# COMMONWEALTH OF MASSACHUSETTS
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**DIVISION OF INSURANCE**
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## BULLETIN 2015-08

TO: Commercial Health Insurers; Blue Cross Blue Shield of Massachusetts, Inc.; and Health Maintenance Organizations Offering or Renewing Insured Health Products in the Massachusetts

FROM: Daniel R. Judson, Commissioner of Insurance

DATE: November 3, 2015

RE: Using Standard Prior Authorization Forms when Reviewing Requests for Behavioral Health Services

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The Division of Insurance ("Division") issues this guidance to inform insured health carriers ("Carriers") about the use of standard prior authorization forms when reviewing requests for behavioral health services. Pursuant to M.G.L. c. 176O, §25(c), the Division is mandated to implement health services prior authorization forms.

The Mass Collaborative, composed of representatives from insurance carriers, provider groups, and associations developed and submitted a series of standard prior authorization forms for use in reviewing behavioral health services. Based on the work of the members of the Collaborative, the group developed the following forms:

1. Behavioral Health Disorders – Level of Care Request Form
2. Repetitive Transcranial Magnetic Stimulation Request Form
3. Psychological and Neuropsychological Assessment Supplemental Form

The Division held informational sessions on June 1 and June 10, 2015 to hear all thoughts about potential changes and received amended forms from the Mass Collaborative that were submitted to the Division to respond to comments raised in the information sessions. The amended forms, as included in the Appendix to this bulletin, are approved by the Division as the standard prior authorization forms for all behavioral health services covered under insured health plans. Carriers may no longer require the use of any other paper form other than the standard form, which it shall make available for use by all contracted providers.

By no later than 90 days after the issuance of the bulletin, the Division expects that all insured health plans shall take all necessary steps to amend their prior authorization processes to accept these standard prior authorization paper forms for behavioral health services that may be

submitted by providers by mail, as an attachment to electronic mail, or by facsimile machine. The form will serve as sufficient information upon which the insured health plan should use in making its decisions for prior authorization of the requested service or procedure. For, providers who use existing forms for prior authorization, carriers will continue to accept these forms until six months after the issuance of this bulletin.

Six months after the issuance of this bulletin, the Division expects that all insured health plans will amend any electronic or internet-based systems used to collect prior authorization information, so that those systems will only ask questions as stated in the approved forms in a format and order substantially similar to the format of the approved format. Carriers wishing to modify the format or order from the standard form are required to submit screenshots of all such forms for the Division's review before their use in the market. Data collected electronically by carriers for prior authorizations should be identical to the data collected on these paper forms.

The Division is aware that Carriers and providers may be at differing degrees of readiness for implementing standard prior authorization forms. Although many provider organizations may be ready to implement the new forms, it appears that other providers may not yet be prepared. As the paper forms become available, the Division strongly encourages Carriers to consider taking steps to work with provider organizations to educate contracted and other providers about the use of uniform prior authorization forms for behavioral health services. Carriers are encouraged to work with contracted providers to use the standard paper forms within 90 days and electronic form by no later than six months after the issuance of this bulletin..

If you have any questions about this Bulletin, please consider contacting Kevin Beagan at 617-521-7323 or Kevin.beagan@state.ma.us.

# BEHAVIORAL HEALTH — LEVEL OF CARE REQUEST FORM

*For Eating Disorders level of care requests, complete the relevant supplemental section on page 2.*

| | |
|---|---|
| MEMBER NAME: | |
| DOB: | GENDER: |
| INSURER: | POLICY #: |
| Requesting Clinician/Facility: | |
| Phone #: | NPI / TIN#: |
| Servicing Clinician/Facility: | |
| Phone #: | NPI / TIN#: |
| Currently in an ER: ☐ Y / ☐ N | Date and Time of Request: |
| Service Date for Request: | |

## LEVEL OF CARE REQUESTED

☐ Inpatient ☐ Partial Hospitalization ☐ Community Stabilization/Treatment (☐ ICBAT ☐ CBAT ☐ CCS/CSU) ☐ Residential
☐ Outpatient Psychotherapy (except 90837/90838) ☐ 90837/90838 (☐ ACT ☐ CBT ☐ Cognitive Processing ☐ DBT ☐ EMDR ☐ Exposure
☐ Functional Family ☐ PCIT ☐ IPT ☐ Other: _____ )
☐ Family Stabilization ☐ Other: _____

