

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

April 20, 2015

PRESENTERS

Sue Kapas

Clinical Services Manager

&

Brent Sparlin

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: <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 for the Illinois Mental Health Collaborative. At the top left, the logo reads "ILLINOIS MENTAL HEALTH COLLABORATIVE FOR ACCESS AND CHOICE". A navigation menu contains "About", "Services", "Feedback", and "Contact". The main heading is "for providers" with a photo of a doctor and a patient. Below the photo is the text "Provider Online Services". A central box titled "Provider Online Services" contains a welcome message and a "ProviderConnect" section with a description and three buttons: "LOG IN", "REGISTER", and "DEMO". A speech bubble points to the "LOG IN" button. A sidebar on the left lists navigation options: Home, Provider Home, Provider Manual, Provider Forms, ReferralConnect, and Provider Information. At the bottom, there is a paragraph about the resources available 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

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

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!

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

Search a Member

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 Required Fields
(Consumer ID is the RIN#
and the Date of Birth)

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**

Select Next

Next

View Spectrum Record

Provider Location

Provider

Provider ID:
 Provider Last Name:
 Provider First Name:



Select Service Address

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

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

PAGE 1 of 3

Complete Clinical Staff Contact Info

Requested Services Header

Requested Start Date 09/17/2013	Consumer Name [REDACTED]	Provider Name [REDACTED]	Vendor ID [REDACTED]	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID TEST	Provider ID [REDACTED]	Provider Alternate ID [REDACTED]	NPI # for Authorization SELECT... [v]
Level of Service OUTPATIENT	Type of Service Mental Health	Level of Care ASSERTIVE COMMUNITY TREATMENT	Type of Care	Authorized User [REDACTED]

* Clinical Staff to Contact if questions
Jennifer Staff

* Phone #
773 555 5555 155

Fax #
773 555 5556

Encrypted Email address
[REDACTED]

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**

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 Description
295.70 SCHIZOAFFECTIVE DISORDER

Diagnosis Code 2 Description
V71.09 NO DIAGNOSIS

Diagnosis Code 3 Description
V71.09 NO DIAGNOSIS

Axis II

*Diagnosis Code 1 Description
V71.09 NO DIAGNOSIS

Diagnosis Code 2 Description
V71.09 NO DIAGNOSIS

Diagnosis Code 3 Description
V71.09 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

**Current GAF Score is pre-populated,
Enter the
Highest GAF Score in the Past Year**

Highest GAF Score in the Past Year 55

Highest CGAS Score in the Past Year

Back Next

LOCUS

LOCUS RESULTS

FUNCTIONAL IMPAIRMENT DOMAIN SCORES

Risk of harm ▼

Functional Status ▼

Co-morbidity ▼

Composite score

Recovery - Environment Stressors ▼

Recovery - Environment Support ▼

Recovery and Treatment History ▼

Acceptance and Engagement ▼

LOCUS Recommended Level of Care
 ▼

Assessor Recommended Level of Care
 ▼

**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

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

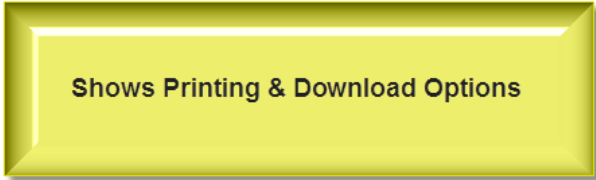
Submit

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
----------------	----------------------

Authorization Printing & Downloading Options:

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

Print Authorization Result <i>Print the Results page (this page)</i>	Print Authorization Request <i>Print the entire Authorization Request</i>	Download Authorization Request <i>Download the entire Authorization Request</i>	Return to Provider Home <i>Return to the ProviderConnect homepage</i>
---	--	--	--

