Utilization Management Request for Services Process

October 21, 2015

PRESENTERS

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Clinical Quality Assurance Analyst

and

Lauren Kelbus

Clinical Care Manager

SUMMARY

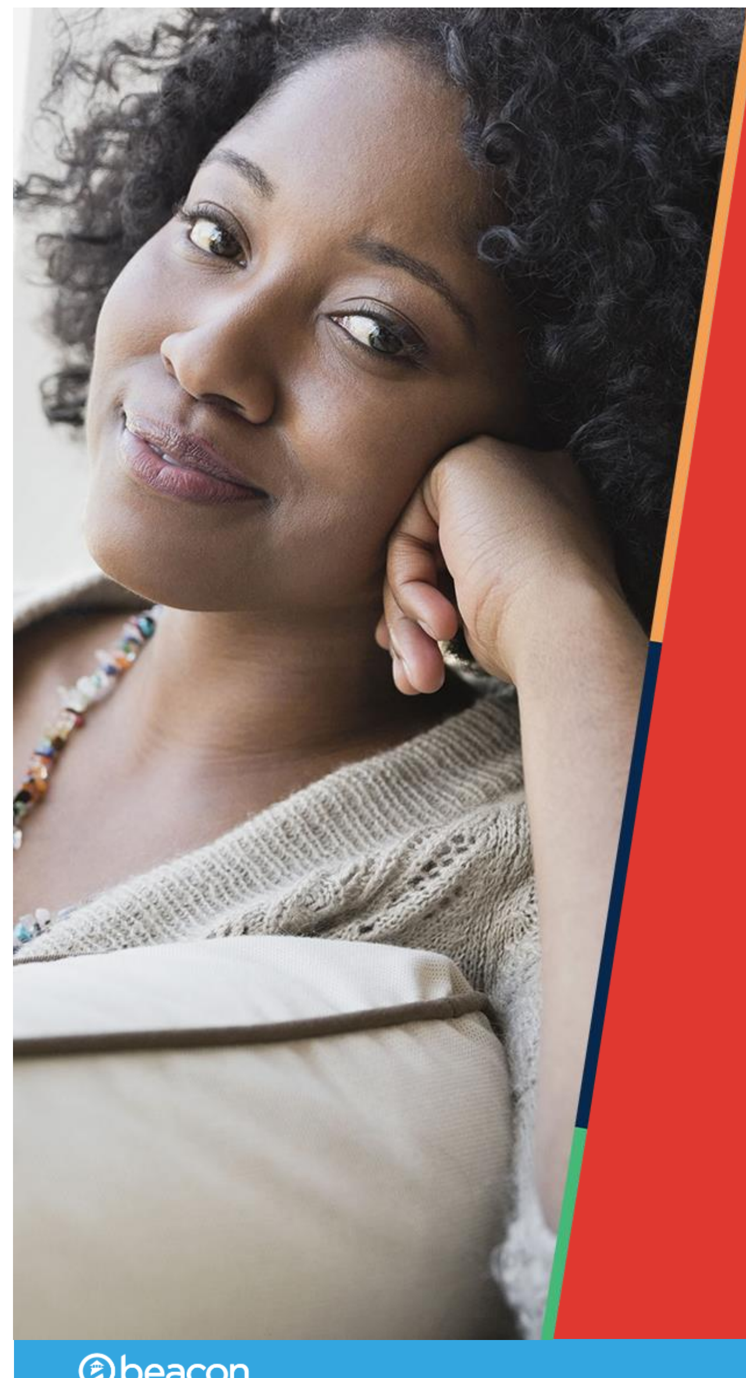
ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

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:**

- **ACT/CST**
  - **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

<u>Initial Authorization Request</u>

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 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 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 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: ☐ 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

ILLINOIS MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

About	Services	Feedback	Contact

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

Provider Online Services

Welcome to Provider Online Services!

Log into ProviderConnect

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 IN
- REGISTER
- DEMO

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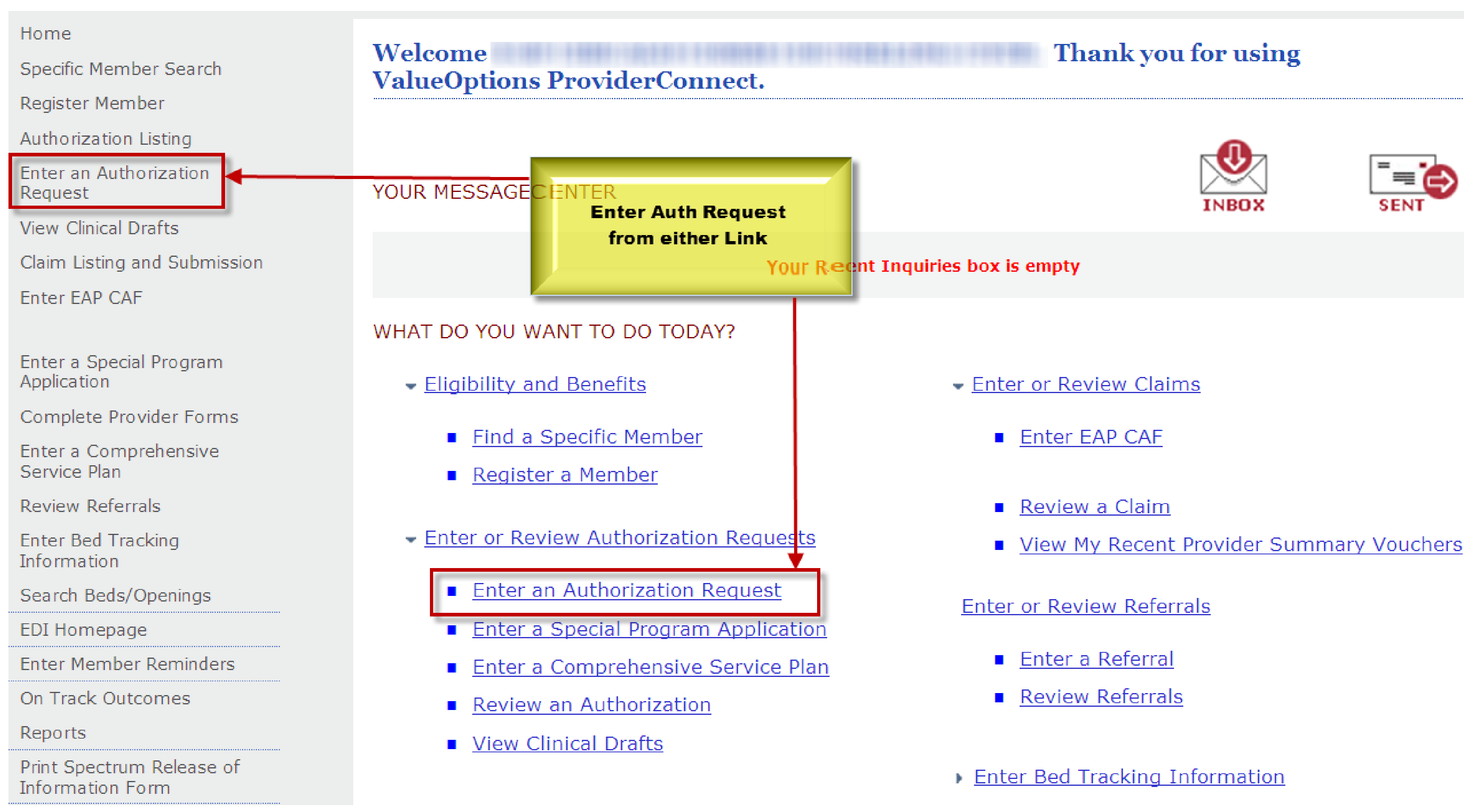
Authorization Request



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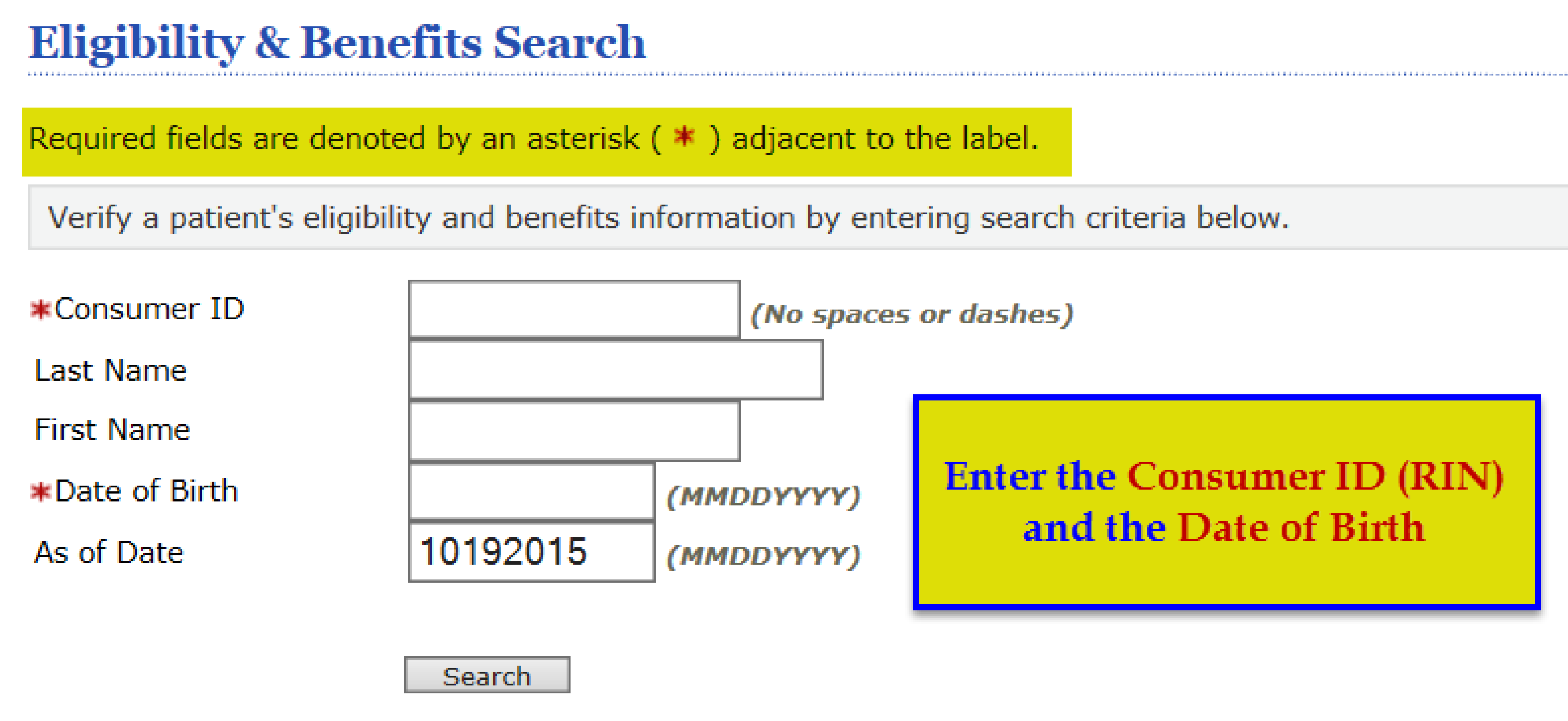
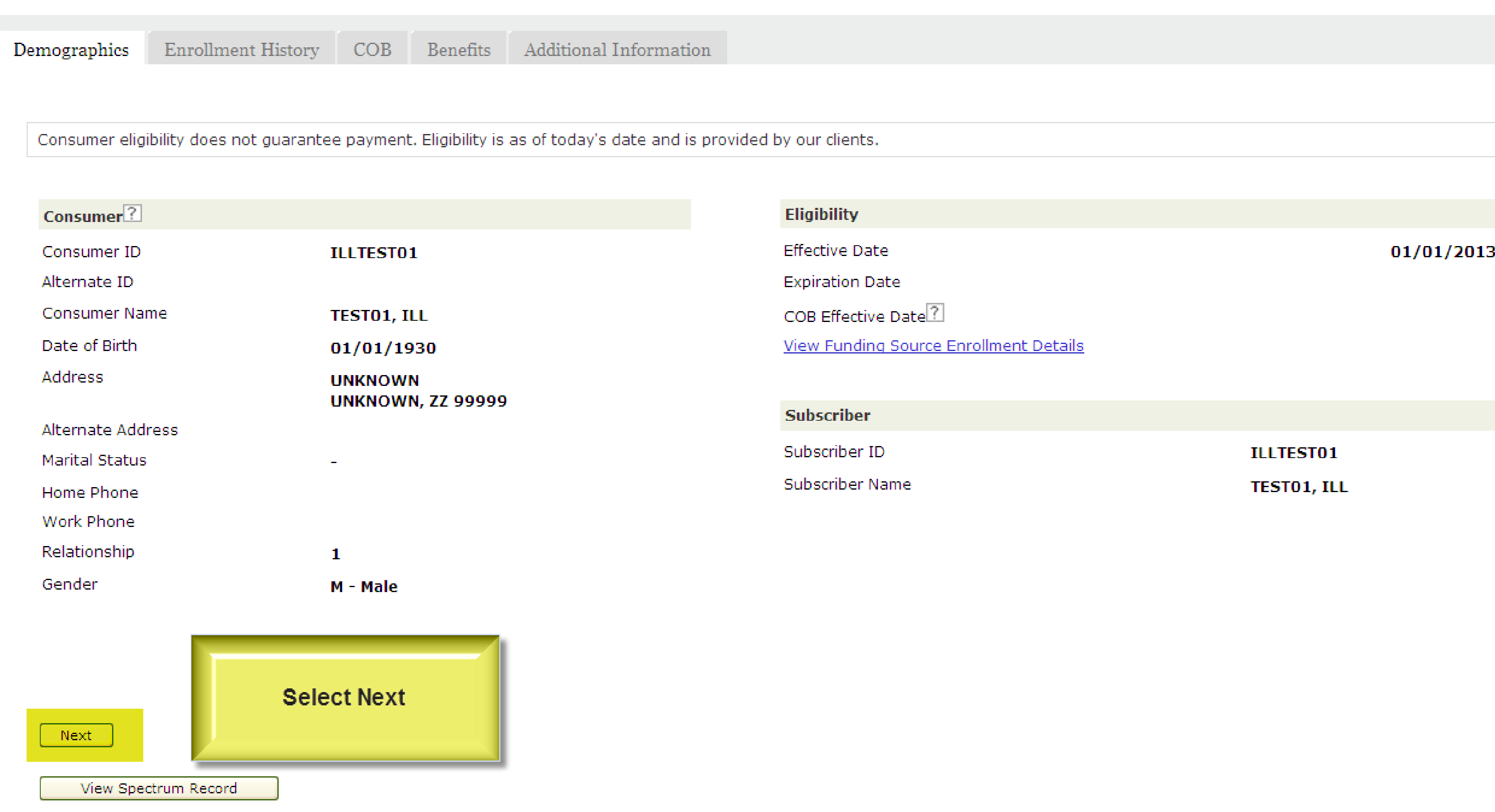
Next

