Modifications to Requesting Services for Therapy/Counseling, PSR, and CSG for Fiscal Year 2012 in Illinois

DHS/DMH has reviewed the policies and procedures related to the authorization processes of our utilization management program and is making some changes for FY12. These changes are the result of feedback from several stakeholders, and are intended to make the process more efficient for providers.

For therapy/counseling, PSR and CSG, providers will continue to submit the electronic authorization request through the Illinois Mental Health Collaborative for Access and Choice website. However, **there will NOT be a requirement for routinely attaching or faxing any additional supporting documentation.**

The following information is provided to assist in the modified authorization process.

Steps for requesting authorizations as thresholds are met

Requesting Services – starting authorization request

Attaching the Mental Health Assessment (MHA) and the Individual Treatment Plan (ITP) is no longer required. However, you may attach any supporting documentation that you feel will assist in determining medical necessity for the service you are requesting authorization for.

Psychotropic Medication Section

Psychotropic Medications

1. Medication Description

Dosage Frequency SELECT…

Is medication found to be effective? 0 1 2 3 N/A

Side effects? Yes No

Usually adherent? Yes No

Prescriber SELECT…

Psychotropic Medications should be considered mandatory. Complete information on the medications is key. Information on side effects, adherence & effectiveness allows for a better understanding of active treatment. Screens allow for 4 key psychotropic medications to be listed.

You should consider this section on Psychotropic Medications a required field. Knowing what meds the consumer is taking is a critical piece of clinical information and we need you to provide this information in order to approve authorization.

Psychotropic Medications

2. Medication OTHER Description Other

Other NONE

Dosage Frequency SELECT…

If there are no medications select **Other** for the medicaion and note **NONE** in free text box that appears

If the consumer is not taking any medication, you should choose "Other" as the medication and then say none in the description field. If the consumer refuses medication that can also be noted.

Assessment Scales

LOCUS Results

Please re-register the consumer if any of the displayed LOCUS information has changed since the last time you registered the consumer.

Functional Impairment Domain Scores **Note: Locus Results information should be populated for Adult Consumers.**

Risk of Harm	SELECT...	Recovery Environment - Environmental Stressors	SELECT...
Functional Status	SELECT...	Recovery Environment - Environmental Support	SELECT...
Co-morbidity	SELECT...	Recovery And Treatment History	SELECT...
		Acceptance and Engagement	SELECT...
Composite Score	0		

LOCUS Recommended Level of Care
SELECT...

Assessor Recommended Level of Care
SELECT...

LOCUS information is key to evaluating the functioning of adult consumers. Any deviation between the tool and assessor **Recommended Level of Care** is important when assessing authorization requests.

Reason for Deviation
Narrative History
Narrative Entry (of 200)

LOCUS information is important. If the LOCUS score differs from the level of care you're requesting, we need to understand why.

Ohio Scale Results

Worker Ohio Problem Severity Scale Score (For youth age 5 - 17) (0-100)
Admission (all) Current (if in treatment more than 90 days)

Score is specific to the **Problems** portion of the Ohio Scale. If the youth scores positive to **any** safety issues, the **Transition or Discharge Plan** should include details on the issue and how it is being addressed. If more space is needed, documentation may be attached or faxed.

Devereaux Scale Results

DECA Subscale (For children under the age of 3)
Protective Factor Scores
Admission (all) % Current (if in treatment more than 90 days) %

DECA Subscale (For children over the age of 3, under the age of 5)
Protective Factor Scores
Admission (all) % Current (if in treatment more than 90 days) %
Behavioral Concerns
Admission (all) % Current (if in treatment more than 90 days) %

For children the **Devereaux Scale** is vital information for making authorization decisions.

For the Ohio Scale, the scores from the Problems portion, as well as details on any safety risk and the plan to address that risk, is important in the authorization decision-making process.

When completing the Devereaux Scale pay careful attention as to what information is needed. For example, if the youth is under the age of 3, the proactive factor scores are required, and for youth between the ages of 3-5, both proactive factor scores **and** behavioral concerns are required. If you are using the Devereaux Early Childhood Assessment for Infants and the Devereaux Early Childhood for Toddlers Record Form, please pay strict attention to the guidelines for scoring. Please score per given directions. For more detailed instructions on scoring please refer to the Devereaux web site, www.devereux.org.

