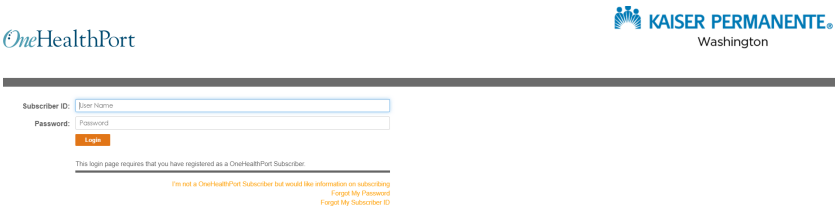
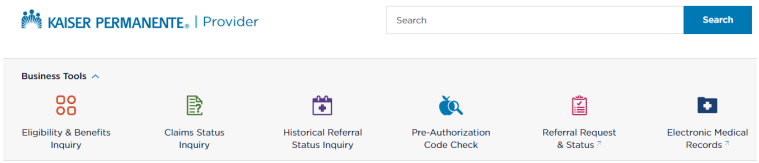
JOB AID: Mental Health & Wellness Providers Requesting Authorizations via Referral/Order Entry (NOT FOR ABA PROVIDERS)

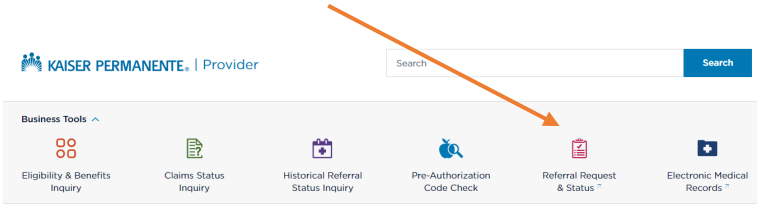
1. Log in via OneHealthPort
    a. Select Kaiser Permanente Washington from the available provider options
    b. Enter your current OneHealthPort user ID and password



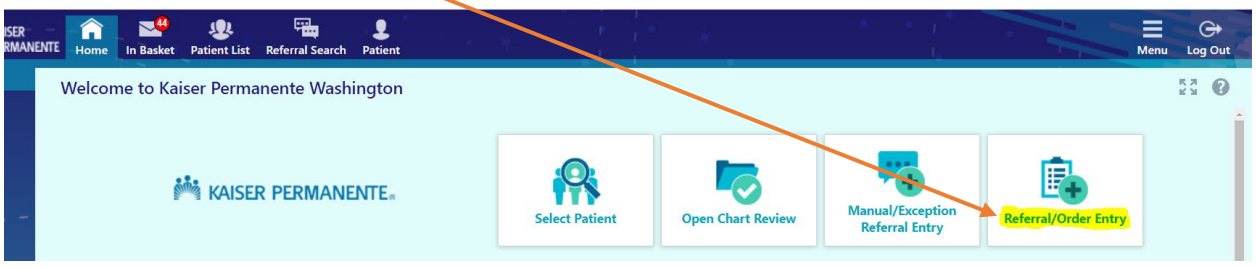
The new navigation toolbar can be used to initiate key activities like checking benefits eligibility or following up on claim status



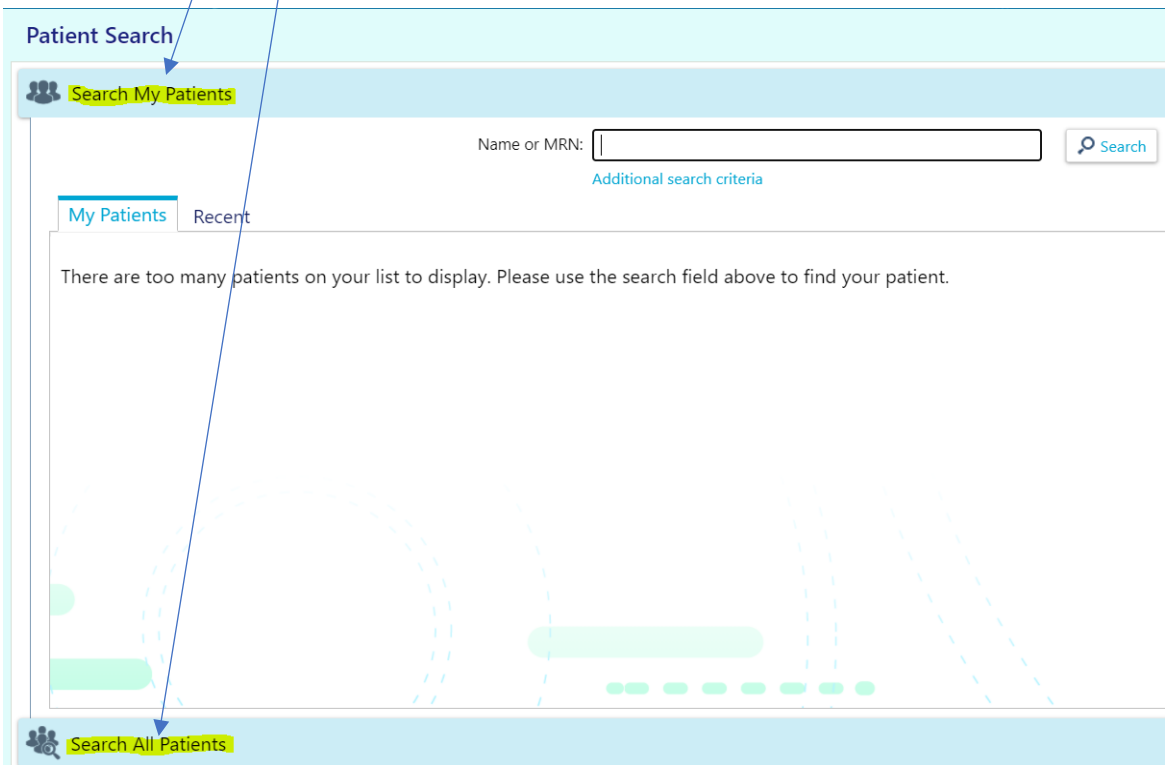
c. Select the Referral Request & Status Tool to access the Affiliate Link Referral Tool



