Washington State Health Care Authority

2024 Apple Health Medicare Connect behavioral health services reference guide

Use this reference guide to assist with coordination of behavioral health benefits and services across Apple Health (Medicaid) Behavioral Health Services Only (BHSO) and Medicare coverage. The table below reviews what services are covered by BHSO plans and which services are covered by the Medicare Dual-Eligible Special Needs Plans (D-SNP). Medicare is the primary payer when individuals are dual-eligible for Apple Health and Medicare.

Coverage and prior authorization

Emergent, unplanned admissions to acute inpatient behavioral health facilities (such as evaluation and treatment or acute inpatient detoxification) do not require prior authorization but do require notification of the admission by means of electronic file, fax, or phone call within 24 hours of that admission. Clinical information shall be provided for medical necessity determination, known as concurrent review, following this notification. This can apply to lower-level services as well.

Note: Providers should send current (within the past 7 days) clinical information to support initial request for bedded services. Interval update to recent assessment is acceptable.

BHSO and D-SNP coverage and authorization reference table

Key: No = prior authorization is not requried | Yes = prior authroization is required

Service type and description	Behavioral Health Services Only plans					Dual-Eligible Special Needs plans
	Community Health Plan of Washington	Coordinated Care	Molina Healthcare of Washington	UnitedHealthcare Community Plan of Washington	Wellpoint Washington (previously Amerigroup)	All plans
Acute Inpatient Care – Mental Health and substance use disorder (SUD) treatment services **Acute Psychiatric Inpatient; Evaluation and Treatment Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital**	**No** Emergent admissions require notification only within 24 hours followed by concurrent review.	**No** Emergent admissions require notification only within one business day followed by concurrent review.	**No** Emergent admissions require notification only within 24 hours followed by concurrent review.	**No** Emergent Acute admissions require notification only within 24 hours followed by concurrent review.	**No** Emergent admissions require notification only within 24 hours followed by concurrent review.	**No** Emergent Acute admissions require notification. Notification based on contract requirements with facility.

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Inpatient Acute Withdrawal (Detoxification) ASAM* 4.0 **Members admitted on an Involuntary Treatment Act (ITA) are reviewed for change in legal status, confirmation of active treatment, and transition of care needs.** **Attach court documents if ITA.**	Voluntary Admission requires initial review within 24 hours of admission. Coordinate with Transitions of Care/Health Home Care coordinator. *Initial: 3-5 days * ITA admissions – Initial for 120 hours, then dependent on further commitment will authorize 14 days. Upon confirmation of 90-day commitment, will continue to authorize in 14-day increments.	Voluntary Admission requires initial review within 24 hours of admission. Coordinate with Transitions of Care/Health Home Care coordinator. * Initial and concurrent: 3-5 days	Coordinate with Transitions of Care/Health Home Care coordinator. Authorization length segments: * Voluntary admissions - Initial and continued stay: 3-5 days (or Medical Director discretion) * ITA admissions – Initial for 120 hours, then dependent on further commitment will authorize 14 days or to the next court date. Upon confirmation of 90-day commitment, will continue to authorize in 14-day increments (or at Medical Director discretion).	Voluntary Admission requires initial review within 24 hours of admission. Coordinate with Whole Person Care/Health Home Care coordinator. *Initial: 3-5 days	Voluntary Admission requires initial review within 24 hours of admission. Coordinate with Transitions of Care/Health Home Care coordinator. *Psych Initial: 7 days *SUD Initial: 5 days *Initial and concurrent for ITAs is 14 days.	ITA admissions require notification. Notification based on contract requirements with facility.
Withdrawal management (in a residential setting) **ASAM 3.7** **ASAM 3.2** **Members admitted on an ITA are reviewed for change in legal status,**	**No** Emergencies require notification only within 24 hours. Auto approve three days with clinical request for concurrent review. **Yes** Prior authorization and	**No** Emergencies require notification only within one business day followed by concurrent review. **Yes** Prior authorization and	**No** Emergencies require notification only within 24 hours. Auto approve three days with clinical request for concurrent review. **Yes** Prior authorization and	**No** Emergencies require notification only within 24 hours followed by concurrent review. **Yes** Prior authorization and	**No** Emergencies require notification only within 24 hours followed by concurrent review. **Yes** Prior authorization and	**No** Emergent acute admissions require notification. Notification based on contract requirements with facility.

