Utilization Management Request for Services Process

April 20, 2015

PRESENTERS

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Clinical Services Manager

&

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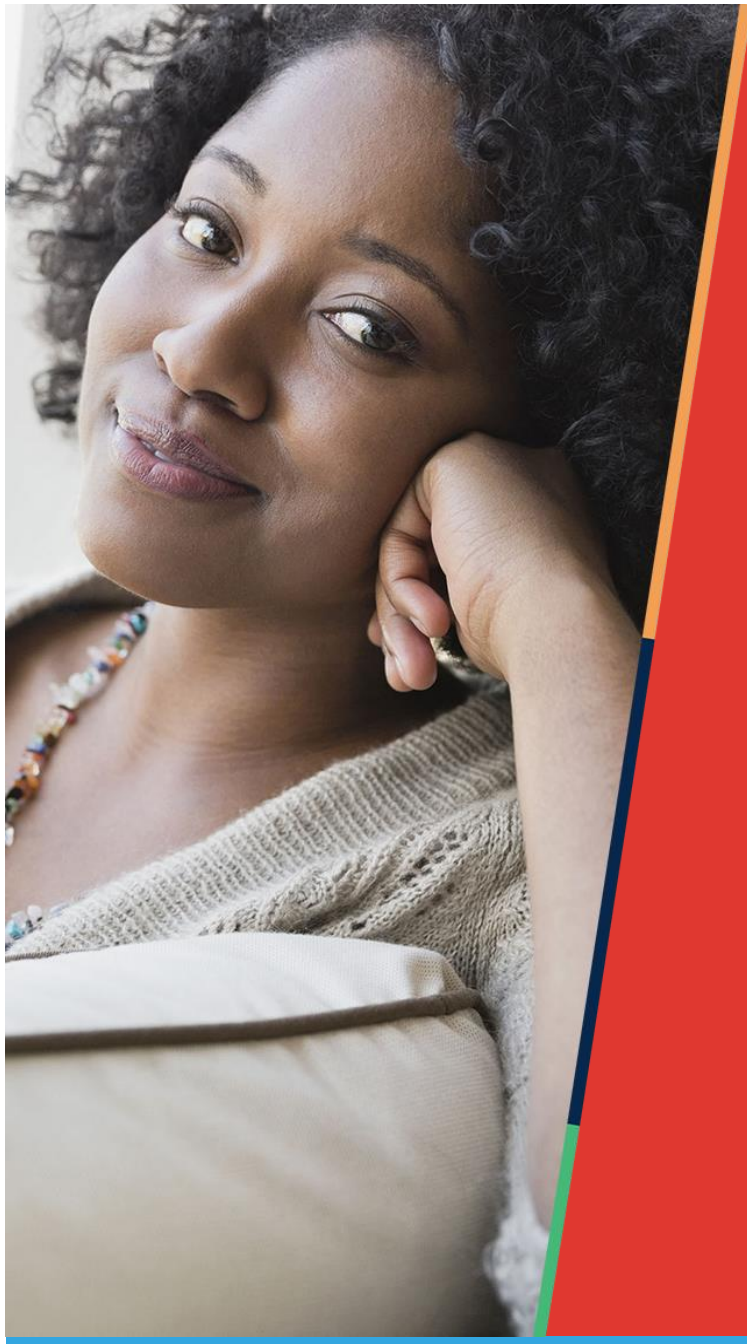
Clinical Quality Assurance Analyst

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 any 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:**

- **ACT/CST**
  - **One (1) business day of 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, the treating provider will submit a complete request for authorization of ACT packet that includes:

- **The ACT Authorization Request Form that includes 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.**
- **Before the initial authorization 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.**

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 Authorization Request Form that includes LOCUS information for adults.**
- **The CST Authorization Request Form that includes Ohio Scale Results for children 5-17.**
- **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 authorization or a (12) twelve month authorization.**
- **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 authorization.**
- **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: ☐ **Female:** ☐ **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: ☐ **Female:** ☐ **Date CST Service Started:** _____

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

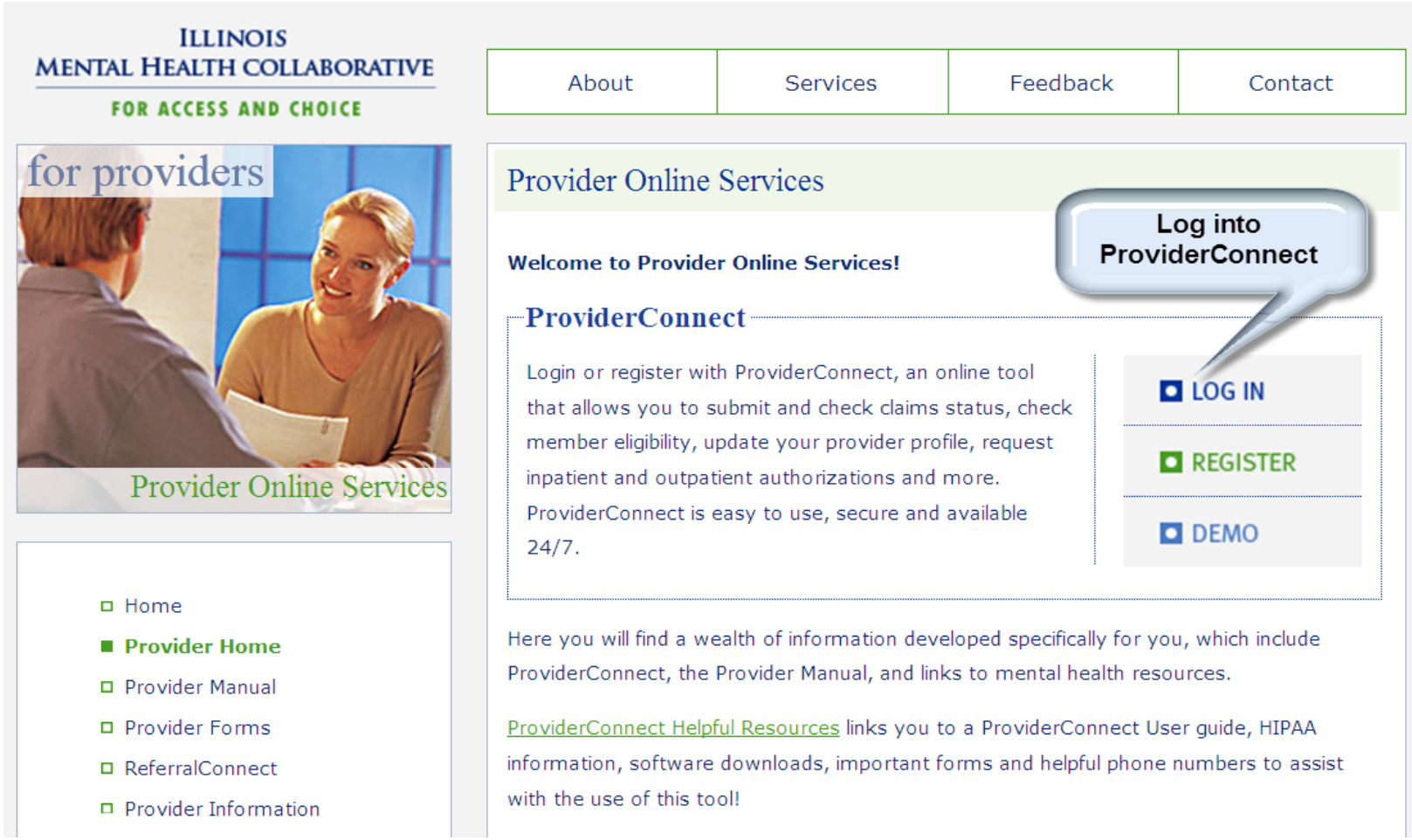
PLEASE PRINT (must include)
Staff to contact with any REGISTRATION questions: _____
Phone: _____ **Secure Fax Number:** _____
Encrypted Email Address: _____

Current Medications: (Name, Dose, Frequency)

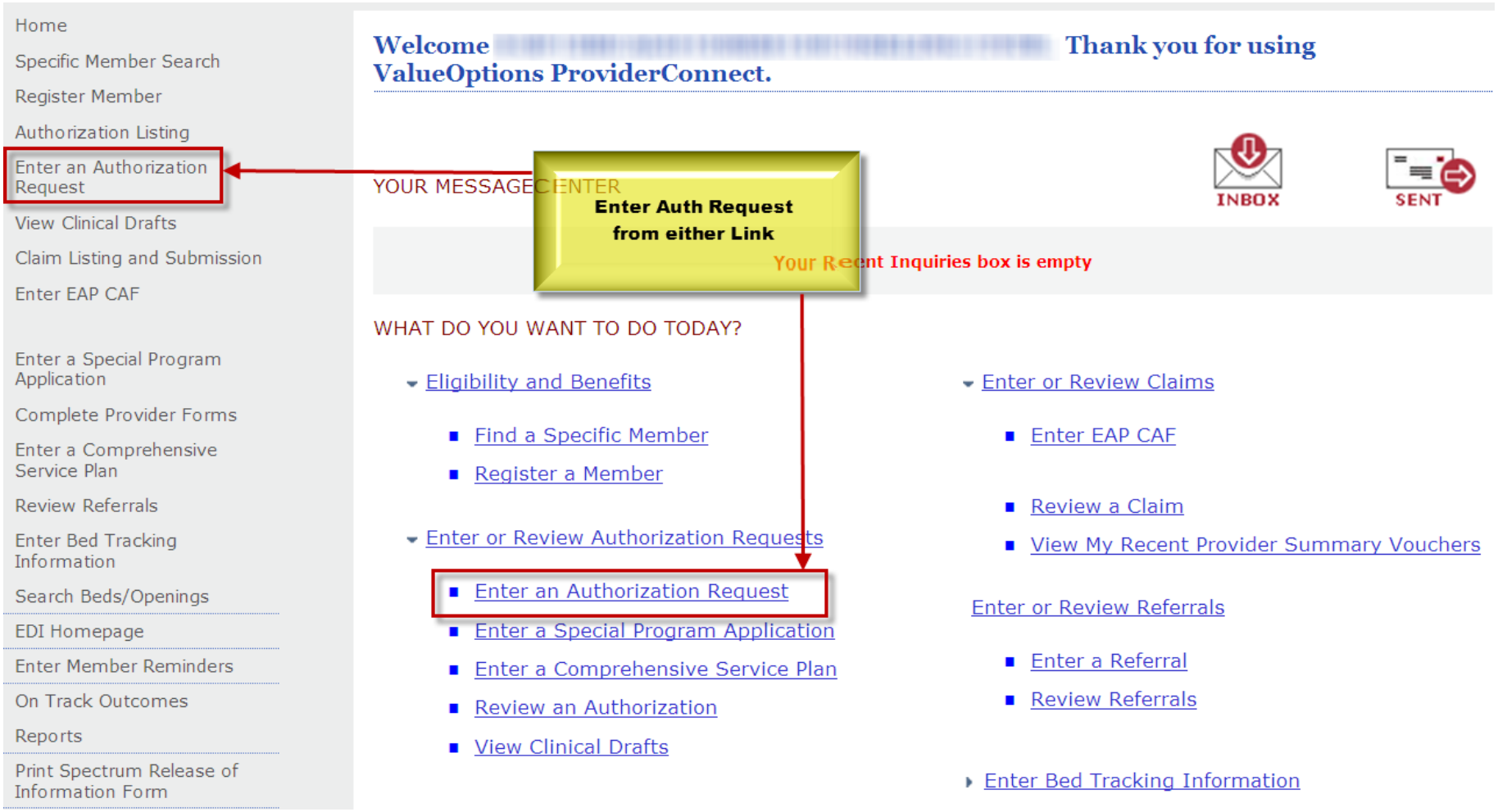
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