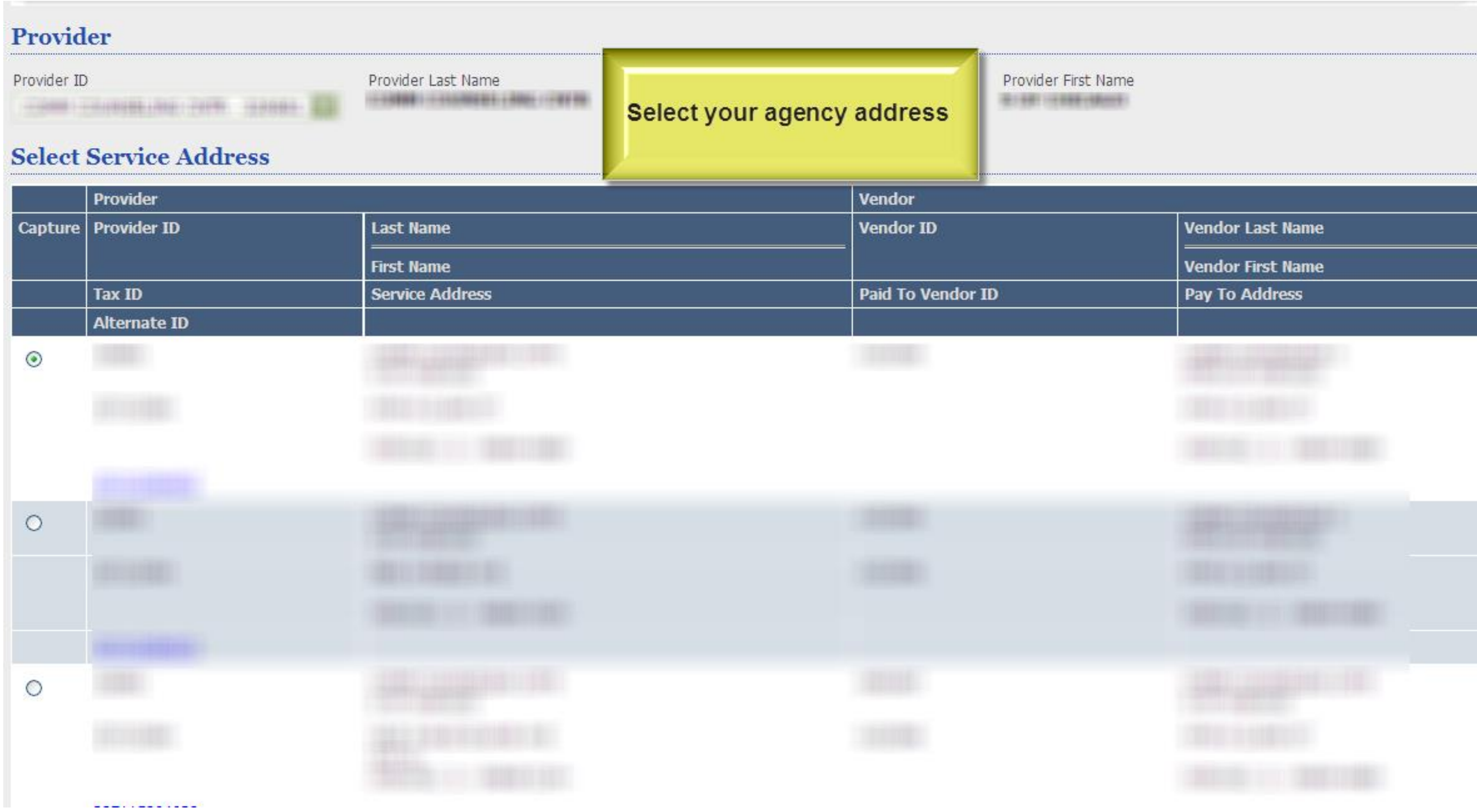
Member Search



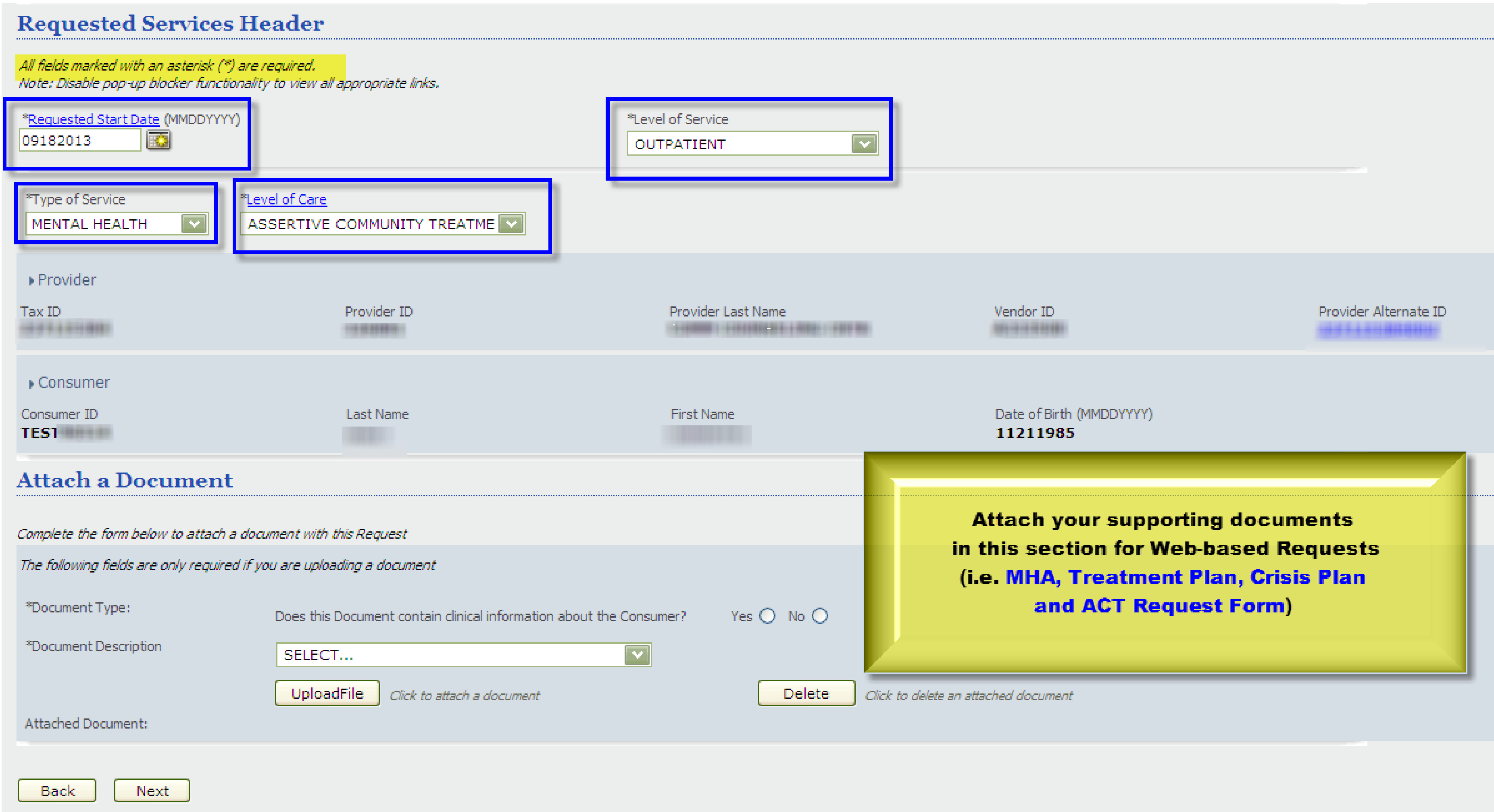
Member Demographics



Provider Location

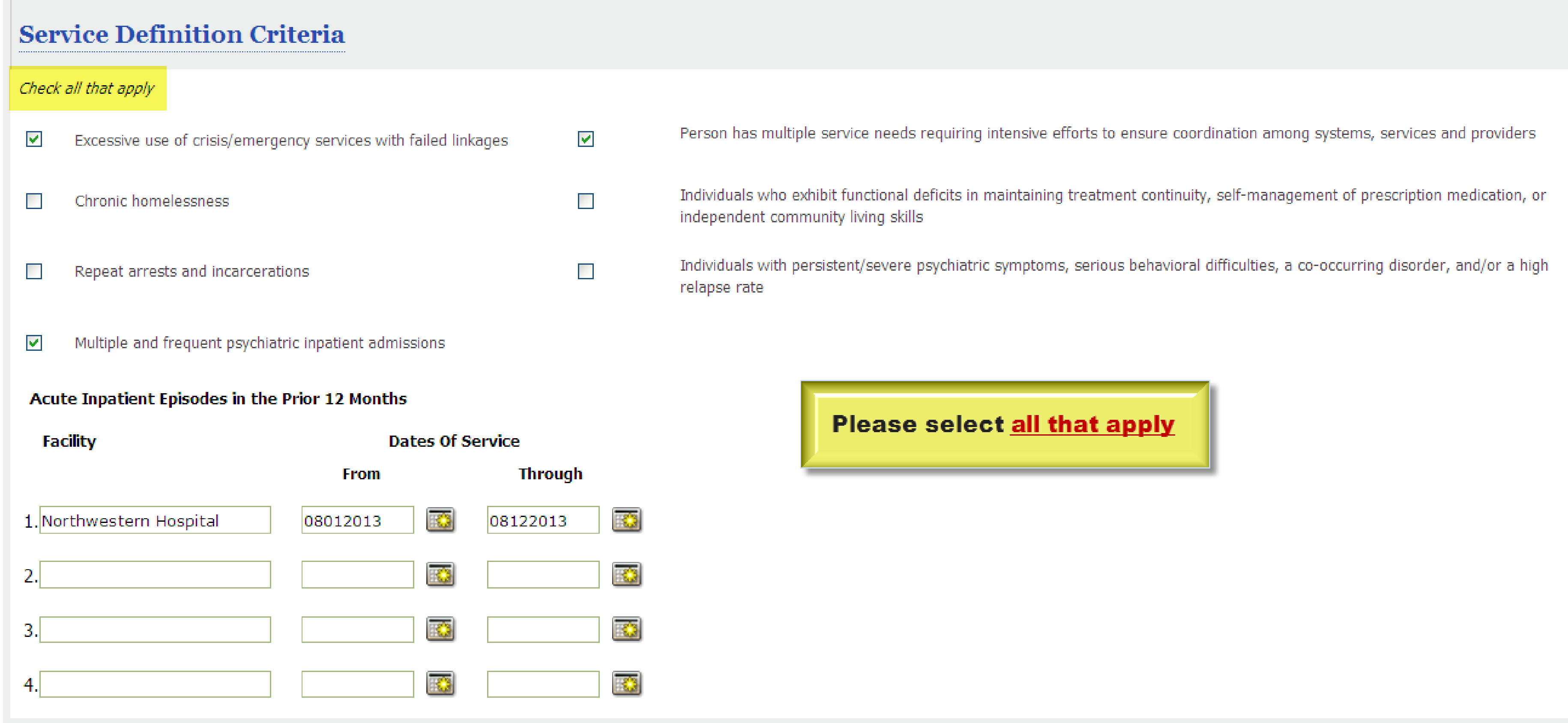


Request Services



Requested Services Header

Service Definition Criteria



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
SELECT...		