## SERVICE TYPE

☐ Behavioral Health ☐ BH in General Hospital ☐ Dual Diagnosis ☐ Eating Disorder

## CHIEF COMPLAINT/REASON FOR REQUEST/DIAGNOSES

**Chief Complaint/Reason for Request** (Frequency, intensity, duration of symptoms)
☐ mild ☐ moderate ☐ severe ☐ acutely life threatening _____
Are there any functional impairments? ☐ Y / ☐ N

Medications: ☐ none ☐ antidepressant ☐ antianxiety ☐ antipsychotic ☐ mood stabilizer ☐ stimulant ☐ other

| | |
|---|---|
| **Primary Psychiatric diagnosis:** | ICD/DSM Code: |
| Secondary Psychiatric diagnosis: | ICD/DSM Code: |
| **Substance Use Disorder diagnosis:** | ICD/DSM Code: |
| Relevant active medical problems ☐ Y / ☐ N Medically cleared ☐ Y / ☐ N Needs further evaluation/intervention ☐ Y / ☐ N | |
| **Relevant Active Medical diagnoses:** | ICD Code: |
| Prior Admissions ☐ Y / ☐ N / ☐ Unknown | INPATIENT: # of times ____ most recent _____ |
| SUBSTANCE USE/DETOX: # of times _____ most recent _____ | OTHER: (specify) _____ # of times _____ most recent _____ |

## MEDICAL/PSYCHOSOCIAL RISKS AND FUNCTIONAL IMPAIRMENTS *(select all that apply to the current request)*:

1. Suicidal: ☐ Current Ideation ☐ Active Plan ☐ Current Intent ☐ Access to Lethal Means ☐ None ☐ Section 12
   ☐ Current Suicide Attempt ☐ Prior Suicide Attempt (<1 year) Explain: _____
2. Homicidal/Violent: ☐ Current Ideation ☐ Active Plan ☐ Current Intent ☐ Access to Lethal Means ☐ None
   ☐ Current Threat to Specific Person ☐ Prior Violent Acts (<1 year) Explain: _____
3. Self-Care/ADLs: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____
   Highest and Lowest Levels of Functioning (<1 year): _____
4. Self-Injurious Behavior: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____
   Agitated/Aggressive Behavior: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____
5. Medication Adherence: ☐ Y / ☐ N / ☐ Unknown, Other Treatment Adherence ☐ Y / ☐ N Explain: _____
6. Legal Issues, Court/DYS Involvement: ☐ Y / ☐ N Explain: _____
7. Employment Risks: ☐ employed ☐ employment at risk ☐ on/requesting medical leave ☐ disabled ☐ unemployed ☐ Other
   Explain: _____
8. Psychosocial/Home environment: ☐ supportive ☐ neutral ☐ directly undermining ☐ home risk/safety concerns ☐ homeless
   ☐ lives alone ☐ married ☐ single ☐ divorced ☐ separated ☐ dependents ☐ Other
   Explain: _____
9. Additional Concerns: ☐ Y / ☐ N Explain: _____
10. Outpatient BH/SUD treatment in place? ☐ Y / ☐ N / ☐ Unknown, Have the outpatient treaters been contacted? ☐ Y / ☐ N

# BH Level of Care: Supplemental — for Eating Disorders

**Eating Disorders level of care requests *(complete the following)*:**

Level of Care:

- ☐ Inpatient Eating Disorders Specialty Unit (medically unstable)
- ☐ Acute Residential Eating Disorders Unit
- ☐ Partial Hospital Eating Disorders Program (seven days per week)
- ☐ Partial Hospital Eating Disorders Program (weekdays, 9–2 or 9–5)
- ☐ Intensive Outpatient Eating Disorders Program (several days per week, a few hours)
- ☐ Outpatient Eating Disorder Program

| Height: | Weight: | BMI: | % IBW: |
|---|---|---|---|
| Highest weight: | Lowest weight: | Weight change in one month: | |

**Orthostatic Vitals:** sitting BP____/____ PR____ standing BP____/____ PR____

**Labs:** Potassium____ Sodium____ Relevant abnormal labs_____
Abnormal_____
EKG: ☐ Y / ☐ N
Medical Evaluation: ☐ Y / ☐ N If yes, when_____
Recent need for IV hydration: ☐ Y / ☐ N If yes, when_____

Current Symptoms: ☐ dizziness ☐ fainting ☐ palpitations ☐ shortness of breath ☐ amenorrhea ☐ cold intolerance ☐ vomiting blood