Getting Started

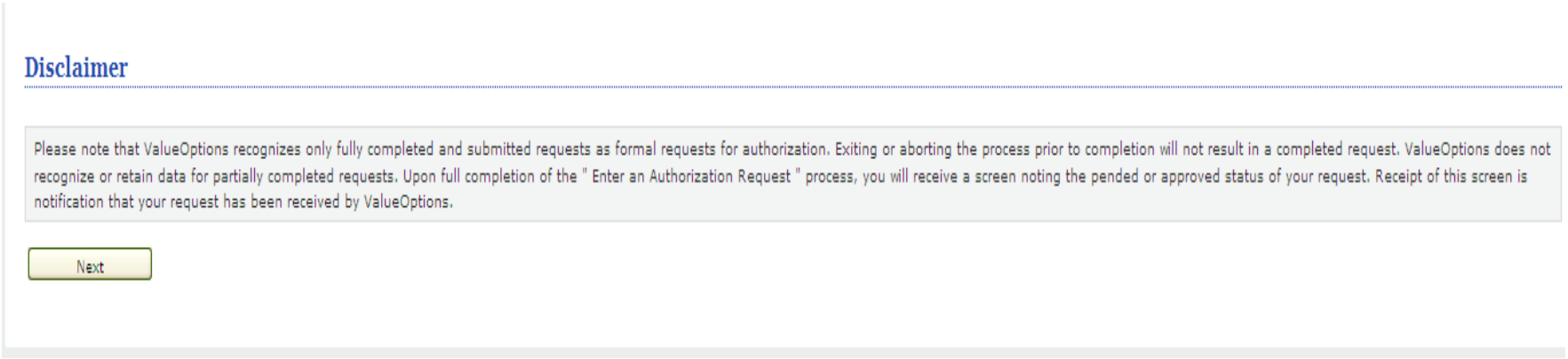
Access ProviderConnect via www.illinoismentalhealthcollaborative.com/providers.htm



Authorization Request



Disclaimer


Disclaimer
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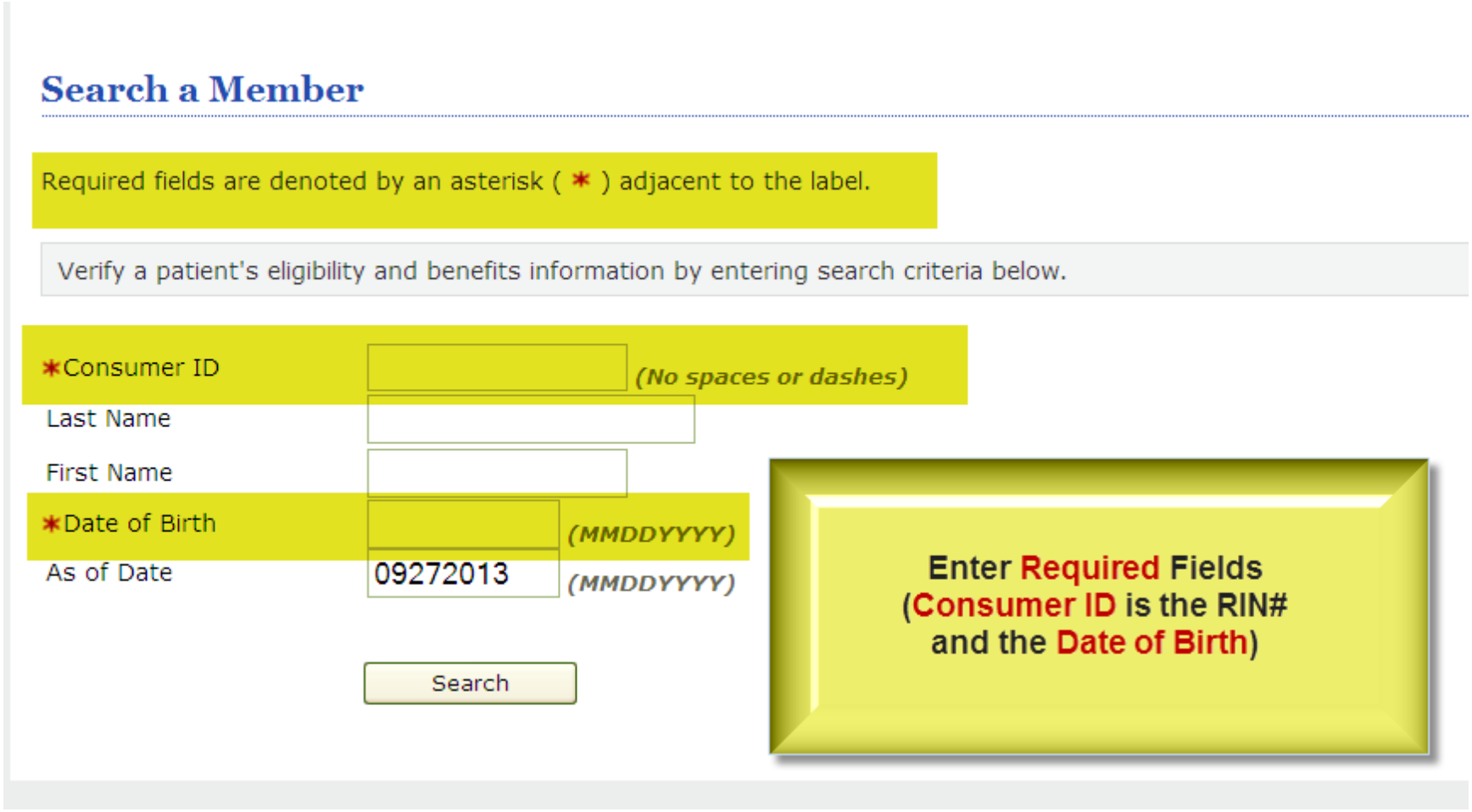
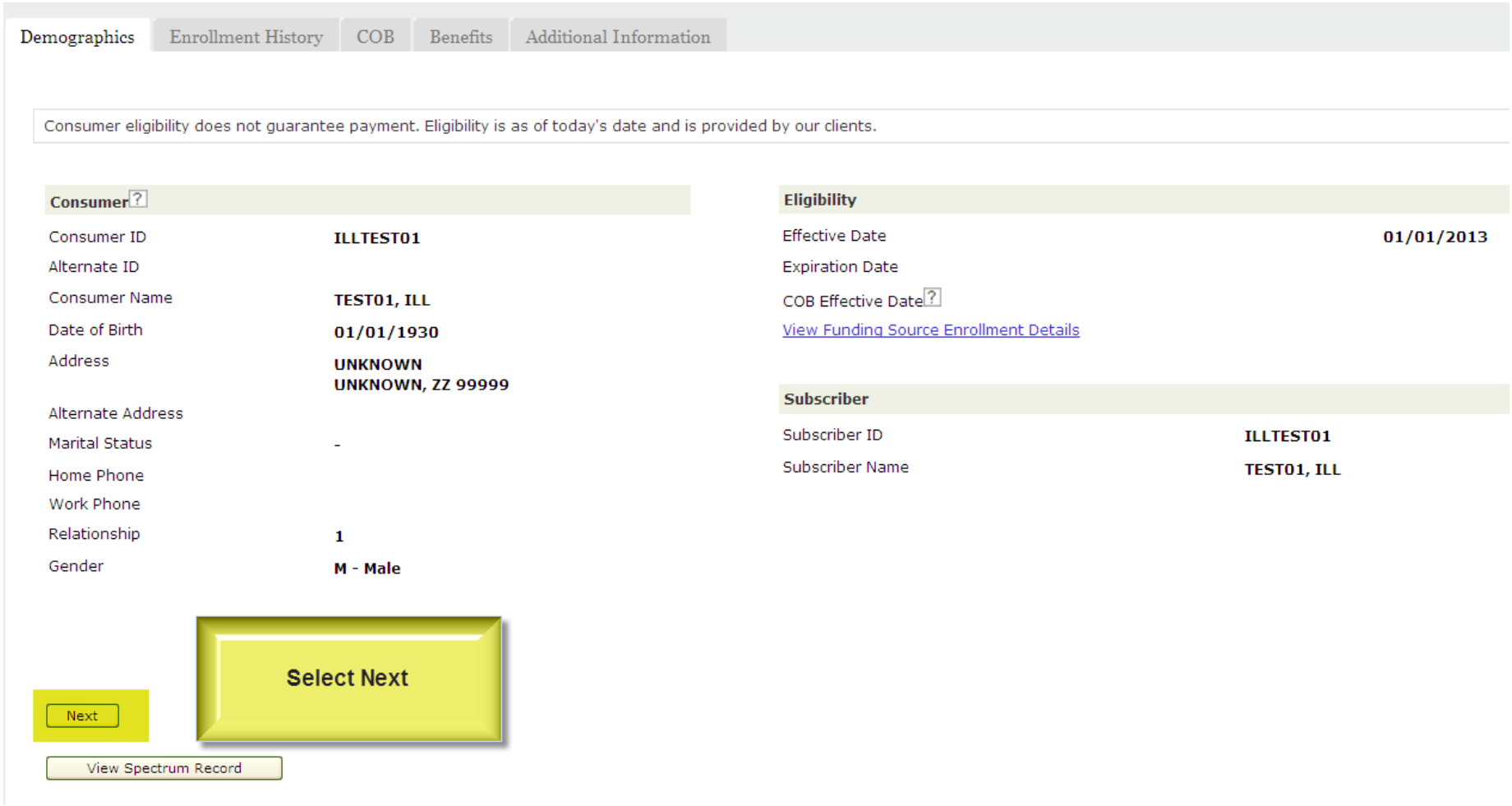
Next

