

Utilization Management Program Request for Services Process

Presenters

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Summary

This section will step through the process of submitting UM Requests for Services through the use of ProviderConnect



Assertive Community Treatment (ACT) Community Support Team (CST)



The Process

FOR ACT & CST



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

- **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**

SUBMISSION METHOD FOR AUTHORIZATION REQUESTS (ACT/CST)

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](tel:(866)928-7177)

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 for 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)

- 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 also submitted, the Clinician may enter an authorization for twelve (12) months.

Initial Authorization Request Continued

- 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
 - The Collaborative will enter an initial authorization of six (6) months of services if a Treatment Plan has also 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 should be submitted within 14 calendar days of the initial authorization expiration date.

Requirements Continued

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 for 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

- 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 should be submitted within two weeks prior to the current authorization expiration date.

Request for Authorization ACT

The Illinois Mental Health Collaborative for Access and Choice

Request for Authorization of Assertive Community Treatment Services (ACT) Initial Request or Reauthorization Request

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

Male: Female:

I. Service Definition Criteria (Please check all that apply)

Multiple and frequent psychiatric inpatient admissions;

Acute Inpatient Episodes in the prior 12 months:

Facility: _____ Dates of Service _____

Facility: _____ Dates of Service _____

Facility: _____ Dates of Service _____

Facility: _____ Dates of Service _____

Excessive use of crisis/emergency services with failed linkages;

Chronic homelessness;

Repeat arrests and incarcerations;

Person has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;

Individuals who exhibit functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or

Individuals with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate

Request for Authorization CST

The Illinois Mental Health Collaborative for Access and Choice

Request for Authorization of Adult Community Support Team Services (CST) Initial Request or Reauthorization Request

Agency: _____
Agency Location: _____
Agency FEIN: _____

Name of Referred: _____
Date of Birth: _____
RIN # _____

Male: Female:

I. Service Definition Criteria (Please check all that apply)

- Multiple and frequent psychiatric inpatient admissions;
- Excessive use of crisis or emergency services with failed linkages;
- Chronic homelessness;
- Repeat arrests and incarcerations;
- History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing.
- High use of detoxification services (e.g., two (2) or more episodes per year.)
- Clinical evidence of suicidal ideation or behavior in last three (3) months.
- Ongoing inappropriate public behavior within the last three months including (but not limited to) such examples as public intoxication, indecency, disturbing the peace.
- Self harm or threats of harm to others within the last three (3) months.
- Medication resistance due to : intolerable side effects or illness-mediated interference with consistent self-management of medications

Getting Started

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

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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

- 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

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 pending 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 your agency address

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	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

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

Provider ID

Provider Last Name

Vendor ID

Provider Alternate ID

Consumer

Consumer ID

Last Name

First Name

Date of Birth (MMDDYYYY)

TEST1

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 <input type="text" value="SELECT..."/>
Level of Service OUTPATIENT	Type of Service Mental Health	Level of Care ASSERTIVE COMMUNITY TREATMENT	Type of Care	Authorized User <input type="text"/>

* Clinical Staff to Contact if questions

* Phone #

Fax #

Encrypted Email address

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

Please select **all that apply**

	Facility	Dates Of Service	
		From	Through
1.	Northwestern Hospital	08012013 	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"/> 

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

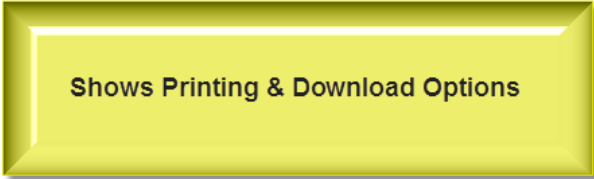
Submit

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

- 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 it to the Collaborative.
- Discontinuance criteria are outlined in the Service Authorization Protocol Manual.
- Detailed information regarding discontinuance of ACT/CST services and linkage to other services must be documented in the consumer’s clinical record.

Notice of Discontinuation ACT

Notification of Discontinuation from Assertive Community Treatment Fax Forms to the Collaborative at: 866-928-7177

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

Male: Female:

Admit Date to ACT: _____

ACT was discontinued on(date): _____

I. DISCONTINUANCE CRITERIA (Please check only one)

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

Notice of Discontinuation CST

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 (T/C)

Psychosocial Rehabilitation (PSR)

Community Support Group (CSG)



The Process

FOR T/C, CSG & PSR

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

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

SUBMISSION METHOD FOR AUTHORIZATION REQUESTS (T/C, CSG, PSR)

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

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

Supporting clinical documentation not attached to the request may be faxed to: [\(866\) 928-7177](tel:8669287177)

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 Continued

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

OR

- If medical necessity is NOT established, the CCM contacts the 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 present the clinical information to a Collaborative Physician Advisor (PA) reviewer.

- PA reviews and either authorizes OR denies authorization.