Additional Behavioral Diagnosis

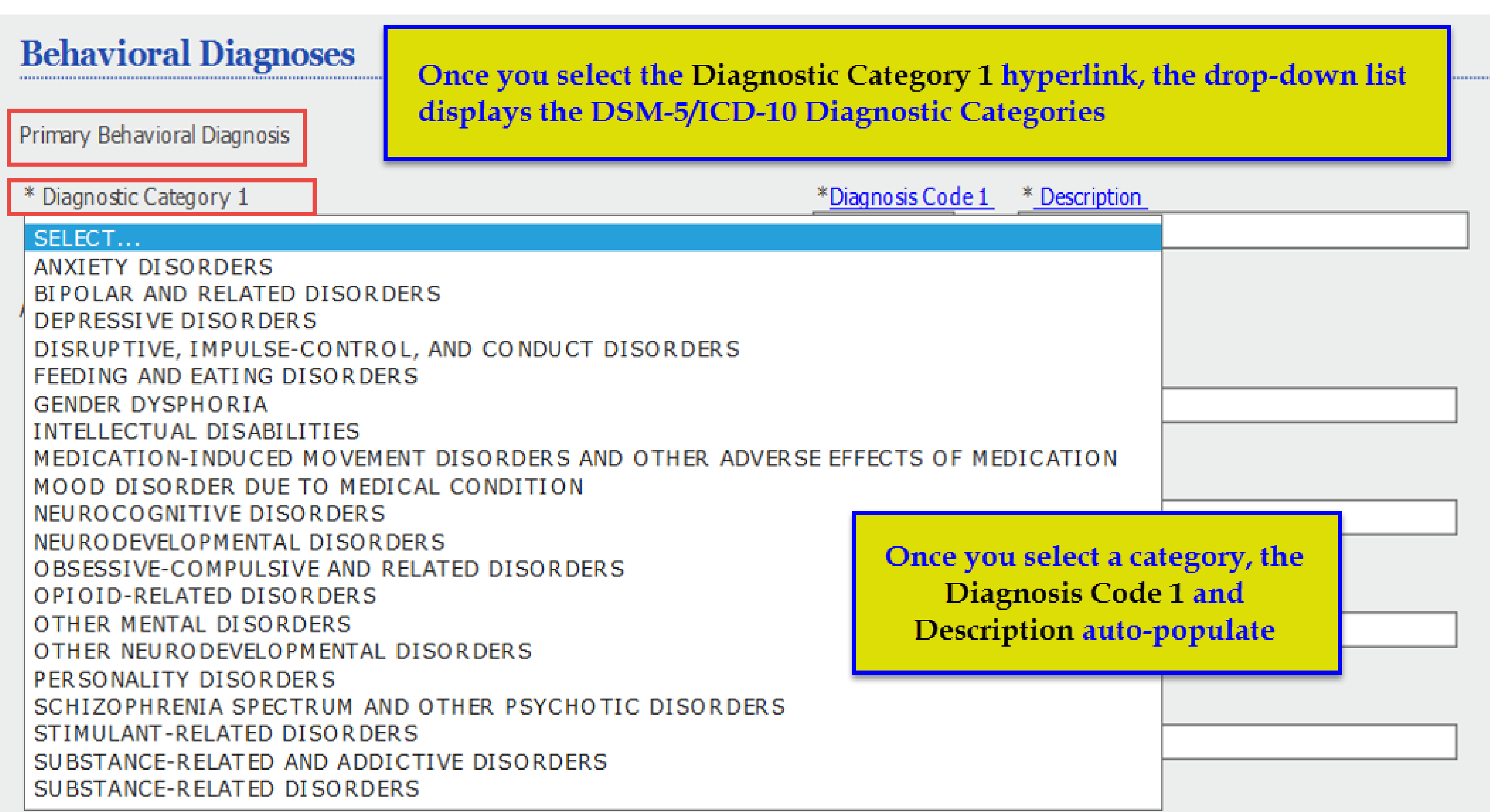
Diagnostic Category	Diagnosis Code	Description
Diagnostic Category 2: SELECT...	Diagnosis Code 2	Description
Diagnostic Category 3: SELECT...	Diagnosis Code 3	Description
Diagnostic Category 4: SELECT...	Diagnosis Code 4	Description
Diagnostic Category 5: SELECT...	Diagnosis Code 5	Description

Primary Medical Diagnosis

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

Diagnostic Category	Diagnosis Code	Description
* Diagnostic Category 1: SELECT...	Diagnosis Code 1	Description
Diagnostic Category 2: SELECT...	Diagnosis Code 2	Description
Diagnostic Category 3: SELECT...	Diagnosis Code 3	Description

Primary Behavioral Diagnosis

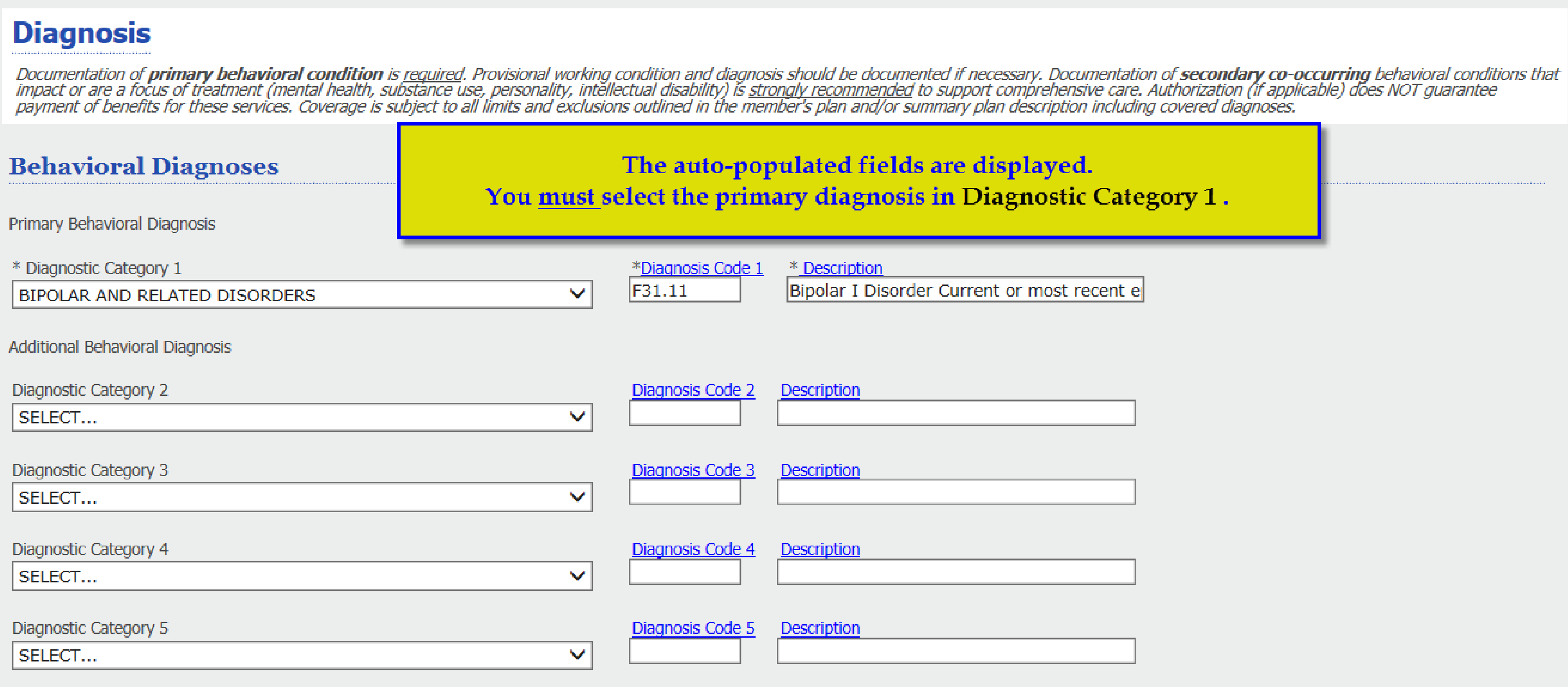


Primary Behavioral Diagnosis

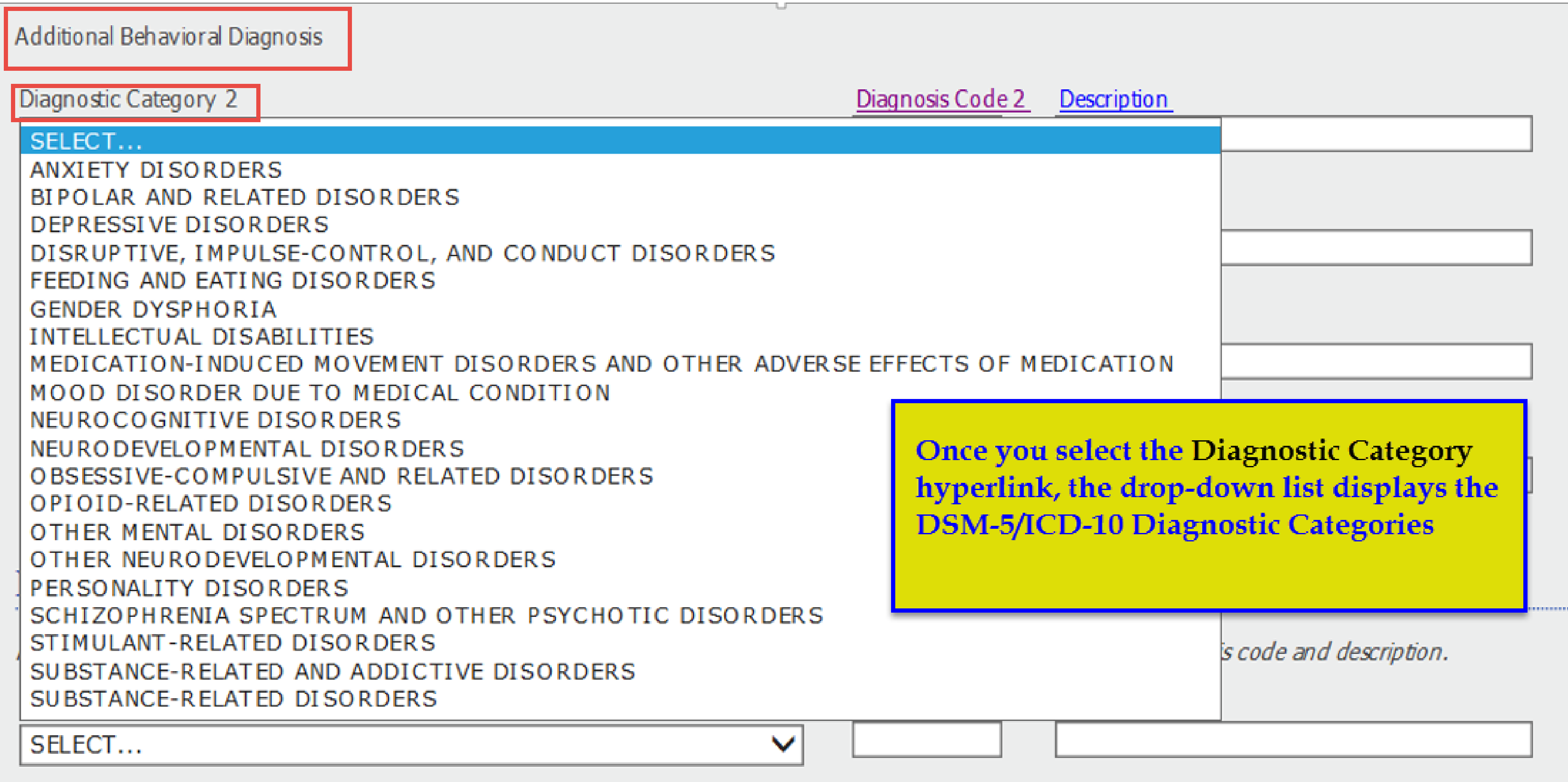
You may select from the Diagnosis Code or Description hyperlink. A pop-up window will appear with the Diagnosis Codes and Descriptions (both sections use the same pop-up window). Once you make your selection, the other fields will auto-populate the diagnosis.
(this screen shot does not show all diagnoses)

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

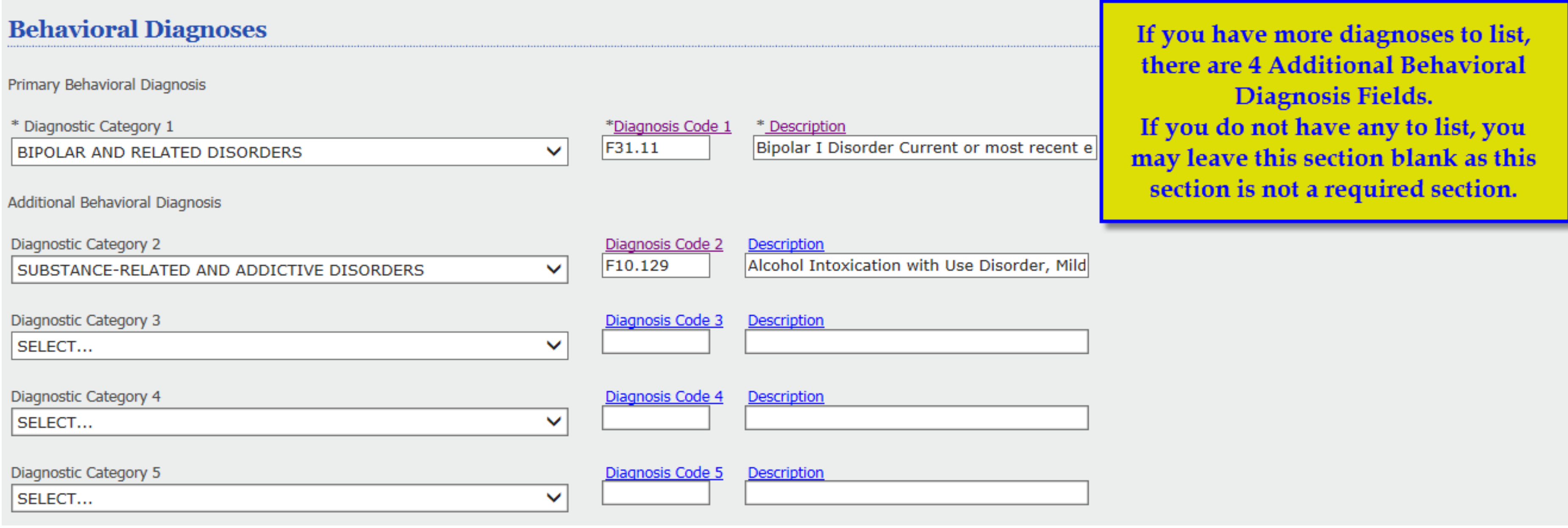
Primary Behavioral Diagnosis



Additional Behavioral Diagnosis



Additional Behavioral Diagnosis



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

- SELECT...
- BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL
- CANCER & NEOPLASMS
- CIRCULATORY SYSTEM - HEART
- CIRCULATORY SYSTEM - OTHER
- CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES
- DIGESTIVE SYSTEM - LIVER
- DIGESTIVE SYSTEM - OTHER
- 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

SELECT...