Current Behaviors: ☐ binging ☐ purging ☐ restricting ☐ over exercising ☐ None

Current Abuse of: ☐ laxatives ☐ diuretics ☐ diet pills ☐ ipecac ☐ None

Specify other pertinent symptoms, behaviors, or high-risk presentations:

** This form is intended for fully-insured plans only. Not all carriers require prior authorization for the above services; not all levels of care are available in member benefit plans. Providers should consult the health plan's coverage policies and member benefits.*

# REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION REQUEST FORM

| | | | |
|---|---|---|---|
| ☐ In Network | | ☐ Out of Network | |
| MEMBER NAME: | | DOB: | GENDER: |
| HEALTH PLAN: | | POLICY #: | |
| Date and Time of Request: | | | |
| Treating Clinician/Facility: | | | |
| If the treating clinician is not making this request, has the treating clinician been notified? ☐ Yes ☐ No | | | |
| Phone #: | | NPI/TIN#: | |
| Servicing Clinician/Facility: | | | |
| Phone #: | | NPI/TIN#: | |

## INITIAL TREATMENT

**1. Has a confirmed diagnosis of severe major depressive disorder (MDD) single or recurrent episode**

| | | | |
|---|---|---|---|
| ☐ F32.2 | Major Depressive Disorder, Single Episode, Severe (Without Psychotic Features) | | |
| ☐ F33.3 | Major Depressive Disorder, Recurrent Episode, Severe (Without Psychotic Features) | | |

Pre-treatment rating scale: GDS ____, PHQ-9 ____, BDI ____, HAM-D ____, MADRS ____, QIDS ____, or IDS-SR ____

***AND***

**2. One or more of the following:**

☐ Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to **four adequate trials of at least six weeks duration** of psychopharmacologic agents in the current depressive episode from at least two different agent classes as documented by standardized rating scales that reliably measure depressive symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS, or IDS-SR); or

☐ Inability to tolerate psychopharmacologic agents as evidenced by **four trials** of psychopharmacologic agents from at least **two different agent classes (at least one of which is in the antidepressant class)**, with distinct side effects; or

☐ History of response to rTMS in a previous depressive episode; or

☐ Currently receiving electroconvulsive therapy (ECT)

☐ Currently considering ECT; rTMS may be considered as a less invasive treatment option

***Note for reference:** Remission is typically defined by the following measurement scores: Beck Depression Scale (BDI) score of <9, Hamilton Depression Rating Scale (HAM-D) score of <8 on the HAM-D-17 and <11 on the HAM-D-24, Montgomery-Asberg Depression Rating Scale (MADRS) score of < 10, Patient Health Questionnaire (PHQ-9) score of < 5*

***AND***

☐ **3. A trial of an *evidence-based psychotherapy* known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms (GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS or IDS-SR).**

***AND***

☐ **4. An order written by a psychiatrist (MD or DO) who has examined the patient and reviewed the record. The physician will have experience in administering TMS therapy. The treatment shall be given under direct supervision of this physician.**

**Potential Contraindications (please select all applicable contraindications the patient has from the list below):**

☐ Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

☐ Presence of acute or chronic psychotic symptoms or disorders in the current depressive episode

☐ Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

☐ Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagus nerve stimulation (VNS), or metal aneurysm clips or coils, staples, or stents.

***Note:*** *Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS.*

☐ Prior failed trial of an adequate course of treatment with ECT or vagus nerve stimulation (VNS) for Major Depressive Disorder

The patient is currently: ☐ pregnant or ☐ nursing

☐ The patient has a current suicide plan or recent suicide attempt

Current active history of (check those that apply):

☐ Eating Disorder

☐ Psychotic Disorder, including Schizoaffective Disorder

☐ Bipolar Disorder

History of (check those that apply):

☐ Substance Abuse

☐ Obsessive Compulsive Disorder

☐ Post-Traumatic Stress Disorder

## RETREATMENT

☐ **1. Patient met the guidelines for initial treatment AND meets guidelines currently.**

***AND***

☐ **2. Subsequently developed relapse of depressive symptoms**

***AND***

☐ **3. Responded to prior treatments as evidenced by a greater than 50% improvement in standard rating scale measurements for depressive symptoms (e.g., GDS, PHQ-9, BDI, HAM-D, MADRS, QIDS or IDS-SR scores).**

Post-treatment rating scale: GDS ____, PHQ-9 ____, BDI ____, HAM-D ____, MADRS ____, QIDS ____, or IDS-SR ____

Dates of initial treatment, if known:

## TREATMENT TYPE(S) REQUESTED

**FDA-approved TMS device to be used for the following treatment:**

| | | | |
|---|---|---|---|
| ☐ 90867 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, AND DELIVERY AND MANAGEMENT | | |
| ☐ 90868 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION | | |
| ☐ 90869 | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT — SUBSEQUENT MOTOR THRESHOLD REDETERMINATION WITH DELIVERY AND MANAGEMENT | | |

# PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

**Provide *specific* information in context of each health plan's unique medical necessity criteria which are available on each plan's website or by request.**

| IDENTIFYING INFORMATION | | |
|---|---|---|
| Dates of Service Requested: Start: ___/___/___ End: ___/___/___ | | |
| First Name: | Last Name: | MI: |
| Date of Birth (MM/DD/YYYY): | Gender: ☐ Male ☐ Female Other: | |
| Policy Number: | | |
| Health Plan: | | |
| Date Form Submitted: | | |
| **Servicing Clinician:** | **Facility:** | |
| Phone Number: | NPI/TIN#: | |
| Name and Role of Referring Individual: | ☐ Self Referred | |
| Contact Person: | Best Time to Contact: | |
| Phone Number: | Fax: | |
| Email: | | |
| **Requesting Clinician/Facility *(only if different than service provider)*:** | | |
| Phone Number: | NPI/TIN#: | |
| Contact Person: | Best Time to Contact: | |
| Phone Number: | Fax: | |
| Email: | | |

## RELEVANT DIAGNOSTIC DATA

Primary possible diagnosis which is the focus of this assessment?

Possible comorbid or alternative diagnoses: ☐ None

List all other relevant medical/neurological or psychiatric conditions suspected or confirmed: ☐ None

Relevant results of imaging or other diagnostic procedures (provide dates for each): ☐ None

## ASSESSMENT PLAN AND HISTORY

Total hours of authorization for testing:

| Psychological Testing: | Neuropsychological Testing: | Neuro-Behavioral Evaluation: |
|---|---|---|
| 96101 = _____ | 96118 = _____ | 96116 = _____ |
| 96102 = _____ | 96119 = _____ | (Note: Preauthorization not required by most plans) |
| 96103 = _____ | 96120 = _____ | |

List Likely Tests:

What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples?

- ☐ Depressed mood
- ☐ Low frustration tolerance
- ☐ Vegetative symptom
- ☐ Grapho-motor deficits
- ☐ Suspected processing speed deficits
- ☐ Physical symptoms or conditions such as: _____
- ☐ Performance anxiety
- ☐ Receptive communication difficulties
- ☐ Other:



*(continued on next page)*

Why is this assessment necessary at this time?

- ☐ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.
- ☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.
- ☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.
- ☐ Evaluation of a member's functional capability to participate in health care treatment.
- ☐ Determine the clinical and functional significance of brain abnormality.
- ☐ Dangerousness Assessment.
- ☐ Assess mood and personality characteristics impact experience or perception of pain.
- ☐ Other (describe): _____

Has a standard clinical evaluation been completed in the past 12 months? ☐ Y ☐ N

If yes, when and by whom?

If no, explain why a standard clinical evaluation cannot answer the assessment questions.

Date of last known assessment of this type: ☐ No prior testing

If testing in past year, why are these services necessary now?

- ☐ Unexpected change in symptoms
- ☐ Evaluate response to treatment
- ☐ Assess function
- ☐ Previous assessment is likely invalid
- ☐ Other (specify): _____

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, and/or learning disorders and/or guiding *health care services*? ☐ Y ☐ N

Are the units requested for the primary purpose of determining special needs educational programs? ☐ Y ☐ N

Are the units requested to answer questions of law under a court order? ☐ Y ☐ N

What are the patient's currently known symptoms and functional impairments that warrant this assessment?

## RELEVANT MENTAL HEALTH/SA HISTORY

Relevant Mental Health History: ☐ None

Is substance abuse/dependence suspected? ☐ Y ☐ N | If yes, how many day of sobriety?

Are medication effects a likely and primary cause of the impairment being assessed ☐ Y ☐ N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly ☐ Y ☐ N

If no, explain why testing is necessary.

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- ☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- ☐ A conclusive diagnosis was not determined by a standard examination and/or
- ☐ Specific deficits related to or co-existing with ADHD need to be further evaluated

Other: _____

Signature of requesting clinician: _____

***Providers may attach any additional data relevant to medical necessity criteria.***