Getting Started

Access ProviderConnect via

www.illinoismentalhealthcollaborative.com/providers.htm

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FOR ACCESS AND CHOICE

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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.

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ProviderConnect

LOG IN

REGISTER

DEMO

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Authorization Request

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- Specific Member Search
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Your Recent Inquiries box is empty

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▼ [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](#)
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[Enter or Review Referrals](#)

- [Enter a Referral](#)
- [Review Referrals](#)

▶ [Enter Bed Tracking Information](#)

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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)

Search

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


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

Consumer


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

Description

296.33

MAJOR DEPRESSIVE D/O-RECURRENT-SEVER

Diagnosis Code 2

Description

V71.09

NO DIAGNOSIS

Diagnosis Code 3

Description

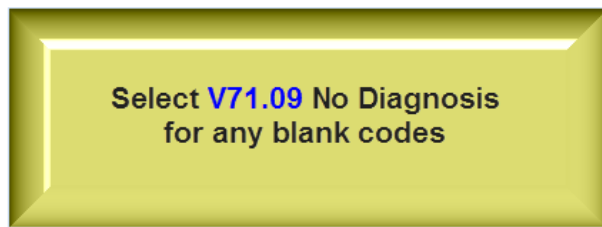
V71.09

NO DIAGNOSIS

Axis III

*Diagnosis Code 1

DIABETES



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 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

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"/>
Composite Score	<input type="text" value="14"/>	Acceptance and Engagement	<input type="text" value="2"/>

LOCUS Recommended Level of Care

Assessor Recommended Level of Care

Reason for Deviation

[▶ Narrative History](#)

[▶ Narrative Entry](#)

(of 200)

Ohio Scale Results

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

Admission (all)

Current (if in treatment more than 90 days)

Devereaux Scale Results

DECA Subscale (For children under the age of 3)

Protective Factor Scores

Admission (all)

%

Current (if in treatment more than 90 days)

%

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

Protective Factor Scores

Admission (all)

%

Current (if in treatment more than 90 days)

%

Behavioral Concerns

Admission (all)

%

Current (if in treatment more than 90 days)

%


Required Documents

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







Attached	Faxed	N/A	
<input checked="" type="radio"/>	<input type="radio"/>		Mental Health Assessment dated within the past year.
<input checked="" type="radio"/>	<input type="radio"/>		Individual Treatment Plan dated within past six months.
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment Update, if indicated.
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	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?

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.

- 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 enter the following:

- 1. Reason for request**
- 2. Current Symptoms**
- 3. Specific time-limited treatment goals and objectives**
- 4. Progress made for each specific time-limited treatment goal and objective**
- 5. Demonstrated benefit from this service**
- 6. Specific transition plan outlining the supports that will need to be in place in order to maintain therapeutic gains once treatment goals have been met**

(Per Rule 132 Medical Necessity Criteria) (See link below)

<http://www.dhs.state.il.us/page.aspx?item=72408>

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 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 237115384002	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

Common Reasons:

- The consumer is not currently Medicaid enrolled.
- The provider did not respond to a request for additional information.
- The request was not received within the required timeframe.
- The requested activity is not consistent with Rule 59 IL Admin Code 132.

You will receive a call informing you that the request has been administratively denied as well as a letter which will outline the steps for an appeal.

If a consumer does not meet the Medical Necessity Criteria (MNC) found through this link: (<http://www.dhs.state.il.us/page.aspx?item=72408>), the clinician will notify the provider as to why the consumer does not meet criteria and will explain the next steps:

- First, the clinician will offer an option to negotiate a decreased amount of units or a shorter authorization period, so the discharge/transition plan may be enacted.
- Next, if no agreement is reached after negotiation, the clinician will present the consumer's clinical information to an Illinois Board Certified Psychiatrist for a determination at a **Second Level Review**.
- If the psychiatrist denies the authorization request because the consumer does not meet MNC, you have the right to ask for a **Reconsideration Request** within 30 days.
 - With a Reconsideration Request, you can submit additional clinical information to be reviewed by a different Illinois Board Certified Psychiatrist.
- If the second psychiatrist upholds the decision made by the first psychiatrist, you have the right to request a **DMH Secretary Appeal Review**.
 - With a **DMH Secretary Appeal Review**, you must make a request in writing to the DMH Appeal Coordinator within 5 days of the receipt of the Reconsideration Request denial letter.
 - Additional clinical information or documentation may not be sent with the appeal request as this appeal determines if the appropriate policies were followed in the Second Level Review as well as the Reconsideration Request.

You will receive a call from the clinician on the day the determination is made explaining the process and the next steps. You will also receive a letter of denial within 5-7 business days.

Technical Issues

- EDI Help Desk **(888) 247-9311**, and select **Prompt “1”**
- **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



QUESTIONS & ANSWERS

**Thanks for your
participation**