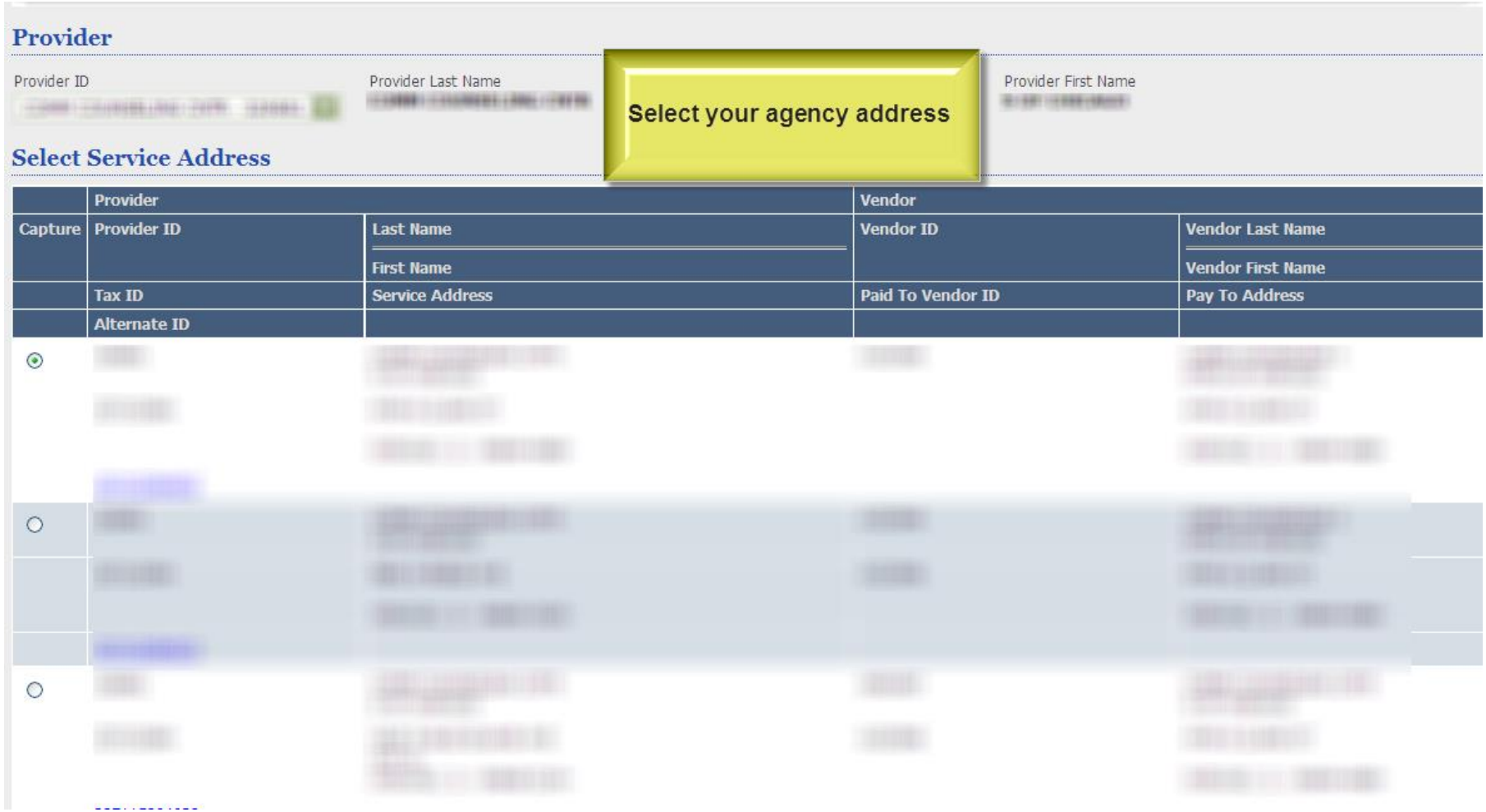
Member Search



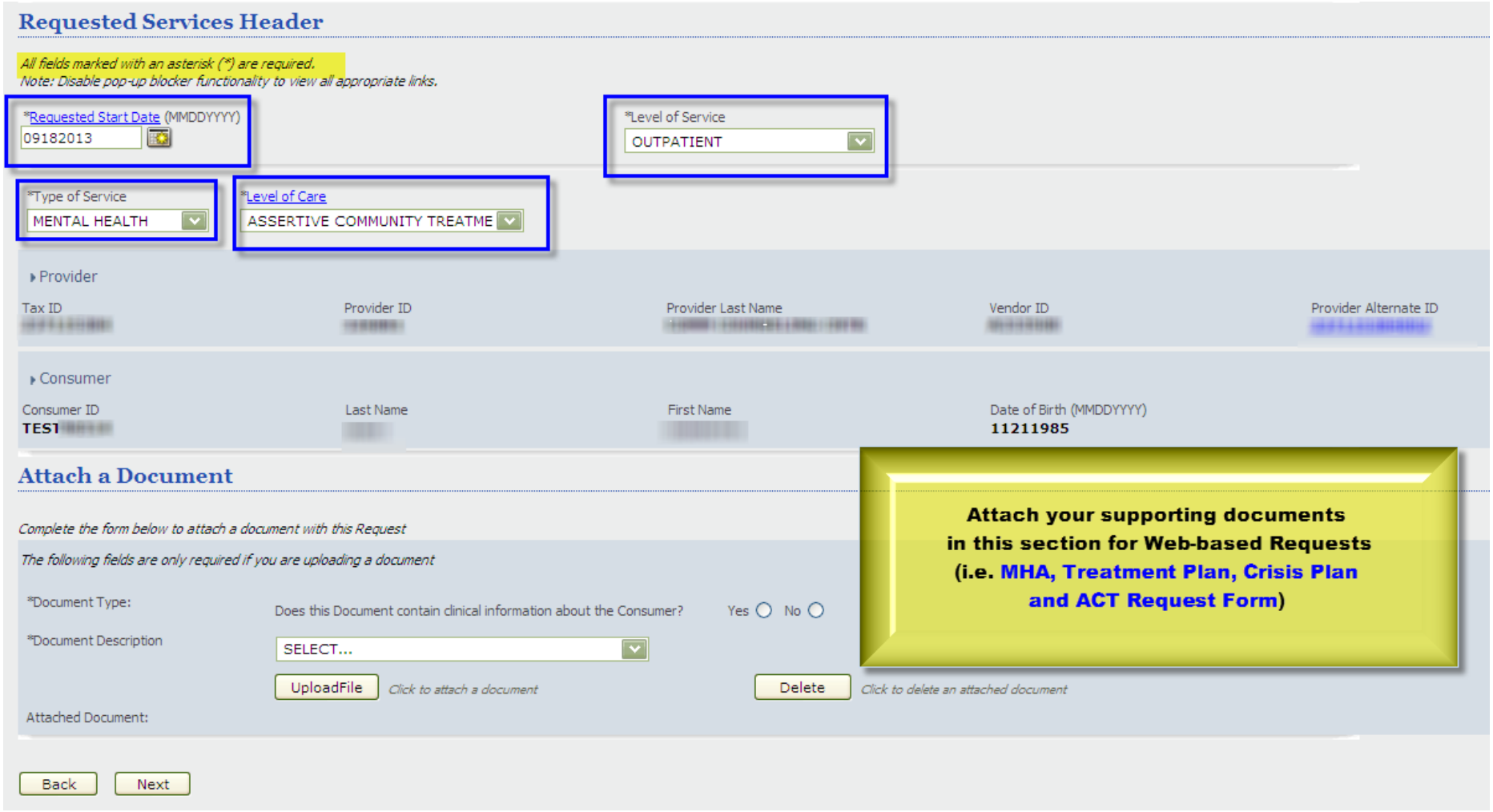
Member Demographics



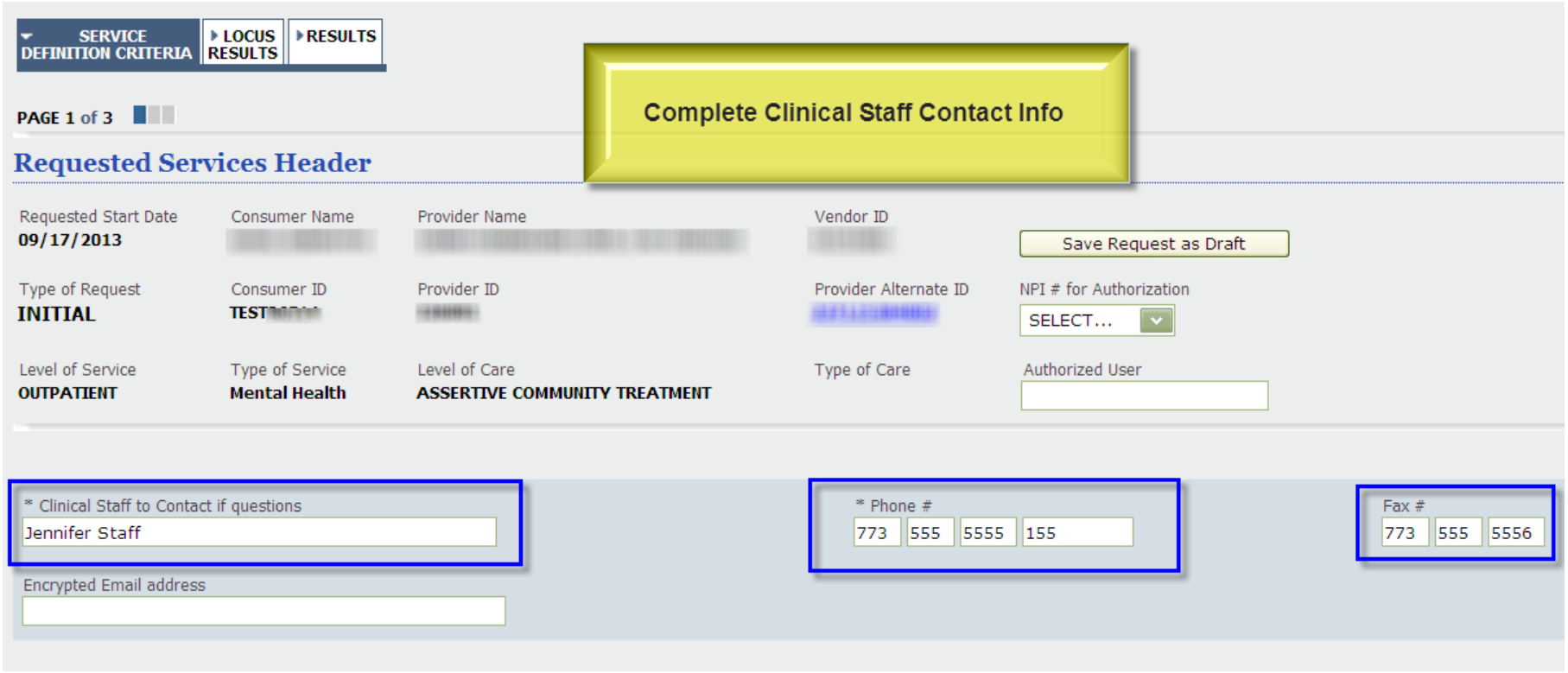
Provider Location



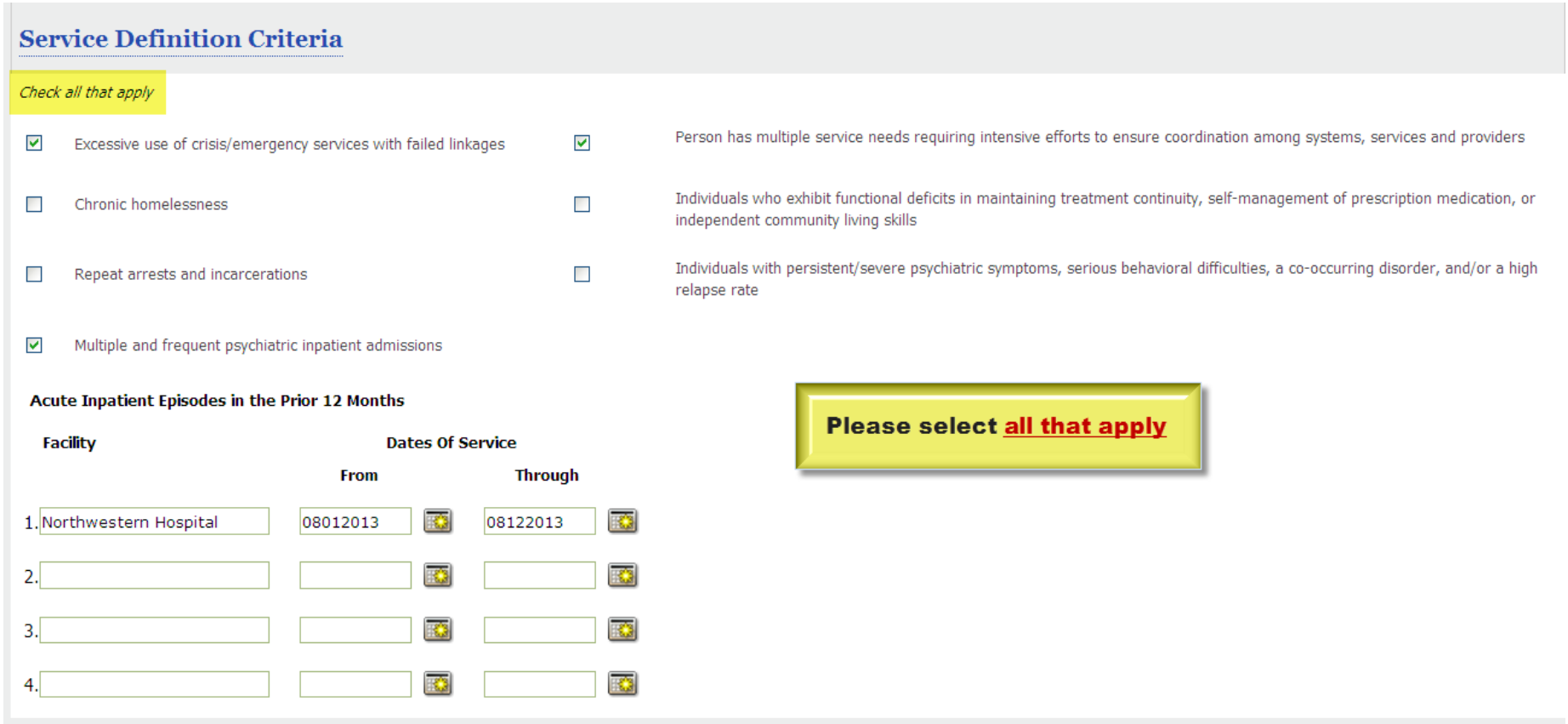
Request Services



Requested Services Header



Service Definition Criteria



Service Definition Criteria

Check all that apply

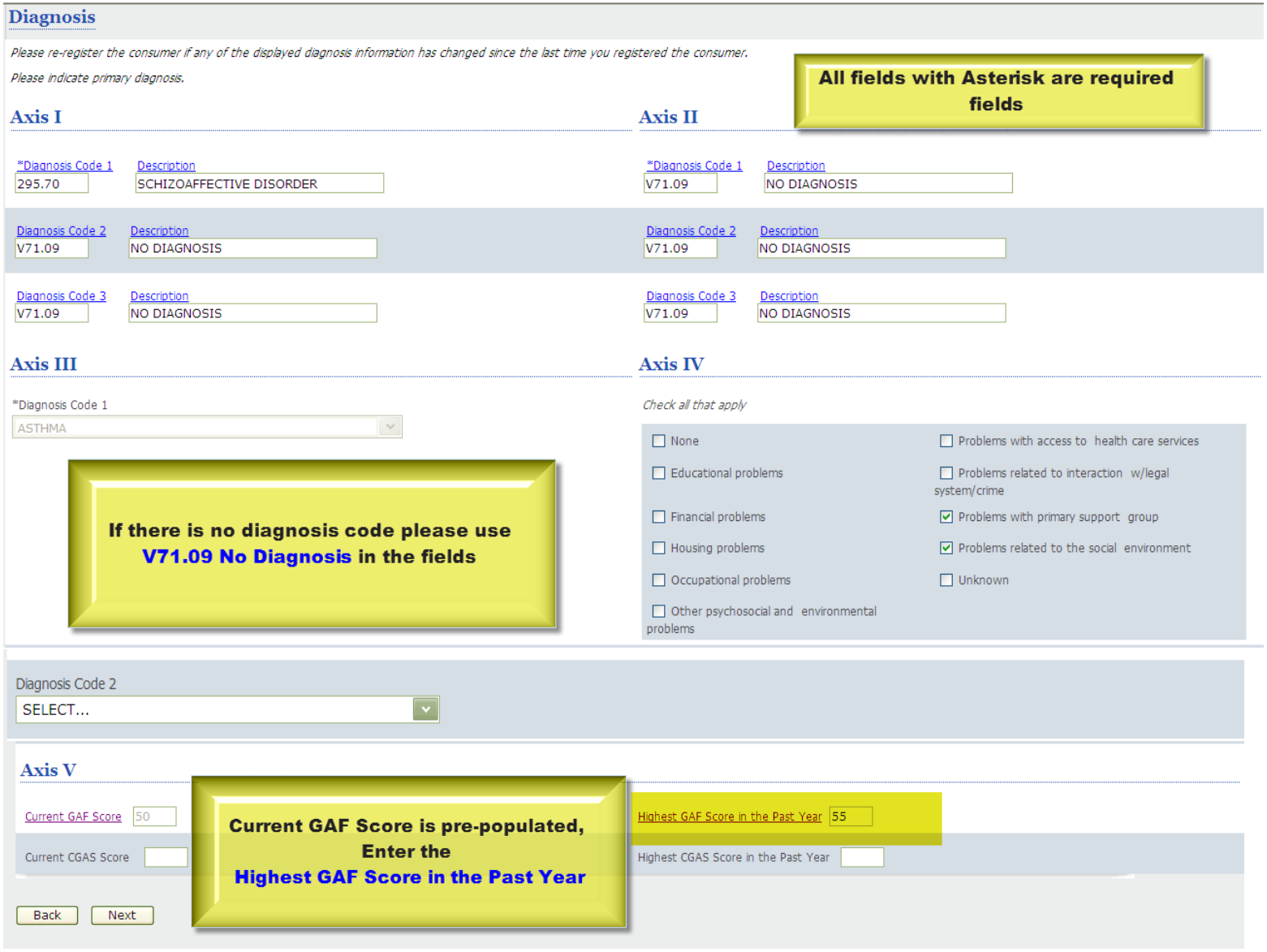
- [x] Excessive use of crisis/emergency services with failed linkages
- [ ] Chronic homelessness
- [ ] Repeat arrests and incarcerations
- [x] Multiple and frequent psychiatric inpatient admissions
- [x] Person has multiple service needs requiring intensive efforts to ensure coordination among systems,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

Acute Inpatient Episodes in the Prior 12 Months

	Facility	Dates Of Service From	Through
1.	Northwestern Hospital	08012013	08122013
2.			
3.			
4.			

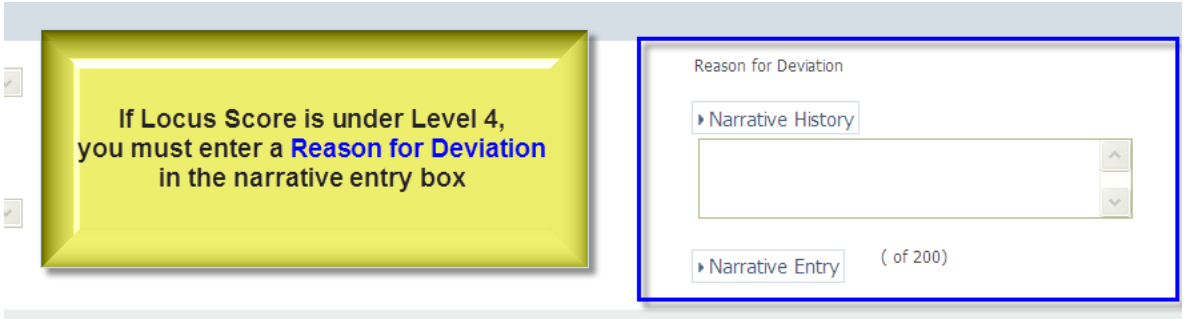
Please select all that apply

Diagnosis

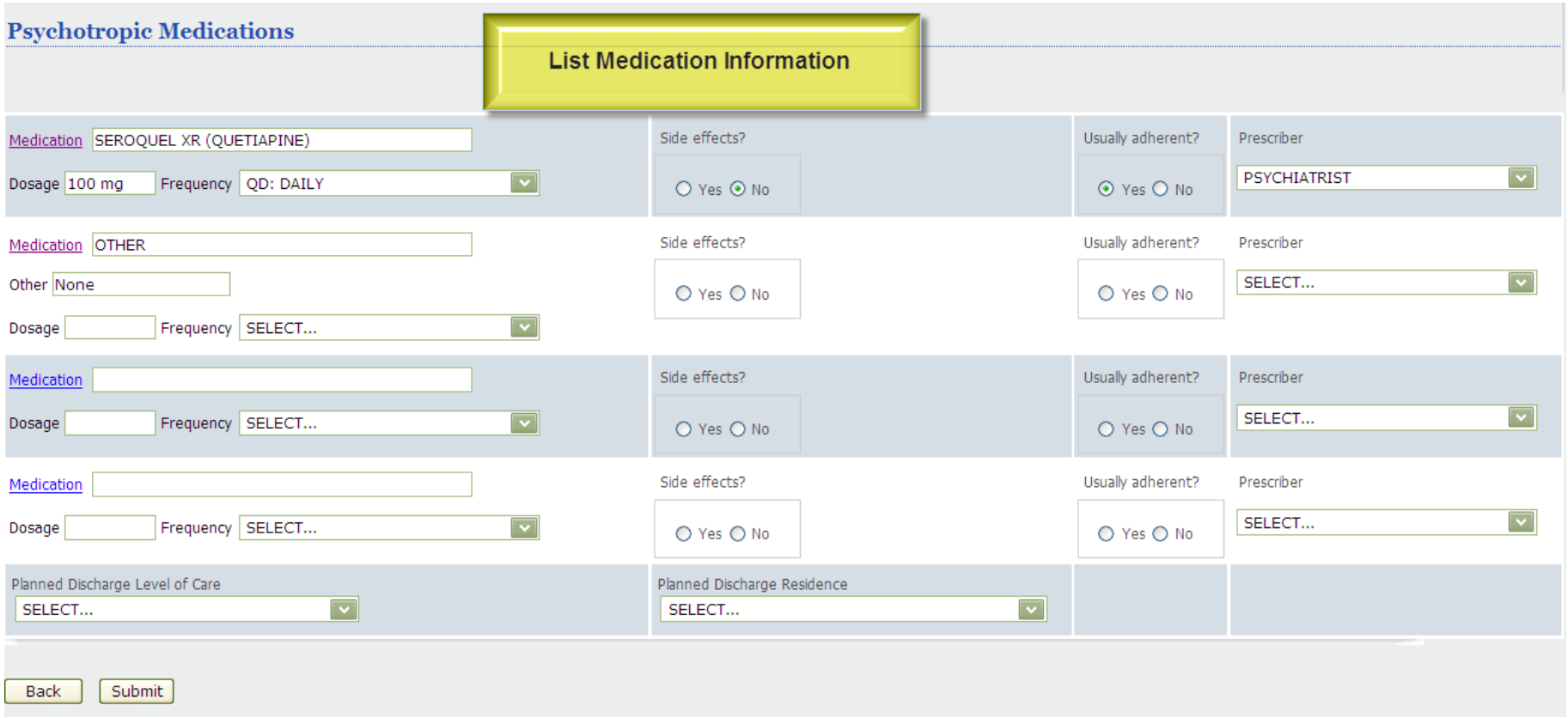

Diagnosis
Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.
All fields with Asterisk are required fields
Axis I
*Diagnosis Code 1
295.70
Description
SCHIZOAFFECTIVE DISORDER
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis II
*Diagnosis Code 1
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis III
*Diagnosis Code 1
ASTHMA
If there is no diagnosis code please use V71.09 No Diagnosis in the fields
Axis IV
Check all that apply
None
Educational problems
Financial problems
Housing problems
Occupational problems
Other psychosocial and environmental problems
Problems with access to health care services
Problems related to interaction w/legal system/crime
Problems with primary support group
Problems related to the social environment
Unknown