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

SELECT...
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL
CANCER & NEOPLASMS
CIRCULATORY SYSTEM - HEART
CIRCULATORY SYSTEM - OTHER
CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES
DIGESTIVE SYSTEM - LIVER
DIGESTIVE SYSTEM - OTHER
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

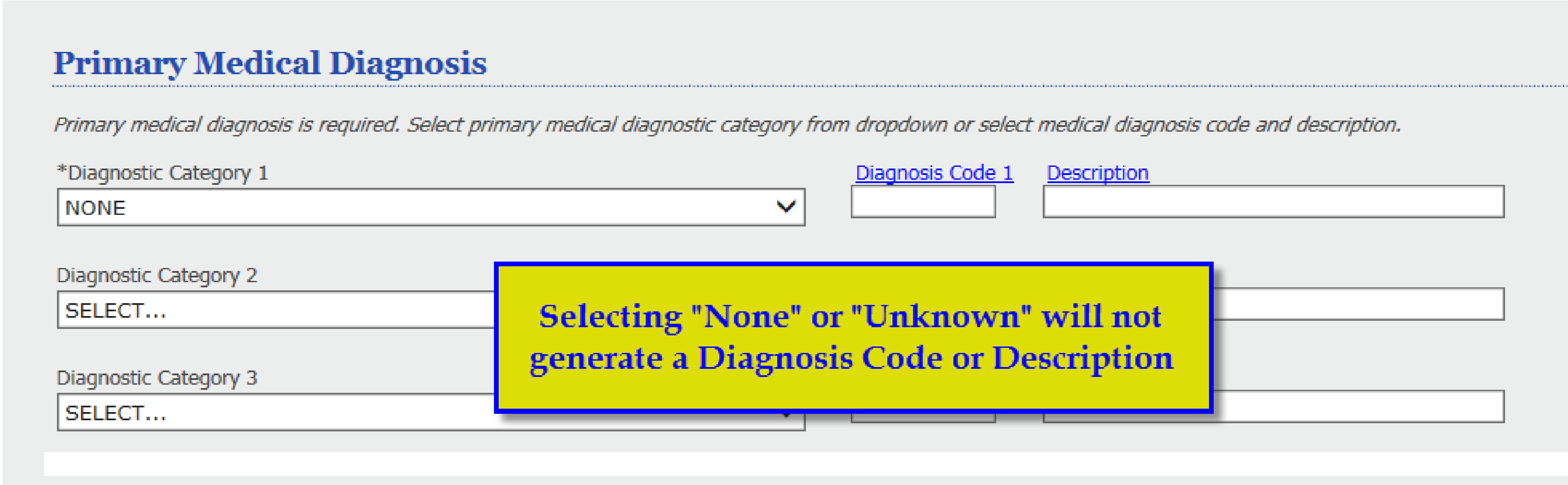
Description

Description

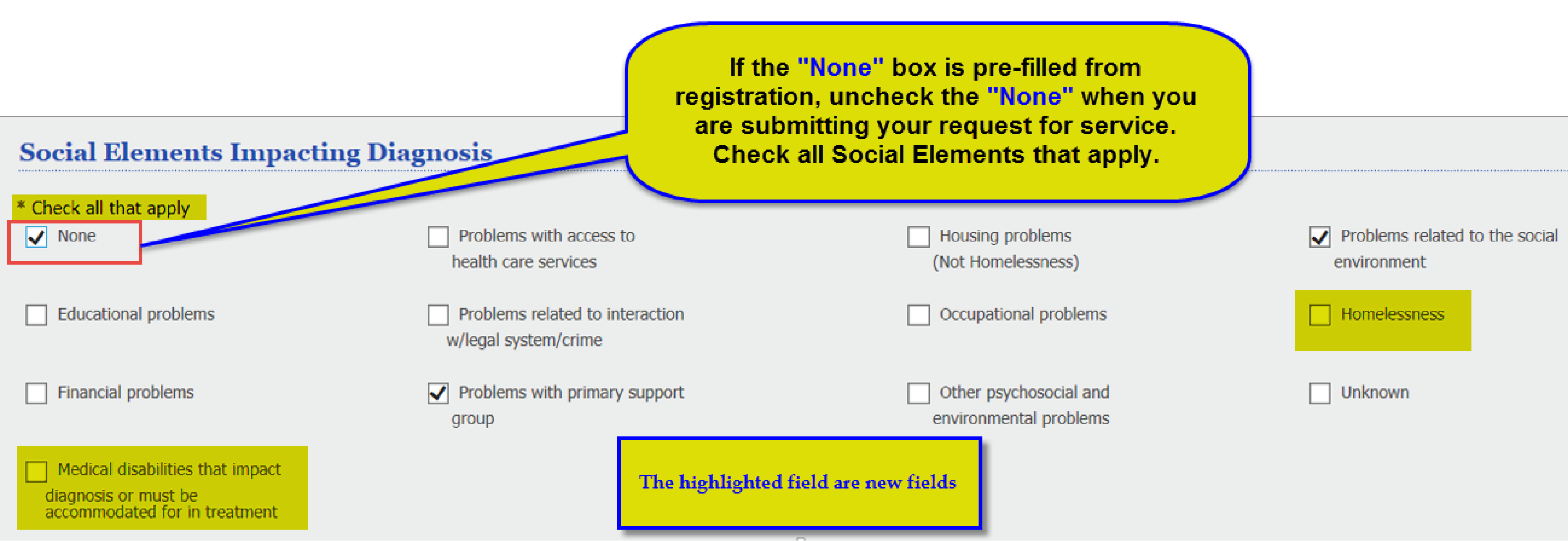
You may select None or Unknown

- [ ] Housing problems (Not Homelessness)
- [ ] Occupational problems
- [ ] Financial problems
- [x] Problems with primary support group
- [ ] Other psychosocial and environmental problems

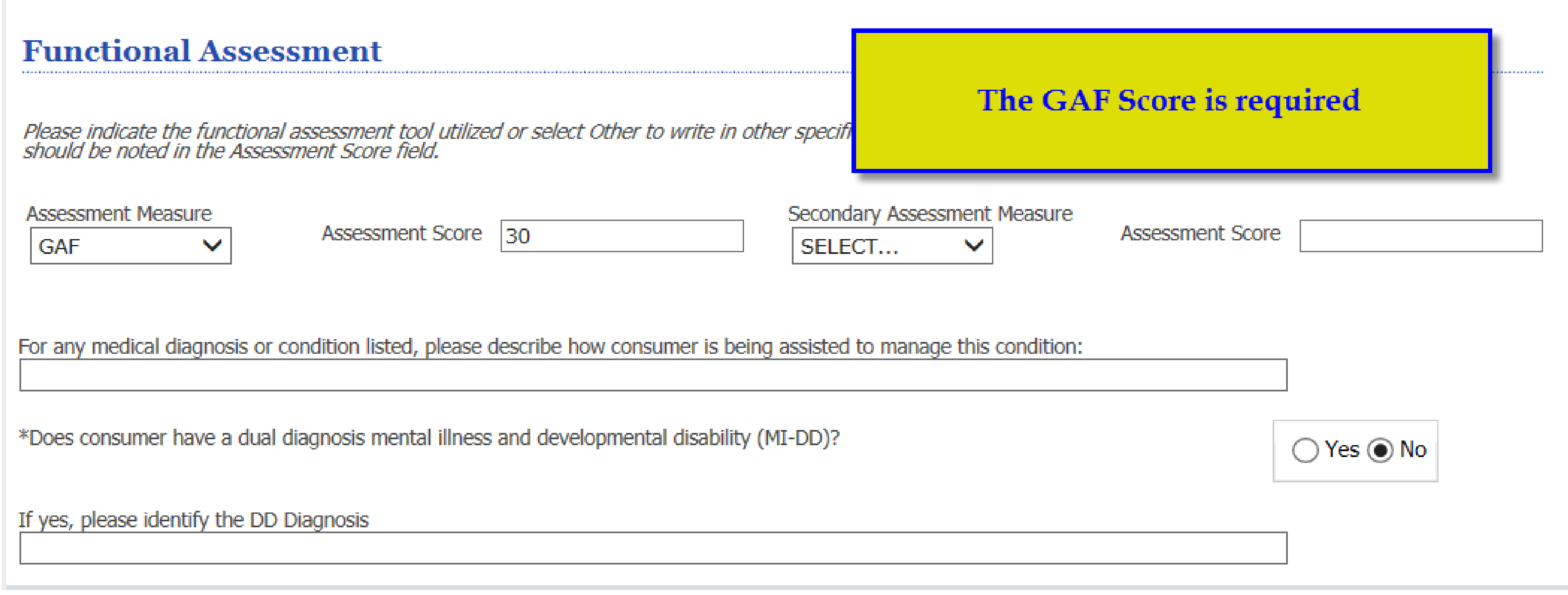
Primary Medical Diagnosis



Social Elements Impacting Diagnosis



Functional Assessment



LOCUS

LOCUS Results

Functional Impairment Domain Scores:

Domain	Score	Domain	Score
*Risk of Harm	3	*Recovery - Environment Stressors	3
*Functional Status	3	*Recovery - Environment Supports	3
*Co-Morbidity	2	*Recovery and Treatment History	3
		*Acceptance and Engagement	2

Composite Score: 19

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

Level Of Care Recommended - Locus

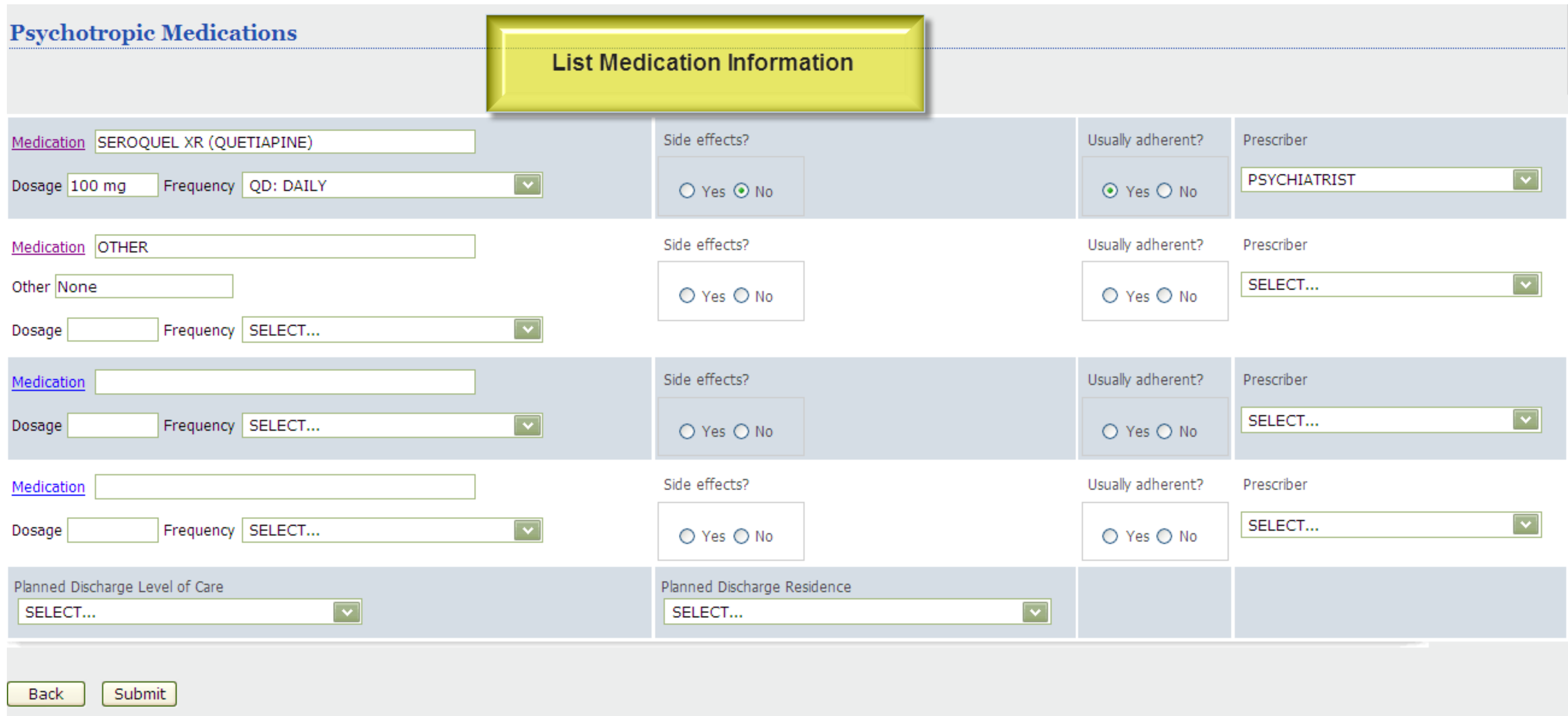
III-HIGH INTENSITY COMMUNITY BASED SRVS (17-19)

Level Of Care Recommended - Assessors

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

Reason for deviation of recommended Level Of Care

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: ______________________________
Agency Location:_______________________
Agency FEIN:__________________________
Team Name: __________________________

Name of Referred: ____________________________
Date of Birth: _________________________
RIN # ________________________________

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: ____________________________
Agency Location:______________________
Agency FEIN:_________________________
Team Name: ________________________

Name of Referred: ___________________________
Date of Birth: ________________________
RIN # _____________________________

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 (T/C)

Psychosocial Rehabilitation (PSR)

Community Support Group (CSG)

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) requested, 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.**

