors.*
  - *Submit a provider dispute. See the section on how to dispute a denial.*

8. **How do I request a peer-to-peer review for medical necessity denials?**

To request a peer-to-peer review for any medical necessity denial, call the BH UM clinical care reviewer working with you, and request a peer-to-peer review within three days of the date of the denial.

- The BH UM clinical care reviewer will ask for the attending MD/clinician name, contact number and best time to be reached. Once this information is provided, the BH UM clinical care reviewer will inform the Select Health medical director/psychologist of the request, and the Select Health medical director/psychologist will conduct the peer-to-peer review.
- Once the peer-to-peer review has been completed:
  - *If the Select Health medical director/psychologist determines to approve the service, then a medical necessity denial will not be issued.*
  - *If the Select Health medical director/psychologist determines to deny the service, then a medical necessity denial will be issued. A member appeal and/or provider dispute can still be submitted following the peer-to-peer review.*

9. How is an expedited appeal requested?

An expedited appeal is a request to change an adverse denial for emergency services, urgent or ongoing medical care or treatment to which the application of the time periods otherwise could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or; in the opinion of a health care professional with knowledge of the member's medical condition, would subject the member to the severe pain that cannot be adequately managed without the care or treatment that is subject of the request.

To submit an expedited appeal:

- Discuss the denial with the member and member appeal rights.
- Determine that the denial of the service would result in the seriously jeopardize the member's life or health and/or the member's ability to regain maximum function.
- If the treatment team determines this to be the case, contact the BH UM care reviewer responsible for the review and request an expedited appeal.
- Once an expedited appeal is requested, a different medical director (different from the MD that issued the initial denial) will review the clinical information and determine if the appeal will be expedited.
- If Select Health denies the request for an expedited resolution, the appeal will be transferred to the standard timeframe for adverse determinations.

10. How do I submit an appeal or provider dispute for a denial?

If you get a denial (before or after a peer-to-peer review) you can submit a dispute to the Select Health Appeals department. The member can also request a member appeal within 90 calendar days of the date the denial is issued.

To submit a provider dispute:

- Call **1-888-276-2020** to initiate a provider dispute orally.
- Mail in a written provider dispute. Include a copy of the denial letter, a written letter detailing your request and all pertinent clinical information showing the reason for the services. Send written requests to:

  Select Health of South Carolina
  Medical Director, Appeals
  P.O. Box 40849
  Charleston, SC 29423-0849

Appendix

1. Example of Fax Authorization
2. Example of Behavioral Health Fax Form
3. Level I/Discrete Services Table
4. Prior Authorization Checklist
5. Commonly Used Acronyms

Example of Fax Authorization

Select Health of South Carolina

Healthy Connections

Facsimile Transmittal

To		From	
Name	DAODAS Provider	Name	
Fax	1-888-555-1234	Fax	
Phone		Phone	
Re		Date	2/4/16
Cc		Pages	0

☐ Urgent ☐ For review ☐ Please comment ☐ Please reply

Provider name: DAODAS Facility
Date and time request received: 2/3/2016 at 1352
Fax #: 000-000-0000
Mode of contact: Fax
Eligibility verified via JIVA
Member Name: Doe, Jane
Authorization #: 123456789
Bundles/Services: Level I
36 Encounters of Cluster 3 (90832, 90834, 90837, 90853, 90847, 90846)
280 Units H2017 HQ
36 Encounters H0005

PLEASE NOTE: no more than 8 hours per week of Level I services may be provided.

Dates: 2/3/2016 - 8/5/2016
Authorization is based on medical necessity or plan guidelines and not available benefits.

Please note that if you disagree with the authorization contact us at 1-866-341-8765

PO Box 40849 | Charleston, SC 29423 | p: 843.569.1759 | f: 843.569.7228 | www.selecthealthofsc.com

Example of Behavioral Health Fax Form

Select Health of South Carolina

Behavioral Health Fax Form

When complete, please fax to 1-888-796-5521.

