PRECERTIFICATION/AUTHORIZATION OF TREATMENT

EAP Treatment

It is the policy of IEAP to use an EAP session for the initial assessment whenever possible. If IEAP only manages EAP services for a particular plan, then all available EAP sessions will be authorized up front, with no paperwork required other than the billing form. In plans for which we manage the insurance as well as the EAP, we request that you fax your recommended treatment plan with clinical information (*see Clinical Feedback Form in The SAMPLE FORMS section of this manual*). An IEAP Care Coordinator will then speak with the patient about the options available. Patients may use additional sessions available under EAP with you or they may be referred to treatment under their insurance. Referrals under insurance may be for regular outpatient therapy with you or another provider, ***or*** inpatient, partial hospitalization, or intensive outpatient therapy with another provider.

Patients who choose to utilize their insurance after the assessment for regular outpatient therapy will have the option to continue with you for that treatment if IEAP manages care for this company. A patient who chooses additional EAP sessions with you ***may not*** continue therapy under insurance after the EAP sessions are exhausted unless otherwise specified by an IEAP Care Coordinator. This choice will be explained by an IEAP Care Coordinator before any authorization and is also outlined in the IEAP Explanation of EAP Benefits and Release of Information form, which you provide to patients. The ultimate decision of the course of treatment will be left up to the patient.

Initial Authorization of EAP Counseling Sessions

Patients contacting IEAP to use services are assigned an IEAP case number. This number becomes the process by which all patients are tracked. Patients must call IEAP to open a case. Providers may not open a case for a patient unless the patient is incapable of speaking with IEAP and no family member is available. The procedure for authorization of EAP sessions will vary according to the plan design for that account.

1. **EAP only accounts:**

   On EAP only accounts, IEAP does not manage the mental health care insurance for the patients. The providers are responsible for obtaining name of insurance plan from patient and verifying benefits and eligibility if additional sessions beyond the authorized EAP are requested. No clinical feedback form or release of information is needed on EAP only accounts. All sessions are authorized up front and an authorization/billing letter is mailed to providers confirming authorizations.

2. **Extended EAP with Managed Care Exhausting EAP sessions prior to using insurance:**

   Under the Extended EAP model, patients are allowed to use all of their available EAP sessions. After these free sessions are exhausted, the patient may be allowed to continue treatment with the EAP provider under the provisions of the health plan. Interface requires submission of a clinical feedback form to support medical necessity prior to Interface's authorization of continued treatment.

PRECERTIFICATION/AUTHORIZATION OF TREATMENT

3. EAP and Managed Care Accounts:

When using EAP sessions beyond the initial assessment, specific short-term goals are set, which both you and the patient feel can be accomplished. The EAP process should help patients identify and address problems; it should not leave them feeling abandoned at the end of their allotted sessions.

Patient must choose between the EAP and insurance:

a) After completing the initial assessment session, the provider must submit clinical data and treatment recommendations within 48 hours of the initial session. IEAP will require sufficient information to support clinical necessity in the event that authorization under insurance is requested.

b) After the first session, the patient will contact an IEAP Care Coordinator to discuss the most appropriate course of treatment based on the recommendations of the provider and authorize additional sessions appropriately.

c) The patient will inform IEAP as to which treatment option they wish to use. They will make the final choice regarding their care (*after IEAP has provided options to the patient*). IEAP will contact the provider with the patient's treatment choice and mail the appropriate authorization letter within 24 hours.

Providers unable to schedule an IEAP referral within 3 working days (unless otherwise requested by patient) should direct the patient back to IEAP for an alternate referral. Authorization for an EAP assessment will be valid for 30 days. Patients who have not made an appointment or contacted IEAP in this time may be required to open a new case. EAP cases with no activity will be closed.

Failure to obtain authorization may result in provider not being paid by IEAP. Provider agrees not to bill patient for any EAP sessions not paid as a result of provider's failure to obtain authorizations.

MANAGED CARE OUTPATIENT TREATMENT

IEAP requires a patient or, in the case of a minor or incapacitated adult, a member of the patient's family to contact IEAP to begin the pre-certification process for authorizing treatment. In cases of psychiatric emergencies, intake data can be obtained from a provider. Authorization for a specific course of treatment will only be given after IEAP receives clinical data. At IEAP, it is not our policy to contact a health care provider more often than is required to obtain needed clinical data. IEAP feels that the health care provider has primary responsibility for providing the clinical data needed to certify requested treatment as medically necessary. Care Coordinators are available to discuss this **Monday-Friday, 8am-11am and 2pm-5pm CST**.