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FOR ACCESS AND CHOICE

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Provider Online Services

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ProviderConnect

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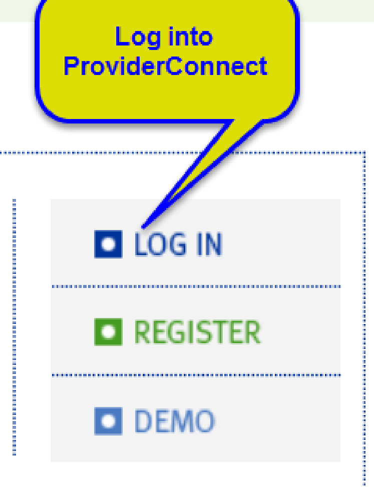

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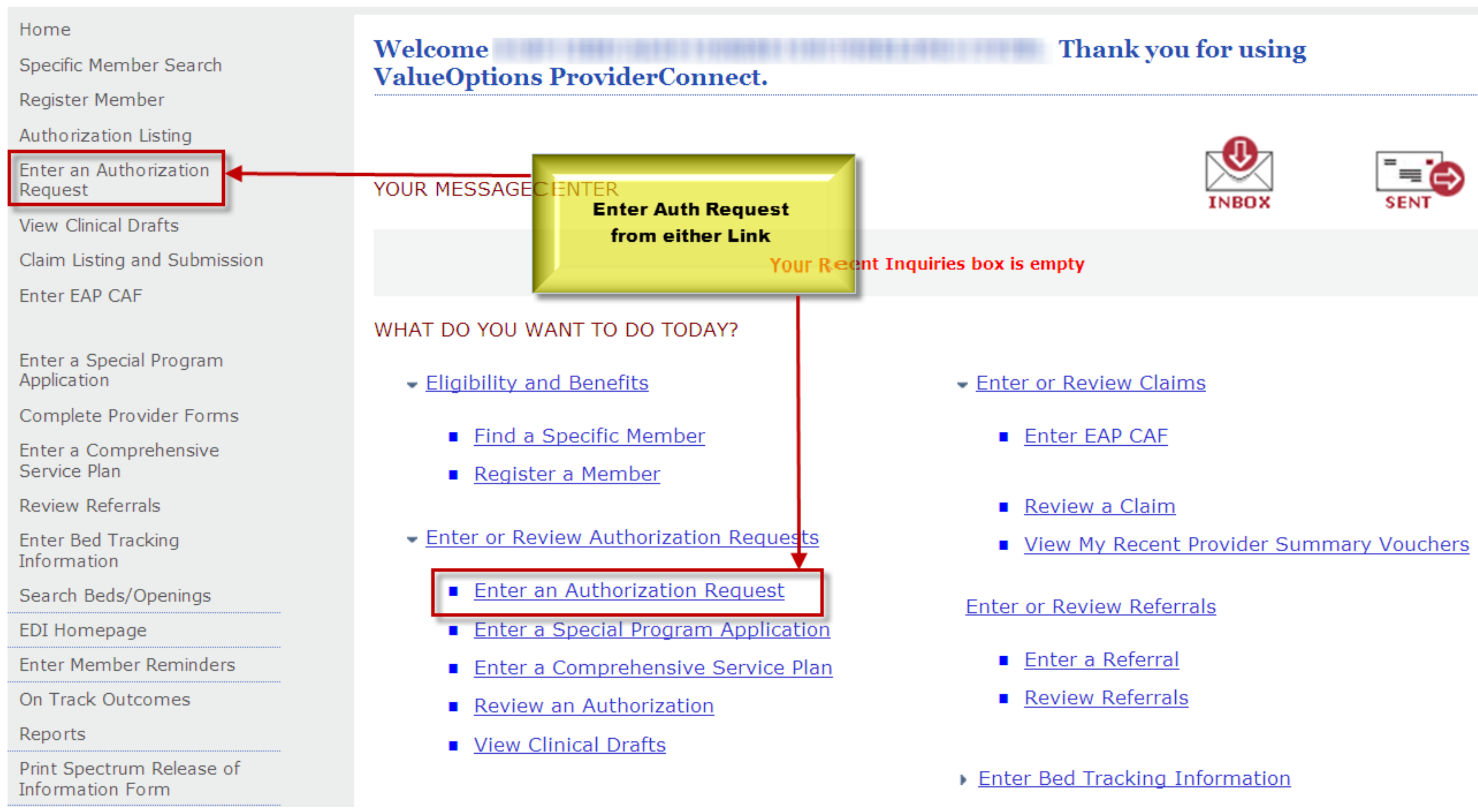
Authorization Request



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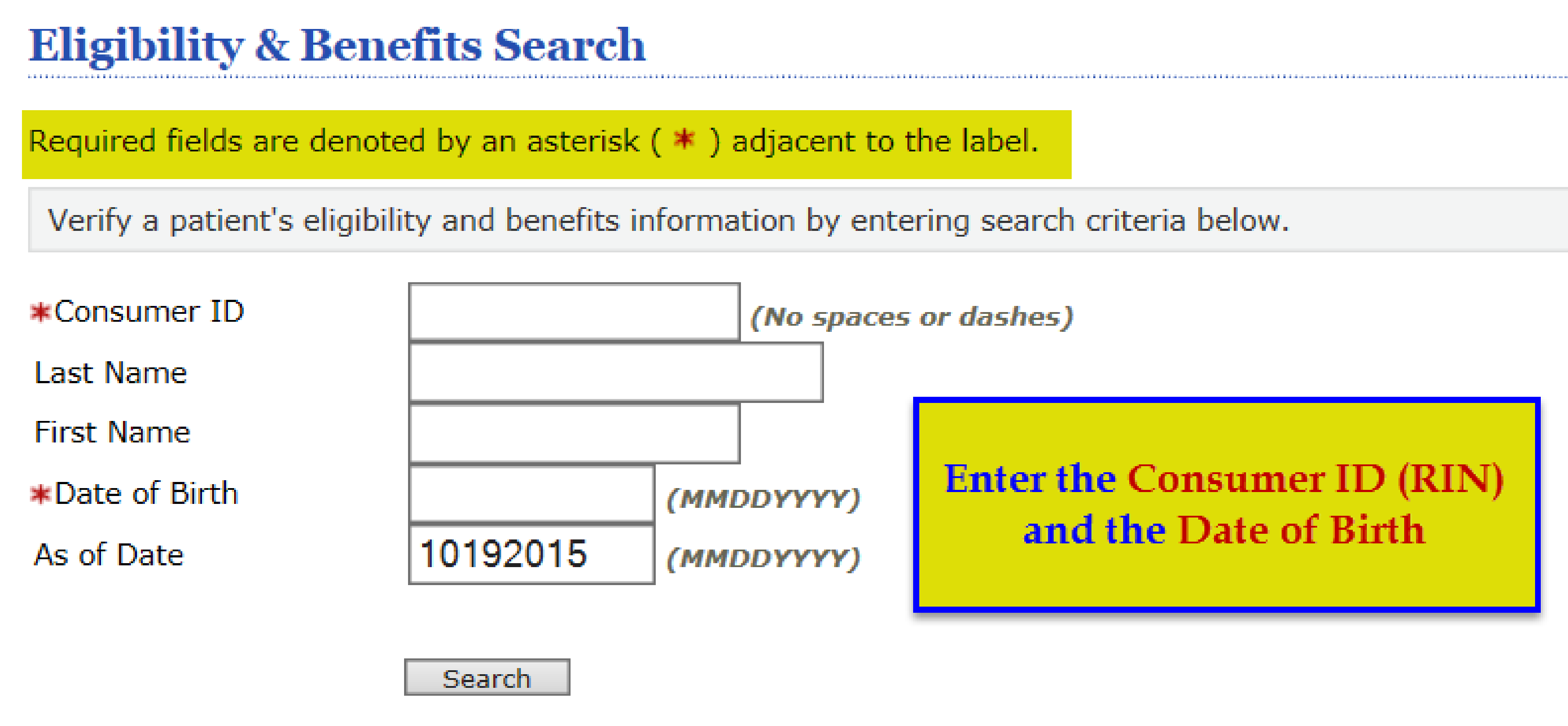
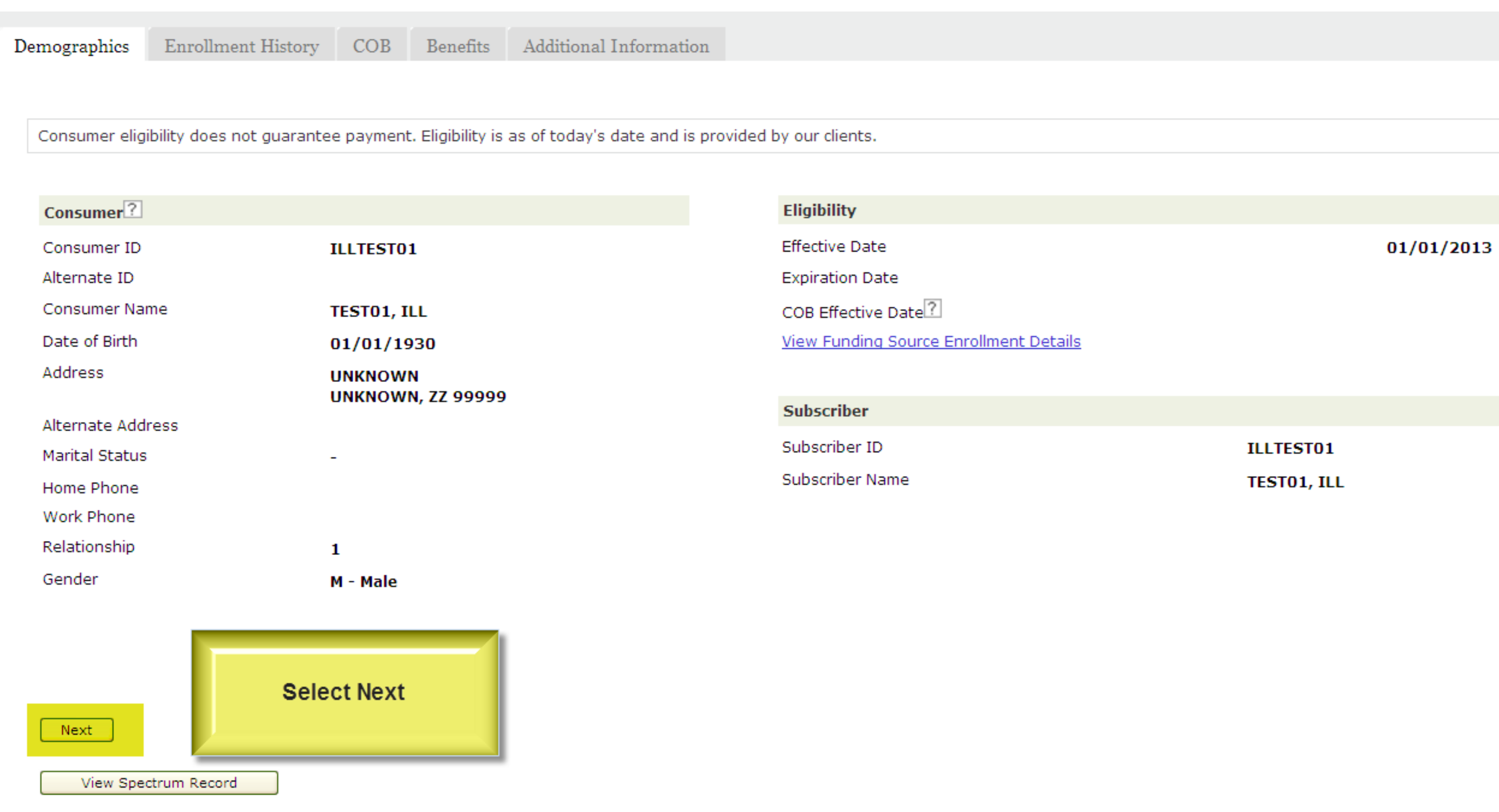
Next