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confirmation of active treatment and transition of care needs. **Attach court documents if ITA for secure detox.**	concurrent review is required if services are planned. *Initial: 3 calendar days *Reference- HB 2642	concurrent review is required if services are planned. * Initial and concurrent: 3-5 days	concurrent review is required if services are planned. *Initial: 3-5 days depending on severity of detoxification and types of substances used * ITA admissions for secure detox– Initial for 120 hours, then dependent on further commitment will authorize 7-day increments (or at Medical Director discretion).	concurrent review is required if services are planned. *5 days	concurrent review is required if services are planned. *Initial: 5 days	**Yes** if planned – Admissions require notification. Notification based on contract requirements with facility.
Crisis stabilization in a Residential Treatment setting **Attach court documents if least restrictive alternative (LRA) or conditional release (CR).**	**No**. if Emergent –requires notification only within 24 hours followed by concurrent review. **Yes**. if planned – requires pre-service review and concurrent review. *Initial: 3-5 days	**No**. if Emergent –requires notification only within 1 business day followed by concurrent review. * Initial and concurrent: 3-5 days	**No**. if Emergent –requires notification only within 24 hours followed by concurrent review. **Yes**. if planned – requires prior authorization and concurrent review. Authorization length segments: *Initial: 3-5 days (or Medical Director discretion) Continued stay: Based on medical necessity and at Medical Director's discretion	**No**. if Emergent –requires notification only within 24 hours followed by concurrent review. **Yes**. if planned – requires pre-service review and concurrent review. *Initial: 3-5 days	**No**. if Emergent –requires notification only within 24 hours followed by concurrent review. **Yes**. if planned – requires pre-service review and concurrent review. *Initial and Concurrent: 5 days	Not a covered benefit.

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Residential treatment – mental health and SUD **If for SUD:** **ASAM 3.5** **ASAM 3.3** **ASAM 3.1** **Attach court documents if LRA or CR.**	**Yes** Prior authorization is required when services are planned. Concurrent review is required. Provide notification within 24 hours if services are not planned. *Reference- HB 2642 Yes, if planned – request pre-service review and concurrent review. *14 days for long-term and short-term SUD treatment services *30 days if parenting, 60 days if pregnant for SUD residential treatment for pregnant or parenting women *Mental health residential treatment is based on clinical assessment.	**Yes** Prior authorization is required when services are planned. Concurrent review is required. *7 to 14 days for ASAM 3.1 and 3.5 *30 days for ASAM 3.3 *14 days for short-term mental health *30 days for long-term mental health	**No** SUD if emergent – requires notification only within 24 hours followed by concurrent review. Per ESHB 2642 MCO required to cover first 2 business days including holidays and weekends Yes, requires prior authorization and concurrent review. Authorization length segments: *Initial and Concurrent for ASAM 3.5 and short-term mental health residential treatment facility (MH RTF) (H0018): *7 to 14 days (or Medical Director discretion) *For ASAM 3.3 and 3.1, authorization segments are 30 days for initial and concurrent review (or Medical Director discretion) *Long-term MH RTF (H0019), authorization segments are	**Yes** Prior authorization is required when services are planned. Concurrent review is required. *Initial 14-days for ASAM 3.5/service encounter reporting instructions (SERI) code H0018 *Initial 30 Days for ASAM 3.3/SERI code H0019 *Initial: 30 Days: ASAM 3.1/SERI code H2036 *All initial and concurrent reviews are subject to medical director discretion	**Yes** Prior authorization is required when services are planned. Concurrent review is required. *Initial and concurrent: 14 days *Long-term concurrent: 30 days *Long-term MH RTF (H0019), authorization segments are 30 days for initial and concurrent review (or Medical Director discretion)	Not a covered benefit.

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			30 to 60 days for initial and concurrent review (or Medical Director discretion)			
Partial Hospital Program (mental health)	**Yes** *Initial: 10 Business days New authorization request needed for continued care.	**Yes** *Initial and concurrent: 7 business days	**Yes** Prior authorization and concurrent review is required. *Initial: 5 to 10 days *Continued stay: Based on request and medical necessity	**Yes** *Initial: 4 days	**Yes** *Initial: 14 days	**Yes** Prior authorization and concurrent review is required.
Intensive outpatient services and programs **ASAM 2.1**	**No**	**No**	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers. Outlier monitoring with concurrent and post-service medical necessity reviews.	**No** Prior authorization is not required for code 96153. **Yes** Prior authorization is required for non-network providers. *Initial: Less than or equal to 12 visits based on authorization and notification rules and outlier monitoring.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers. *Initial: 20 days	Not a covered benefit.

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Medication Evaluation and Management	**No**	**No**	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.
Medications for Opioid Use Disorder (MOUD)	**No** Prior authorization is not required for preferred medication. **Yes** Prior authorization is required for buprenorphine monotherapy and non-preferred medication.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**Yes** CPT codes 80305, 80306, and 80307 require prior authorization for more than 12 tests in any combination. CPT codes G0480, G0481, G0482, and G0483 require prior authorization for more than 8 tests in any combination. CPT code 82075 requires prior authorization after 12 tests.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.