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: _____	

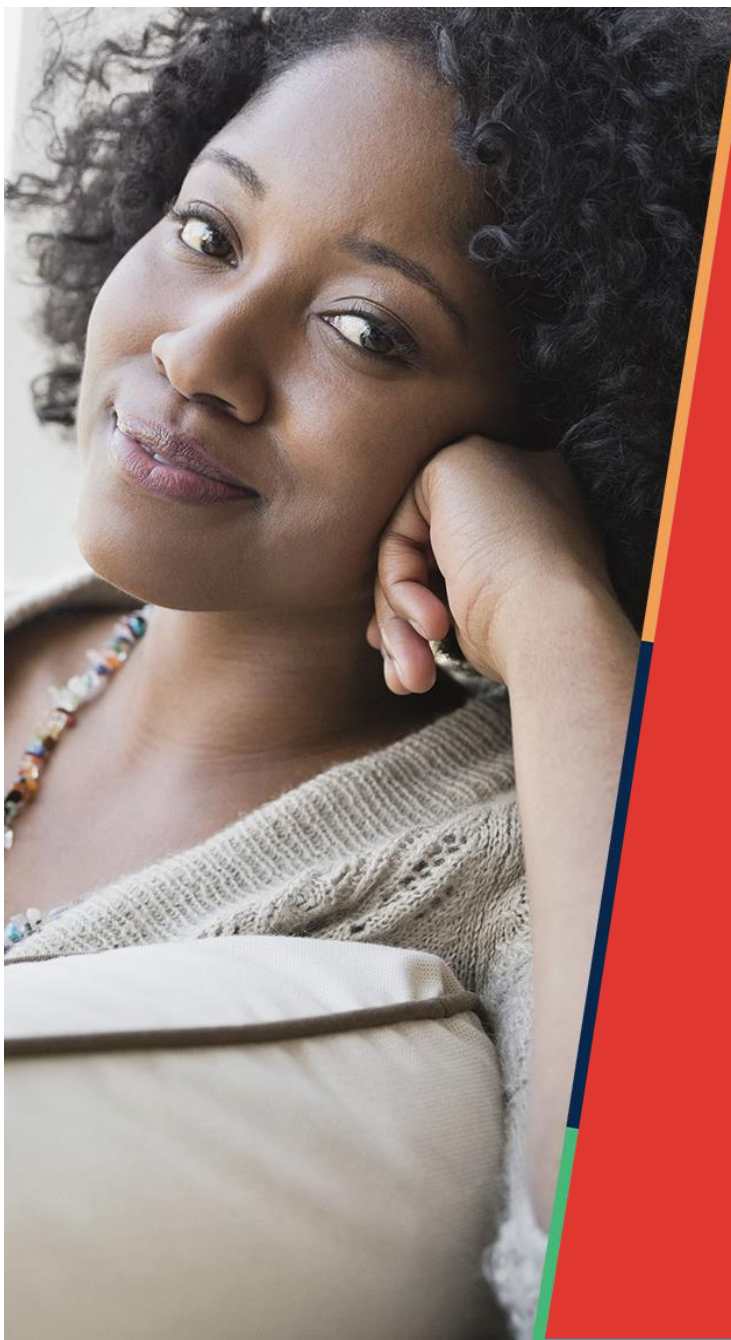
Male: Female:

Admit Date to CST: _____

CST was discontinued on (date) _____

I. DISCONTINUATION CRITERIA (please check one)

- Person requests termination from 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

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

About Services Feedback Contact

for providers



Provider Online Services

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

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!

Authorization Request

The screenshot shows the ValueOptions ProviderConnect website interface. On the left is a navigation menu with the following items: Home, Specific Member Search, Register Member, Authorization Listing, Enter an Authorization Request (highlighted with a red box), 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, and Print Spectrum Release of Information Form. The main content area features a welcome message, a 'YOUR MESSAGE CENTER' section with an 'INBOX' icon and a 'SENT' icon, and a 'WHAT DO YOU WANT TO DO TODAY?' section. A yellow callout box with the text 'Enter Auth Request from either Link' and 'Your Recent Inquiries box is empty' is positioned over the 'Enter an Authorization Request' link in the menu and the 'Enter or Review Authorization Requests' section. A red arrow points from the callout box to the menu item, and another red arrow points from the callout box to the 'Enter an Authorization Request' link in the main content area. The 'Enter or Review Authorization Requests' section contains a list of links: Find a Specific Member, Register a Member, Enter an Authorization Request (highlighted with a red box), Enter a Special Program Application, Enter a Comprehensive Service Plan, Review an Authorization, and View Clinical Drafts. Other sections include 'Eligibility and Benefits', 'Enter or Review Claims', and 'Enter or Review Referrals'.

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

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
 - 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

Search a Member

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 **Required** Fields
(**Consumer ID** is the RIN#
and the **Date of Birth**)

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 Service Address

Select your agency address

Capture	Provider		Vendor	
	Provider ID	Last Name First Name	Vendor ID	Vendor Last Name Vendor First Name
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address
	Alternate ID			
<input checked="" type="radio"/>	1000	10000000000000000000 10000000000000000000 10000000000000000000	1000	10000000000000000000 10000000000000000000 10000000000000000000
<input type="radio"/>	1000	10000000000000000000 10000000000000000000 10000000000000000000	1000	10000000000000000000 10000000000000000000 10000000000000000000
<input type="radio"/>	1000	10000000000000000000 10000000000000000000 10000000000000000000	1000	10000000000000000000 10000000000000000000 10000000000000000000


Requested Services Header

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)