Today's date: 02/03/2016 **Start date of admission/service:** 02/04/2016

Type of Review	Type of Admission	Admission Status	Estimated length of stay:
■ Precertification	☐ IOP ■ Substance Abuse:	■ Voluntary commitment	5 days (days/units)
☐ Continued stay	☐ MH-IP ■ Detox	☐ Involuntary commitment	**Re-admission within 30 days?**
☐ Discharge	☐ PHP/Day treatment ☐ Rehab		☐ Yes ■ No

Member Information

Member name (Last, First, MI)	
Doe, Jane J.	
Eligibility ID #	Date of birth
123000123 4	12/05/1990
Member address	
1234 Select Health Way, Charleston, SC 29402	
Emergency contact (other than primary caregiver)	Phone
Doris Doe	843-555-1234
Legal guardian/parent	Phone
N/A	

Provider Information

Facility/Provider name	NPI #/Tax ID
DAODAS Facility Name	9870043 21
Attending MD	Provider ID
Dr. Daodas	09876
Facility/Provider address	
5678 Daodas Blvd., Charleston, SC 29403	
UM review contact	Phone
Mary Smith	843-555-3210
DSM-5 Diagnoses (include mental health, substance abuse & medical)	
303.90, 305.50	

Medications

Medication name	Dosage	Frequency	Date of last change	Type of change
Prozac	20 mg	Daily	11/10/15	■ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New

Additional information

Presenting Problem/Current Clinical Update *(Include SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SA)*

Patient is being admitted for alcohol detox; patient presented to the ER requesting detox from alcohol due to withdrawal symptoms of seizures, shakes, sweats, and vomiting. Patient reported that she recently lost custody of her child due to her alcohol use and also lost her job. Patient is also fearful of losing her home if she continues drinking. Patient stated she has been depressed for years however denies any current suicidal/homicidal ideations or psychotic symptoms. Patient's mood and affect is depressed, she reports she has decreased appetite over the past few weeks and lack of sleep; she averages around 5 hours of sleep each night.

Page 1 of 2

Revised February 4, 2016

Select Health of South Carolina | PO Box 40849 | Charleston, SC 29423 | Phone 1-866-341-8765 | Fax 1-888-796-5521

FC-05202015-P-001

Behavioral Health Fax Form continued

When complete, please fax to 1-888-796-5521.

Page 2 of 2 for member name: Doe, Jane J.

Eligibility ID#: 1 2 3 0 0 0 1 2 3 4

Treatment History and Current Treatment Participation

Previous MH/SA inpatient, rehab or detox:	Patient has been in mental health inpatient in 2013, no previous SA rehab or detox
Outpatient treatment history:	Patient has been in outpatient therapy in the past and recently began seeing a psychiatrist for depression
Is the member attending therapy and groups? ■ Yes ☐ No If yes, please specify:	Patient will attend substance abuse therapy and group sessions while on the detox unit
Explain clinical treatment plan:	Clinical treatment plan is to safely help the patient withdraw from alcohol and no longer experience physical withdrawal symptoms
Family involvement and/or support system:	Patient's mother came with her to the ER for admission to detox and will be involved with patent's treatment

Substance Abuse: ■ Yes ☐ No

If yes, MH services only, please explain how substance abuse is being treated: N/A

If yes, please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/Day Treatment, SA Detox and SA Rehab.

Dimension Rating (0–4)	Current ASAM Dimensions are Required			
Dimension 1: Acute intoxication and/or withdrawal potential Rating: 4	Substances used (pattern, route, last used): Alcohol: daily use; oral; last used 2/3/16 Opiates: used every other day; oral; last used 2/2/16	Tox screen completed? ■ Yes ☐ No If yes, results: Opiates	History of withdrawal symptoms: Vomiting, sweats, flu-like symptoms, seizures	Current withdrawal symptoms: Vomiting, sweats, 1 seizure, depression, joint pain
Dimension 2: Biomedical conditions and complications Rating: 2	Vital signs: BP 152/91, Temp 100.5, reps 25, heart rate 95	Is member under doctor care? ■ Yes ☐ No Current medical conditions: Liver problems	History of seizures? ■ Yes ☐ No	
Dimension 3: Emotional, behavioral or cognitive conditions and complications Rating: 2	MH diagnosis: Non-identified however patient reports feelings of depression for a long time	Cognitive limits? ☐ Yes ■ No	Psych medications and dosages: Prozac 20 mg daily	Current risk factors (SI, HI, psychotic symptoms, etc.): None noted per patient
Dimension 4: Readiness to change Rating: 3	Awareness/commitment to change: Patient reports a commitment to quit drinking based on recent losses	Internal or external motivation: Internal: health concerns, lost custody of child External: DSS involvement	Stage of change, if known: Pre-contemplation	Legal problems/probation officer: None noted
Dimension 5: Relapse, continued use or continued problem potential Rating: 3	Relapse prevention skills: None	Current assessed relapse risk level: ■ High ☐ Moderate ☐ Low	Longest period of sobriety: 4 weeks in 2013	
Dimension 6: Recovery/living environment Rating: 3	Living situations: With boyfriend	Sober support system: Mother	Attendance at support group: None prior to admission	Issues that impede recovery: Chronic alcohol use

