

A photograph of a man with a beard, wearing a plaid shirt, holding a young child who is laughing joyfully. The scene is set outdoors with bright sunlight, creating a warm and happy atmosphere. The image is partially obscured by a dark blue overlay on the right side of the slide.

Utilization Management Request for Services Process

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PRESENTERS

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and

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SUMMARY

ILLINOIS
MENTAL HEALTH COLLABORATIVE

FOR ACCESS AND CHOICE

**This presentation will step through the process of submitting
Utilization Management Request for Services
through the use of ProviderConnect®**



**Assertive
Community
Treatment**

**Community
Support
Team**

SUBMISSION PROCESS

A provider may submit an ACT/CST authorization request using either of the following methods:

1. Submit Online at:

www.IllinoisMentalHealthCollaborative.com/providers.htm

2. Submit via secure fax to:

(866) 928-7177

REQUIREMENTS

- **DHS/DMH requires the Collaborative to respond to requests for authorizations within:**
 - **One (1) business day from receipt of a complete initial authorization request, excluding holidays and weekends.**
 - **Three (3) business days for a complete reauthorization request, excluding holidays and weekends.**

REQUIREMENTS

Initial Authorization Request

To request an authorization for a consumer who is not currently receiving ACT/CST, the treating provider will submit a complete request for authorization of ACT/CST packet that includes:

- The ACT Authorization Request Form including LOCUS information for adults.
- The CST Authorization Request Form that includes LOCUS information for adults 18+ and Ohio Scale Results for children ages 5-17.
- An initial treatment plan with ACT/CST listed as a service.
- The consumer's initial crisis plan.
- A Mental Health Assessment (MHA).

REQUIREMENTS

Initial Authorization Request (cont'd)

- Once the initial ACT request is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an initial authorization for 90 days of services, if only a MHA is submitted at the time of the initial request. If a treatment plan is submitted the Clinician may enter a authorization for twelve (12) months.
- Once the initial CST request is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an initial authorization for 90 days of services if MHA has been submitted, or an initial authorization of six (6) months of services if a Treatment Plan has been submitted.
- If the consumer continues to need ACT/CST services, the ACT /CST team must submit a reauthorization request before the initial authorization expires. This request may be submitted 14 Calendar days in advance of the authorization expiration date.

REQUIREMENTS

Reauthorization Request

To request a reauthorization for a consumer who is currently receiving ACT/CST, the treating provider will submit a complete Request for Authorization of ACT/CST packet that includes:

- The ACT/CST Authorization Request Form that includes LOCUS information for adults.
- If the CST Authorization Request is for a child (ages 5-17), the form should include Ohio Scale Results.
- An updated ACT/CST treatment plan.
- The consumer's crisis plan.

REQUIREMENTS

Reauthorization Request (Cont'd)

- **Once the request for reauthorization of ACT services is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for either a nine (9) month or a (12) twelve month period.**
- **Once the request for reauthorization of CST services is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for 180-day period.**
- **Before the reauthorization expires, the ACT/CST team is to submit a reauthorization request if the consumer continues to need ACT/CST services. This request can be submitted 14 Calendar days in advance of the authorization expiration date.**

ACT Request for Authorization Form

The Illinois Mental Health Collaborative for Access and Choice
**REQUEST FOR AUTHORIZATION OF
ASSERTIVE COMMUNITY TREATMENT SERVICES (ACT)**
 Initial Request (ACT) -or- Reauthorization Request (ACT)

ENHANCED SKILLS TRAINING (EST)
 IN-HOME RECOVERY SUPPORT (IHR)

NOTE: Reauthorizations are not permitted for EST and IHR Services

Agency: _____	Name of Referred: _____
Agency Location: _____	Date of Birth: _____
Agency FEIN: _____	RIN#: _____
Team Name: _____	
Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Date ACT Service Started: _____	

PLEASE PRINT (Must Include)
Staff to contact with any CLINICAL questions: _____
Phone: _____ Secure Fax Number: _____
Encrypted Email Address: _____

PLEASE PRINT (must include)
Staff to contact with any REGISTRATION questions: _____
Phone: _____ Secure Fax Number: _____
Encrypted Email Address: _____

Current Medications: (Name, Dose, Frequency)

Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____

CST Request for Authorization Form

The Illinois Mental Health Collaborative for Access and Choice

REQUEST FOR AUTHORIZATION OF ADULT COMMUNITY SUPPORT TEAM SERVICES (CST)

Initial Request (CST) -or- Reauthorization Request (CST)

ENHANCED SKILLS TRAINING (EST)

IN-HOME RECOVERY SUPPORT (IHR)

NOTE: Reauthorizations are not permitted for EST and IHR Services

Agency: _____	Name of Referred: _____
Agency Location: _____	Date of Birth: _____
Agency FEIN: _____	RIN#: _____
Team Name: _____	
Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Date CST Service Started: _____	