2. Select the Referral/Order Entry tool to begin requesting an initial or reauthorization request

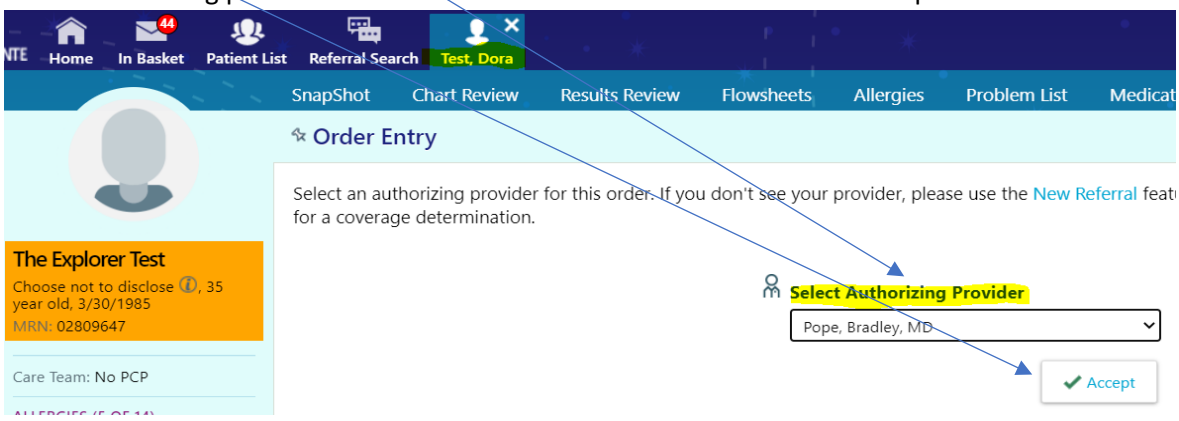


3. Select patient from either Search My Patients or Search All Patients
    a. Search My Patients – Use this function to search your loaded patient list. Patients can be loaded to a patient list if they have an approved authorization or if added by the contracted provider using the Search All Patients and adding to the Patient list
    b. Search All Patients – Use this function to search the entire Kaiser Permanente system for patients and to select them to add to a patient list.

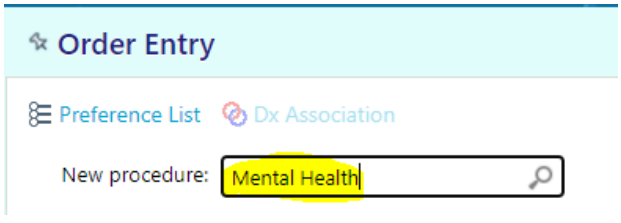


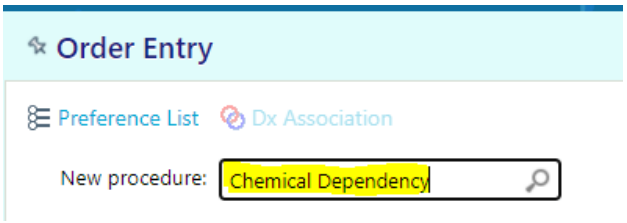
4. Once a patient is selected, they will show in the top tool bar and will remain selected until a different patient is selected

5. Select Authorizing Provider – This is the Provider who is "ordering/requesting" the services. Click Accept.
    a. If a provider is not showing in the Select Authorizing Provider drop down, please email KPWA.provider-services@kp.org and include the provider name, tax id and individual NPI of the missing provider. We will research the issue and submit it for an update.

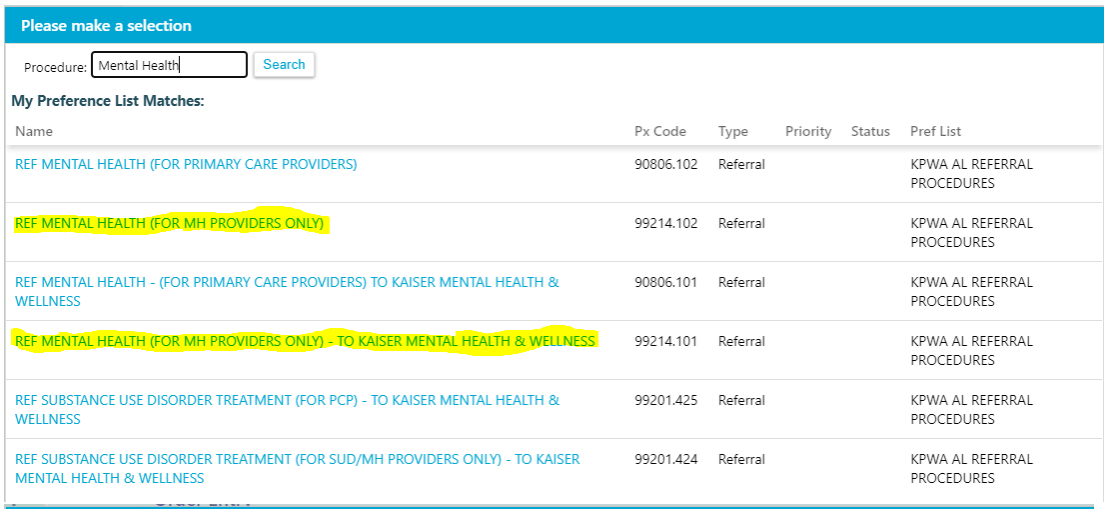


6. Fill in the New procedure field: This is the Referral Template type being requested.





7. We have several templates available. Within those templates, there are two templates for Mental Health and Wellness Providers to utilize. Select the one that is appropriate for the services.
    a. REF Mental Health (FOR MH PROVIDERS ONLY)
    b. REF Mental Health (FOR MH PROVIDERS ONLY) – TO KAISER MENTAL HEALTH & WELLNESS
    c. REF Chemical Dependency (FOR CD PROVIDERS ONLY)