Diagnosis Code 2
SELECT...
Axis V
Current GAF Score
50
Current CGAS Score
Highest GAF Score in the Past Year
55
Highest CGAS Score in the Past Year
Current GAF Score is pre-populated, Enter the Highest GAF Score in the Past Year
Back
Next

LOCUS


LOCUS RESULTS
FUNCTIONAL IMPAIRMENT DOMAIN SCORES
Risk of harm
3
Functional Status
3
Co-morbidity
3
Recovery - Environment Stressors
3
Recovery - Environment Support
3
Recovery and Treatment History
3
Acceptance and Engagement
3
Composite score
21
LOCUS Recommended Level of Care
IV-MEDICALLY MONITORED NON-RES. SRVS (20-22)
Assessor Recommended Level of Care
IV-MEDICALLY MONITORED NON-RES. SRVS (20-22)


If Locus Score is under Level 4, you must enter a Reason for Deviation in the narrative entry box
Reason for Deviation
Narrative History
Narrative Entry
(of 200)

Medications



Determination Status

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: ☐ **Female:** ☐

Admit Date to ACT: _____

ACT was discontinued on(date): _____

I. DISCONTINUANCE CRITERIA (Please check only one)

- ☐ Person requests termination from ACT and is currently stable (complete transition plan for ongoing services)
- ☐ 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)
- ☐ Person has moved out of the ACT teams geographic area and has been linked to the following program
- ☐ Person has moved out of the State and has been linked to the following services
- ☐ 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.)
- ☐ Person requests termination from ACT despite the clinical recommendation of the team
- ☐ Person has been incarcerated
- ☐ Person is in need of hospitalization that may exceed 90 days
- ☐ Person is in need of nursing facility level of care that may exceed 90 days
- ☐ 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: _____