PLEASE PRINT (Must Include)
Staff to contact with any CLINICAL questions: _____
Phone: _____ Secure Fax Number: _____
Encrypted Email Address: _____

PLEASE PRINT (must include)
Staff to contact with any REGISTRATION questions: _____
Phone: _____ Secure Fax Number: _____
Encrypted Email Address: _____

Current Medications: (Name, Dose, Frequency)

Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____
Name: _____	Dose: _____	Frequency: _____

Getting Started

Access ProviderConnect via

www.illinoismentalhealthcollaborative.com/providers.htm

The screenshot shows the website interface for Provider Online Services. At the top left is the logo for the Illinois Mental Health Collaborative, with the tagline 'FOR ACCESS AND CHOICE'. A navigation menu contains links for 'About', 'Services', 'Feedback', and 'Contact'. A central banner features a photo of a man and a woman in a professional setting, with the text 'for providers' and 'Provider Online Services'. Below this is a sidebar menu with options: Home, Provider Home (highlighted), Provider Manual, Provider Forms, ReferralConnect, and Provider Information. The main content area is titled 'Provider Online Services' and includes a welcome message, a description of the ProviderConnect tool, and three buttons: LOG IN, REGISTER, and DEMO. A yellow callout bubble points to the LOG IN button with the text 'Log into ProviderConnect'. At the bottom, there is a paragraph of introductory text and a link to 'ProviderConnect Helpful Resources'.

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

About Services Feedback Contact

for providers

Provider Online Services

Provider Online Services

Welcome to Provider Online Services!

ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7.

Log into ProviderConnect

LOG IN REGISTER DEMO

Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

[ProviderConnect Helpful Resources](#) links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!

- Home
- Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect
- Provider Information

Authorization Request

Home

Specific Member Search

Register Member

Authorization Listing

Enter an Authorization Request

View Clinical Drafts

Claim Listing and Submission

Enter EAP CAF

Enter a Special Program Application

Complete Provider Forms

Enter a Comprehensive Service Plan

Review Referrals

Enter Bed Tracking Information

Search Beds/Opening

EDI Homepage

Enter Member Reminders

On Track Outcomes

Reports

Print Spectrum Release of Information Form

Welcome [REDACTED] Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

Enter Auth Request from either Link

Your Recent Inquiries box is empty

INBOX

SENT

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
 - Enter a Comprehensive Service Plan
 - Review an Authorization
 - View Clinical Drafts
- Enter or Review Claims
 - Enter EAP CAF
 - Review a Claim
 - View My Recent Provider Summary Vouchers
- Enter or Review Referrals
 - Enter a Referral
 - Review Referrals
- Enter Bed Tracking Information

Disclaimer

Disclaimer

Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for authorization. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the " Enter an Authorization Request " process, you will receive a screen noting the pended or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions.

Next

Member Search

Eligibility & Benefits Search

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

Verify a patient's eligibility and benefits information by entering search criteria below.

*Consumer ID

(No spaces or dashes)

Last Name

First Name

*Date of Birth

(MMDDYYYY)

As of Date

(MMDDYYYY)

**Enter the Consumer ID (RIN)
and the Date of Birth**

Search

Member Demographics

Demographics | Enrollment History | COB | Benefits | Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Consumer [?]

Consumer ID **ILLTEST01**
Alternate ID
Consumer Name **TEST01, ILL**
Date of Birth **01/01/1930**
Address **UNKNOWN
UNKNOWN, ZZ 99999**
Alternate Address
Marital Status -
Home Phone
Work Phone
Relationship **1**
Gender **M - Male**

Eligibility

Effective Date **01/01/2013**
Expiration Date
COB Effective Date [?]
[View Funding Source Enrollment Details](#)

Subscriber

Subscriber ID **ILLTEST01**
Subscriber Name **TEST01, ILL**

Next

Select Next

View Spectrum Record

Provider Location

Provider

Provider ID

Provider Last Name

Provider First Name

Select your agency address

Select Service Address

Capture	Provider		Vendor	
	Provider ID	Last Name	Vendor ID	Vendor Last Name
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address
	Alternate ID			
<input checked="" type="radio"/>	1000	1000	1000	1000
<input type="radio"/>	1000	1000	1000	1000
<input type="radio"/>	1000	1000	1000	1000

Request Services

Requested Services Header

All fields marked with an asterisk (*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MMDDYYYY)

09182013

*Level of Service

OUTPATIENT

*Type of Service

MENTAL HEALTH

*Level of Care

ASSERTIVE COMMUNITY TREATME

► Provider

Tax ID

(XXXXXXXXXX)

Provider ID

(XXXXXXXXXX)

Provider Last Name

(XXXXXXXXXXXXXXXXXXXXXXXXXX)

Vendor ID

(XXXXXXXXXX)

Provider Alternate ID

(XXXXXXXXXX)

► Consumer

Consumer ID

TEST

Last Name

(XXXXXXXXXX)

First Name

(XXXXXXXXXX)

Date of Birth (MMDDYYYY)

11211985

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the Consumer?