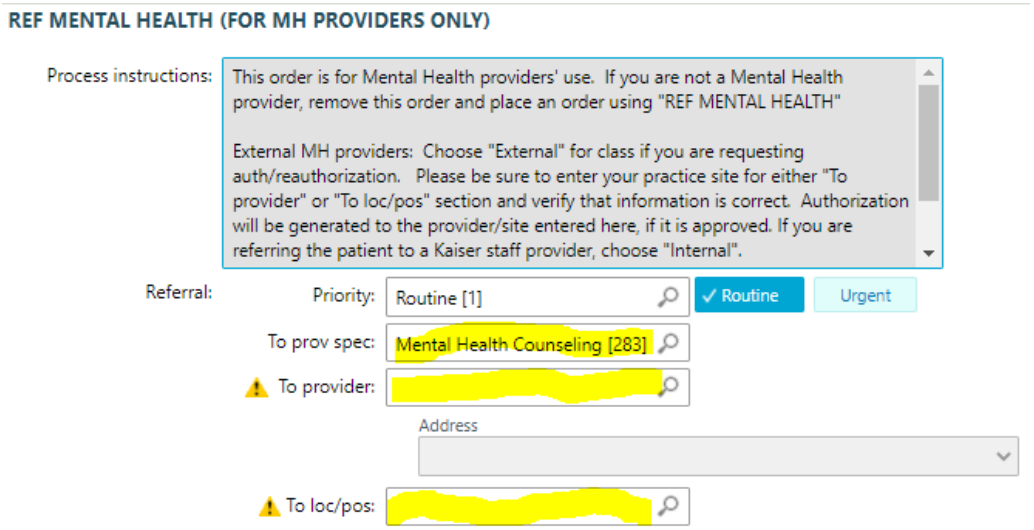
8. Once a template is selected, the Order will be opened.

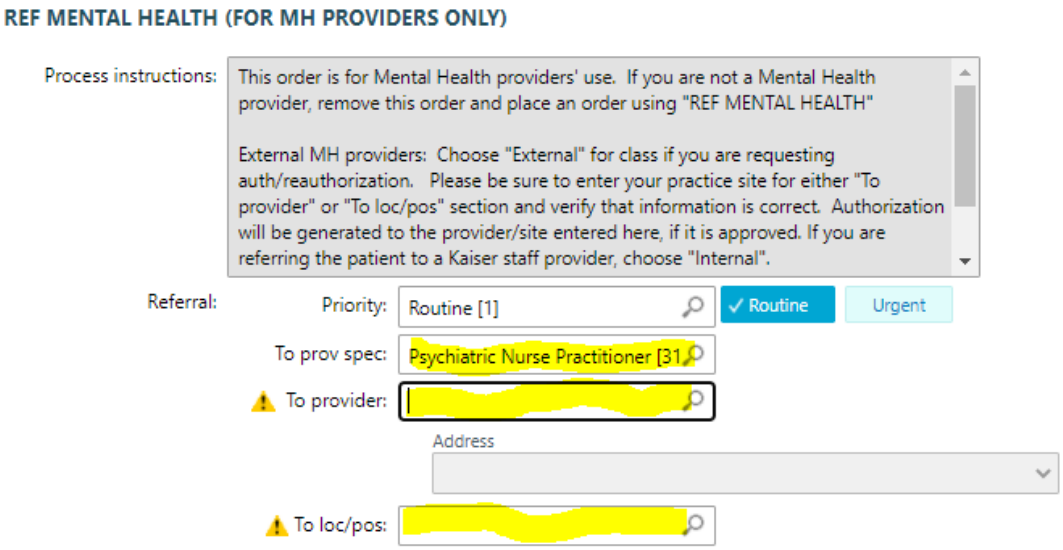
9. Class: External will auto populate. If referring internal to Kaiser Permanente Mental Health & Wellness use that template

10. To prov spec: This field will auto populate with Mental Health Counseling. NOTE: If the specialty/organization is Psychiatric Nurse Practitioner, change this field to Psychiatric Nurse Practitioner here.

11. Select To provider: Enter the Organization Name in this Field. This field is very important, as this information attaches the authorization to your Tax ID. The address will display as the billing address for the organization.

12. To loc/pos: Enter/Select the Care Site or Location where patient will be seen
    b. If you do not locate your organization or location, please use our troubleshooting tool to submit the information so we can research the system setup. Troubleshooting Form Link: [Affiliate Link Issue Troubleshooting Form]