A. Pre-Certification/Authorization of Assessments Under Managed Care

1. Patients contacting IEAP to request treatment are assigned an IEAP case number. This number becomes the process by which all patients are tracked. Patients and providers must refer to this case number when calling or writing to IEAP concerning a case.
2. The patient must call IEAP to open a case. Providers may not open a case for a patient unless the patient is incapable of speaking with IEAP and no family member is available. IEAP will:
   a) Assign patient an IEAP case number
   b) Refer patient to an appropriate provider
   c) Give patient the provider's name, phone number, and address
   d) Instruct patient to call provider using their case number to schedule an assessment
   e) Instruct patient to contact their TPA to verify eligibility and coverage
3. IEAP will contact provider to inform of the authorization of the initial assessment session under the patient's managed care. IEAP will:
   a) Give provider patient's name and IEAP case number
   b) Mail provider a letter documenting this authorization, although this may be given to the provider or their staff by the telephone. The authorization letter will be mailed and will be specific regarding frequency, length, and number of sessions approved
   c) Remind provider to contact the patient's TPA to verify eligibility and coverage
4. After completing the initial assessment the provider must provide IEAP with clinical data and treatment recommendations. IEAP requests this be faxed within 48 hours of the initial assessment. IEAP provides a form to report this information (*see CLINICAL FEEDBACK FORM in SAMPLE FORMS section of this manual*). This information may be given by telephone if there is an emergency or if a provider does not have access to a fax, however, IEAP does require a paper copy. Care Coordinators are available to discuss this data **Monday-Friday, 8am-11am and 2pm-5pm CST**.
   a) The minimum data required will be:
      i) DSM IV-TR diagnosis (*Axis I-V*)
      ii) Symptoms that support that diagnosis
      iii) Any relevant history
      iv) Any suicidal or homicidal ideation
      v) All medications prescribed and their diagnosis
      vi) Type, frequency, and estimated duration of treatment sessions being requested

b) Upon review of clinical data received, an IEAP Care Coordinator will at their discretion, discuss with the patient the most appropriate course of treatment based on the recommendations of the provider. Additional treatment will be authorized appropriately and may include one or more of the following:

i) Psychological testing (*See Authorization of Psychological Testing*)

ii) Regular outpatient treatment (*See Authorization for Outpatient Care*)

iii) Structured program or inpatient treatment (*See Authorization for Inpatient Care*)

B. Additional Authorization for Regular Outpatient Treatment

IEAP authorizes treatment based on medical necessity. The provider is expected to track sessions used by a patient and make sure there are sufficient authorizations in place to cover scheduled sessions. In the spirit of empowering the patient, IEAP requires the patient to initiate requests for authorization by calling IEAP and opening a case.

1. Patient informs a Care Coordinator that he/she wishes to use their managed care services (*patient will be advised to verify eligibility and coverage*).
2. IEAP notifies provider in writing of the authorization, which will be for a specific frequency, CPT code, and number of sessions. Authorization letter will be mailed.
3. IEAP will provide the name and phone number for the TPA. Provider will be solely responsible for verifying eligibility and coverage.
4. Provider will be responsible for providing IEAP with clinical updates on the patient's progress before authorization expires.

Failure to obtain authorization may result in insurance claims being processed and payment recommended as non-network.

STRUCTURED PROGRAM OR INPATIENT TREATMENT

IEAP is committed to maintaining a high level of participant involvement in treatment planning. Our policies **require** that IEAP have contact with either the participant or a family member of the participant before (*or within 48 hours in the case of an emergency*) a non-emergent admission to a facility. If a provider or hospital makes the initial telephone call to IEAP, they will be expected to assist in our efforts to contact the participant or family of the participant.

A. Pre-certification Procedures for Inpatient Care

1. Pre-certification of an admission is not equivalent to authorization. Pre-certification of treatment ONLY acknowledges the facility's notification of IEAP that an individual is seeking treatment. Whatever the source of a facility's initial contact with a participant (*participant call, physician call, etc*), as soon as the facility has been notified of IEAP's role of managing the mental health care in a case, they **must** contact IEAP to certify the admission.

    a) IEAP Care Coordinators are available Monday-Friday, 8am-5pm CST. Messages left after business hours will be returned on the next business day.

    b) Each admission is assessed for medical necessity per IEAP's admission criteria. The admission criteria are available upon request.

