sunshine health
Medicaid

Changes to Prior Authorization Requirements
Frequently Asked Questions

What is changing?

Cenpatico will require participating providers to obtain prior authorization for individual, group and family therapy services, after twelve (12) sessions are utilized in a calendar year.

Why is this changing?

In order to more effectively assure that members, with Medicaid coverage, are receiving the appropriate type and frequency of therapy services and maintain access to needed care, Cenpatico is looking at the requests for these services after 12 sessions have been utilized in a year. In order to best serve our members, we will be making sure that the requests are leading to clinical improvement, and we will continue to assist in every way to assure members are receiving the care they will most benefit from with the support of our care coordination programs.

When will prior authorizations be needed?

Effective **July 15, 2016** prior authorizations will be required after the member's twelfth (12th) visit per calendar year.

BILLING

What services are being affected?

The following codes are affected nationwide. These will affect you if the codes below are covered benefits in Florida:

Code	Description
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an E/M service
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an E/M service
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an E/M service
90840	Psychotherapy for crisis; each additional 30 minutes]
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90845	Psychoanalysis
90875	Individual therapy with biofeedback, 30 min
90876	Individual therapy with biofeedback, 60 min
90880	Hypnotherapy

Will any of the codes listed above count towards the twelve (12) visits if they are billed as an add-on with any other service?

Yes, codes: 90833, 90836, 90838, and 90840.

Will there be additional codes added to this list?

Not at this time.

What products are being affected?

All CHIP, Medicaid and Foster Care:

- STARS
- STARS Plus
- Medicaid Managed Care

COUNTING TWELVE (12) VISITS

When does a member's visits renew?

Every calendar year on January 1st a member can start to receive twelve (12) visits without prior authorization being required. If a member has already begun treatment, but has not completed twelve (12) visits prior to December 31st in a given calendar year, and they continue treatment into the following calendar year, the member's benefits still renew starting January 1st for twelve (12) visits without prior authorization being required.

If a member sees two (2) different providers who belong to the same group, will both visits count towards the twelve (12) visit threshold?

No, visits are counted per provider. Therefore, only one (1) visit will count towards each provider's twelve (12) visit threshold for that member.

How will I know how many visits a member has completed?

You can view your claims submitted for a member on our secure provider portal at provider.cenpatico.com.

How will the authorizations be counted if I have more than one (1) location?

Visits are calculated by a Cenpatico provider ID number. Each individual provider is assigned one in our system. This ID number remains the same for all locations a provider may serve. This means we will count each time an individual provider sees a member regardless of location.

MEMBER ELIGIBILITY

Are there any limits to the number of outpatient therapy visits a member can receive?

There are currently no coverage limits regarding the number of medically necessary outpatient therapy services a member can receive, and this will not change.

What will happen if a member changes plans?

If a member changes Plans, please contact the new carrier for prior authorization procedures.

What happens when a member becomes ineligible?

When a member is no longer eligible, their authorization is null and void. Cenpatico only ensures claims payment on eligible members.

What will happen if a member changes plans and returns to Cenpatico before the end of the year?

The visit counts will continue where the member left off.

How will the changes be applied per member?

Changes will be applied per member, per provider, and visits renew each calendar year in January.

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AUTHORIZATION REQUESTS

How do I submit a prior authorization request for outpatient therapy?

The most efficient way is to submit a request via the secure provider portal online at provider.cenpatico.com. Or, you can download an Outpatient Treatment Request (OTR) Form from our website at www.cenpatico.com/providers/florida/fl-provider-tools.

How can I request a retro authorization?

You may fax a retrospective review to our Appeals department at (866) 714-7991. This does not guarantee authorization will be granted for services that required prior authorization; however, you may request a review of services rendered through this process

Will there be prior authorization changes to any therapeutic crisis intervention services or substance use disorder treatments?

No.

What will happen if I unwittingly submit a claim for services rendered after the twelfth (12th) visit without receiving prior authorization?

You may fax a retrospective review to our Appeals department at (866) 714-7991. This does not guarantee authorization will be granted for services that required prior authorization; however, you may request a review of services rendered through this process.

EXCLUSIONS

What locations are excluded?

The following locations are excluded where applicable, based on state benefits. If you are performing services at any of the below locations, you do NOT need to request prior authorization. There are no authorization requirements for outpatient therapy services performed at the below locations:

21	Inpatient Hospital
51	Inpatient Psychiatric Hospital
61	Comprehensive Inpatient Rehab Facility
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
32	Nursing Facility

Will this requirement apply to all outpatient providers?

Yes, this will affect all outlined codes provided in an outpatient setting.

Are there any provider specialties that are excluded from the requirement to submit a prior authorization request for outpatient therapy services?

No.

Are there any changes for behavioral health assessments or evaluations?

No, there are no changes for behavioral health assessments or evaluations.