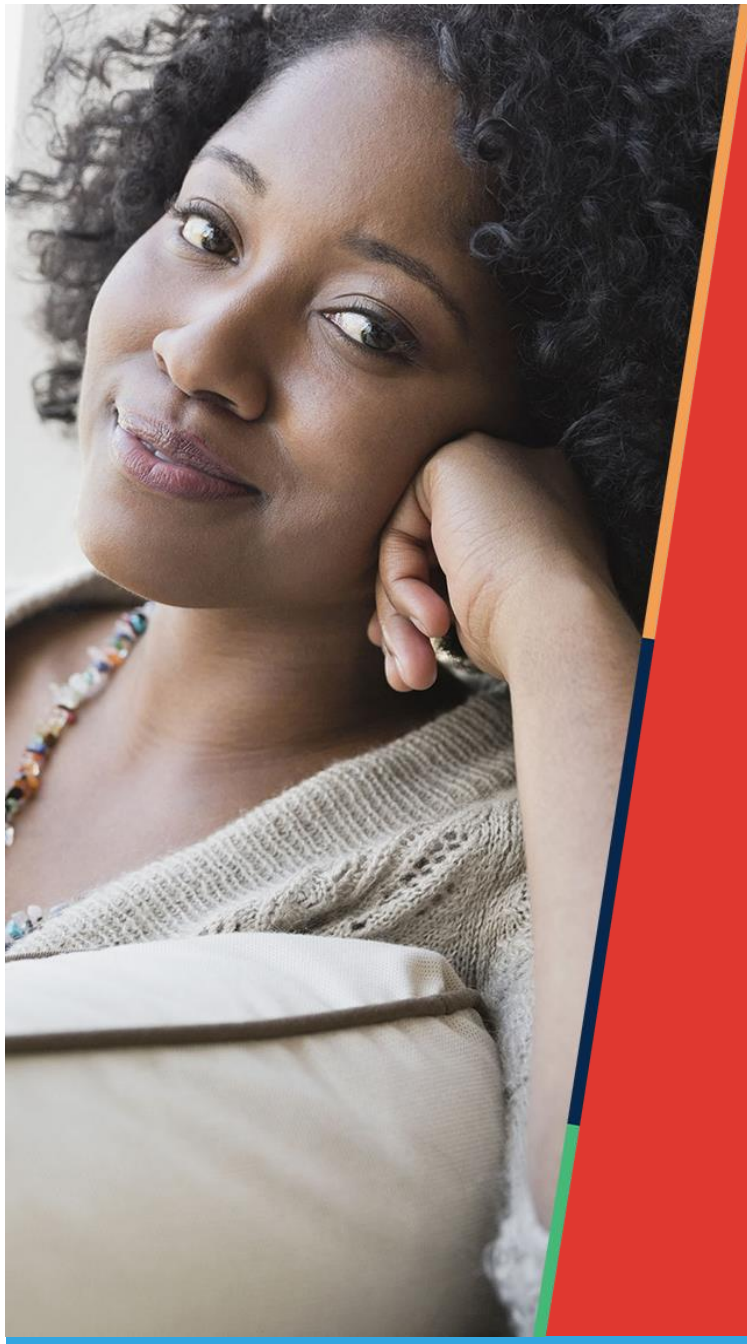
Male: ☐ **Female:** ☐

Admit Date to CST: _____

CST was discontinued on (date) _____

I. DISCONTINUATION CRITERIA (please check one)

- ☐ Person requests termination form CST and is stable
- ☐ 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)
- ☐ Person has moved out of the CST Teams' geographic area (provide linkage information to new CST Team or community service)
- ☐ Person has moved out of State (make attempts to link with other CST or community services)
- ☐ 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.)
- ☐ Person requests termination from CST despite the clinical recommendation of the team
- ☐ Person has been incarcerated
- ☐ Person is in need of hospitalization that may exceed 90 days
- ☐ Person is in need of nursing facility level of care that may exceed 90 days
- ☐ Deceased



Therapy Counseling

Psychosocial Rehabilitation

Community Support Group

SUBMISSION PROCESS

A provider may submit a Therapy Counseling, CSG, PSR authorization request using the following method only:

1. **Submit Online at:**
   www.IllinoisMentalHealthCollaborative.com/providers.htm

Supporting clinical documentation not attached to the online request may be faxed to: (866) 928-7177

Requirements

DHS/DMH requires the Collaborative to respond to requests for authorizations within:

T/C, CSG, PSR

- **Seven (7) business days of receipt of a completed authorization request excluding holidays and weekends.**

Requirements

Collaborative staff verifies:

- **Information for completeness (documents required based upon request type).**
- **The information in the request is consistent with information found in the supporting documentation. If inconsistencies are found, the provider will be contacted regarding the inconsistencies.**
- **If additional clinical information is required the clinician will contact the provider to obtain clinical via telephone and the clinical information will be documented in the review.**

Collaborative clinical care manager (CCM) reviews submitted documents for the following 3 elements:

1. **Completeness**
2. **Adherence to Rule 132**
3. **Adherence to Medical Necessity Criteria (MNC)**

If the above 3 elements are met for the service(s), the CCM will enter in an authorization.

REQUIREMENTS

If medical necessity IS established, the request is authorized by the CCM and communicated to provider in writing.

OR

If medical necessity is NOT established, the CCM contacts provider to seek clarification and offer education/consultation regarding authorization criteria:

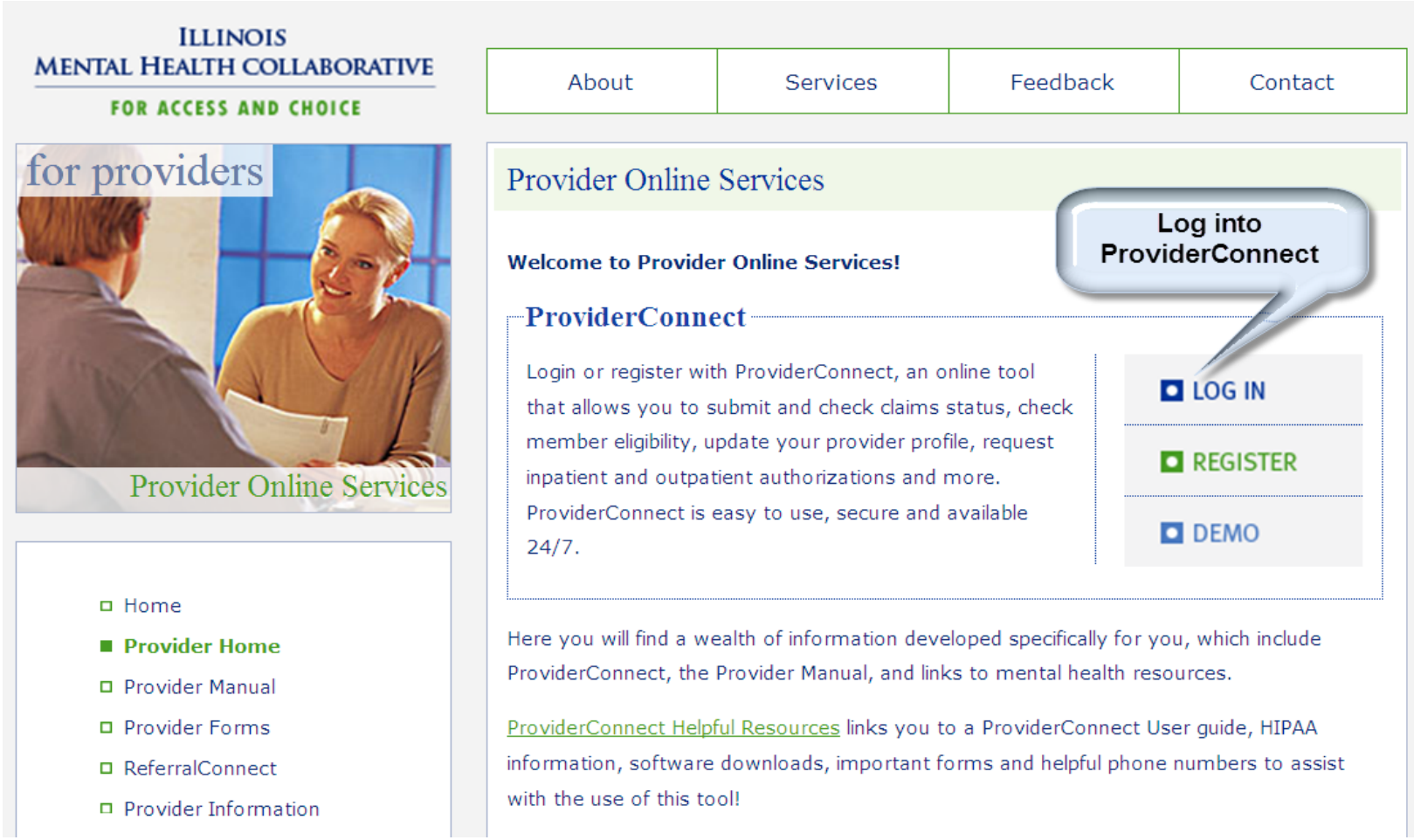
- **The Collaborative and the Provider will reach mutual agreement with respect to next steps (e.g., additional information will be submitted for review, alternative service will be considered, etc.)**

OR

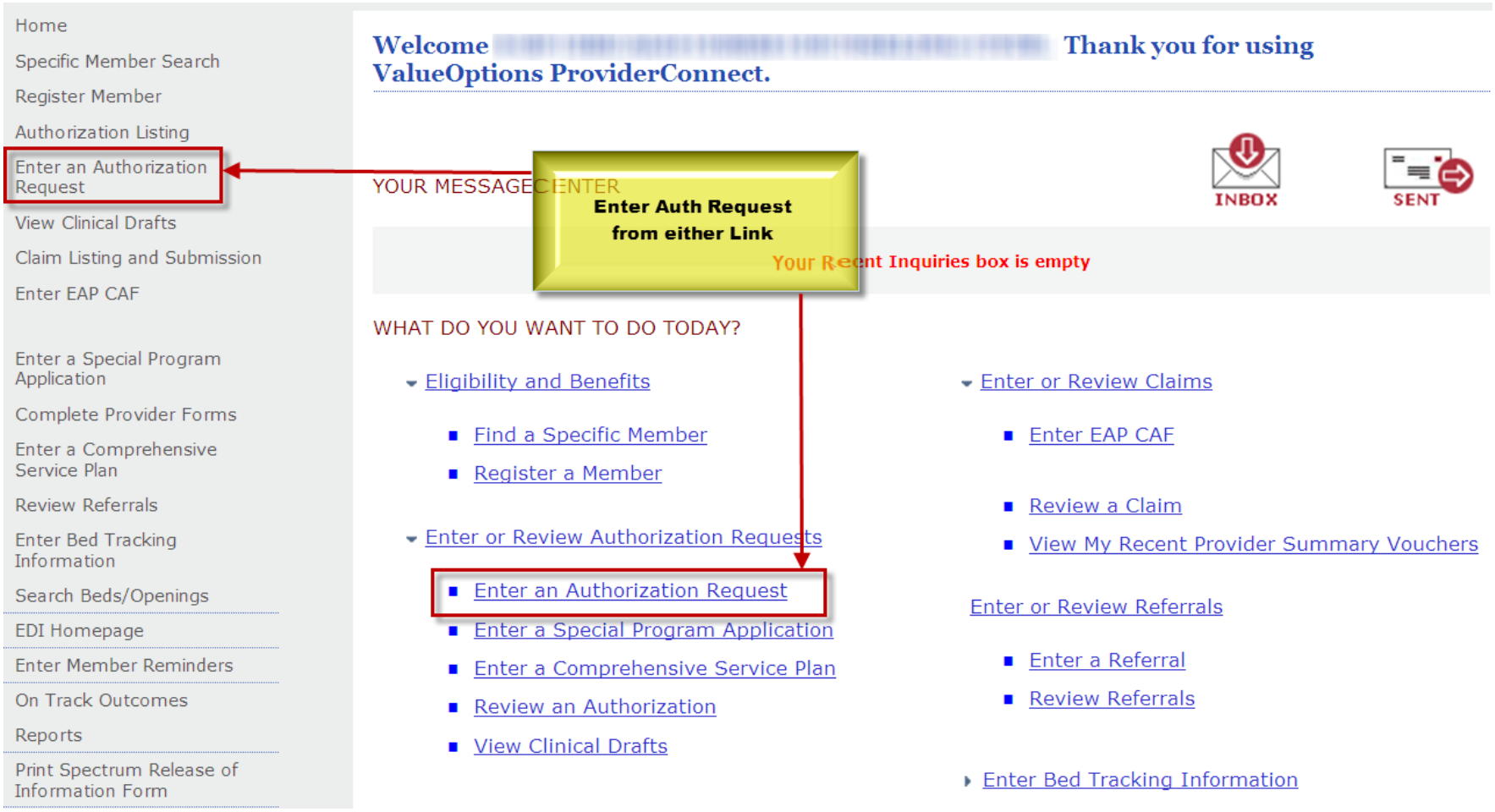
- **If mutual agreement has NOT occurred and the provider believes medical necessity is present, the CCM will forward the information to a Collaborative physician advisor (PA) reviewer.**
  - **The PA reviews and either authorizes OR denies authorization.**

Getting Started

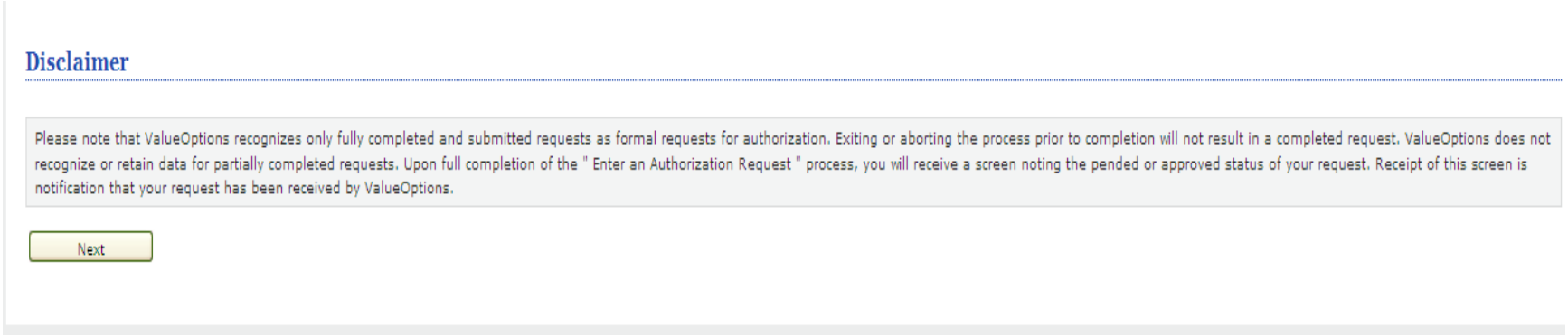
Access ProviderConnect via www.illinoismentalhealthcollaborative.com/providers.htm