11052013 

*Level of Service

OUTPATIENT 

*Type of Service

MENTAL HEALTH 

*Level of Care

THERAPY/COUNSELING 

Provider

Tax ID 237115384	Provider ID 326881	Provider Last Name COMM COUNSELING CNTR	Vendor ID A333508	Provider Alternate ID 237115384002
----------------------------	------------------------------	---	-----------------------------	---

Consumer


Consumer ID ILLTEST01	Last Name TEST01	First Name ILL	Date of Birth (MMDDYYYY) 01011930
---------------------------------	----------------------------	--------------------------	---

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: 

Click to attach a document

Click to delete an attached document

Attached Document:

**If you have PDF capability,
you may attach your documents
to the request at this time.
If not, you may **fax** your supporting documents to
(866) 928-7177**

Request Services Continued


▼ DIAGNOSIS ▸ ASSESSMENTS ▸ TRANSITION OR DISCHARGE PLAN ▸ RESULTS

PAGE 1 of 4

Requested Services Header

Requested Start Date 11/05/2013	Consumer Name TEST01, ILL	Provider Name COMM COUNSELING CNTR, S OF CHICAGO	Vendor ID A333508	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST01	Provider ID 326881	Provider Alternate ID 237115384002	NPI # for Authorization <input type="text" value="SELECT..."/>
Level of Service OUTPATIENT	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	Authorized User <input type="text"/>

Date Therapy/ Counseling, Community Support Group or Psychosocial Rehabilitation Started:



Clinical Staff to Contact if questions

Phone #

Ext

Fax #

Encrypted Email address

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

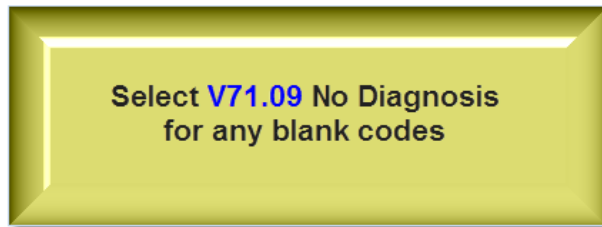
Description

NO DIAGNOSIS

Axis III

*Diagnosis Code 1

DIABETES



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

Diagnosis Code 2

SELECT... 

Axis V

Current GAF Score


Highest GAF Score in the Past Year

Current CGAS Score

Highest CGAS Score in the Past Year

Psychotropic Medications


1. Medication Description

Dosage Frequency 


[Is medication found to be effective?](#) 0 1 2 3 N/A

Side effects?
 Yes No

Usually adherent?
 Yes No

Prescriber 

2. Medication Description

Dosage Frequency 

[Is medication found to be effective?](#) 0 1 2 3 N/A

Side effects?
 Yes No

Usually adherent?
 Yes No

Prescriber 

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	<input type="text" value="2"/>	Recovery Environment - Environmental Stressors	<input type="text" value="2"/>
Functional Status	<input type="text" value="2"/>	Recovery Environment - Environmental Support	<input type="text" value="2"/>
Co-morbidity	<input type="text" value="2"/>	Recovery And Treatment History	<input type="text" value="2"/>
		Acceptance and Engagement	<input type="text" value="2"/>
Composite Score	<input type="text" value="14"/>		

LOCUS Recommended Level of Care

Assessor Recommended Level of Care

Reason for Deviation

[▶ Narrative History](#)

^v

[▶ 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

Requested Services Header

Requested Start Date 11/05/2013	Consumer Name TEST01, ILL	Provider Name COMM COUNSELING CNTR, S OF CHICAGO	Vendor ID A333508	Save Request as Draft
Type of Request INITIAL	Consumer ID ILLTEST01	Provider ID 326881	Provider Alternate ID 237115384002	NPI # for Authorization SELECT... 
Level of Service OUTPATIENT	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	Authorized User <input type="text"/>

Services Requested

<input checked="" type="checkbox"/> Therapy/Counseling - Individual	Start Date <input type="text" value="11052013"/> 	End Date <input type="text" value="06302014"/> 	Number of Units <input type="text" value="200"/>
<input type="checkbox"/> Therapy/Counseling - Group	Start Date <input type="text"/> 	End Date <input type="text"/> 	Number of Units <input type="text"/>
<input type="checkbox"/> Therapy/Counseling - Family	Start Date <input type="text"/> 	End Date <input type="text"/> 	Number of Units <input type="text"/>


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?