Yes No

*Document Description

SELECT...

UploadFile

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back

Next

**Attach your supporting documents
in this section for Web-based Requests
(i.e. MHA, Treatment Plan, Crisis Plan
and ACT Request Form)**

Requested Services Header

SERVICE DEFINITION CRITERIA		LOCUS RESULTS		RESULTS	
Complete Clinical Staff Contact Information					
Requested Services Header					
Requested Start Date 09/16/2015	Consumer Name TEST33, ILL	Provider Name [REDACTED]	Vendor ID [REDACTED]	Save Request as Draft	
Type of Request INITIAL	Consumer ID ILLTEST33	Provider ID [REDACTED]	Provider Alternate ID [REDACTED]	NPI # for Authorization SELECT... ▼	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care ASSERTIVE COMMUNITY TREATMENT	Type of Care [REDACTED]	Authorized User [REDACTED]	
* Clinical Staff to Contact if questions Case Manager [REDACTED]		* Phone # 312 555 5555 [REDACTED]		Fax # 312 555 5556	
Encrypted Email address Casemanager@company.com					









Service Definition Criteria

Service Definition Criteria

Check all that apply

- | | |
|---|--|
| <input checked="" type="checkbox"/> Excessive use of crisis/emergency services with failed linkages | <input checked="" type="checkbox"/> Person has multiple service needs requiring intensive efforts to ensure coordination among systems, services and providers |
| <input type="checkbox"/> Chronic homelessness | <input type="checkbox"/> Individuals who exhibit functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills |
| <input type="checkbox"/> Repeat arrests and incarcerations | <input type="checkbox"/> Individuals with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate |
| <input checked="" type="checkbox"/> Multiple and frequent psychiatric inpatient admissions | |

Acute Inpatient Episodes in the Prior 12 Months

Facility	Dates Of Service	
	From	Through
1. <input type="text" value="Northwestern Hospital"/>	<input type="text" value="08012013"/> 	<input type="text" value="08122013"/> 
2. <input type="text"/>	<input type="text"/> 	<input type="text"/> 
3. <input type="text"/>	<input type="text"/> 	<input type="text"/> 
4. <input type="text"/>	<input type="text"/> 	<input type="text"/> 

Please select **all that apply**

Behavioral & Medical Diagnoses

Behavioral Diagnoses

DSM-5/ICD-10 Diagnosis Sections
effective as of 10-1-2015

Primary Behavioral Diagnosis

* Diagnostic Category 1


 

* [Diagnosis Code 1](#)

* [Description](#)

Additional Behavioral Diagnosis

Diagnostic Category 2

[Diagnosis Code 2](#)

[Description](#)

Diagnostic Category 3

[Diagnosis Code 3](#)

[Description](#)

Diagnostic Category 4

[Diagnosis Code 4](#)

[Description](#)

Diagnostic Category 5

[Diagnosis Code 5](#)

[Description](#)

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.


* Diagnostic Category 1

[Diagnosis Code 1](#)

[Description](#)

Diagnostic Category 2

[Diagnosis Code 2](#)

[Description](#)

Diagnostic Category 3

[Diagnosis Code 3](#)

[Description](#)

Primary Behavioral Diagnosis

Behavioral Diagnoses

Once you select the [Diagnostic Category 1](#) hyperlink, the drop-down list displays the DSM-5/ICD-10 Diagnostic Categories

Primary Behavioral Diagnosis

* Diagnostic Category 1

*[Diagnosis Code 1](#)

*[Description](#)

SELECT...

ANXIETY DISORDERS
BIPOLAR AND RELATED DISORDERS
DEPRESSIVE DISORDERS
DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS
FEEDING AND EATING DISORDERS
GENDER DYSPHORIA
INTELLECTUAL DISABILITIES
MEDICATION-INDUCED MOVEMENT DISORDERS AND OTHER ADVERSE EFFECTS OF MEDICATION
MOOD DISORDER DUE TO MEDICAL CONDITION
NEUROCOGNITIVE DISORDERS
NEURODEVELOPMENTAL DISORDERS
OBSESSIVE-COMPULSIVE AND RELATED DISORDERS
OPIOID-RELATED DISORDERS
OTHER MENTAL DISORDERS
OTHER NEURODEVELOPMENTAL DISORDERS
PERSONALITY DISORDERS
SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS
STIMULANT-RELATED DISORDERS
SUBSTANCE-RELATED AND ADDICTIVE DISORDERS
SUBSTANCE-RELATED DISORDERS

Once you select a category, the
Diagnosis Code 1 and
Description auto-populate

Primary Behavioral Diagnosis

You may select from the [Diagnosis Code](#) or [Description](#) hyperlink. A pop-up window will appear with the Diagnosis Codes and Descriptions (both sections use the same pop-up window). Once you make your selection, the other fields will auto-populate the diagnosis.