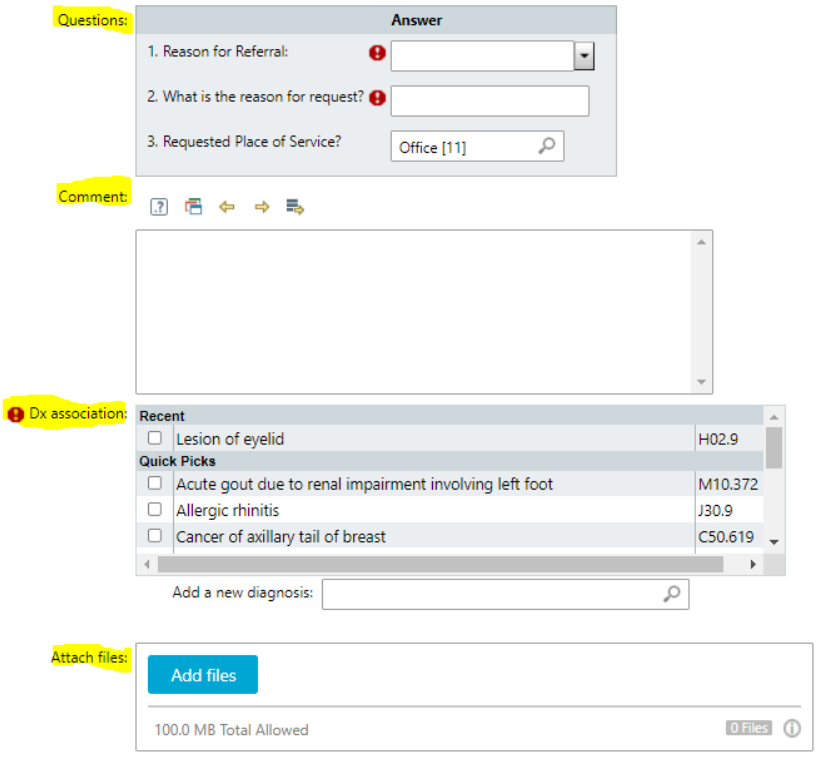
13. Questions: Depending on the service selected, the corresponding questions will appear below. See examples of the questions at the end of this job aid for more detailed screen shots.

14. Comment: This field will not be reviewed for coverage determination but can be used to add comments that may support the request.

15. DX Association: Enter Diagnoses in this field. Multiple diagnoses may be selected. Enter either the DX code or name and select the most appropriate code. You may be asked to answer specific questions related to the diagnosis code selected if the code selected is not specific enough for billing.

16. Attach files: You may upload documents to support your request. Document size max is 100.0 MB. The system will recognize the following file types: .jpg, .png, .doc, docx, .tiff

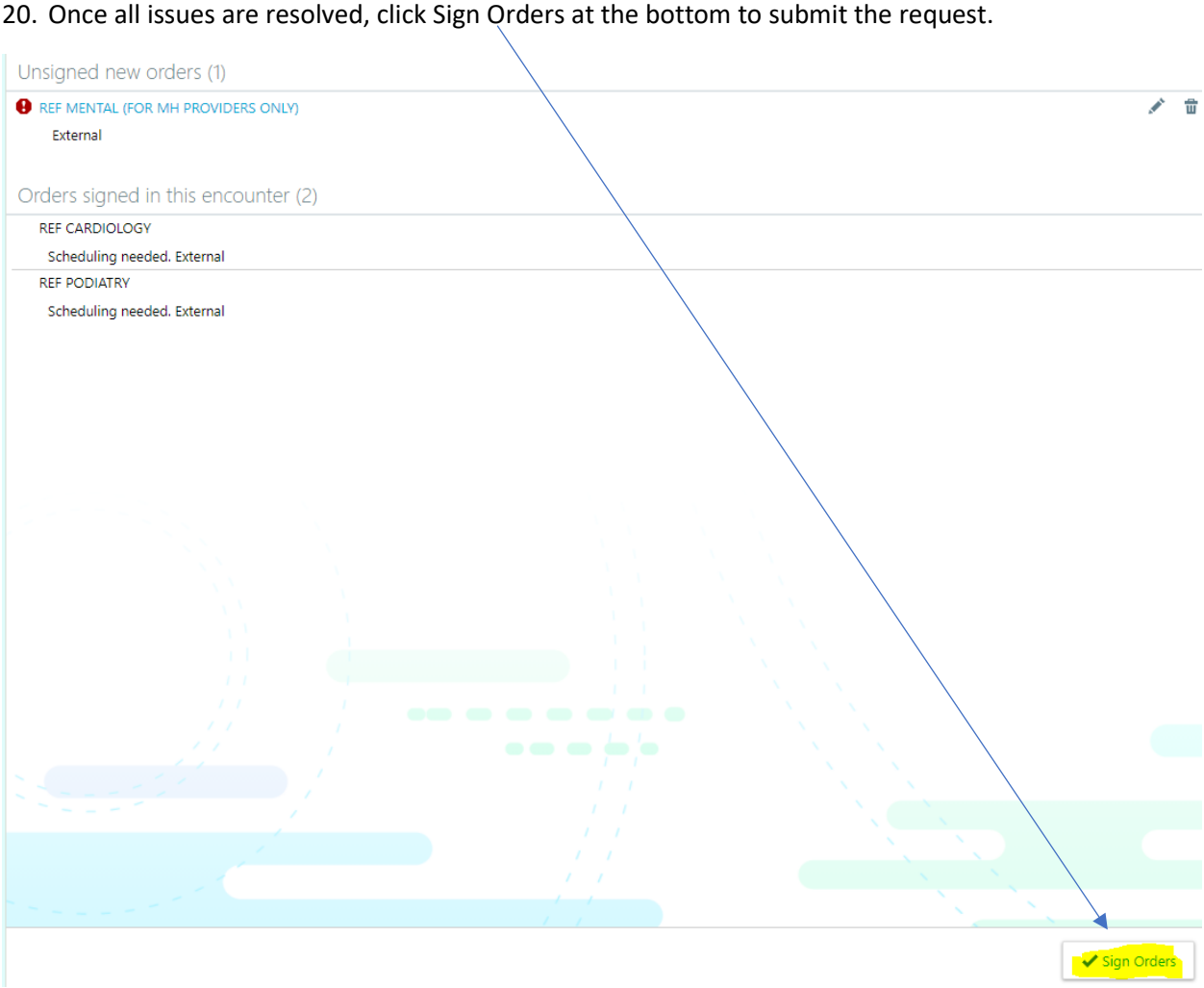
17. Accept: Click this button when the all fields are complete. This will place the Order in your "Unsigned Orders List".



18. Unsigned new orders: This list has not been transmitted to our referral team. You can edit the order by clicking the pencil or delete it with the trash can.