Authorization Request



Disclaimer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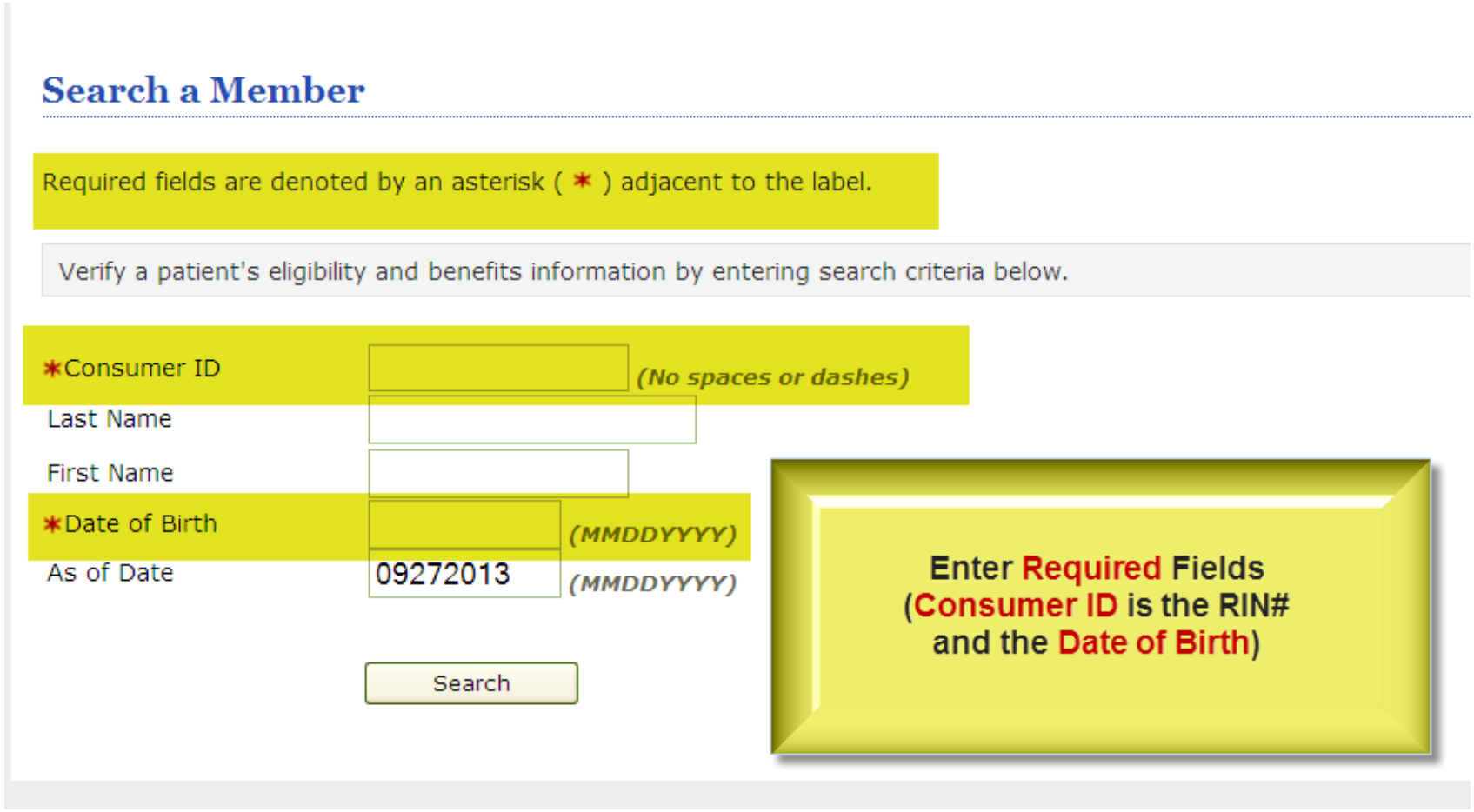
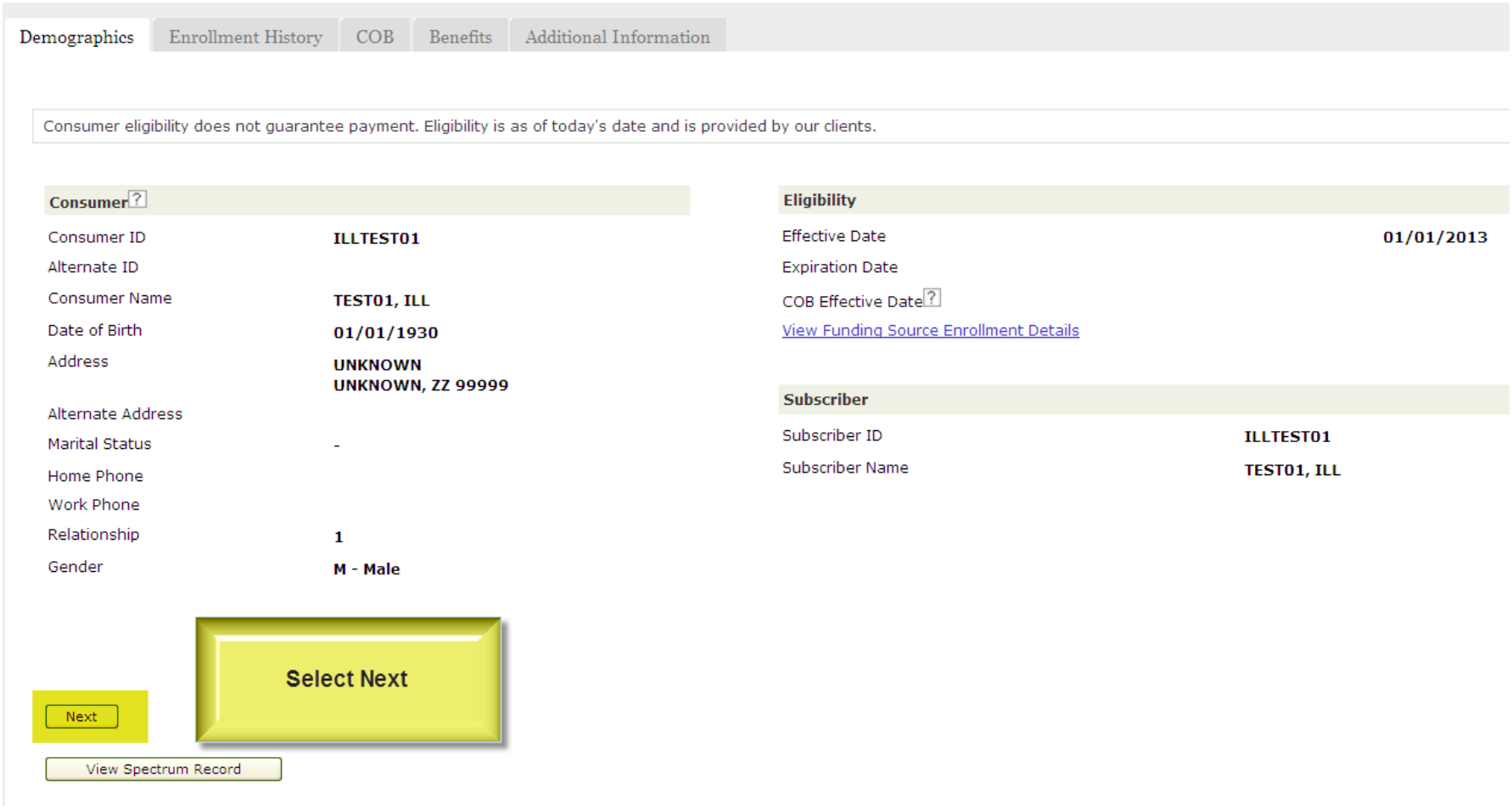
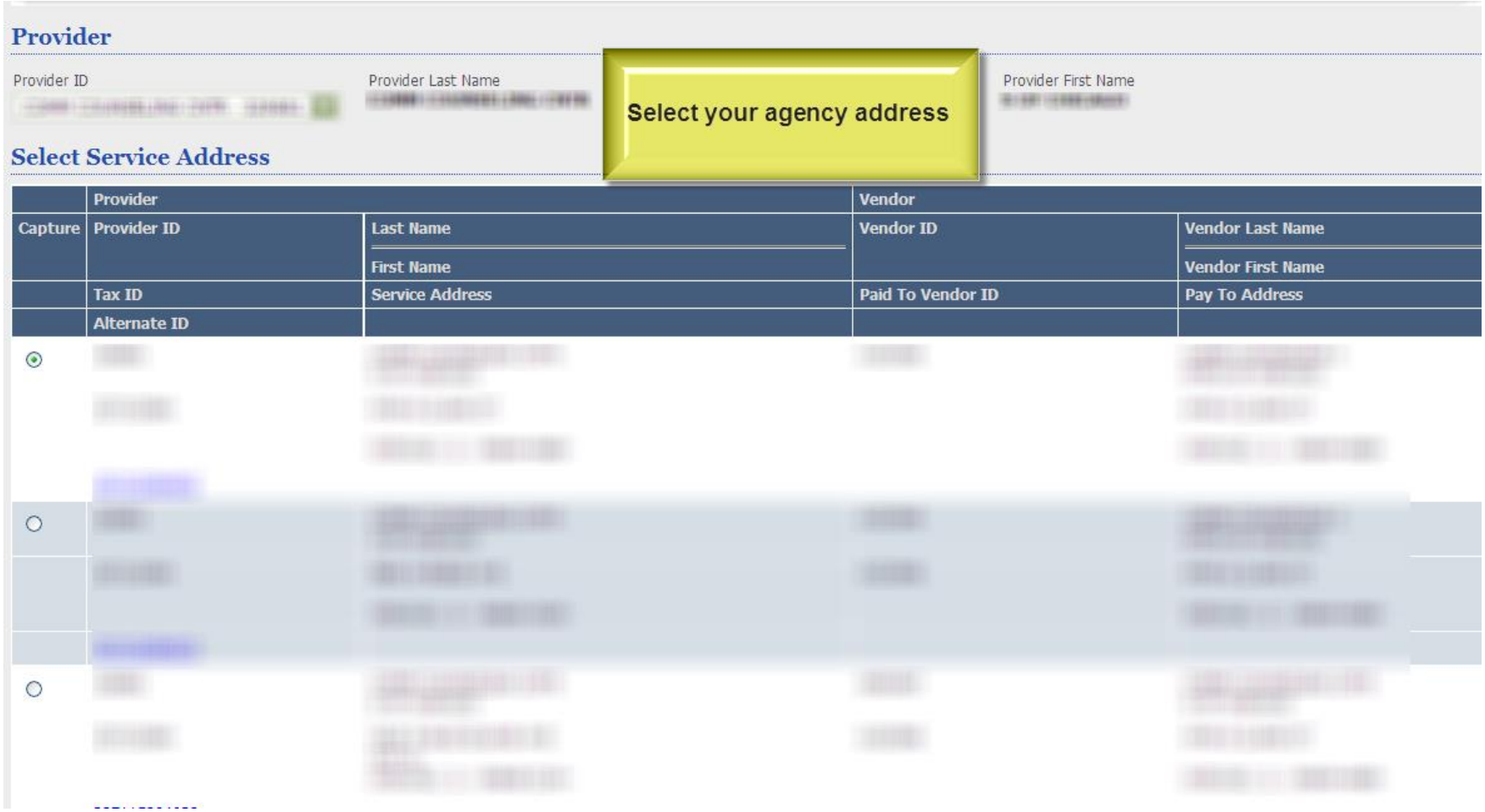
Member Search