(this screen shot does not show all diagnoses)

Category	Code	Description
ANXIETY DISORDERS	F40.00	AGORAPHOBIA
ANXIETY DISORDERS	F06.4	ANXIETY DISORDER DUE TO ANOTHER MEDICAL CONDITION
BIPOLAR AND RELATED DISORDERS	F06.34	BIPOLAR AND RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION WITH MIXED FEATURES
BIPOLAR AND RELATED DISORDERS	F31.0	BIPOLAR I DISORDER CURRENT OR MOST RECENT EPISODE HYPOMANIC
BIPOLAR AND RELATED DISORDERS	F31.11	BIPOLAR I DISORDER CURRENT OR MOST RECENT EPISODE MANIC - MILD
DEPRESSIVE DISORDERS	F06.34	DEPRESSIVE DISORDER DUE TO ANOTHER MEDICAL CONDITION WITH MIXED FEATURES
DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS	F60.2	ANTISOCIAL PERSONALITY DISORDER
FEEDING AND EATING DISORDERS	F50.01	ANOREXIA NERVOSA - RESTRICTING TYPE
FEEDING AND EATING DISORDERS	F50.8	AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER
FEEDING AND EATING DISORDERS	F50.8	BINGE-EATING DISORDER
FEEDING AND EATING DISORDERS	F50.2	BULIMIA NERVOSA
FEEDING AND EATING DISORDERS	F50.8	OTHER SPECIFIED FEEDING OR EATING DISORDER
FEEDING AND EATING DISORDERS	F50.8	PICA IN ADULTS
GENDER DYSPHORIA	F64.1	GENDER DYSPHORIA
GENDER DYSPHORIA	F64.1	GENDER DYSPHORIA IN ADOLESCENTS AND ADULTS
INTELLECTUAL DISABILITIES	F88	GLOBAL DEVELOPMENTAL DELAY

Primary Behavioral Diagnosis

Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnoses.

Behavioral Diagnoses

The auto-populated fields are displayed.
You must select the primary diagnosis in Diagnostic Category 1 .

Primary Behavioral Diagnosis

* Diagnostic Category 1

BIPOLAR AND RELATED DISORDERS

*Diagnosis Code 1

F31.11

* Description

Bipolar I Disorder Current or most recent e

Additional Behavioral Diagnosis

Diagnostic Category 2

SELECT...

Diagnosis Code 2

Description

Diagnostic Category 3

SELECT...

Diagnosis Code 3

Description

Diagnostic Category 4

SELECT...

Diagnosis Code 4

Description

Diagnostic Category 5

SELECT...

Diagnosis Code 5

Description

Additional Behavioral Diagnosis

Additional Behavioral Diagnosis

Diagnostic Category 2

[Diagnostic Code 2](#)

[Description](#)

SELECT...

ANXIETY DISORDERS
BIPOLAR AND RELATED DISORDERS
DEPRESSIVE DISORDERS
DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS
FEEDING AND EATING DISORDERS
GENDER DYSPHORIA
INTELLECTUAL DISABILITIES
MEDICATION-INDUCED MOVEMENT DISORDERS AND OTHER ADVERSE EFFECTS OF MEDICATION
MOOD DISORDER DUE TO MEDICAL CONDITION
NEUROCOGNITIVE DISORDERS
NEURODEVELOPMENTAL DISORDERS
OBSESSIVE-COMPULSIVE AND RELATED DISORDERS
OPIOID-RELATED DISORDERS
OTHER MENTAL DISORDERS
OTHER NEURODEVELOPMENTAL DISORDERS
PERSONALITY DISORDERS
SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS
STIMULANT-RELATED DISORDERS
SUBSTANCE-RELATED AND ADDICTIVE DISORDERS
SUBSTANCE-RELATED DISORDERS

Once you select the **Diagnostic Category** hyperlink, the drop-down list displays the **DSM-5/ICD-10 Diagnostic Categories**

s code and description.

SELECT... ▼

Additional Behavioral Diagnosis

Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is **strongly recommended** to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnoses.

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1

BIPOLAR AND RELATED DISORDERS

*[Diagnosis Code 1](#)

F31.11

*[Description](#)

Bipolar I Disorder Current or most recent e

Additional Behavioral Diagnosis

Diagnostic Category 2

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

[Diagnosis Code 2](#)

F10.129

[Description](#)

Alcohol Intoxication with Use Disorder, Mild

Diagnostic Category 3

SELECT...

[Diagnosis Code 3](#)

[Description](#)

Diagnostic Category 4

SELECT...

[Diagnosis Code 4](#)

[Description](#)

Diagnostic Category 5

SELECT...

[Diagnosis Code 5](#)

[Description](#)

If you have more diagnoses to list, there are 4 Additional Behavioral Diagnosis Fields. If you do not have any to list, you may leave this section blank as this section is not a required section.