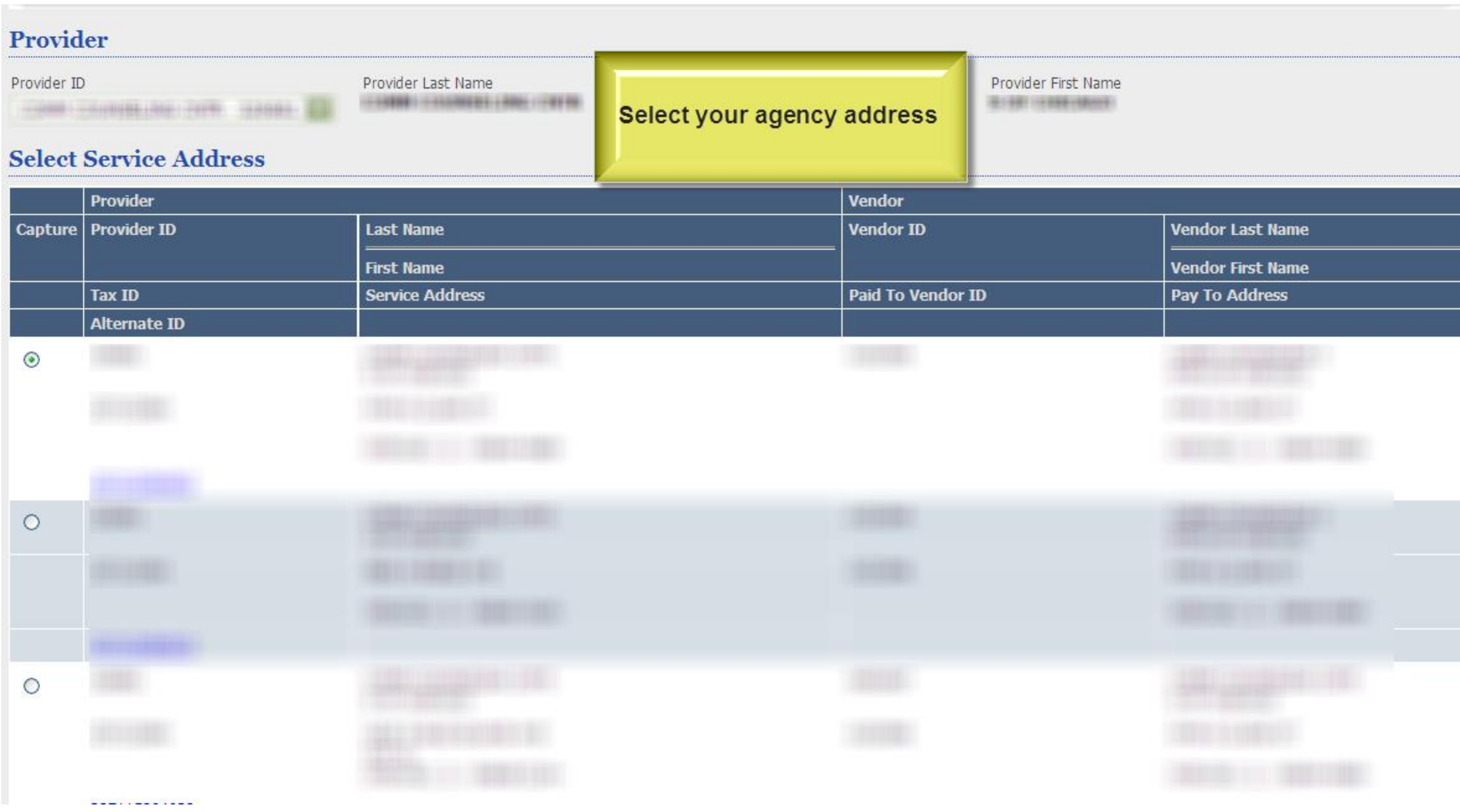
Member Search



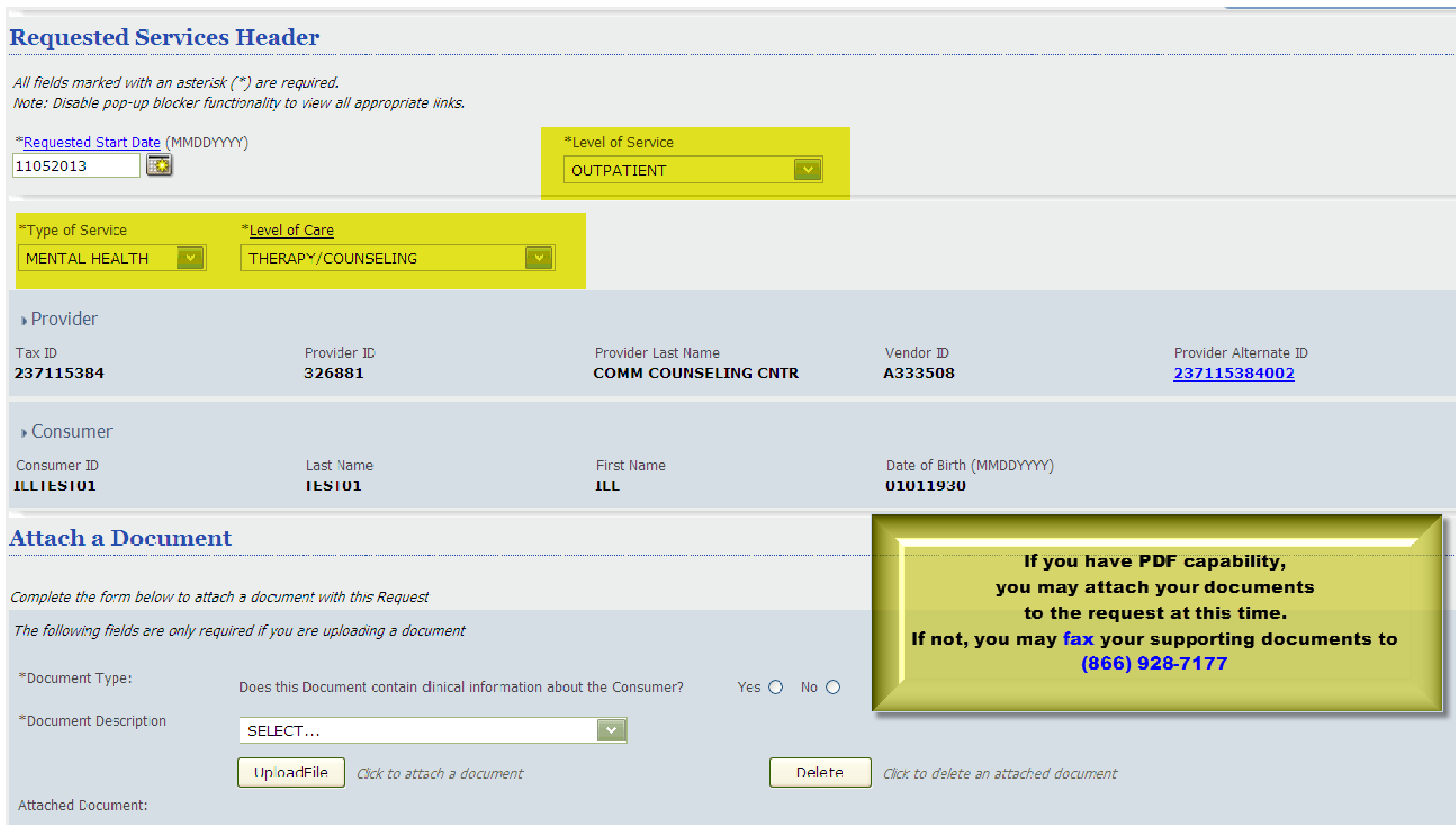
Member Demographics



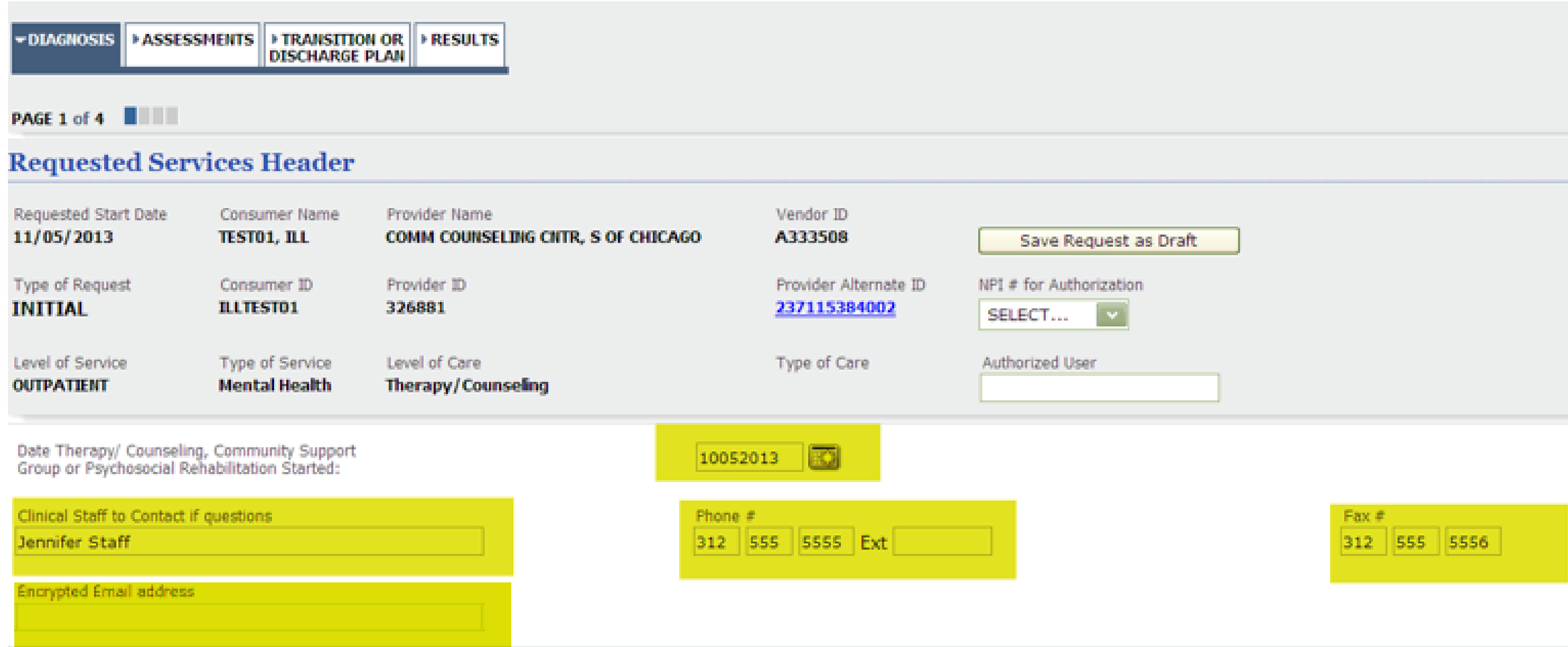
Provider Location



Requested Services Header



Request Services Continued



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
SELECT...		

Additional Behavioral Diagnosis

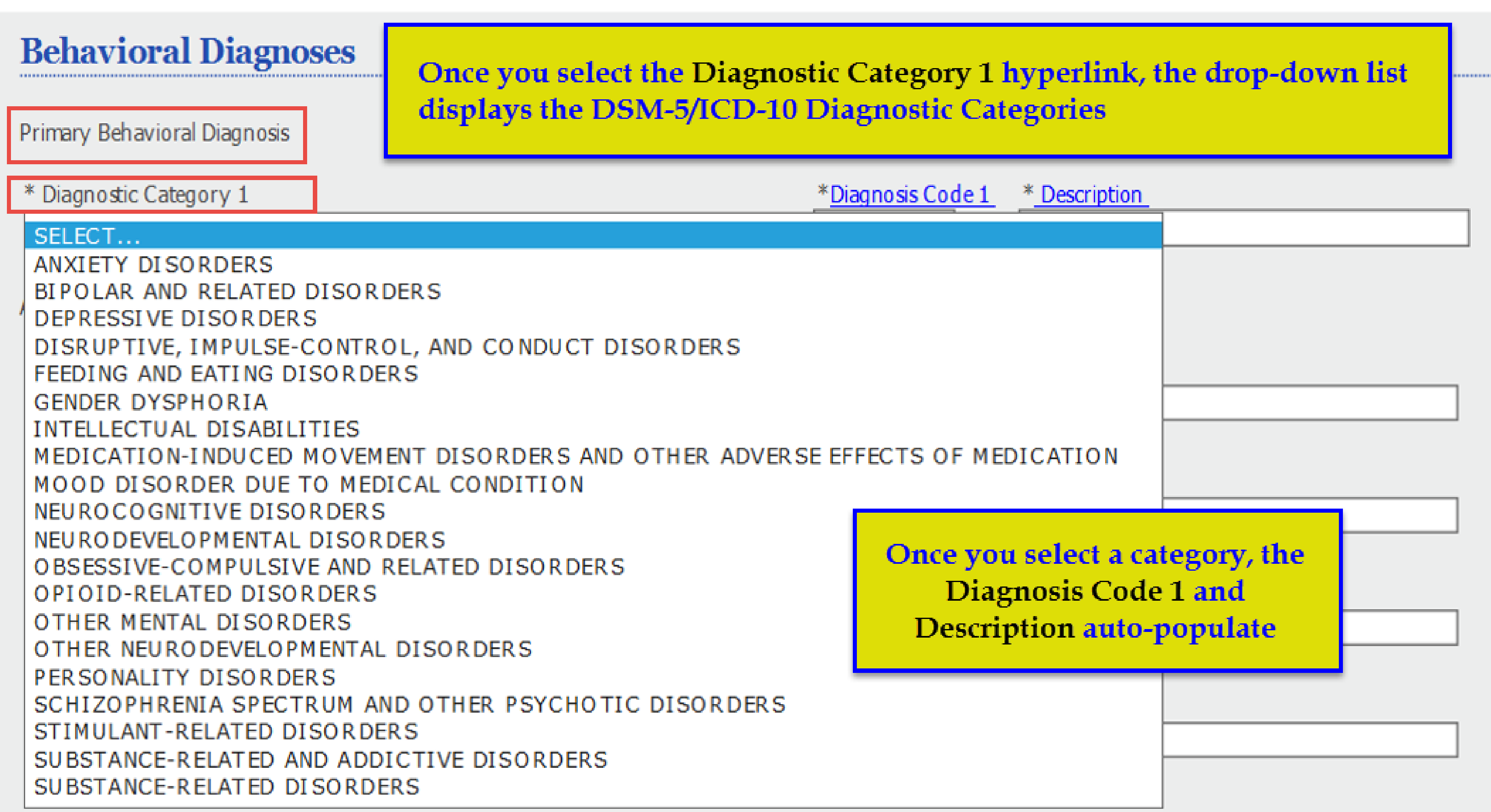
Diagnostic Category	Diagnosis Code	Description
Diagnostic Category 2: SELECT...	Diagnosis Code 2	Description
Diagnostic Category 3: SELECT...	Diagnosis Code 3	Description
Diagnostic Category 4: SELECT...	Diagnosis Code 4	Description
Diagnostic Category 5: SELECT...	Diagnosis Code 5	Description

Primary Medical Diagnosis

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

Diagnostic Category	Diagnosis Code	Description
* Diagnostic Category 1: SELECT...	Diagnosis Code 1	Description
Diagnostic Category 2: SELECT...	Diagnosis Code 2	Description
Diagnostic Category 3: SELECT...	Diagnosis Code 3	Description