Required Documents Section - Workaround

Required Documents

All required supporting documents for this request, including the Mental Health Assessment and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this request submission. Should the required documents not be faxed to the Collaborative within one business day, the request will not be considered for processing. The provider will be required to submit a new request for authorization.

This statement is no longer applicable.

Attached	Faxed	N/A	
◉	○		Mental Health Assessment dated within the past year.
◉	○		Individual Treatment Plan dated within past six months.
○	○	◉	Mental Health Assessment Update, if indicated.
○	○	◉	Other clinical documentation supporting medical necessity.

Default options for revised workflow is to set first 2 items as **Attached** and last 2 as **N/A** UNLESS provider is intending to send in supplemental information - then should reflect if attached to auth request or being faxed.

Back Next

Since these documents are no longer routinely required, please check "Attached" for the first 2 items and "N/A" for the second 2 items. This will help the system to keep things straight.

Transition or Discharge Plan Section

Transition or Discharge Plan

* Is there a written plan to facilitate the consumer's transition to alternative services or to terminate service provision altogether? ○ Yes ○ No

* Has the consumer/guardian been involved in the discharge/transition planning? ○ Yes ○ No

* If the consumer will transition to alternative services, have treatment resources been identified and contacts made to coordinate discharge/transition planning? ○ Yes ○ No ○ N/A

If yes, please provide the following information:

Provider Name	Appointment Date	Services Planned

Accurate and complete information for all the fields in the **Transition or Discharge Plan** section will allow for efficient review of the authorization request and minimize need for followup contact on the authorization requests.

* How many days until anticipated discharge or transition to alternative services?

* If the consumer will not need continuing services, have natural community supports been identified and has the consumer been assisted in accessing them? ○ Yes ○ No ○ N/A

*Does the individual have a current Crisis Plan and understand how to access the services and supports included in it? ○ Yes ○ No ○ N/A

* Barriers to Discharge
Check all that apply.

- ☐ Consumer is not meeting criteria for lower level of care or discharge
- ☐ Transitional services not identified or not available
- ☐ Community resources not identified or difficult to obtain
- ☐ Consumer/guardian/family not engaged/participating in care or transition planning

* Describe plan to overcome barriers to discharge:
Please provide updates for ongoing requests, as needed.

Narrative History

Narrative Entry (of 250)

If it is desired to provide more detail than character limit provides for - additional documentation **MAY** be attached to authorization request on first page of authorization workflow.

Again, consider the Transition or Discharge Plan to be a required field. We will be unable to authorize services without this information. If you find that the Narrative History field doesn't provide enough room for you, please feel free to attach additional documentation.

Authorization Requests Selected for Auditing

As a quality check, the Collaborative will randomly select a small sample of authorized requests and then request the provider to send the additional supporting documentation for that small sample in order to do a more in-depth validation that the services are medically necessary. ProviderConnect can be utilized to submit these documents electronically. Alternatively, documents may be faxed in for the audits if the web-based process is not an option for the provider. Below is a brief overview of the steps in the auditing process:

- The Provider submits an electronic authorization request
- The Collaborative authorizes care
- Chart is chosen as part of random sample
    - This will be done weekly to ensure timeliness of audit
- The Collaborative notifies provider of selection by telephone and follow-up letter. Provider has 10 business days (due date will be provided) to respond and provide the requested documentation
- Once the information is received the Collaborative will review the documentation to verify that services meet the medical necessity criteria for the services.
    - Providers will be notified of the results of the audit via mail
    - If medical necessity is not supported and a denial occurs the reconsideration and appeal process is available.
- On the 10th day, if the Collaborative has not received the information from the Provider, the Collaborative will call the Provider to notify them that no information has been received and inquire as to whether the requested documentation has been sent
    - If the information is not received by the due date, the Collaborative will void the authorization effective on the 11th business day
    - The Provider will be notified by letter that the authorization has been voided and further claims will not be reimbursed until the documentation is received and the audit completed
    - If the Provider sends the materials required for review at a later date the Collaborative will review the information to validate medical necessity
    - If medical necessity is validated, the Collaborative will enter the authorization back to the original void date (so that all dates from point of original authorization are covered for reimbursement)
    - If medical necessity is not validated, the void remains and no claims will be paid
    - If no documentation is submitted, the void remains and no claims will be paid