Primary Medical Diagnosis

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

*Diagnostic Category 1

[Diagnosis Code 1](#)

[Description](#)

Diagnosis Code 1	Description
SELECT...	
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL CANCER & NEOPLASMS	ption
CIRCULATORY SYSTEM - HEART	
CIRCULATORY SYSTEM - OTHER	
CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES	
DIGESTIVE SYSTEM - LIVER	
DIGESTIVE SYSTEM - OTHER	ption
EAR AND MASTOID PROCESS	
ENDOCRINE, NUTRITIONAL & METABOLIC - DIABETES MELLITUS	
ENDOCRINE, NUTRITIONAL & METABOLIC - OTHER	
ENDOCRINE, NUTRITIONAL & METABOLIC - THYROID	
EYE - BLINDNESS	
EYE - OTHER	
INFECTIOUS & PARASITIC - HIV	
*INFECTIOUS & PARASITIC - OTHER	
NERVOUS SYSTEM - CHRONIC PAIN, OTHER	
NERVOUS SYSTEM - MIGRAINE, EPILEPSY, STROKE	
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	
SKIN & SUBCUTANEOUS TISSUE	
SYMPTOMS, SIGNS & ABNORMAL CLINICAL/LAB	
NONE	
UNKNOWN	

Once you select the Diagnostic Category hyperlink, the drop-down list displays the DSM-5/ICD-10 Diagnostic Categories

Primary Medical Diagnosis

You may select from the [Diagnosis Code](#) or [Description](#) hyperlink. A pop-up window will appear with the Diagnosis Codes and Descriptions (both sections use the same pop-up window). Once you make your selection, the other fields will auto-populate the diagnosis.
(this screen shot does not show all diagnoses)

BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL	D53	OTHER NUTRITIONAL ANEMIAS
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL	D51	VITAMIN B12 DEFICIENCY ANEMIA
CANCER & NEOPLASMS	D3A	BENIGN NEUROENDOCRINE TUMORS
CANCER & NEOPLASMS	C91	LYMPHOID LEUKEMIA
CANCER & NEOPLASMS	C41	MALIGNANT NEOPLASM OF BONE AND ARTICULAR CARTILAGE OF OTHER AND UNSPECIFIED SITES
CANCER & NEOPLASMS	C18	MALIGNANT NEOPLASM OF COLON
CANCER & NEOPLASMS	C00	MALIGNANT NEOPLASM OF LIP
CANCER & NEOPLASMS	C19	MALIGNANT NEOPLASM OF RECTOSIGMOID JUNCTION
CANCER & NEOPLASMS	C20	MALIGNANT NEOPLASM OF RECTUM
CIRCULATORY SYSTEM - HEART	I43	CARDIOMYOPATHY IN DISEASES CLASSIFIED ELSEWHERE
CIRCULATORY SYSTEM - HEART	I24	OTHER ACUTE ISCHEMIC HEART DISEASES
CIRCULATORY SYSTEM - HEART	I26	PULMONARY EMBOLISM
CIRCULATORY SYSTEM - HEART	I22	SUBSEQUENT ST ELEVATION (STEMI) AND NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION
CIRCULATORY SYSTEM - OTHER	I95	HYPOTENSION

Primary Medical Diagnosis

Diagnostic Category 5

Diagnosis Code 5

Description

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

*Diagnostic Category 1

SELECT...	Diagnosis Code 1	Description
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL		
CANCER & NEOPLASMS		Description
CIRCULATORY SYSTEM - HEART		
CIRCULATORY SYSTEM - OTHER		Description
CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES		
DIGESTIVE SYSTEM - LIVER		
DIGESTIVE SYSTEM - OTHER		Description
EAR AND MASTOID PROCESS		
ENDOCRINE, NUTRITIONAL & METABOLIC - DIABETES MELLITUS		
ENDOCRINE, NUTRITIONAL & METABOLIC - OTHER		
ENDOCRINE, NUTRITIONAL & METABOLIC - THYROID		
EYE - BLINDNESS		
EYE - OTHER		
INFECTIOUS & PARASITIC - HIV		
INFECTIOUS & PARASITIC - OTHER		
NERVOUS SYSTEM - CHRONIC PAIN, OTHER		
NERVOUS SYSTEM - MIGRAINE, EPILEPSY, STROKE		
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM		
SKIN & SUBCUTANEOUS TISSUE		
SYMPTOMS, SIGNS & ABNORMAL CLINICAL/LAB		
NONE		
UNKNOWN		

You may select None or Unknown

Financial problems

Problems with primary support group

Housing problems (Not Homelessness)

Occupational problems

Other psychosocial and environmental problems

Primary Medical Diagnosis

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

*Diagnostic Category 1

Diagnosis Code 1

Description

Diagnostic Category 2

Selecting "None" or "Unknown" will not generate a Diagnosis Code or Description

Diagnostic Category 3

Social Elements Impacting Diagnosis

Social Elements Impacting Diagnosis

* Check all that apply

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Housing problems (Not Homelessness) | <input checked="" type="checkbox"/> Problems related to the social environment |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> Occupational problems | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Financial problems | <input checked="" type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Other psychosocial and environmental problems | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Medical disabilities that impact diagnosis or must be accommodated for in treatment | | | |

If the "None" box is pre-filled from registration, uncheck the "None" when you are submitting your request for service. Check all Social Elements that apply.