Primary Behavioral Diagnosis

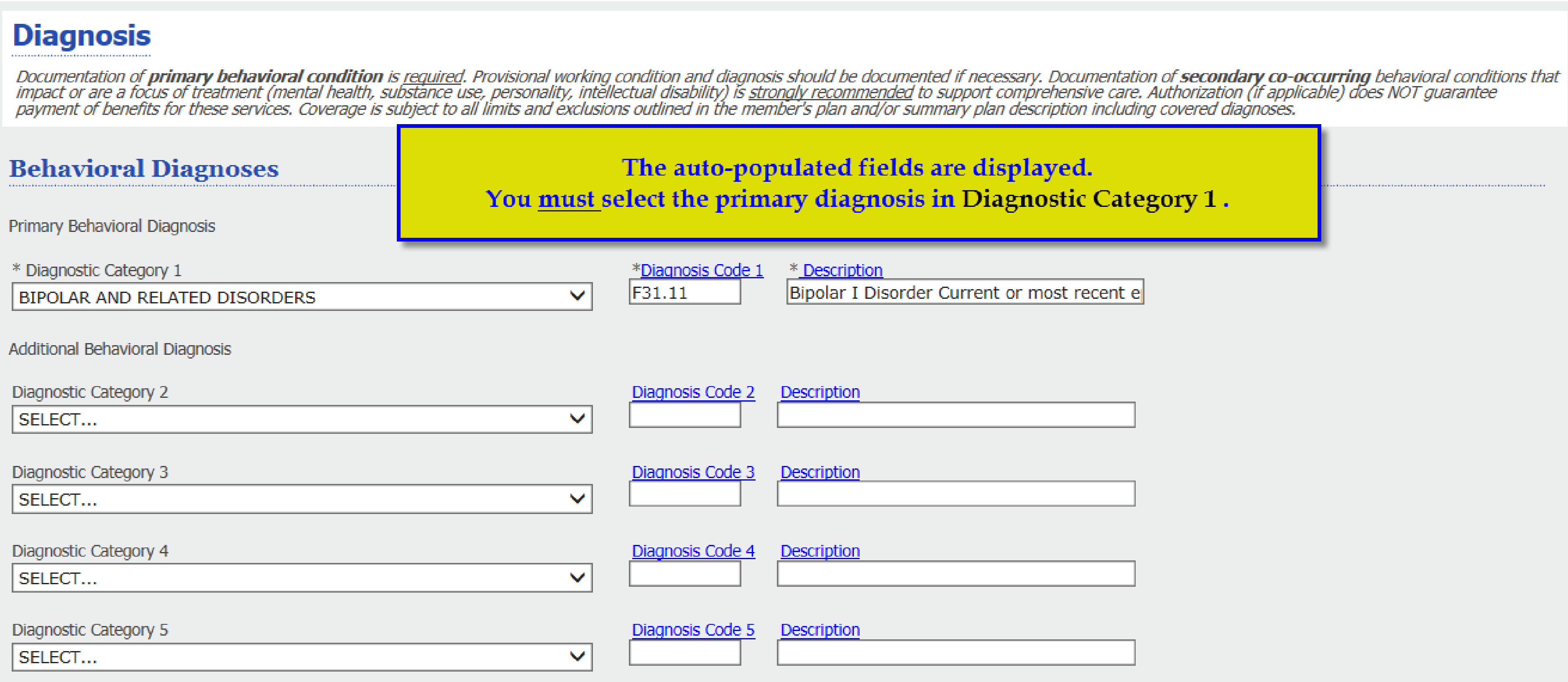


Primary Behavioral Diagnosis

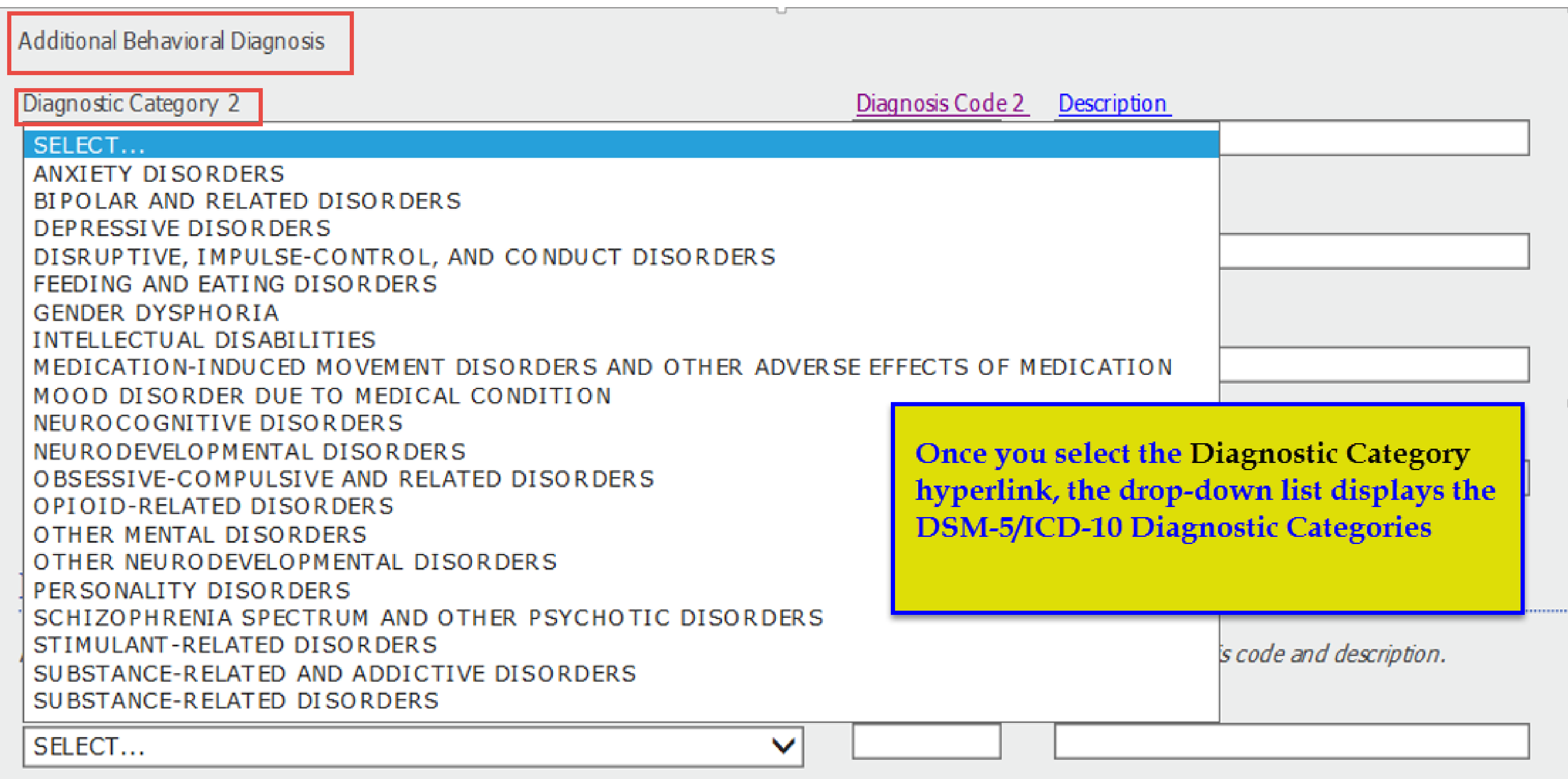
You may select from the Diagnosis Code or Description hyperlink. A pop-up window will appear with the Diagnosis Codes and Descriptions (both sections use the same pop-up window). Once you make your selection, the other fields will auto-populate the diagnosis.
(this screen shot does not show all diagnoses)

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

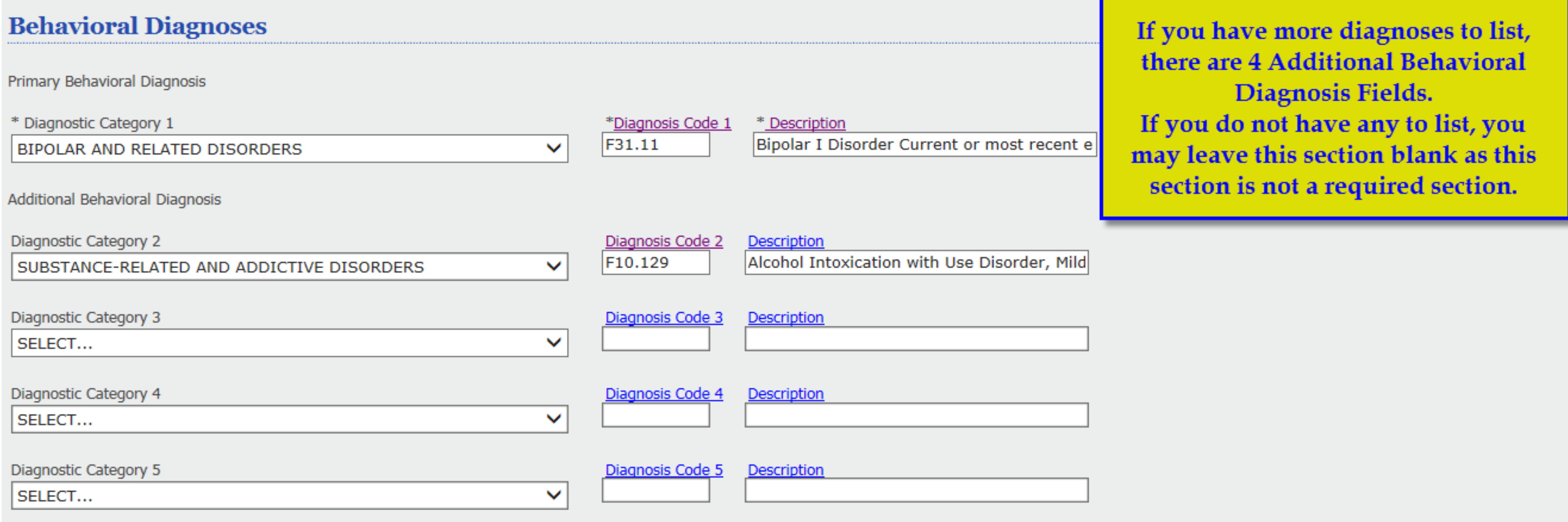
Primary Behavioral Diagnosis



Additional Behavioral Diagnosis



Additional Behavioral Diagnosis



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

SELECT...
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL
CANCER & NEOPLASMS
CIRCULATORY SYSTEM - HEART
CIRCULATORY SYSTEM - OTHER
CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES
DIGESTIVE SYSTEM - LIVER
DIGESTIVE SYSTEM - OTHER
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

SELECT...

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

SELECT...
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL
CANCER & NEOPLASMS
CIRCULATORY SYSTEM - HEART
CIRCULATORY SYSTEM - OTHER
CONGENITAL DEFORMATIONS, MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES
DIGESTIVE SYSTEM - LIVER
DIGESTIVE SYSTEM - OTHER
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

Description

Description

You may select None or Unknown

Housing problems (Not Homelessness)