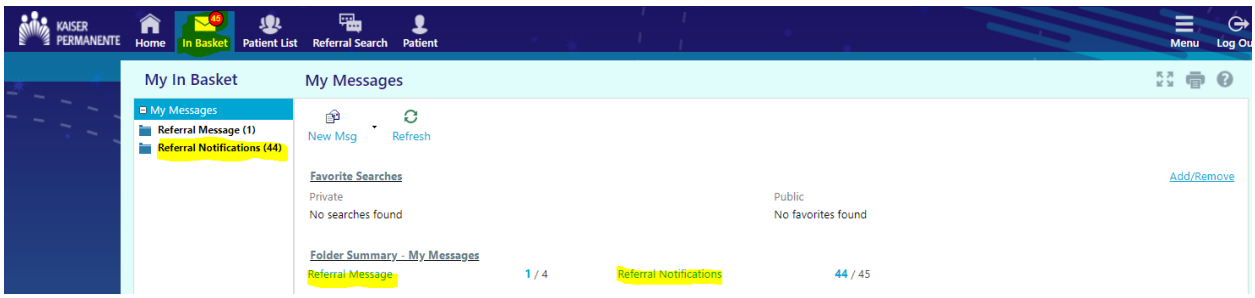
19. If an order has a red circle with an exclamation point, the order has unresolved fields and will not be able to be signed/transmitted without resolving them. Click edit and find the red stop sign fields to complete them before signing the order.

20. Once all issues are resolved, click Sign Orders at the bottom to submit the request.

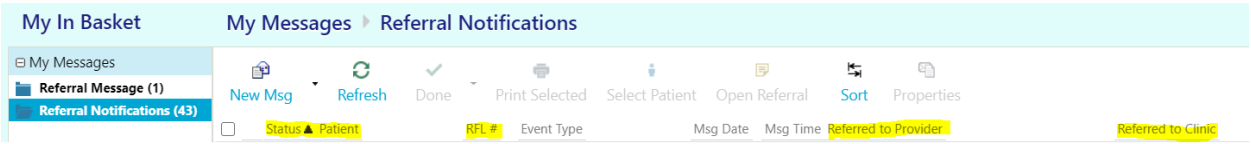


21. In Basket: Notification of completed referrals are only delivered electronically and will appear the In Basket. The In Basket is attached to a Tax ID and ALL notifications for the Tax ID will be found here.

22. Click on Referral Notifications to view In basket messages.



23. The In basket can be sorted by any of the column headers within the in basket.



24. The In Basket Authorization can also be sorted and opened by Patient. If the patient is selected, there will be an option at the bottom of the In Basket labeled “Opened Patient”. Click that field and the screen will show authorizations specific for the selected patient.

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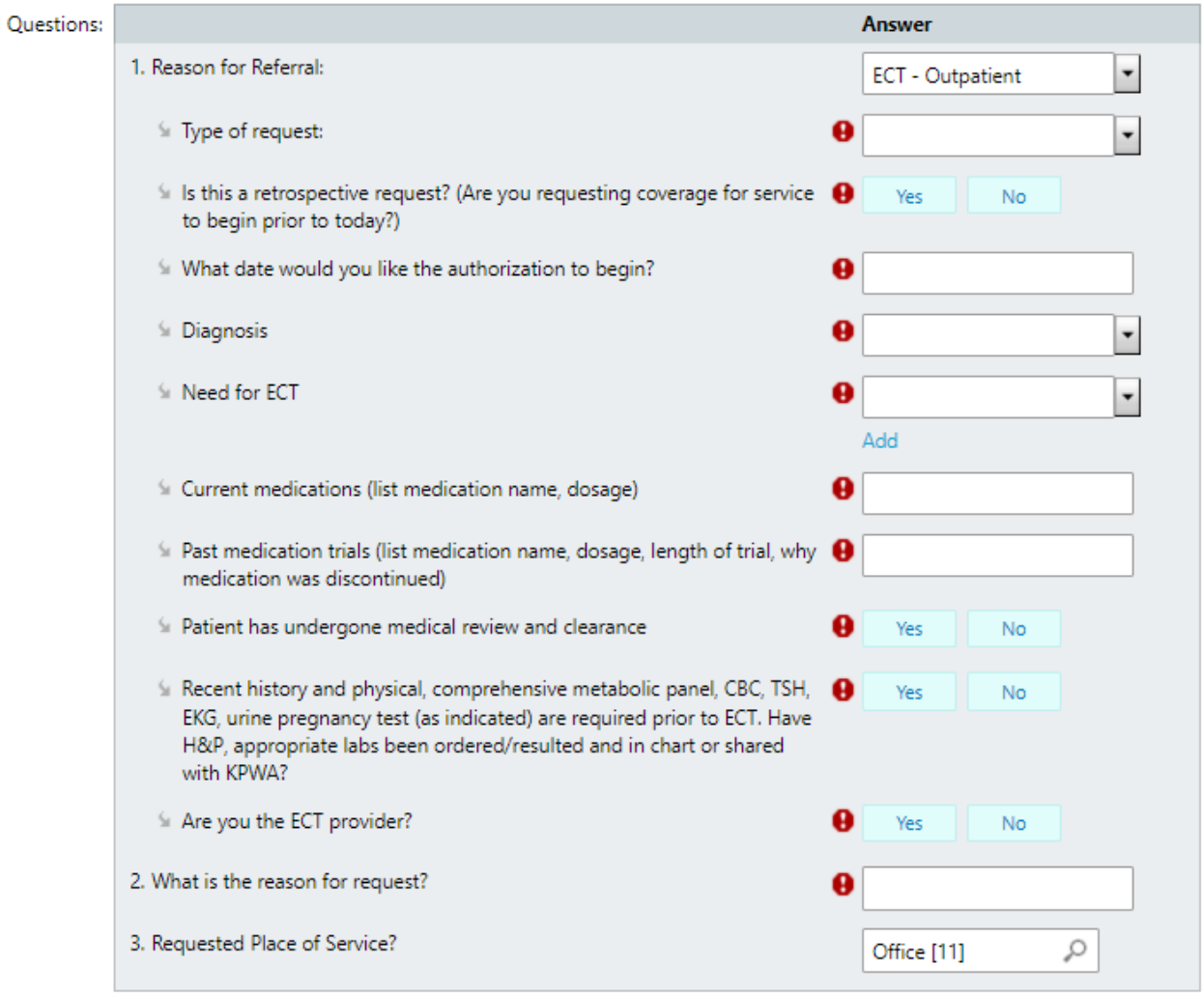
Examples of Requested Services with Corresponding Questions