The highlighted field are new fields

Functional Assessment

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific should be noted in the Assessment Score field.

The GAF Score is required

Assessment Measure

GAF ▼

Assessment Score

30

Secondary Assessment Measure

SELECT... ▼

Assessment Score

For any medical diagnosis or condition listed, please describe how consumer is being assisted to manage this condition:

*Does consumer have a dual diagnosis mental illness and developmental disability (MI-DD)?

Yes No

If yes, please identify the DD Diagnosis

LOCUS

LOCUS Results

Functional Impairment Domain Scores:

*Risk of Harm	<input type="text" value="3"/>	▼	*Recovery - Environment Stressors	<input type="text" value="3"/>	▼
*Functional Status	<input type="text" value="3"/>	▼	*Recovery - Environment Supports	<input type="text" value="3"/>	▼
*Co-Morbidity	<input type="text" value="2"/>	▼	*Recovery and Treatment History	<input type="text" value="3"/>	▼
			*Acceptance and Engagement	<input type="text" value="2"/>	▼
Composite Score	<input type="text" value="19"/>				

Level Of Care Recommended - Locus

III-HIGH INTENSITY COMMUNITY BASED SRVS (17-19)

Level Of Care Recommended - Assessors

▼

Reason for deviation of recommended Level Of Care

**If the LOCUS Score is under Level 4,
you must enter a Reason for Deviation
in the Narrative Entry Box**

Medications

Psychotropic Medications

List Medication Information

Medication <input type="text" value="SEROQUEL XR (QUETIAPINE)"/>	Side effects? <input type="radio"/> Yes <input checked="" type="radio"/> No	Usually adherent? <input checked="" type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text" value="PSYCHIATRIST"/>
Dosage <input type="text" value="100 mg"/> Frequency <input type="text" value="QD: DAILY"/>			
Medication <input type="text" value="OTHER"/>	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text" value="SELECT..."/>
Other <input type="text" value="None"/>			
Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/>			
Medication <input type="text"/>	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text" value="SELECT..."/>
Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/>			
Medication <input type="text"/>	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text" value="SELECT..."/>
Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/>			
Planned Discharge Level of Care <input type="text" value="SELECT..."/>	Planned Discharge Residence <input type="text" value="SELECT..."/>		

Back

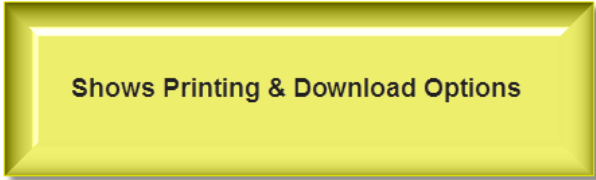
Submit

Determination Status

Determination Status:

***** PENDED *****

The services requested require additional review. You will be contacted regarding the status of this request if further information is needed. An authorization decision will be made within the required timeframes and details of that decision may be found under the consumer's authorization history.

Consumer Name [REDACTED]	Consumer ID TEST [REDACTED]	Consumer DOB 11/21/1985	Subscriber Name [REDACTED]	Subscriber ID TEST [REDACTED]
Pended Authorization # 091813-1-10	Client Authorization # N/A	Type of Request INITIAL		
Date of Admission/ Start of Services 09/18/2013	Requested From 09/18/2013	Submission Date 09/18/2013		
Level of Service OUTPATIENT	Type of Service MENTAL HEALTH	Level of Care ASSERTIVE COMMUNITY TREATMENT		
Reason Code P76				
Provider Name & Address [REDACTED]	Provider ID [REDACTED]	Provider Alternate ID [REDACTED]	NPI # for Authorization N/A	

Attached Documents

There are no documents attached with this Authorization Request

Document Title	Document Description
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Authorization Printing & Downloading Options:

(For the best print results, please print in 'Landscape' format)

Print Authorization Result
Print the Results page (this page)

Print Authorization Request
Print the entire Authorization Request

Download Authorization Request
Download the entire Authorization Request

Return to Provider Home
Return to the ProviderConnect homepage

Discontinuation of ACT/CST Services

- Providers must notify the Collaborative when a consumer is discontinuing ACT or CST services by completing a “Notification of Discontinuance of ACT/CST Services” Form and faxing the form to the Collaborative at **(866) 928-7177**.
- Discontinuance criteria are outlined in the Service Authorization Protocol Manual located on the Collaborative website:
http://www.illinoismentalhealthcollaborative.com/provider/prv_manual.htm.
- Detailed information regarding discontinuance of ACT/CST services and linkage to other services must be documented in the consumer’s clinical record.