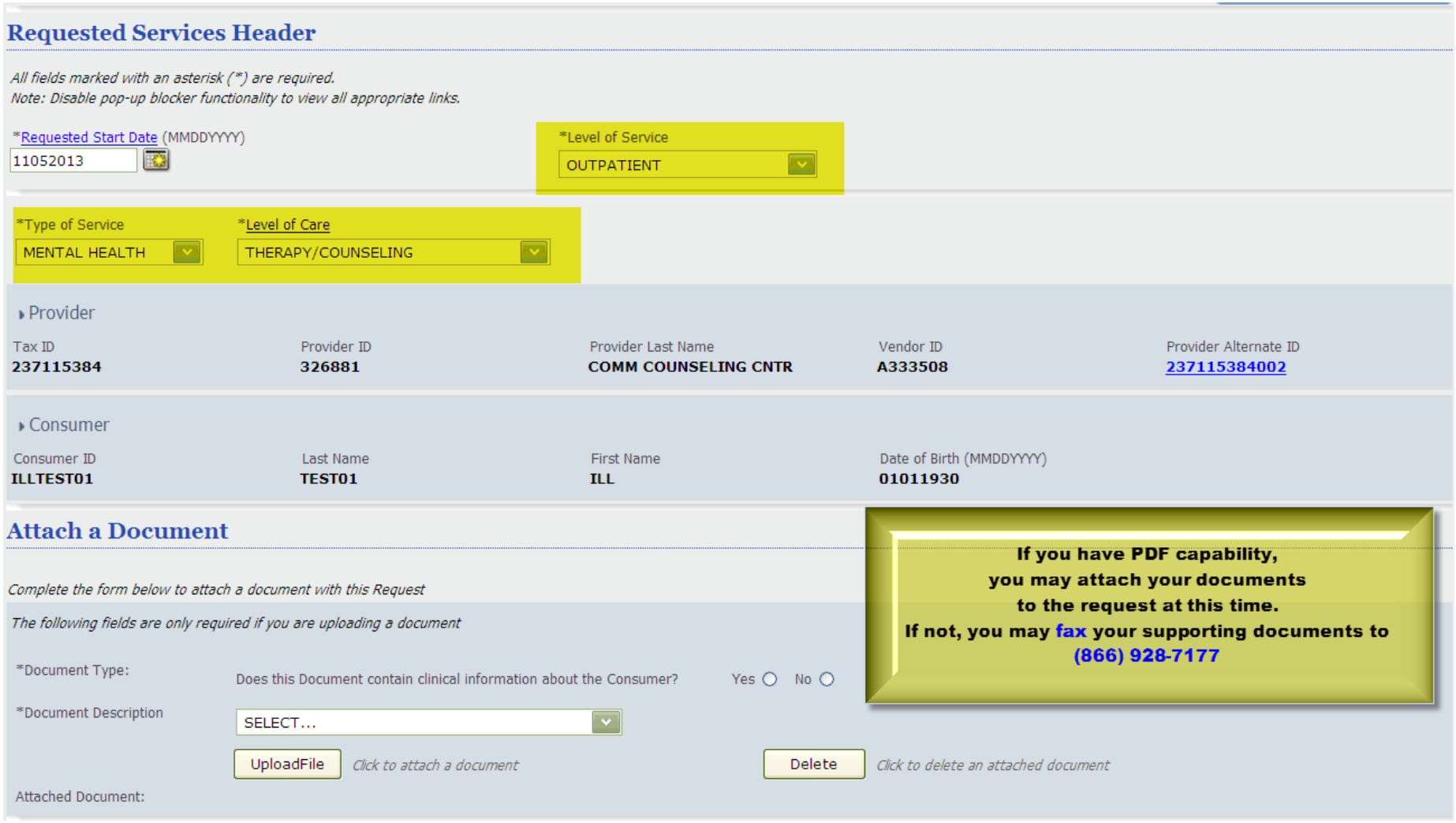
Member Demographics



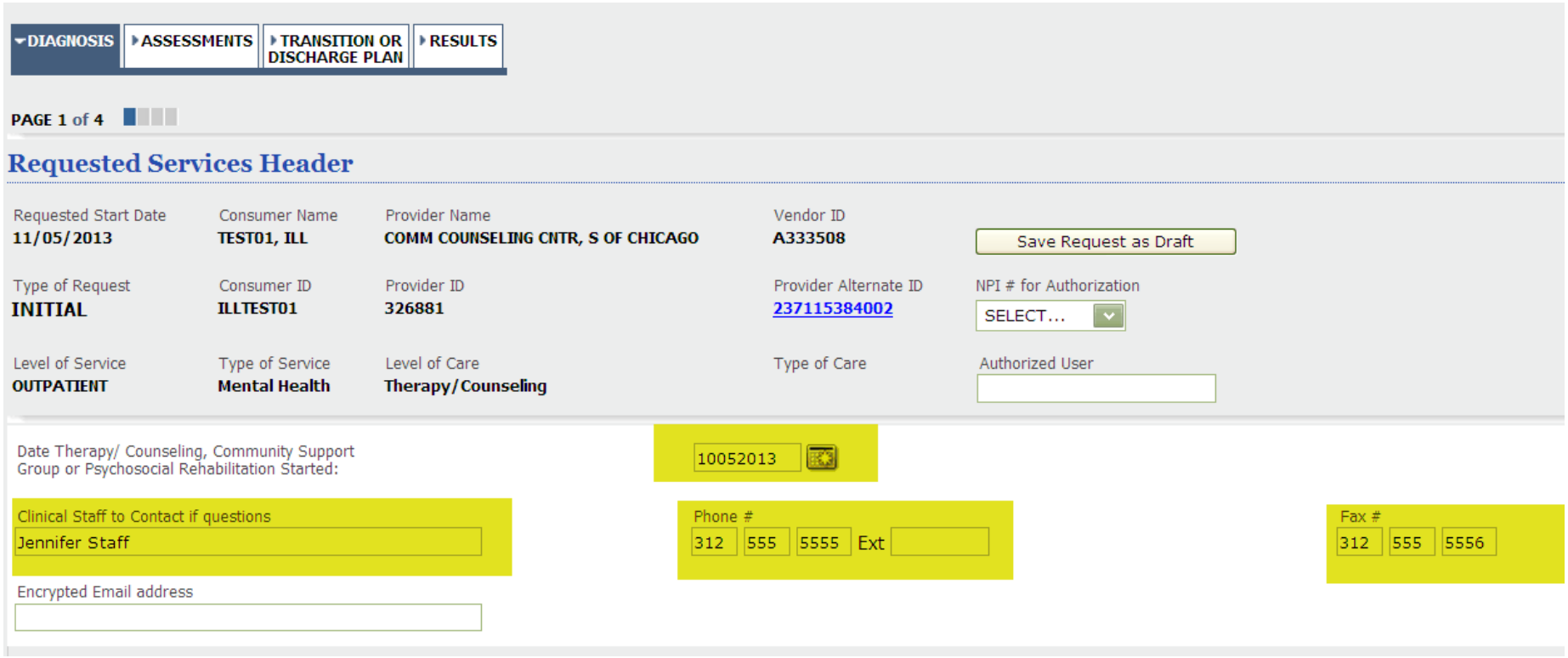
Provider Location



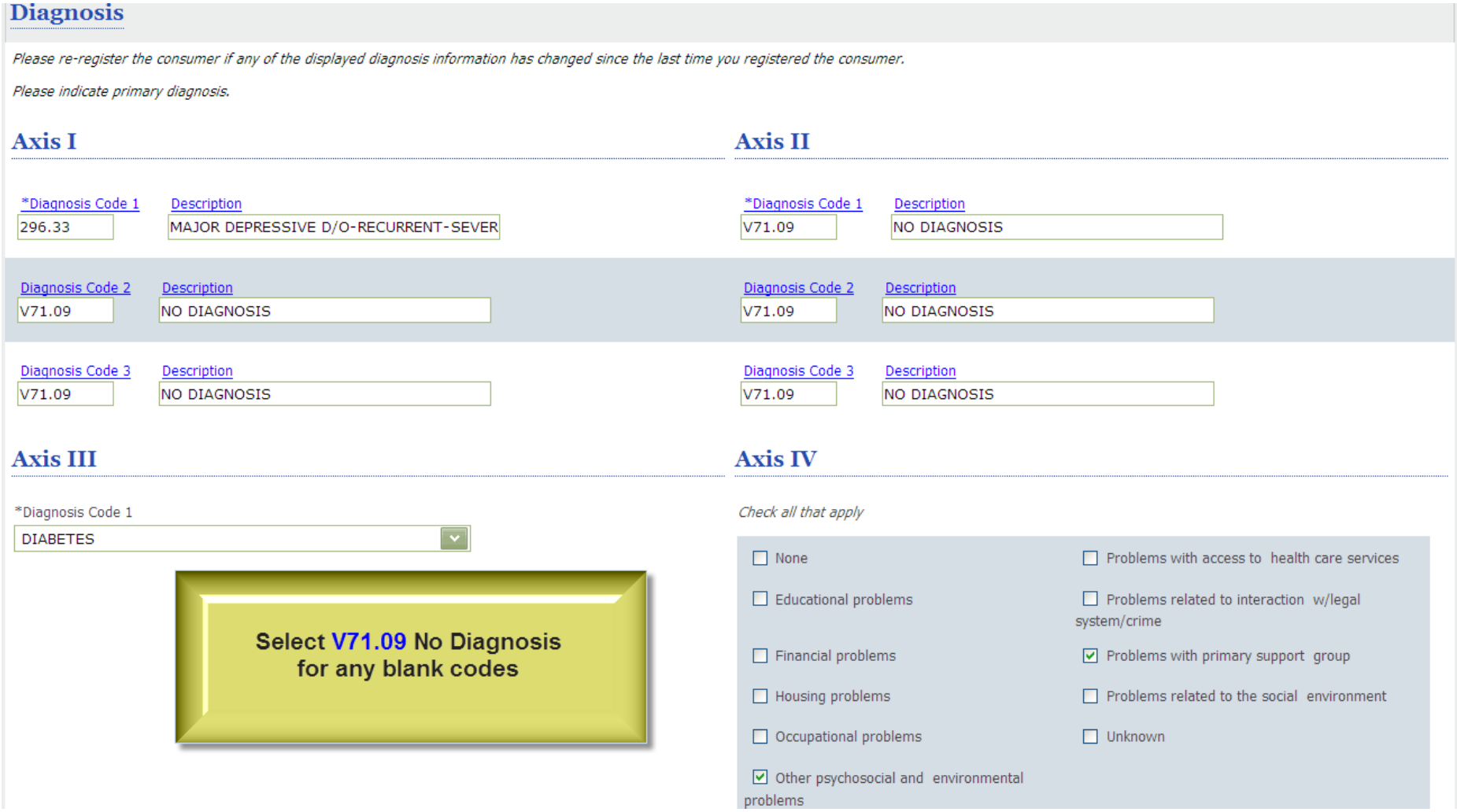
Requested Services Header



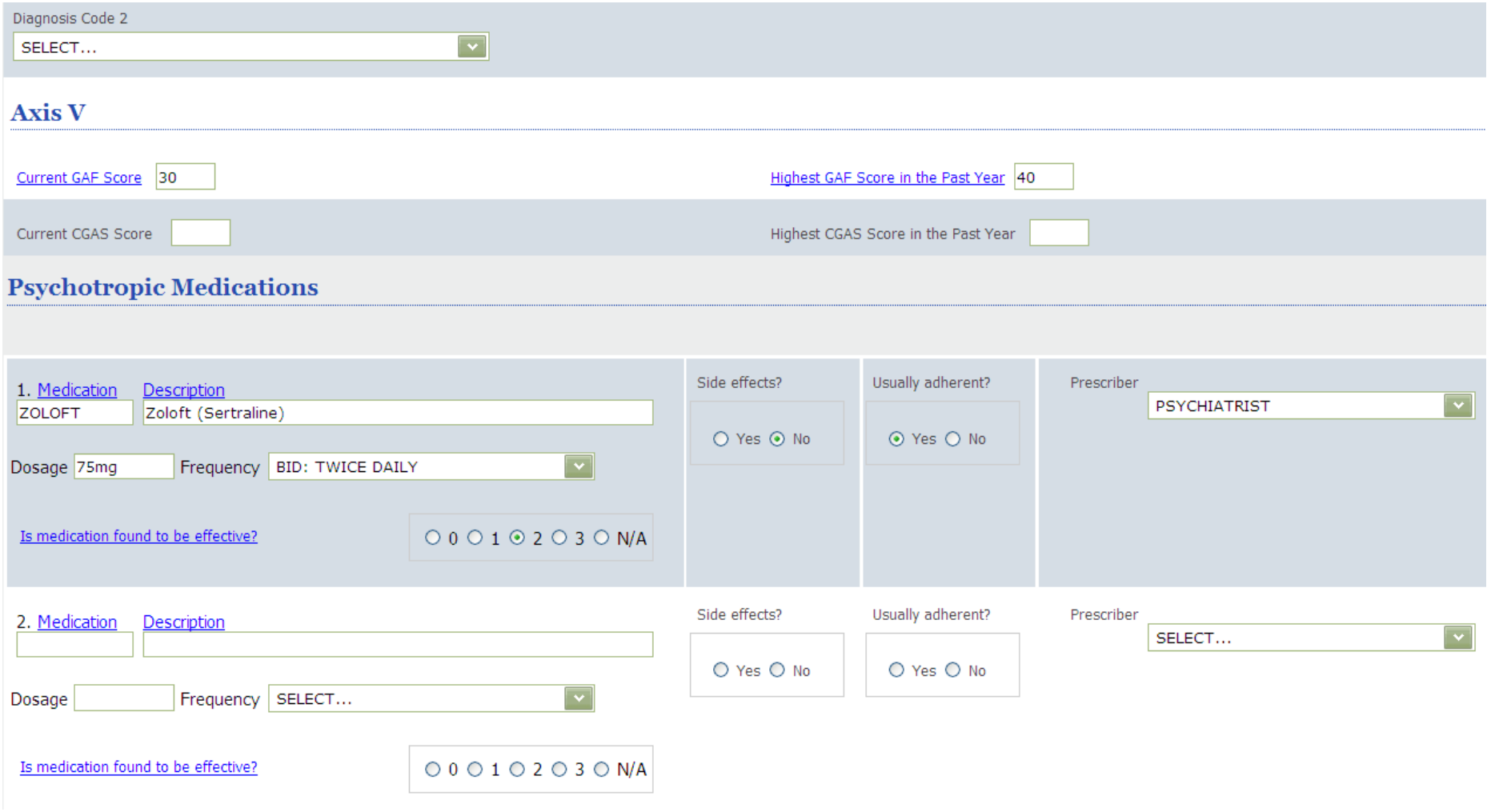
Request Services Continued



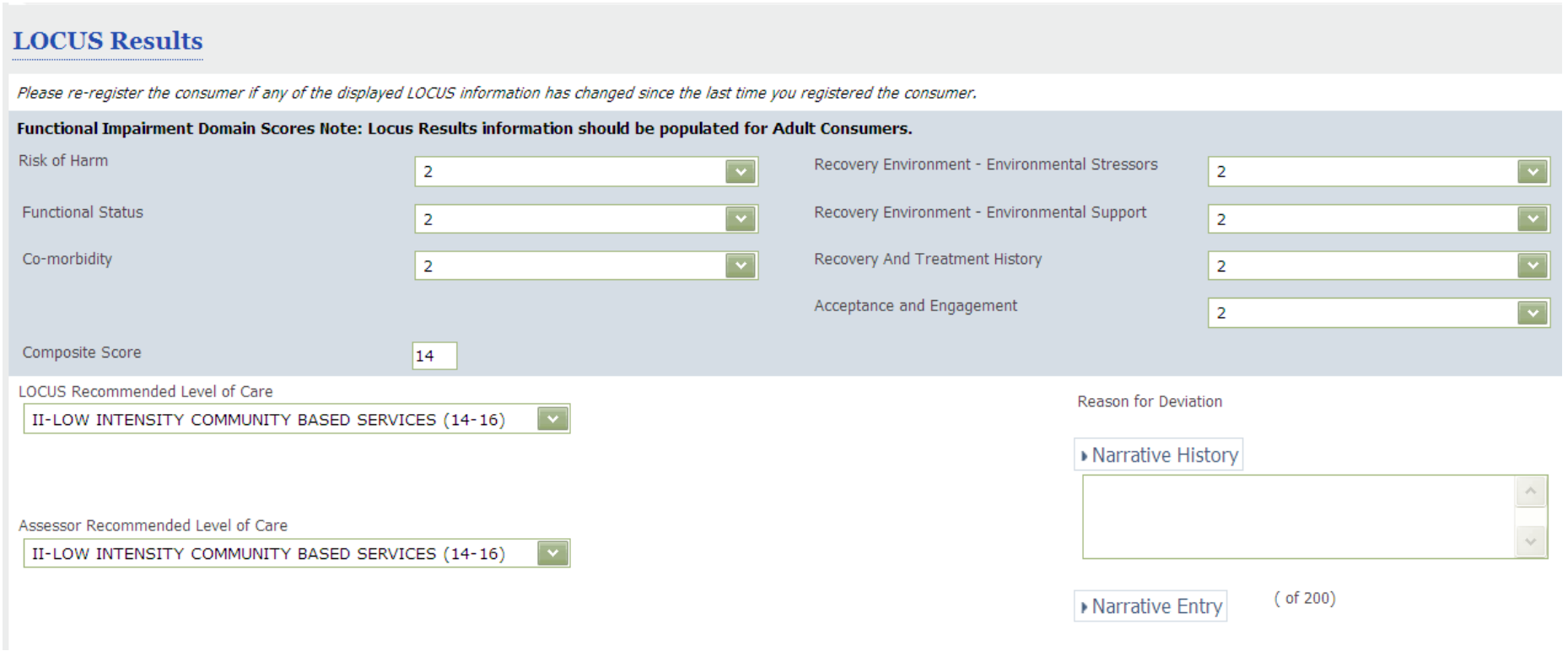
Diagnosis


Diagnosis
Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.
Axis I
*Diagnosis Code 1
296.33
Description
MAJOR DEPRESSIVE D/O-RECURRENT-SEVER
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis II
*Diagnosis Code 1
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis III
*Diagnosis Code 1
DIABETES
Select V71.09 No Diagnosis for any blank codes
Axis IV
Check all that apply
None
Educational problems
Financial problems
Housing problems
Occupational problems
Other psychosocial and environmental problems
Problems with access to health care services
Problems related to interaction w/legal system/crime
Problems with primary support group
Problems related to the social environment
Unknown

Diagnosis Continued



LOCUS


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
2
Functional Status
2
Co-morbidity
2
Recovery Environment - Environmental Stressors
2
Recovery Environment - Environmental Support
2
Recovery And Treatment History
2
Acceptance and Engagement
2
Composite Score
14
LOCUS Recommended Level of Care
II-LOW INTENSITY COMMUNITY BASED SERVICES (14-16)
Assessor Recommended Level of Care
II-LOW INTENSITY COMMUNITY BASED SERVICES (14-16)
Reason for Deviation
Narrative History
Narrative Entry
(of 200)

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) [ ]

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) [ ] %

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.

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.

Service Requested

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

Provider Name	Appointment Date	Services Planned

* How many days until anticipated discharge or transition to alternative services? 240

* 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.

- [x] 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 (15 of 2000)

Enter Info Here

In the Narrative, please enter the following:

1. Reason for requesting service
2. What symptoms/behavior is the consumer exhibiting
3. What progress is the consumer making toward the identified goals
4. What benefit has the consumer demonstrated from this service
5. Description of discharge or transition plan

(Per Rule 132 Medical Necessity Criteria)