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Medications for opioid use disorder (MOUD) (presumptive and definitive) and Ethyl Alcohol (ETOH) testing	**Yes** CPT codes 80305, 80306, and 80307 require prior authorization for more than 24 tests per 12 months or more than 18 tests during a pregnancy. CPT codes G0480 and G0481 require prior authorization for more than 16 tests per 12 months or more than 12 tests during a pregnancy.	**Yes** CPT codes 80305, 80306, and 80307 require prior authorization for more than 24 tests in any combination. CPT code G0480 requires prior authorization for more than 16 tests in any combination. CPT codes G0481, G0482, and G0483 always require prior authorizations. CPT code 82075 requires prior authorization after 12 tests.	**Yes** CPT codes 80305, 80306, and 80307 require prior authorization for more than 12 tests in any combination. CPT codes G0480, G0481, G0482, and G0483 require prior authorization for more than 8 tests in any combination. CPT code 82075 requires prior authorization after 12 tests.	See SERI for billing guidelines.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.
Initial assessment for mental health, SUD, and American Society of Addiction Medicine (ASAM) and outpatient psychotherapy services	**No**	**No**	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.

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			Outlier monitoring with concurrent and post-service medical necessity reviews.	Outlier monitoring with concurrent and post-service medical necessity reviews.		
High intensity outpatient and community-based services (WISe and PACT)	**No** Notifications are required for WISe services for adverse benefit determinations only and members indicated on interest lists waiting for enrollment. WISe members are assigned a behavioral health or regional case manager. *Notifications are required for PACT only for the initial 6 months. New authorization requests are needed for continued care based on medical necessity. King County only - Pre cert request based on medical necessity.	**No** Notifications are required.	**No** Notifications are required.	**Yes** Notifications are required for WISe services.	**No** Notifications are required. Members in WISe/PACT receive case management and participate in case conferences. Notifications are required for WISe services for adverse benefit determinations only.	Not a covered benefit.
Applied Behavior Analysis (ABA)	**Yes** Pre-service authorization is required for ABA therapy and approved for 6 months.	**Yes** Pre-service authorization is required for ABA therapy and approved for 6 months.	**Yes** Pre-service authorization is required for ABA therapy and continued treatment	**Yes** Pre-service authorization is required for ABA therapy and continued treatment	**No** Prior authorization is not required for in network providers.	**No**

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	* Re-certification - New authorization based on medical necessity approved for 6 months. *ABA Inpatient setting- Per-service request required.		authorization every 6 months. *H2020 requires prior authorization after initial 48 service days, or age > 6 years	authorization every 6 months.	**Yes** Prior authorization is required for non-network providers.	
Electroconvulsive therapy (ECT)	**Yes** Pre-service authorization is required for initiation, continuation, and maintenance treatment. *Initial: 6 sessions. Beyond 6 sessions is subject to MD review (for initial and ongoing/ maintenance)	**Yes** Pre-service authorization is required for initiation, continuation, and maintenance treatment. *Initial and concurrent: 10-12 sessions	**Yes** Pre-service authorization is required for initiation, continuation, and maintenance treatment. *Initial: 8-12 sessions (or at Medical Director discretion) for acute/initiation requests. *Continuation: 6 sessions (or at Medical Director discretion)	**Yes** Pre-service authorization is required for initiation, continuation, and maintenance treatment. *6-12 initial sessions	**Yes** Pre-service authorization is required for initiation, continuation, and maintenance treatment. *Initial: 6-10 sessions	**No**
Transcranial magnetic stimulation (TMS)	**Yes**	**Yes**	**Yes** *Initial: Up to 36 treatments over one-year period	**Yes**	**Yes**	**Yes**

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Psychological testing	**No** Prior authorization is not required for the first 2 units of service per client per lifetime. **Yes** Prior authorization is required for additional units of service.	**No**	**No** Prior authorization is not required for the first 2 units of service per client per lifetime. **Yes** Prior authorization is required for additional units of service for all non-participating providers.	**No** Prior authorization is not required for the first 2 units of service per client per lifetime. **Yes** Prior authorization is required for additional units of service.	**No** Prior authorization is not required for the first 2 units of service per client per lifetime. **Yes** Prior authorization is required for additional units of service.	**No**.
Neuropsychological testing	**Yes**	**No**	**Yes**	**No**	**Yes** Prior authorization is required for individuals ages 20 years and older. **No** Prior authorization is not required for individuals ages 19 years and younger for 15 units or less.	**No**
Telehealth and telepsychiatry	**No**	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.	**No** Prior authorization is not required for in network providers. **Yes** Prior authorization is required for non-network providers.

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Wrap-Around Services or State General Fund (SFG) Services	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Payment is limited to GFS allocated amount identified in Provider contract.	Not a covered benefit.
Clubhouse/Day support	**No**	**No**	**No**	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Clubhouse is covered under procedure code H2031.	Not a covered benefit.
Respite care	**No**	**No**	**No**	**No** Payment is limited to GFS allocated amount identified in Provider contract.	**No** Registration and notification is required.	Varies by plan. Each plan has different requirements. Contact the members plan to learn more as this may fall under supplemental benefits.

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