ACT Notice of Discontinuation

Notification of Discontinuation from Assertive Community Treatment

Fax Forms to the Collaborative at: 866-928-7177

Agency: _____	Name of Referred: _____
Agency Location: _____	Date of Birth: _____
Agency FEIN: _____	RIN # _____
Team Name: _____	
Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Admit Date to ACT: _____	
ACT was discontinued on(date): _____	

I. DISCONTINUANCE CRITERIA (Please check only one)

<input type="checkbox"/> Person requests termination from ACT and is currently stable (complete transition plan for ongoing services)
<input type="checkbox"/> Person has improved to the extent that ACT is no longer needed and recovery goals have been met and there is no medical necessity for ACT (complete transition plan for ongoing services)
<input type="checkbox"/> Person has moved out of the ACT teams geographic area and has been linked to the following program
<input type="checkbox"/> Person has moved out of the State and has been linked to the following services
<input type="checkbox"/> Person cannot be located, in spite of repeated ACT efforts (Describe efforts to locate and continue ACT services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
<input type="checkbox"/> Person requests termination from ACT despite the clinical recommendation of the team
<input type="checkbox"/> Person has been incarcerated
<input type="checkbox"/> Person is in need of hospitalization that may exceed 90 days
<input type="checkbox"/> Person is in need of nursing facility level of care that may exceed 90 days
<input type="checkbox"/> Deceased

CST Notice of Discontinuation

Notification of Discontinuance of Community Support Team

Fax Form to the Collaborative at: 866-928-7177

Agency: _____	Name of Referred: _____
Agency Location: _____	Date of Birth: _____
Agency FEIN: _____	RIN # _____
Team Name: _____	

Male: Female:

Admit Date to CST: _____

CST was discontinued on (date) _____

I. DISCONTINUATION CRITERIA (please check one)

<input type="checkbox"/> Person requests termination from CST and is stable
<input type="checkbox"/> Person has improved to the extent that CST is no longer needed and recovery goals have been met. (No medical necessity for CST – please attach transition plan)
<input type="checkbox"/> Person has moved out of the CST Teams' geographic area (provide linkage information to new CST Team or community service)
<input type="checkbox"/> Person has moved out of State (make attempts to link with other CST or community services)
<input type="checkbox"/> Person cannot be located, in spite of repeated efforts. (Describe efforts to locate and continue CST services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
<input type="checkbox"/> Person requests termination from CST despite the clinical recommendation of the team
<input type="checkbox"/> Person has been incarcerated
<input type="checkbox"/> Person is in need of hospitalization that may exceed 90 days
<input type="checkbox"/> Person is in need of nursing facility level of care that may exceed 90 days
<input type="checkbox"/> Deceased

Administrative Denial

If the consumer does not have Medicaid:

- **You will receive a call from the clinician that is processing your request for services, informing you that your request has been administratively denied due to the consumer not having Medicaid enrollment in our system. At that time you will be instructed to re-submit the request with a Medicaid eligible RIN.**
- **If the consumer is Medicaid eligible and it is not reflected in our system, you will be asked to submit verification documents to show verification of Medicaid eligibility. Our clinical department will forward this information to our eligibility department to be researched. If the consumer is determined to be eligible, the records will be updated in our system, allowing the authorization request to be completed.**

Request for Reconsideration and Appeal

- Prior to a denial, the Collaborative staff will support consumers and providers by offering alternative services that can meet the consumers' needs in the least restrictive setting.
- Appeals can be requested by a provider on behalf of a consumer by calling the Collaborative at [\(866\) 359-7953](tel:8663597953).
- Reconsideration requests must be received within 30 days of receipt of the denial.
- Reconsideration requests will then be reviewed by a psychiatrist employed by the Collaborative who was not involved in the original decision, and is not a subordinate of the psychiatrist who made the original decision.

DMH Secretary's Level Appeal

- **If the provider, consumer, or designated representative disagrees with the outcome of the Reconsideration request, an appeal may be filed within 5 days from the decision date of the reconsideration request.**
- **This review shall not be a clinical review, but rather an administrative review to ensure that all applicable appeal procedures have been correctly applied and followed.**
- **The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].**



RESOURCES

ACT/CST FORMS

The following forms are located on the Collaborative Website under the **Provider Information link** in the **Clinical/Utilization Management Section**:

1. ACT/CST Authorization Request Form
2. ACT/CST Notice of Discontinuance Form

http://www.illinoismentalhealthcollaborative.com/provider/prv_information.htm

DIAGNOSIS APPENDIX

The Diagnosis Appendix is found in the [Batch Registration Submission Guide](#), which is located on the Collaborative Website under the [Provider Information link](#) in the [Registration Section](#):

http://www.illinoismentalhealthcollaborative.com/provider/prv_information.htm

The following screen shots will show a quick snapshot of the following:

- APPENDIX A - DSM-5 / ICD-10 MH Diagnostic Categories, Codes, and Descriptions
- APPENDIX B - DSM-5 / ICD-10 Medical Diagnostic Categories, Codes, and Descriptions

DIAGNOSIS APPENDIX A

APPENDIX A – DSM-5 / ICD-10 MH Diagnostic Categories, Codes, and Descriptions

* These are the values that will be entered on the Batch Registration Submission File.