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 w the required timeframes and details of that decision may be found under the consumer's authorization history.

Consumer Name	Consumer ID	Consumer DOB	Subscriber Name	Subscriber ID
ILL TEST01	**ILLTEST01**	**01/01/1930**	**ILL TEST01**	**ILLTEST01**

Pended Authorization #	Client Authorization #	Type of Request
110513-1-4	**N/A**	**INITIAL**

Date of Admission/ Start of Services	Requested From	Submission Date
11/05/2013	**11/05/2013**	**11/05/2013**

Level of Service	Type of Service	Level of Care	Type of Care
OUTPATIENT	**MENTAL HEALTH**	**THERAPY/COUNSELING**	

Reason Code

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Provider Name & Address	Provider ID	Provider Alternate ID	NPI # for Authorization
S OF CHICAGO COMM COUNSELING CNTR **4740 N CLARK ST** **CHICAGO IL 60640**	**326881**	**237115384002**	**N/A**

Message

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Attached Documents

There are no documents attached with this Authorization Request

Document Title | Document Description

Authorization Printing & Downloading Options:

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

Print Authorization Result	Print Authorization Request	Download Authorization Request	Return to Provider Home
Print the Results page (this page)	*Print the entire Authorization Request*	*Download the entire Authorization Request*	*Return to the ProviderConnect homepage*

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 that your request has been administratively denied due to 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 determined to be eligible, the records will be updated in our system allowing the authorization request to be completed.**

Request for Reconsideration and Appeal

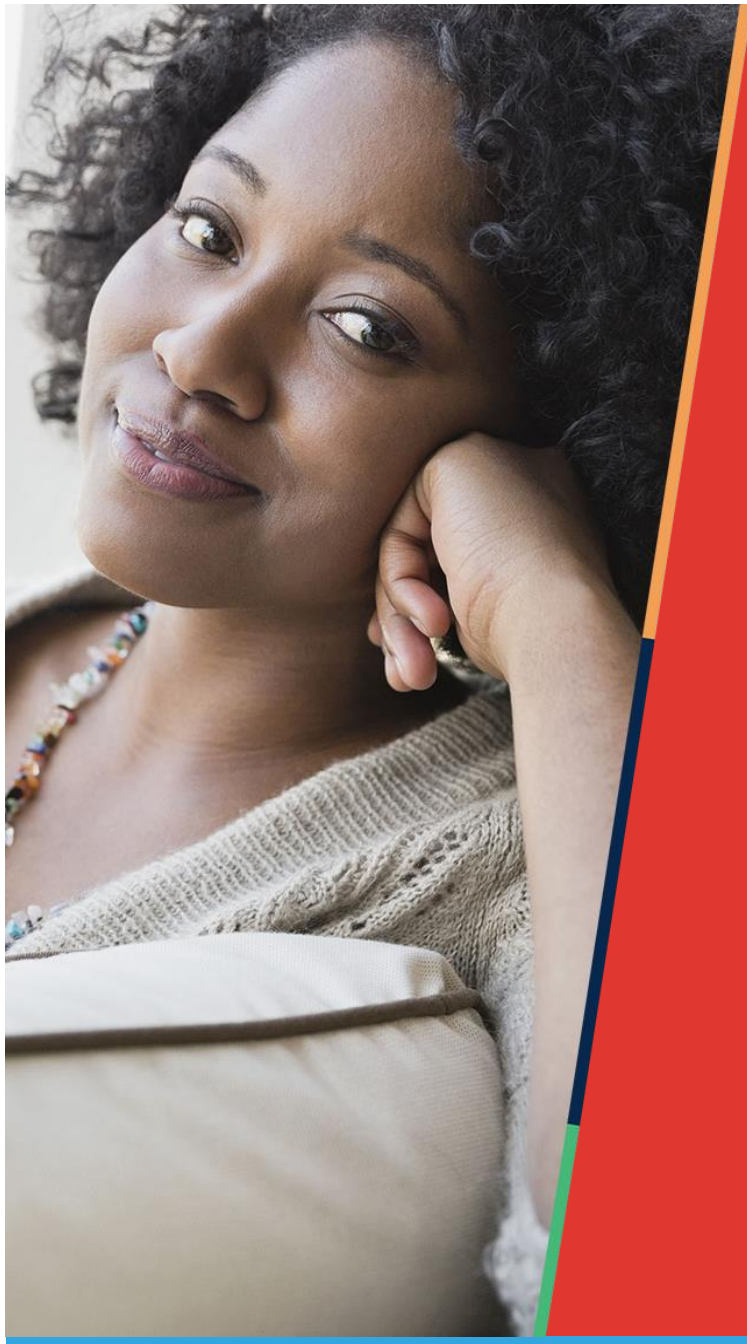
- **Prior to a denial, the Collaborative staff will support consumers and providers by offering alternative services that can meet the consumers' needs in the least restrictive setting.**
- **Appeals can be requested by a provider on behalf of a consumer by calling the Collaborative at (866) 359-7953.**
- **Reconsideration requests must be received within 30 days of receipt of the denial.**
- **Reconsideration requests would 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].

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



QUESTIONS

ILLINOIS
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FOR ACCESS AND CHOICE

www.illinoismentalhealthcollaborative.com