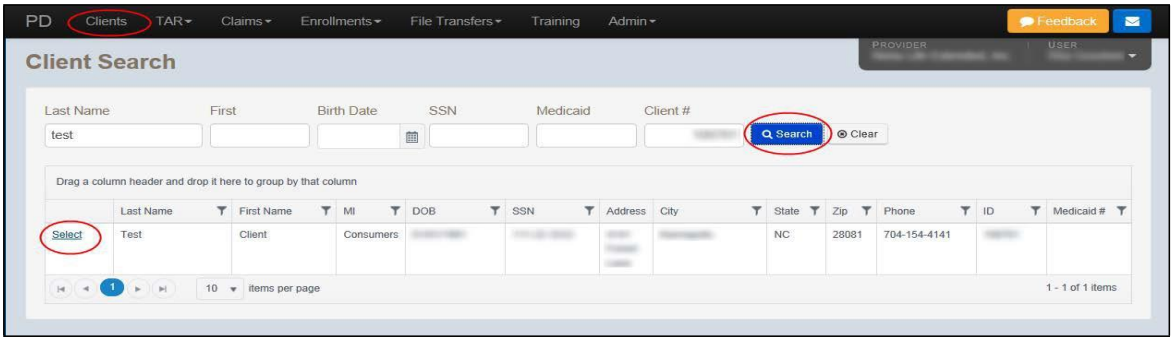
Outpatient Therapy Submission Tips

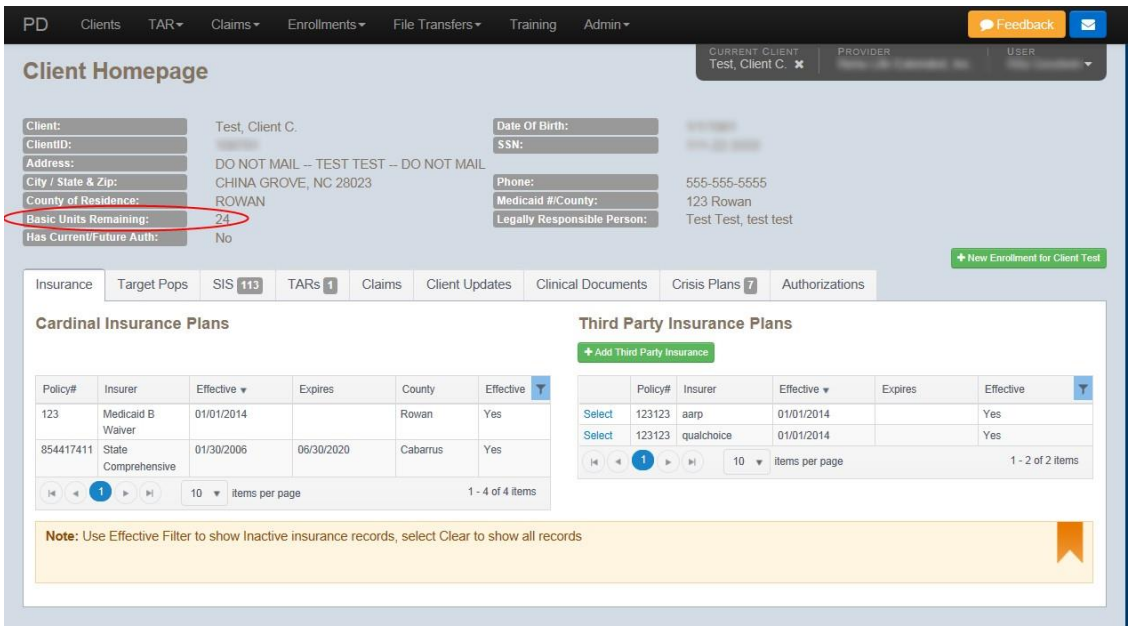
Unmanaged sessions include any therapy and assessment service codes. It does not include psychiatric service codes (E&M) or psychological testing codes.

For Medicaid consumers TARs should be submitted when consumer has five or less unmanaged sessions listed in the provider direct system. IPRS consumers who have five or less may also be submitted only if there is available funding. Please check Authorization Guidelines to determine availability per catchment. http://www.cardinalinnovations.org/providers/resources

To determine the number of unmanaged sessions remaining please complete the following:

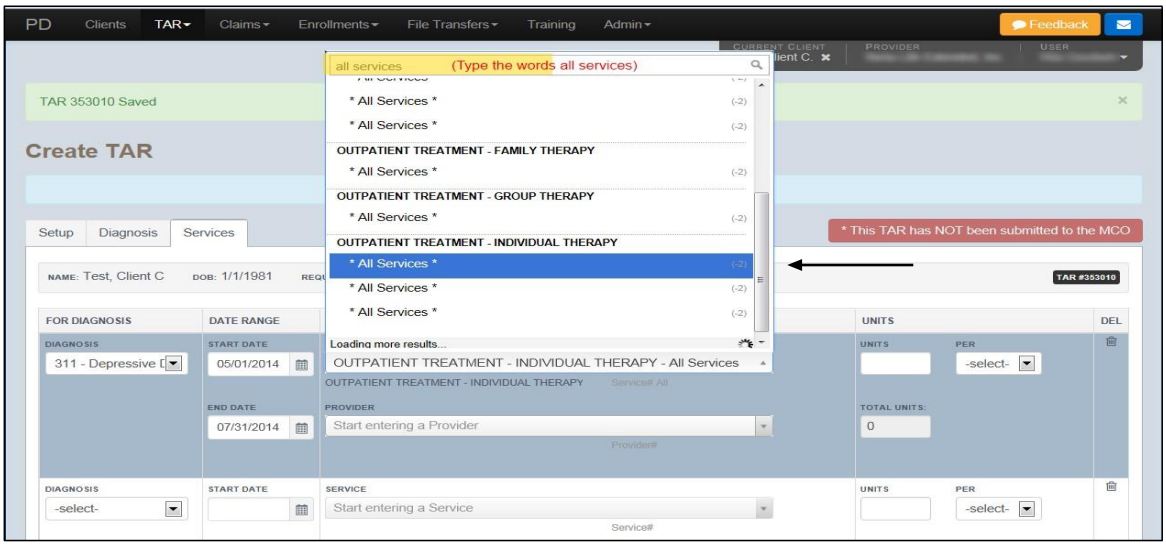
From the Provider Direct Dashboard, click on Clients from the menu bar. Enter the client's first name, last name and date of birth, or SSN alone, or last name and Client ID, or last name and Medicaid #, and then click Search. Once you have found the client, click the select to the left of the client's name. You will then see listed below where it indicates basic units left.





- TARs that are submitted as “Expedited” should clearly explain in the clinical comments what the immediate health and safety concerns exist requiring expedited review. (This would be extremely rare for an outpatient request.) Expedited should not be selected if there is no clinical reason for this, and is being utilized only because the provider has run out of unmanaged sessions.

- It is best to use the “All Service” clusters for each therapy category. This allows providers to determine approximate # of sessions that will be needed and then able to bill any codes in their contract, vs. having to request each individual service code. To do this, on TAR click the appropriate outpatient treatment type and then the “All Services” line. Providers will need to do this for each therapy category: individual, group, and family therapy.



- For requests submitted for Managed sessions, comments should clearly explain progress toward each of goals, and type of therapy being received (Cognitive Behavioral Therapy, Motivational Interviewing, Play therapy, etc.) This should be consistent with best practice for the diagnosis indicated, comments on why outpatient remains the appropriate level of care and a higher level of care or alternative services are not more appropriate. Comments on discharge planning should also be included as these should be discussed from admission. All TAR fields should be completed in full, with no blank questions. Blank fields could result in the return of the request.

- If requesting weekly therapy sessions after the unmanaged sessions are used with no plan for titration, requests should clear outline why this remains appropriate. Providers should outline what adjustments are being made to interventions to increase effectiveness or the specific evidenced based practice modality being used that would indicate a continued high frequency.

- For children in services, family therapy should be a key component of treatment. If family therapy is not being utilized the request should clear outline why this is not clinically appropriate.

- When requesting for Authorization after unmanaged sessions are used, these should be requested "per lifetime" through the end of the fiscal year. It is helpful to indicate in the comments what the typical frequency is i.e. 2 times per month for family, weekly for group.

Note: The Basic Units Left is calculated based on the basic units guidelines (depending on funding source) then is decreased based on paid claims. Please note if a provider is seeing this client and only bills monthly, several of these basic units could be used up as soon as that billing it submitted.

Unmanaged sessions are given per consumer, so if a consumer has seen another provider during the fiscal year some of the unmanaged sessions may have already been used, so it is important to check the system and also discuss with the consumer any prior treatment.

Once an authorization has been given, providers must bill against that authorization until this end date has expired as this is now a "managed" service, even if there are unmanaged sessions available. This is why it is recommended only to request authorization when unmanaged sessions have been used.

If the existing authorization expires during the fiscal year and the consumer still has unmanaged sessions remaining for that year, these can be used since the "managed" dates of service have expired.

For IPRS financial intakes should be completed and provider has evidence of consumer's ability to pay/eligibility for IPRS based on sliding scale requirements. Providers should also assist consumers in applying for Medicaid whenever possible.

If consumers are in MHSA enhanced services or Innovations services and also receiving Outpatient, the outpatient services and frequency must be included in the person centered plan (PCP) or Individual Support Plan (ISP) as required by the clinical coverage policy.

For Enhanced Services that include therapy as a component such as IIHS, MST, Day Treatment, Residential Level III, ACTT, CST, SAIOP, SACOT the plan must include justification for outpatient therapy, and authorization is required, as the intent of unmanaged sessions is for consumers who are not in other higher levels of care. Please refer to Communication Bulletin FY1112 UM 09 for specific details.

H Codes are billed in 15 minute increments, however the actual TAR submitted should be requested 1 session = 1 unit.