Discharge Planning

Discharge planner name	Discharge planner phone
Marian Cunningham	843-555-9999

Residence address upon discharge: 5678 Daodas Blvd., Charleston, SC 29403

Treatment setting upon discharge	Treatment provider upon discharge
Intensive Outpatient Program	DAODAS Facility

Has a post-discharge 7-day follow-up appointment been scheduled? ■ Yes ☐ No

If no, please explain:

If yes, give treatment provider name and date/time of scheduled follow up: DAODAS Facility 2/16/16 at 10 a.m.

Level I/Discrete Services (No more than 8 hours per week)

CODE	DESCRIPTION	MOD & MOD DESCRIPTOR	UNIT	FREQUENCY LIMITS / BENEFIT STRUCTURE	PRIOR AUTH REQUIRED?	MNC	CLUSTER*	COMMENTS
90792	Diagnosis evaluation w/medical	AF - Physician AM - Physician asst. SA - Nurse pract.	Encounter/ DOS = 1 unit	1 per 6 months without authorization	No	ASAM	No	*This code is outside of all bundled service packages.
96101	Psychological testing, includes face-to-face time administering tests, time interpreting results and preparing report	AH - Clinical psychologist	1 unit = 1 hour	All units require prior authorization	Yes	Inter Qual	No	*This code is outside of all bundled service packages.
96102	Psychological testing, includes face-to-face time administering tests and preparing report	HO - Master's level	1 unit = 1 hour	All units require prior authorization	Yes	Inter Qual	No	*This code is outside of all bundled service packages.
H0001	Alcohol and drug assessment w/o physical (initial)	AH - Clinical psychologist HO - Master's level HN - Bachelor's level	Encounter/ DOS = 1 unit	1 per 6 months without authorization	No	ASAM	No	*This code is outside of all bundled service packages.
		TS - Alcohol and drug assessment w/o physical (follow-up)	Encounter/ DOS = 1 unit	1 per 6 months without authorization	No	ASAM	No	*This code is outside of all bundled service packages.
		U2 - A&D nursing services	Encounter/ DOS = 1 unit	22 units per rolling 12-months without authorization	No	ASAM	No	*This code is outside of all bundled service packages.
99408	Alcohol and/or substance abuse structured screening and brief intervention services	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level HN - Bachelor's level TD - Registered nurse (RN) TE - Lic. prac. nurse (LPN)	Encounter/ DOS = 1 unit	12 per rolling 12 months without authorization	No	ASAM	No	H0001 and 99408 cannot be billed on the same DOS. Billable screenings must be conducted face-to-face. *This code is outside of all bundled service packages.
H0032	Service plan development with and/or without patient present		Encounter/ DOS = 1 unit	6 units per rolling 12-month period without authorization, combined total of Cluster 2 codes	No	ASAM	Cluster 2	*This code is outside of all bundled service packages.

