



Provider Bulletin # 18-08: Prior Authorization Requirement Waived for Medically Monitored Residential Care (Level 3B) Frequently Asked Questions (FAQ)

1. What happens if the 7th day of 3B falls on a weekend? Do we do the review on the next business day?

CBH will authorize an initial 7 days or 9 days so that the last covered day does not fall on a weekend. Sunday and Monday admissions will receive an initial 9 days and all other days of the week will receive an initial 7 days.

2. If a 4A or 3A member is assessed as meeting criteria for 3B, does the accepting provider call CBH for the authorization number or do they call their assigned clinical care manager?

Authorization numbers will be given the same way; the accepting 3B provider should call CBH for the authorization number.

3. Will members being admitted to 3B receive an initial 7 days with review on day 7 or will the review be done on the first uncovered day?

CBH will continue to review on the last covered day.

4. If a member is denied continued stay, do they still have continuation rights for up to 30 days like they do now?

The grievance process has not changed so members will continue to have continuation rights.

5. How will additional time be provided by clinical care managers to ensure that continued stay reviews are completed in a timely manner?

CBH will ensure each clinical care manager has a manageable caseload and continue to obtain any additional coverage if needed. CBH is also utilizing a uniform template for clinical care managers and providers so that reviews can be conducted in the most efficient manner possible.

6. Can a community-based provider send their members to a 3B provider without precertification?

Community-based providers should assess members using the Pennsylvania Client Placement Criteria (PCPC) (or American Society of Addiction Medicine [ASAM] once in use) and for those needing 3B level of care, admission should be coordinated through the community-based provider and the 3B unit. Approval from CBH will not be required; however, the receiving residential facility should contact CBH for an authorization number.

7. How should a detoxification provider get a member into 3B?

A detoxification provider should assess the member for the next level of care and make a

referral based on that assessment. The detoxification provider can refer directly to 3B without approval from CBH.

8. What role does treatment history and recidivism have in the process?

A member's treatment and readmission history should be incorporated into the assessment and clinical decision making by the provider.

9. My concern is getting a quality assessment on all dimensions in 72 hours; why is this necessary?

CBH expects assessment and discharge planning to begin upon admission using the PCPC (or ASAM once in use); the 72-hour timeframe helps ensure readiness for the 7-day review, when the member will either meet PCPC criteria or be ready for discharge.

10. Our members are admitted under Department of Corrections (DOC) funding and then become CBH eligible at which point we ask CBH to start funding, will they also get the same 7-day approval?

Yes. On the day providers would normally complete a precertification with CBH, they should now call CBH for an authorization number; the continued stay review would then be completed on day 7 from the call to CBH.

11. What about members who are admitted under Behavioral Health Special Initiatives (BHSI) and become CBH eligible?

If a BHSI member becomes CBH eligible, the provider needs to contact the assigned clinical care manager within 2 business days of the member becoming CBH eligible to notify CBH of the funding change. An authorization number will then be generated for 7 days.

12. When should an alternative level of care be requested?

CBH expects members to be assessed regularly for the appropriate level of care, and a request for an alternate level of care should be made when clinically indicated.

13. What if a member has unmanaged Medicare primary and CBH secondary and we want to admit to 3B which is not a covered benefit for Medicare?

A 3B request to CBH will no longer be required for unmanaged Medicare members. The process for 4B remains the same.

14. What will the threshold be for 3B with Medication-Assisted Treatment (MAT)? Does that require a special authorization?

CBH does not distinguish between 3B and 3B with MAT on a utilization management level, so no special request is indicated and should be at the physician's discretion.

15. Are these changes only to short-term rehabilitation or do they apply to long-term as well?

Provider Bulletin # 18-08: Prior Authorization Requirement Waived for Medically Monitored Residential Care (Level 3B) applies to short-term medically monitored rehabilitation only.