MH Diagnostic Category *	Long Description for MH Diagnostic Category	MH ICD Code *	Description for MH ICD Code *	Long Description for MH ICD Code
AXDO	Anxiety Disorders	F06.4	AXDOAMC	Anxiety Disorder Due to Another Medical Condition
AXDO	Anxiety Disorders	F11.188	OPIADWDM	Opioid - Induced Anxiety Disorder, With mild use disorder
AXDO	Anxiety Disorders	F11.288	OPIADWMS	Opioid - Induced Anxiety Disorder, With moderate or severe use disorder
AXDO	Anxiety Disorders	F11.988	OPIADWOD	Opioid - Induced Anxiety Disorder, Without use disorder
AXDO	Anxiety Disorders	F12.180	CAIADWUM	Cannabis - Induced Anxiety Disorder, With mild use disorder
AXDO	Anxiety Disorders	F12.280	CAIADWMS	Cannabis - Induced Anxiety Disorder, With moderate or severe use disorder
AXDO	Anxiety Disorders	F12.980	CAIADWOU	Cannabis - Induced Anxiety Disorder, Without use disorder
AXDO	Anxiety Disorders	F13.180	SHAIADWM	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, With mild use disorder
AXDO	Anxiety Disorders	F13.280	SHAIADMS	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, With moderate or severe use disorder
AXDO	Anxiety Disorders	F13.980	SHAADWOD	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, Without use disorder
AXDO	Anxiety Disorders	F16.180	OHIADWUD	Other hallucinogen - Induced Anxiety Disorder, With mild use disorder
AXDO	Anxiety Disorders	F16.180	PIADWUDM	Phencyclidine - Induced Anxiety Disorder, With mild use disorder
AXDO	Anxiety Disorders	F16.280	OHIADWMS	Other hallucinogen - Induced Anxiety Disorder, With moderate or severe use disorder
AXDO	Anxiety Disorders	F16.280	PIADWDMS	Phencyclidine - Induced Anxiety Disorder, With moderate or severe use disorder

DIAGNOSIS APPENDIX B

APPENDIX B – DSM-5 / ICD-10 Medical Diagnostic Categories, Codes, and Descriptions

* These are the values that will be entered on the Batch Registration Submission File.

Medical Diagnostic Category *	Long Description for Medical Diagnostic Category	Medical ICD Code *	Description for Medical ICD Code *	Long Description for Medical ICD Code
BBFOIM	Blood, blood-forming organs, & immunological	D50	IRNDFANM	Iron deficiency anemia
BBFOIM	Blood, blood-forming organs, & immunological	D51	VB12DANM	Vitamin B12 deficiency anemia
BBFOIM	Blood, blood-forming organs, & immunological	D52	FOLDFANM	Folate deficiency anemia
BBFOIM	Blood, blood-forming organs, & immunological	D53	OTNUTANM	Other nutritional <u>anemias</u>
BBFOIM	Blood, blood-forming organs, & immunological	D55	ANMENZDO	Anemia due to enzyme disorders
BBFOIM	Blood, blood-forming organs, & immunological	D56	THLSMIA	Thalassemia
BBFOIM	Blood, blood-forming organs, & immunological	D57	SICELDO	Sickle-cell disorders
BBFOIM	Blood, blood-forming organs, & immunological	D58	OTHRHANM	Other hereditary hemolytic <u>anemias</u>
BBFOIM	Blood, blood-forming organs, & immunological	D59	ACQHMAMM	Acquired hemolytic anemia
BBFOIM	Blood, blood-forming organs, & immunological	D60	APRCAPLA	Acquired pure red cell aplasia [<u>erythroblastopenia</u>]
BBFOIM	Blood, blood-forming organs, & immunological	D61	OAAOBMFS	Other aplastic <u>anemias</u> and other bone marrow failure syndromes
BBFOIM	Blood, blood-forming organs, & immunological	D62	ACPSMANM	Acute <u>posthemorrhagic</u> anemia

TECHNICAL ISSUES

- EDI Help Desk (888) 247-9311
- 7AM to 5PM CST (Monday-Friday)
- Examples of Technical Issues:

- Account disabled
- Forgot password
- System “freezing” or “crashing”
- System unavailable due to system errors
- Registration errors



Thank
You

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www.illinoismentalhealthcollaborative.com