CODE	DESCRIPTION	MOD & MOD DESCRIPTOR	UNIT	FREQUENCY LIMITS / BENEFIT STRUCTURE	PRIOR AUTH REQUIRED?	MNC	CLUSTER*	COMMENTS
90832	Psychotherapy 30 mins.	AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	
99203	Medical evaluation and management for new patient	AF - Physician AM - Physician asst. SA - Nurse pract.	Encounter/ DOS = 1 unit		No		No	If the prescriber also does therapy, the use add on codes 90833 (30 min) or 90836 (45 mins.)
99213	Medical evaluation and management for established patient	AF - Physician AM - Physician asst. SA - Nurse pract.	Encounter/ DOS = 1 unit		No		No	If the prescriber also does therapy, the use add on codes 90833 (30 min) or 90836 (45 mins.)
90834	Psychotherapy 45 mins.	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	Modifiers AF, AM
90846	Family psychotherapy (w/o patient present)	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	
90847	Family psychotherapy (with patient present)	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	
90849	Multiple family group psychotherapy	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	
90853	Group psychotherapy other than a multiple family group	AF - Physician AM - Physician asst. SA - Nurse pract. AH - Clinical psychologist HO - Master's level	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	Cluster 3	
H0004	Substance abuse counseling—individual	NA	1 unit = 15 mins	All units require prior authorization	No	ASAM	No	
H0005	Substance abuse counseling—group	NA	Encounter/ DOS = 1 unit	All units require prior authorization	No	ASAM	No	

CODE	DESCRIPTION	MOD & MOD DESCRIPTOR	UNIT	FREQUENCY LIMITS / BENEFIT STRUCTURE	PRIOR AUTH REQUIRED?	MNC	CLUSTER*	COMMENTS
H0038	Peer support services	No modifier - individual HQ - group	1 unit = 15 mins	All units require prior authorization	Yes	DHHS Svc. Desc.	No	
H2011	Crisis intervention services face-to-face and telephonic	No modifier - face-to-face HF - telephonic	1 unit = 15 mins.	16 per day without prior authorization	No	DHHS Svc. Desc.	No	PA not required as this is a crisis service. Instead service may be reviewed retrospectively to ensure compliance. *This code is outside of all bundled service packages.
H2017	Rehabilitative psychosocial services	No modifier - individual HQ - group	1 unit = 15 mins.	All units require prior authorization	Yes	DHHS Svc. Desc.	No	
S9482	Family support	No modifier - Bachelor's and above HM - less than a Bachelor's	1 unit = 15 mins.	All units require prior authorization	Yes	DHHS Svc. Desc.	No	
H0034	Medication training and support (face-to-face)	UB - Pharmacist AH - Clinical psychologist HO - Master's level HN - Bachelor's level TD - RN TE - LPN	1 unit = 15 mins.	All units require prior authorization	Yes	DHHS Svc. Desc.	No	Cannot be billed on same DOS as med check (E/M code)
J2315	Injection—Vivitrol	AF - Physician AM - Physician asst. SA - Nurse pract.	Reimburses at the same rate as the physician's fee schedule	1 per month is manufacturer's recommended limit All units require prior authorization	Yes	Pharmacy	No	*This code is outside of all bundled service packages. *submitted on the universal medication form to pharmacy*
96372	Medication Administration	AF - Physician AM - Physician asst. SA - Nurse pract. TD - RN TE - LPN Pract. Nurse		All units require prior authorization	Yes	ASAM	No	Must be billed in conjunction with J2315. Code will reject if not billed along with J2315. *This code is outside of all bundled service packages.
***Cluster 2**		Services within this cluster are not interchangeable but are counted together towards total units allowed without prior authorization.						

Prior Authorization Checklist

DAODAS Prior Authorization Checklist for Bundled Services

☐ Absolute Total Care/ Cenpatico	☐ BlueChoice Health Plan Medicaid	☐ First Choice by Select Health	☐ United Healthcare Community Plan
Phone: 866-694-3649	**Phone: 866-902-1689**	**Phone: 866-341-8765**	**Phone: 866-261-7692**
Fax: 866-534-5976	**Fax: 877-664-1499**	**Fax: 888-796-5521**	**Fax: 877-821-7350**

☐ Member Demographics *(name, DOB, Medicaid ID)*

Initial PA Checklist:

I. Admission and Intake Paperwork

☐ Current Location of Member *(admitted, waiting to be admitted, at home, ER, etc.)*
☐ Admission Date
☐ Type of Admission *(Voluntary/Involuntary)*
☐ Level of Care Requested
☐ Treating Physician / Primary Counselor Name and Telephone #
☐ Emergency Contact Information and Relationship to Member

II. Assessment Summary and Outline

☐ Diagnoses (Axis I – Axis V)
☐ Previous SA/MH Treatment
☐ Re-admission to Same LOC Within 30 Days *(Yes / No)*
☐ Current SA/MH Treatment *(Yes / No)*
☐ Compliance With Current/Past Treatment

III. ASAM Dimensions

☐ Dimension 1 – History and current withdrawal symptoms; Results of toxicity screen or UDS; CIWA; Substance used, route of use, pattern of use, age started, and last used.