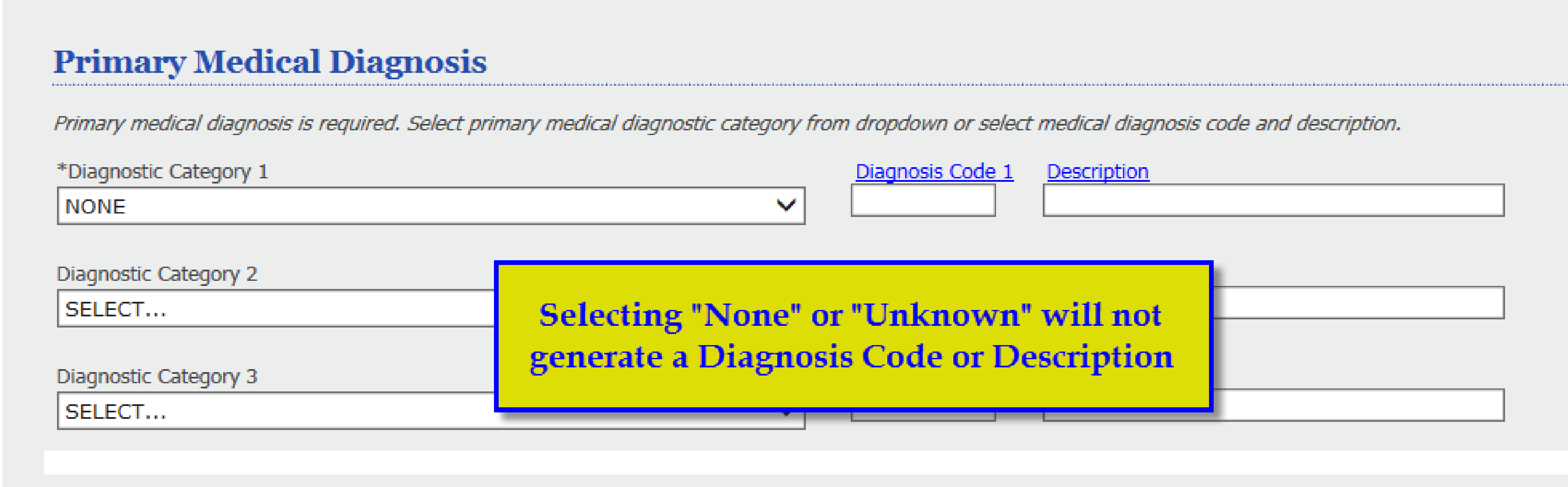
Occupational problems

Financial problems

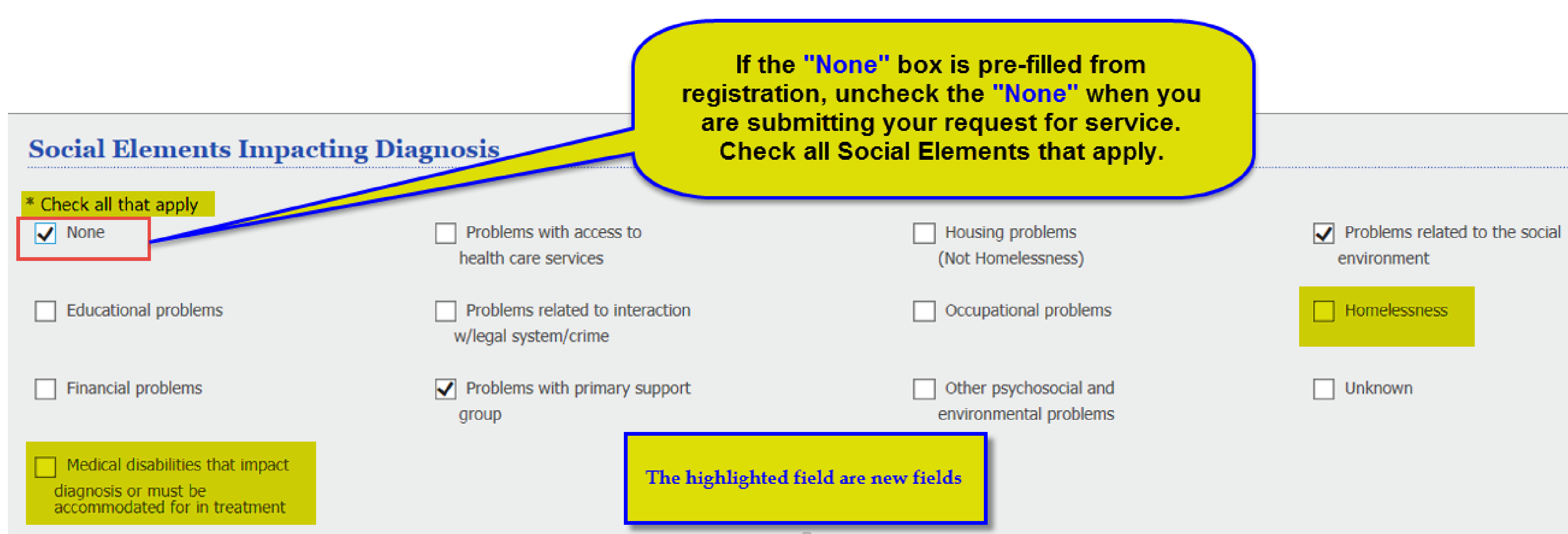
Problems with primary support group

Other psychosocial and environmental problems

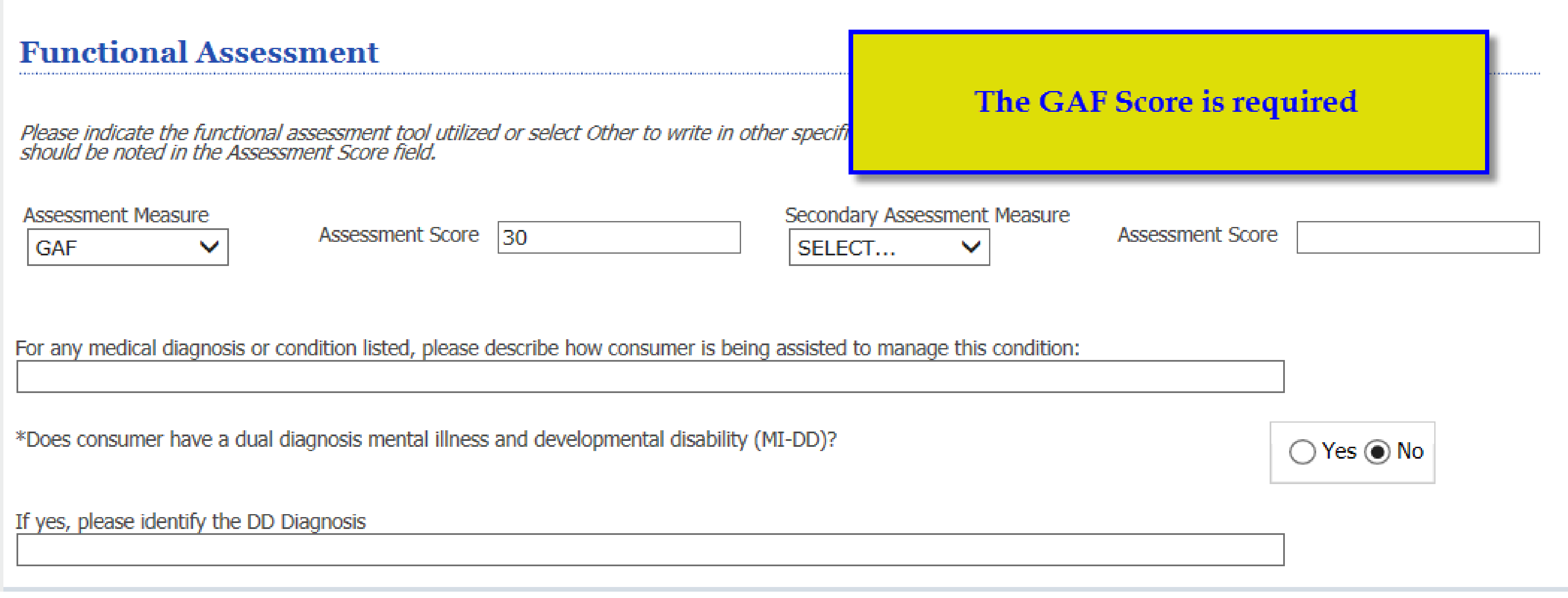
Primary Medical Diagnosis



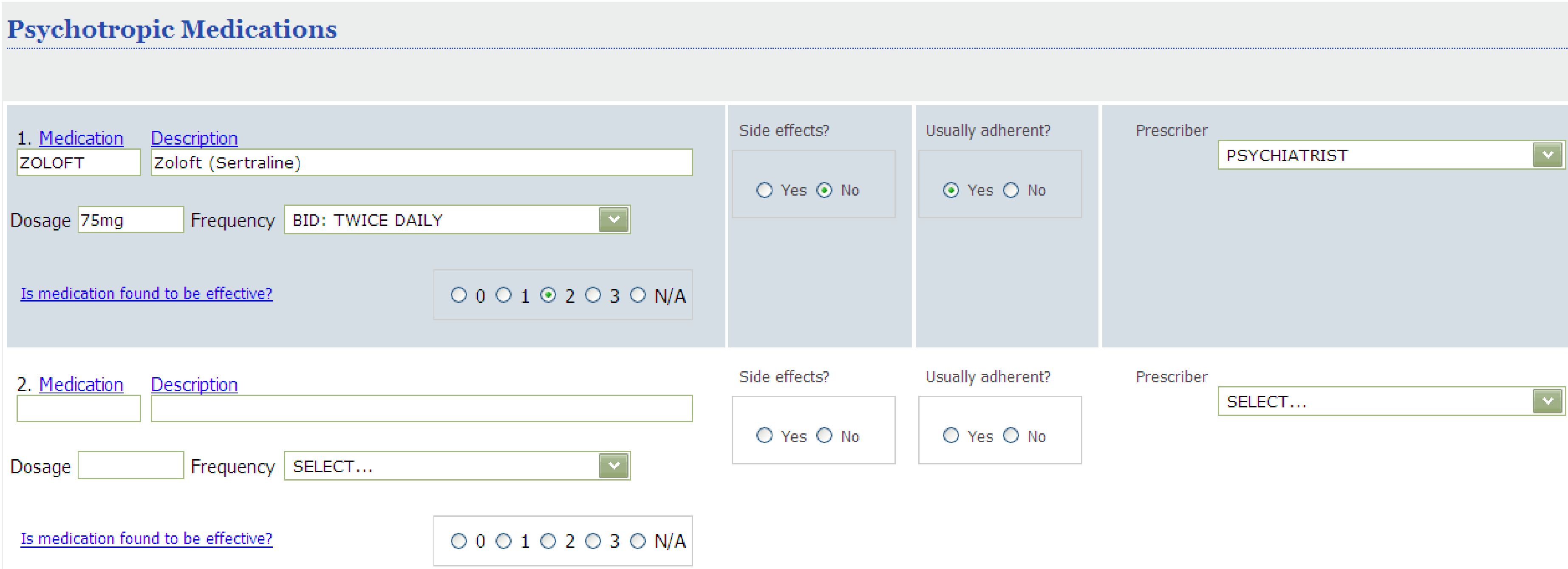
Social Elements Impacting Diagnosis



Functional Assessment



Psychotropic Medications



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.

Field	Value	Field	Value
Risk of Harm	2	Recovery Environment - Environmental Stressors	2
Functional Status	2	Recovery Environment - Environmental Support	2
Co-morbidity	2	Recovery And Treatment History	3
		Acceptance and Engagement	2
Composite Score	15		

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 & Devereaux Scale Results

Ohio Scale Results

Worker Ohio Problem Severity Scale Score (For youth age 5 - 17) (0-100)

Admission (all) 0 Current (if in treatment more than 90 days) 0

Devereaux Scale Results

DECA Subscale (For children under the age of 3)

Protective Factor Scores

Admission (all) 0 % Current (if in treatment more than 90 days) 0 %

DECA Subscale (For children over the age of 3, under the age of 5)

Protective Factor Scores

Admission (all) 0 % Current (if in treatment more than 90 days) 0 %

Behavioral Concerns

Admission (all) 0 % Current (if in treatment more than 90 days) %

Required Documents

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.

Fax supporting documents to the Collaborative at (866) 928-7177

Service Requested

Transition or Discharge Plan

Question	Response
* 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

Question	Response
* 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 (0 of 2000)

In the Narrative, please answer 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?
5. What benefit has the consumer demonstrated from this service?
6. 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

P76

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

Shows Printing and Download Options

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 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.**

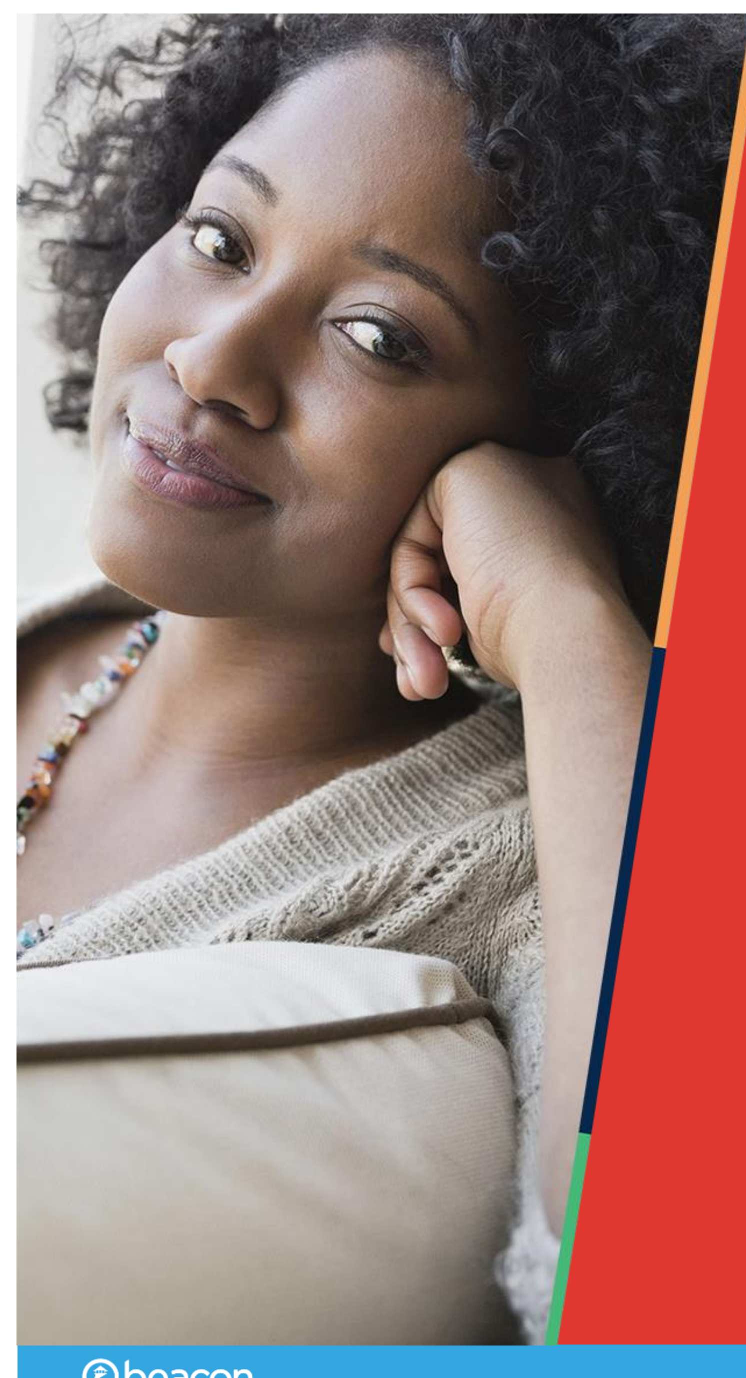
- **If the consumer is Medicaid eligible and it is not reflected in our system, you will be asked to submit verification documents to show verification of Medicaid eligibility. Our clinical department will forward this information to our eligibility department to be researched. If the consumer is determined 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.**
- **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

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 anemias
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 anemias
BBFOIM	Blood, blood-forming organs, & immunological	D59	ACQHMANM	Acquired hemolytic anemia
BBFOIM	Blood, blood-forming organs, & immunological	D60	APRCAPLA	Acquired pure red cell aplasia [erythroblastopenia]
BBFOIM	Blood, blood-forming organs, & immunological	D61	OAAOBMFS	Other aplastic anemias and other bone marrow failure syndromes
BBFOIM	Blood, blood-forming organs, & immunological	D62	ACPSMANM	Acute posthemorrhagic 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

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MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

www.illinoismentalhealthcollaborative.com