* 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

(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:

***** **PENED** *****

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 ILL TEST01	Consumer ID ILLTEST01	Consumer DOB 01/01/1930	Subscriber Name ILL TEST01	Subscriber ID ILLTEST01
Pended Authorization # 110513-1-4	Client Authorization # N/A	Type of Request INITIAL		
Date of Admission/ Start of Services 11/05/2013	Requested From 11/05/2013	Submission Date 11/05/2013		
Level of Service OUTPATIENT	Type of Service MENTAL HEALTH	Level of Care THERAPY/COUNSELING	Type of Care	
Reason Code P76				
Provider Name & Address S OF CHICAGO COMM COUNSELING CNTR 4740 N CLARK ST CHICAGO IL 60640	Provider ID 326881	Provider Alternate ID <u>237115384002</u>	NPI # for Authorization N/A	

Message

P76

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 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

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](tel:8663597953).
- 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.

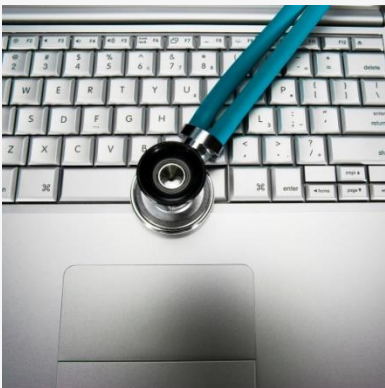
DMH Secretary's Level Appeal

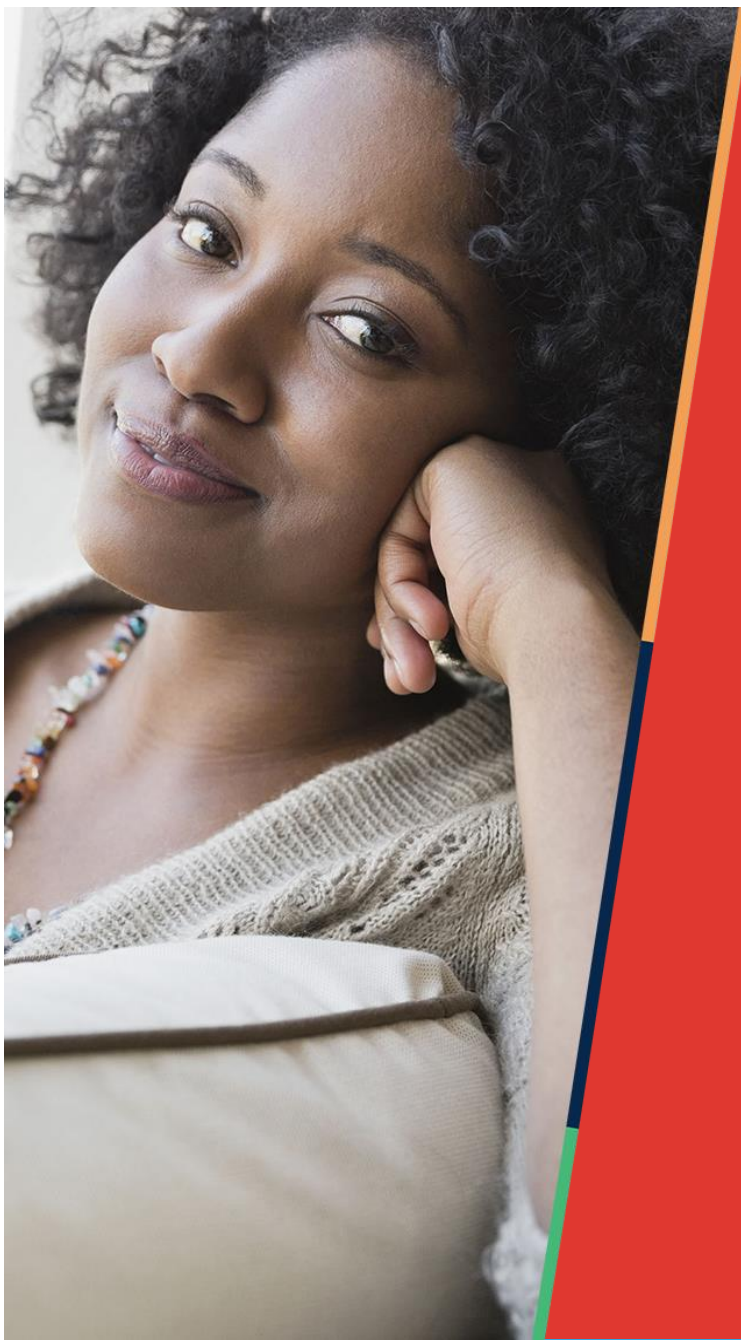
- **If the provider, consumer, or designated representative disagrees with the outcome of the Reconsideration request, an appeal may be filed within 5 days from the decision date of the reconsideration request.**
- **This review shall not be a clinical review, but rather an administrative review to ensure 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

Thank
You

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

www.illinoismentalhealthcollaborative.com