Reason for Referral: ECT – Outpatient



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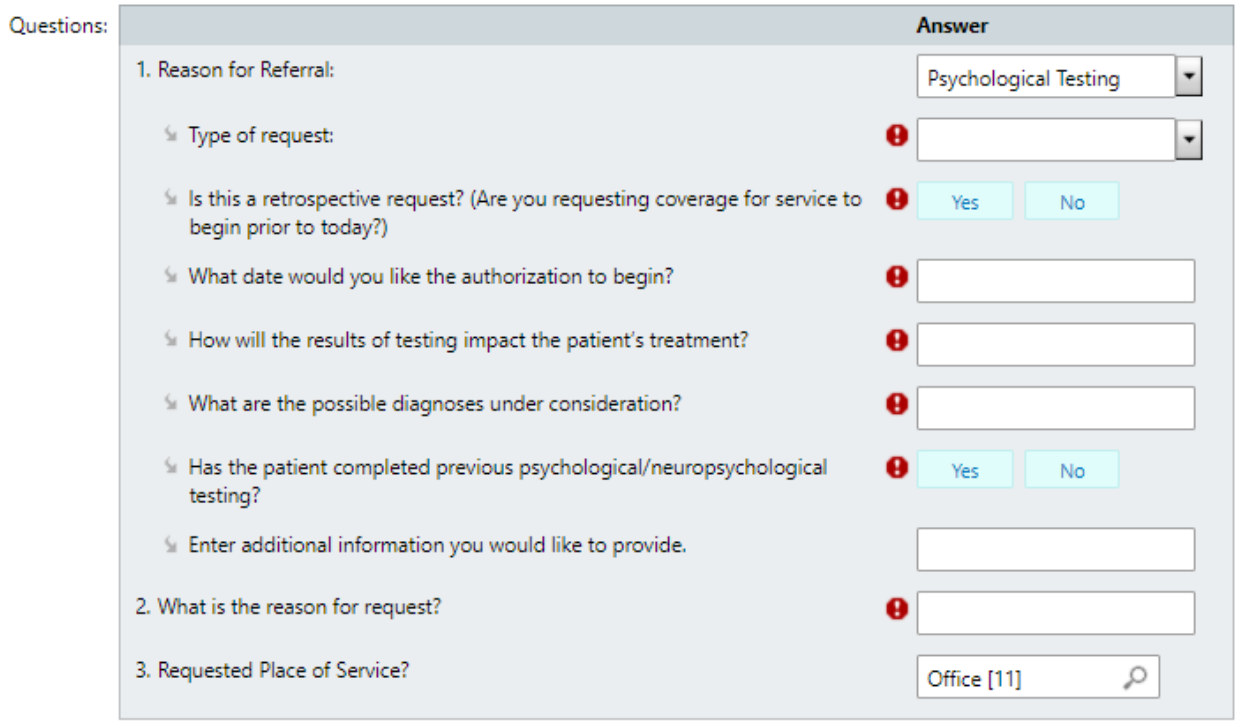
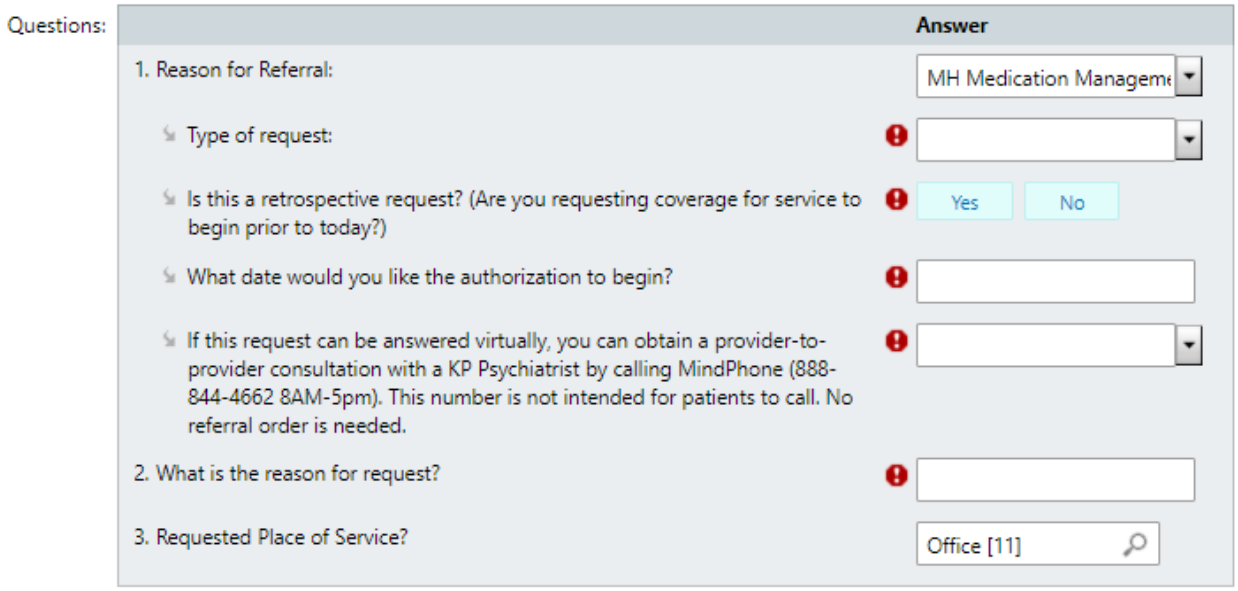
Reason for Referral: rTMS (Repetitive Transcranial Magnetic Stimulation)

