Attention All Behavioral Health Providers

In January 2021, Wyoming Medicaid began requiring prior authorization (PA) for behavioral health services for children when the annual thresholds have been exceeded. The PA requirements for children are the same as the requirements for adults. Telligen and WDH have been reviewing the submissions for the past year and would like to take the opportunity to reiterate the policy and treatment plan requirements. Please review all below information as the policy, treatment plan, and progress note requirements will be strictly adhered to effective immediately. If all required documentation is not submitted with the request, a technical denial will be issued.

Each client should have only 1 PA requested every 90 days. That PA request must match the services documented in the Treatment Plan for those 90 days. If an emergency situation arises you may submit another PA for that specific situation. If changes need to be made to the providers or modifiers within the request, those changes may be requested after the services have been rendered.

In some cases, the submitted treatment plans do not match the services that are being requested. For example, the request to Telligen may be for multiple visits per week but the treatment plan is for monthly visits. Please ensure your request matches your treatment plan. Providers need to verify that the correct code is submitted
and the documentation supports the requested codes.

Treatment Plans (per CMS 1500 Provider Manual, Chapter 13)
https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins

Treatment plans for services must be based on a comprehensive assessment of an individual's rehabilitation needs, including diagnoses and presence of a functional impairment in daily living, and be reviewed every 90-days.

Treatment plans must also:

- Be developed by qualified Provider(s) working within the State scope of practice with significant input from the Member, Member's family, the Member's authorized healthcare decision maker and/or persons of the Member's choosing
- Ensure the active participation of the Member, Member's family, the Member's authorized healthcare decision maker and/or persons of the Member's choosing in the development, review and modification of these goals and services
- Specify the Member's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders
- Specify the mental health and/or substance related disorder that is being treated
- Specify the anticipated outcomes within the goals of the treatment plan

- Indicate the type, frequency, amount, and duration of the services
- Be signed by the individual responsible for developing the rehabilitation plan
- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than 90 days
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan
- Include the name of the individual
- The date span of services the treatment plan covers
- The progress made toward functional improvement and attainment of the individual's goals

The written treatment plan is one of the key elements to providing medical necessity. According to the Centers for Medicare and Medicaid Services (CMS), it should include a recommended level of care (duration and frequency of visits), specific treatment goals, and objective measures to evaluate treatment effectiveness. A treatment plan is important to help establish the clinical reasoning or thought process behind the care given and is an important document that should be updated frequently to match the progress the patient is making in their treatment. Wyoming Medicaid requires that the treatment plan be updated every 90 days, or more frequently if necessary.

Documentation of Services/Progress Notes (per CMS 1500 Provider Manual, Chapter 13)
https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins

Documentation of the services must contain the following:

- Name of the Member
- The covered services provided and the procedure code billed to Medicaid
- The date, length of time (start and end times in standard or military format), and location of the service
- All persons involved
- Legible documentation that accurately describes the services rendered to the Member and progress towards identified goals
- Full signature, including licensure or certification of the treating Provider involved
- Providers shall not sign for a service prior to the service being completed
- No overlapping behavioral health services, except for codes 97153 and 97155

Progress notes are required with each submission. Telligen needs to review the 3-5 most recent progress notes for each requested code. For example, there are multiple requests for services (medication services, targeted case management services, individual therapy, etc.). The 3-5 most recent progress notes may not have medication services or targeted case management progress notes included, therefore Telligen doesn't have enough information to determine if the services are medically necessary.

Another example may be a request for family therapy but within the submitted documented progress notes, there is nothing to support the request. The reasoning for the 3-5 progress notes

per code is that a provider that bills as a facility or organization may have different treating providers that provide different services (medication services, targeted case management, etc.) at different times. Medication service may be provided monthly while targeted case management might be provided every other week while individual therapy is provided weekly.

***Please note that if you don't have 3-5 progress notes, you may send Telligen what is currently in the chart on that service along with an explanation of why more notes aren't available. This process will decrease the back and forth between Telligen and the provider. Additionally, do not send all progress notes for a member. Please only include progress notes relevant to the services requested. Submitting excessive documents can delay the review process.

Clinical Assessments/Intake Assessments (per CMS 1500 Provider Manual, Chapter 13)

A clinical assessment/clinical intake form completed prior to the provision of treatment services which shall include at a minimum:

- The specific symptoms/behaviors of a mental/substance abuse disorder which constitute the presenting problem
- History of the mental/substance abuse disorder and previous treatment
- Family and social data relevant to the mental/substance abuse disorder
- Medical data, including a list of all medications being used, major physical illnesses, and substance abuse (if not the presenting problem)
- Mental status findings
- A diagnostic interpretation
- A DSM (current edition) diagnosis
- The clinical assessment must be updated annually at a minimum

A clinical assessment or intake assessment should be completed at the first visit. This is an important part of proper documentation. During the evaluation or assessment visit, information is collected regarding the patient's history and condition through various forms and examinations. The training and professional judgement of the healthcare provider is used to develop a diagnosis and a treatment plan with measurable goals. It should also be updated once a year or more frequently if needed. (Effective April 1, 2018, Wyoming Medicaid will require the clinical assessment be updated at least annually).

Prior authorization submissions will require the initial assessment and the most current updated assessment. All assessments need to be signed by the treating provider.

Denials/Appeals Process (per CMS 1500 Provider Manual, Chapter 13)

If the initial request for prior authorization is denied or reduced, a request for reconsideration can be submitted through Telligen, including any additional clinical information that supports the request for services.

Should the reconsideration request uphold the original denial or reduction in services, an appeal can be made to the state by sending a written appeal via email to the Medicaid Benefits Quality Control Manager, Brenda Stout (Brenda.stout1@wyo.gov).

The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Telligen's system. The appeal will be reviewed in conjunction with the documentation uploaded into Telligen's system.

For questions, please contact Brenda Stout, Medicaid Benefits Quality Control Manager at brenda.stout1@wyo.gov.