How to attach documentation if selected for auditing

Staging

ValueOptions Home Provider Hom

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
Enter a Special Program Application
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
My Online Profile
My Practice Information
Provider Data Sheet
Performance Report
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Welcome . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

INBOX SENT

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter a Special Program Application
  - Review an Authorization
  - View Clinical Drafts
- Enter Member Reminders
- Enter or Review Claims
  - Enter a Claim
  - Review a Claim
  - View My Recent Provider Summary Vouchers
- View My Recent Authorization Letters

CLINICAL SUPPORT TOOLS

- View My Outcomes with On Track

YOUR NEWS & ALERTS

After logging in to ProviderConnect, click on “Review an Authorization”.

Search Authorizations

Required fields are denoted by an asterisk (*) adjacent to the label.
Please select a Provider ID below, to perform any one of the Authorization Search transactions below.

* Provider ID
NPI # for Authorization ? Select...

Enter Consumer RIN or Authorization # and search for authorization.

Vendor ID
Consumer ID
Authorization # - - (No spaces or dashes)
Client Authorization #
Effective Date 06212010 (MMDDYYYY)
Expiration Date 06212011 (MMDDYYYY)

Activity Date span cannot exceed seven (7) days.
Activity Date Range can only be entered without a value in the Effective or Expiration Date fields above (or vice-versa).

Activity Date From (MMDDYYYY)
Activity Date To (MMDDYYYY)
Delimiter Type ? Comma ',' Pipe '|'

View All Search Download

Enter the consumer's RIN or their authorization number and click "Search".

Authorization Search Results

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Click on hyperlink for authorization to attach additional information being requested for audit process.

Next

Auth # / View Letter	Consumer ID / Consumer Name	Consumer DOB	Provider ID / Provider Alt. ID	Vendor ID / Alternate Provider	Service
					Therapy/Counseling
					Therapy/Counseling
					PSR
					PSR

Click on the hyperlink to access the correct authorization that is being audited.

Auth Summary | Auth Details | Associated Claims

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Authorization Header

Consumer ID	
Consumer Name	
Authorization #	
Client Auth #	**N/A**
NPI # for Authorization	**N/A**
Authorization Status	**O - Open**
From Provider	
Admit Date	**06/21/2011**
Discharge Date	

Select **Send Inquiry.**

Return to search results

Send Inquiry

Complete Discharge Review

Click on "Send Inquiry".

Customer Service Inquiry

Required fields are denoted by an asterisk (*) adjacent to the label.

Authorization information has been captured for this inquiry. Please provide additional information below before submitting the inquiry.

Please note, inquiries are responded to within 5 business days. The response from ValueOptions will appear in your Inbox in ProviderConnect.

Current Authorization

Authorization #

Service From 06/21/2011

Service Through

Authorization Status O - Open

Patient ID

Patient Name

Provider Name

Contact Details

Provider ID

Provider Name

Contact Name
(if other than provider)

*State your reason for the inquiry. Additional clinical information for auditing of auth attached

Enter note that additional clinical is attached for auditing. **DO NOT** put clinical in note itself.

Maximum characters: 1500

You have 1439 characters left.

Attach a Document

Attach documents using the **Attach a Document** function. Indicate that document type contains clinical;once all documents are attached, message can be submitted.

Complete the form below to attach a document with this Inquiry

If this is an Authorization Request, it must be initiated by clicking the 'Enter an Authorization Request' link.

*Document Type: Type of Document you are attaching... Document Containing Clinical Information abou

*Document Description Document Containing Clinical Information about Member

UploadFile *Click to attach a document* Delete *Click to delete an attached document*

Under "Contact Details", enter a note that you are attaching a *document for auditing of auth*. **DO NOT** put any clinical information here.

Then under "Attach a Document", pull down the dropdown choices under "Document Type" and choose "Document Containing Clinical Information …".

Once all of your documents have been attached, click on "Upload File" and then "Submit". Multiple documents may be attached by this method.