Questions:	Answer
1. Reason for Referral:	rTMS (Repetitive Transcran
Type of request:	
Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?)	Yes / No
What date would you like the authorization to begin?	
Is the patient age 18+	Yes / No
Diagnosis	
Patient does not have any current or past history of psychosis (eg, Major Depressive Disorder with psychotic features; Schizoaffective Disorder, Schizophrenia or other psychotic disorders)	
Current medications:	
Past medication trials (list medication name, dosage, length of trial, why medication was discontinued)	
Patient does not have a cochlear implant, deep brain stimulator, or vagus nerve stimulator	
Patient does not have epilepsy or history of seizure	
Patient does not have metallic hardware or implanted magnetic-sensitive medical device (eg, implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging coil	
Patient does not have implanted magnetic-sensitive medical device (eg, implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging	
Enter current progress monitoring tool used, tool score, date of score during TMS treatment	
Are you the TMS provider?	Yes / No
2. What is the reason for request?	
3. Requested Place of Service?	Office [11]

Reason for Referral: Psychological Testing



Reason for Referral: MH Medication Management



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Reason for Referral: MH Intensive Outpatient Evaluation

Questions:	Answer
1. Reason for Referral:	MH Intensive Outpatient E
↳ Type of request:	
↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?)	Yes / No
↳ What date would you like the authorization to begin?	
↳ What CPT/Revenue code(s) and quantity are you requesting for treatment?	
↳ Number of visits requested?	
↳ Is the patient currently experiencing suicidal/homicidal ideation?	
↳ Does the patient have an alcohol/substance use problem?	Yes / No
↳ Does the patient have any current social impairments?	Yes / No
↳ Does the patient have any current psychological impairments	Yes / No
↳ Does the patient have any current physical/health impairments?	Yes / No
↳ Does the patient have any current work/school impairments?	Yes / No
↳ Is the patient taking psychotropic medications?	Yes / No
↳ What is the primary diagnosis being treated?	
↳ What symptoms are being treated?	Add
↳ Duration of symptoms being treated?	
↳ Current symptom severity?	
↳ What is the primary therapeutic method utilized for treatment?	
↳ What are the goals for treatment?	
↳ How is progress measured in treatment?	
↳ Current interventions to meet goals.	
↳ Current status on patient progress towards goals.	
↳ Planned changes in treatment to better meet goals?	
↳ Is there a secondary diagnosis being treated?	Yes / No
↳ Select all that apply:	Add
↳ Can care be provided at a lower level of care at this time?	Yes / No
2. What is the reason for request?	
3. Requested Place of Service?	Office [11]

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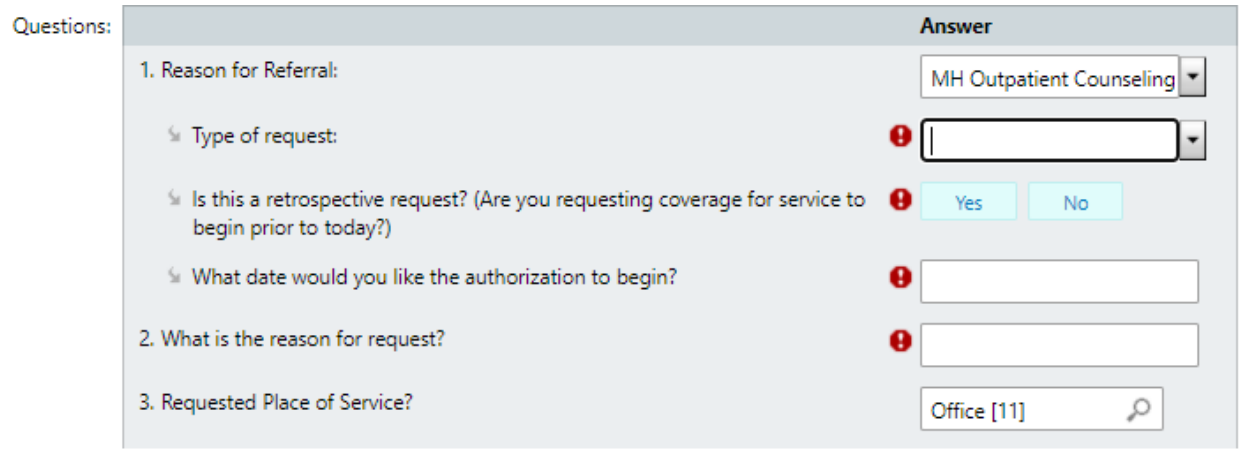
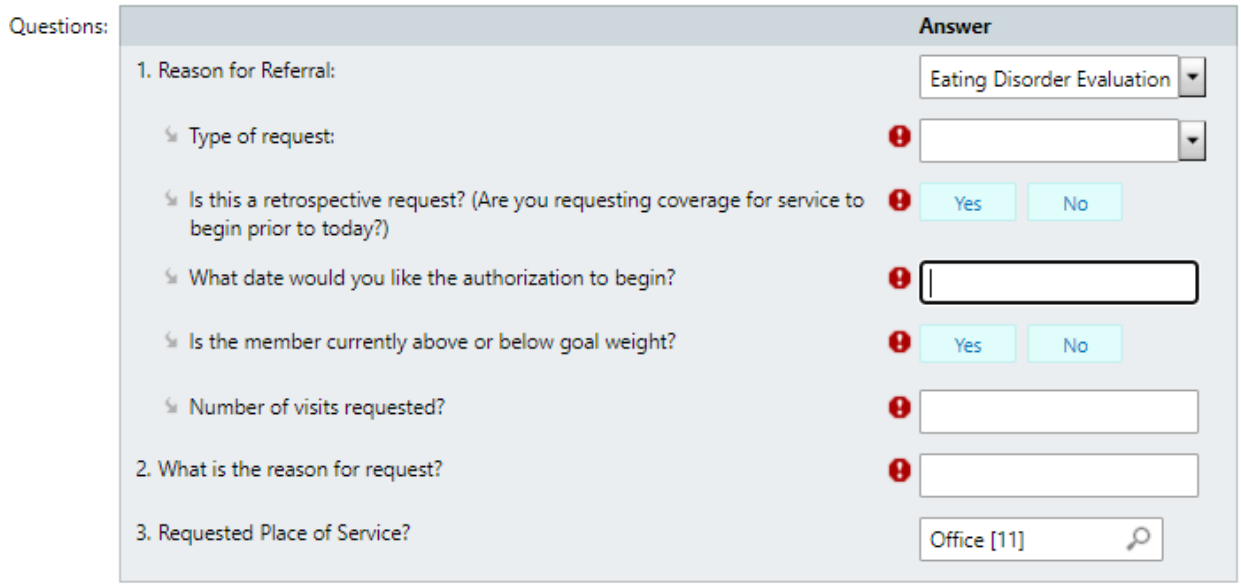
Reason for Referral: MH Intensive Outpatient Treatment