2. IEAP requires contact with either the participant or the participant's family to pre-certify treatment in a case. If a participant contacts a facility directly requesting a non-emergent assessment, please have the IEAP participant or participant's guardian contact IEAP for directions in seeking treatment.

B. Authorization of Treatment at a Facility

1. Prior to initial authorization of an admission, IEAP will require clinical data to support medical necessity of the level of care requested.

2. A facility's UR Department is required to maintain a regular schedule of communication with IEAP. Clinical updates and request for additional treatment must be provided promptly (*i.e., **prior** to services being rendered*).

    a) IEAP will make reasonable efforts to contact a facility's Utilization Review Department to receive clinical data on a case.

        1) It is the responsibility of a facility to ensure that treatment has been authorized.

        2) Payment of benefits resulting from failure to obtain authorizations may be subject to reduction or denial of benefits.

    b) IEAP requires that the *IEAP Hospital Admissions Form* be faxed to IEAP upon admission or within the first *48 hours* of notification of IEAP's role. IEAP has several forms to assist a facility in providing this needed information.

    c) A letter detailing the specifics of the authorization (*dates and level of treatment*) is sent to the physician and the facility within 2 business days of authorization.

STRUCTURED PROGRAM OR INPATIENT TREATMENT

C. Authorization of Inpatient Consultation With an Independent Provider

IEAP's contract with facilities includes payment for individual, group and family therapy as part of the negotiated per diem rate. Authorization for treatment by an independent provider (one not working for the facility) is given only in cases where medical necessity is found.

1. In the event that the physician requests an independent provider to render services for a participant who is currently inpatient, that provider must contact IEAP to obtain prior authorization for the treatment.

2. In cases in which a participant has a history of outpatient treatment with an independent provider, IEAP is generally willing to authorize a limited number of sessions for the independent provider to supply needed data to the facility treatment team and to re-establish rapport with participant prior to their discharge from the hospital.

3. As with any treatment, all sessions with an independent provider must be pre-authorized by IEAP.

    - MEDICAL - IEAP is only empowered to authorize mental health/chemical dependency treatment. Any consultation of a medical nature should be pre-authorized with the participant's TPA or medical managed health care company.

    - PSYCHIATRIC – All treatment provided by other mental health professionals to whom you refer a participant **must be pre-authorized by IEAP**. As with any treatment to be rendered, IEAP will require data to support the need for treatment, the name of the provider and her/his credentials, and the approximate costs of the service. Failure to obtain pre-authorization may result in a reduction in benefits or penalties (*possibly including non-payment of the claim*).

Failure to obtain pre-authorization may result in a reduction in the proportion of the claim reimbursable by insurance.

AUTHORIZATION OF PSYCHOLOGICAL TESTING

Psychological testing can be included as a component of a thorough diagnostic evaluation in conjunction with interviews, observations and information obtained from other sources, in order to develop an effective treatment plan. Testing alone is not a substitute for a comprehensive behavioral health evaluation. Diagnostic testing is defined as the utilization of formal and informal instrumentation to better understand or conceptualize the characteristics of an individual.

Interface EAP supports the appropriate use of psychological testing in this manner, and authorizations are based on accepted minimum standards of practice as well as growing information from research and practice concerning assessment. The general requirements for authorization follow.

A. Psychological testing must be requested and authorized prior to the services being rendered.

1. For certification of any such testing, the provider must complete a Request For Psychological Testing form in advance before performing any testing.

2. Many insurance plans provide limited or no coverage for psychological testing. - The **provider** is responsible for verifying with the TPA that testing is covered by the participant's health plan.

IEAP reserves the right to substitute an In-Network Provider to render psychological testing services for inpatient cases.

B. Interface EAP authorizes care that is medically necessary only. The provider must justify the need for testing based on information gathered through a clinical interview and any other sources of information available.

C. After testing is completed, IEAP will expect a brief statement (*via telephone or in writing*) of the results of tests, specifically:

1. Diagnosis indicated by testing

2. The treatment implications of the test results