☐ Dimension 2 – Member under care of a doctor; Current medical condition; History of seizures; Medical medications and dosages, who prescribed, and member's compliance status; Vitals.

☐ Dimension 3 – MH diagnosis; Cognitive limits; Psychiatric medications and dosages, who prescribed, member's compliance status, and current risk factors.

☐ Dimension 4 – Awareness/commitment to change; Internal and external motivations; Stage of change, if known; Legal problems; Probation officer, if applicable.

☐ Dimension 5 – Relapse potential; Recovery support; Longest period of sobriety.

☐ Dimension 6 – Living arrangement; Recovery support; Attendance of a support group in the community; Central theme that will work for or against recovery.

IV. Length of Treatment

☐ Requested Length of Treatment
☐ Projected Discharge Date

DAODAS Prior Authorization Checklist for Bundled Services

☐ **Absolute Total Care/ Cenpatico** **Phone: 866-694-3649** **Fax: 866-534-5976**	☐ **BlueChoice Health Plan Medicaid** **Phone: 866-902-1689** **Fax: 877-664-1499**	☐ **First Choice by Select Health** **Phone: 866-341-8765** **Fax: 888-796-5521**	☐ **United Healthcare Community Plan** **Phone: 866-761-7692** **Fax: 877-821-7350**

Continuation of Services PA Checklist:

☐ Type of Admission *(Voluntary/Involuntary) *only need if there has been a change*
☐ Treating Physician / Primary Counselor Name and Telephone # *only need if there has been a change*
☐ Emergency Contact Information and Relationship to Member *only need if there has been a change*
☐ Diagnoses (Axis I – Axis IV) *only need if there has been a change*
☐ Current SA/MH Treatment *(Yes / No) *only need if there has been a change*
☐ Compliance with Current/Past Treatment *only need if there has been a change*
☐ ASAM Dimensions *Ongoing withdrawal symptoms? Medical interventions needed / PRNs used, change in medications/vitals? Updated current status and risk factors. Discharge planning.*
☐ Updated Physician's and Staff Notes
☐ Member Status – how progressing in treatment; changes in treatment due to member's response
☐ Family Involvement
☐ Specific Discharge Plan – place of residence, provider, appointment date, etc.

Change in Level of Care or Discharge Review Checklist:

☐ Admit Date
☐ Discharge Date
☐ Type of Discharge *(successful, AMA, step-down, step-up, etc.)*
☐ Five Axes Discharge Diagnosis
☐ Psychiatric Medications and Plan for Continuation (i.e., who will prescribe and monitor)
☐ Risk Factors and Plan to Manage *(includes relapse potential, sober supports, etc.)*
☐ Aftercare Place of Residence – Address and Phone Number
☐ If Member Is a Minor, Parent/Guardian Name and Contact Information
☐ Aftercare Treatment Level of Care
☐ Aftercare Provider
☐ Aftercare Appointment(s)
☐ Identified Barriers to Aftercare

Commonly Used Acronyms

DAODAS Department of Alcohol and Other Drug Abuse Services

MCO Managed Care Organization

IPOC Individualized/Individual Plan of Care

PHP Partial Hospitalization Program

IOP Intensive Outpatient Program

OPT Outpatient

SUD Substance Use Disorder

UM Utilization Management

ASAM American Society of Addition Medicine

BH Behavioral Health

MH Mental Health

SA Substance Abuse

BH UM Behavioral Health Utilization Management

SCDHHS South Carolina Department of Health and Human Services

AOD Alcohol and Other Drugs

MD Medical Doctor

Toll free: 1-800-741-6605 | Charleston: 843-569-1759

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Select Health of South Carolina

Healthy Connections

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