Questions:	Answer
1. Reason for Referral:	MH Intensive Outpatient Ti
Type of request:	
Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?)	Yes / No
What date would you like the authorization to begin?	
What CPT/Revenue code(s) and quantity are you requesting for treatment?	
Number of visits requested?	
Is the patient currently experiencing suicidal/homicidal ideation?	
Does the patient have an alcohol/substance use problem?	Yes / No
Does the patient have any current social impairments?	Yes / No
Does the patient have any current psychological impairments	Yes / No
Does the patient have any current physical/health impairments?	Yes / No
Does the patient have any current work/school impairments?	Yes / No
Is the patient taking psychotropic medications?	Yes / No
What is the primary diagnosis being treated?	
What symptoms are being treated?	Add
Duration of symptoms being treated?	
Current symptom severity?	
What is the primary therapeutic method utilized for treatment?	
What are the goals for treatment?	
How is progress measured in treatment?	
Current interventions to meet goals.	
Current status on patient progress towards goals.	
Planned changes in treatment to better meet goals?	
Is there a secondary diagnosis being treated?	Yes / No
Select all that apply:	Add
Can care be provided at a lower level of care at this time?	Yes / No
2. What is the reason for request?	
3. Requested Place of Service?	Office [11]

Reason for Referral: MH Outpatient Counseling



Reason for Referral: Eating Disorder Evaluation



Reason for Referral: Eating Disorder Intensive Outpatient Treatment

Questions:	Answer
1. Reason for Referral:	Eating Disorder Intensive C
Type of request:	
Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?)	Yes / No
What date would you like the authorization to begin?	
Number of visits requested?	
Is the member currently above or below goal weight?	Yes / No
Starting BMI?	
Current BMI?	
ADA Ideal weight?	
Current weight	
Current goal weight?	
Weight stable?	Yes / No
Patients calorie intake goal per day?	
Actual calorie intake per day?	
Is the patient adhering to current dietary plan?	Yes / No
Is patient binging?	Yes / No
Is the patient purging?	Yes / No
Is the patient exercising?	Yes / No
Is the patient using laxatives, diuretics?	Yes / No
Is supervision required for bathroom use?	Yes / No
Is the patient currently experiencing suicidal/homicidal ideation?	
Is the patient taking psychotropic medications?	Yes / No
What symptoms are being treated?	Add
Duration of symptoms being treated?	
Current symptom severity?	
2. What is the reason for request?	
3. Requested Place of Service?	Office [11]

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Reason for Referral: Esketamine (Sprovato)

Questions:	Answer
1. Reason for Referral:	Esketamine (Sprovato)
Type of request:	
Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?)	Yes / No
What date would you like the authorization to begin?	
Diagnosis	
Is patient currently prescribed an antidepressant?	Yes / No
Has the patient inadequately responded to 3 antidepressant medications in at least 3 different classes including: SSRIs, SNRIs, atypical antidepressants, MAOIs and/or TCAs for treatment of MDD	Yes / No
Has the patient inadequately responded to the augmentation therapies listed below?	
Lithium augmentation?	Yes / No
First atypical antipsychotic augmentation?	Yes / No
Another atypical antipsychotic or bupropion or mirtazapine or liothyronine or buspirone augmentation?	Yes / No
Has the patient been treated with ECT before?	Yes / No
Has the patient been treated with TMS before?	Yes / No
Provide rationale why TMS is not being considered for treatment	
What is the patient's most recent Patient Health Questionnaire-9 (PHQ-9) score?	
Does the patient have a history of psychosis?	Yes / No
Does the patient have active substance or alcohol abuse?	Yes / No
Does the patient have active use of cannabinoids, cannabis, or cannabis derivatives?	Yes / No
Does the patient have unstable angina, history of myocardial infarction, or uncontrolled hypertension?	Yes / No
Does the patient have aneurysmal vascular disease, arteriovenous malformation, or history of intracerebral hemorrhage?	Yes / No
Does the patient have increased intracranial pressure nor increased intraocular pressure?	Yes / No
Does the patient have severe hepatic impairment (Child-Pugh Class C) or on renal dialysis?	Yes / No
Is the patient pregnant or breast-feeding?	Yes / No
Does the patient have hypersensitivity to esketamine, ketamine, or any of the excipients?	Yes / No
Are you the esketamine (Spravato) provider?	Yes / No
2. What is the reason for request?	
3. Requested Place of Service?	Office [11]

