Utilization Management Program Request for Services Process

Presenters

Sue Kapas, Clinical Quality Assurance Advisor

Callie Lacy, Clinical Supervisor

Summary

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

The Process

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**

T/C, CSG, PSR

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

SUBMISSION METHOD
FOR AUTHORIZATION REQUESTS (ACT/CST)

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

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)

- 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 or 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 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 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**
- **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: _____	**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;
☐ 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

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

Log into ProviderConnect

Welcome to Provider Online Services!

ProviderConnect

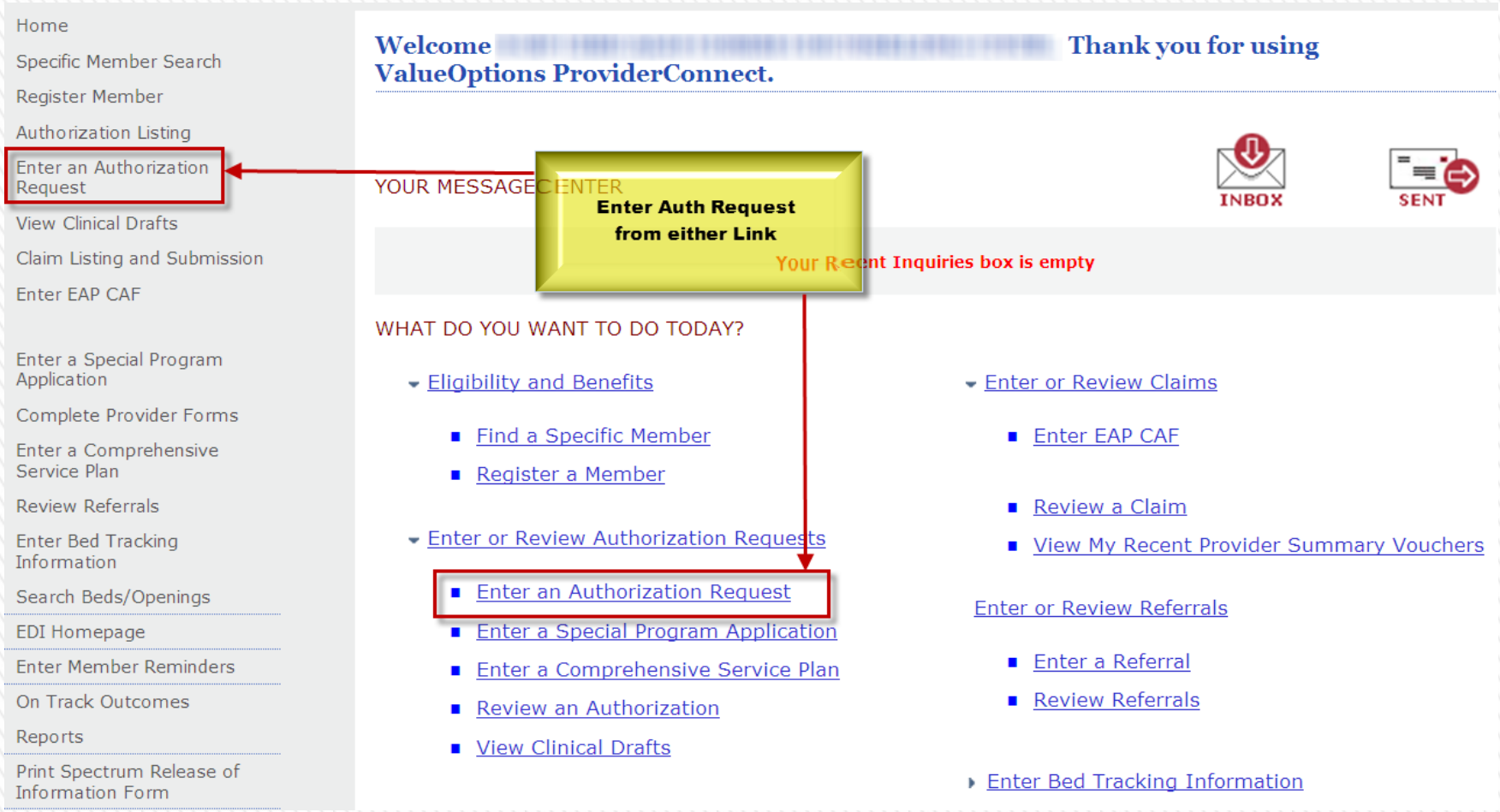
Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7.

LOG IN
REGISTER
DEMO

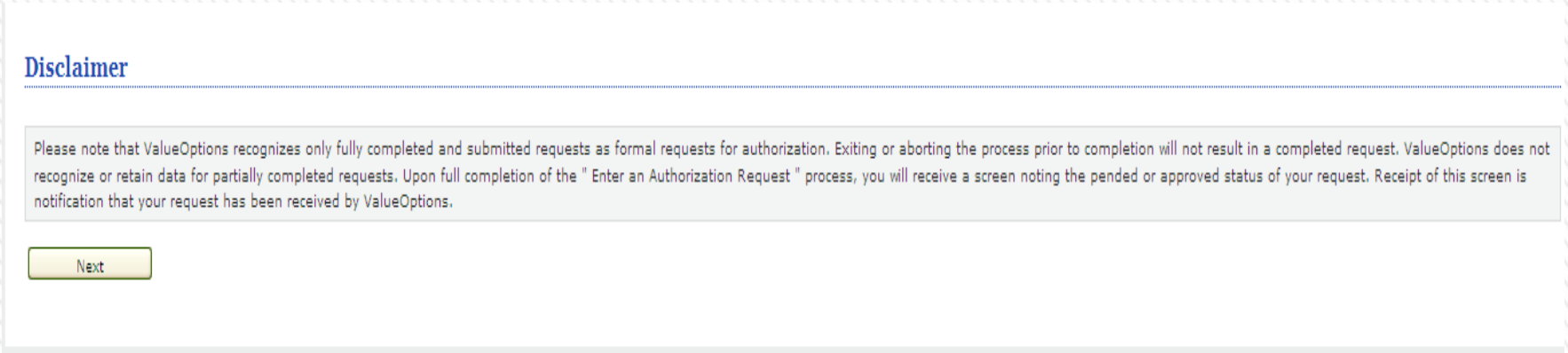
Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

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!

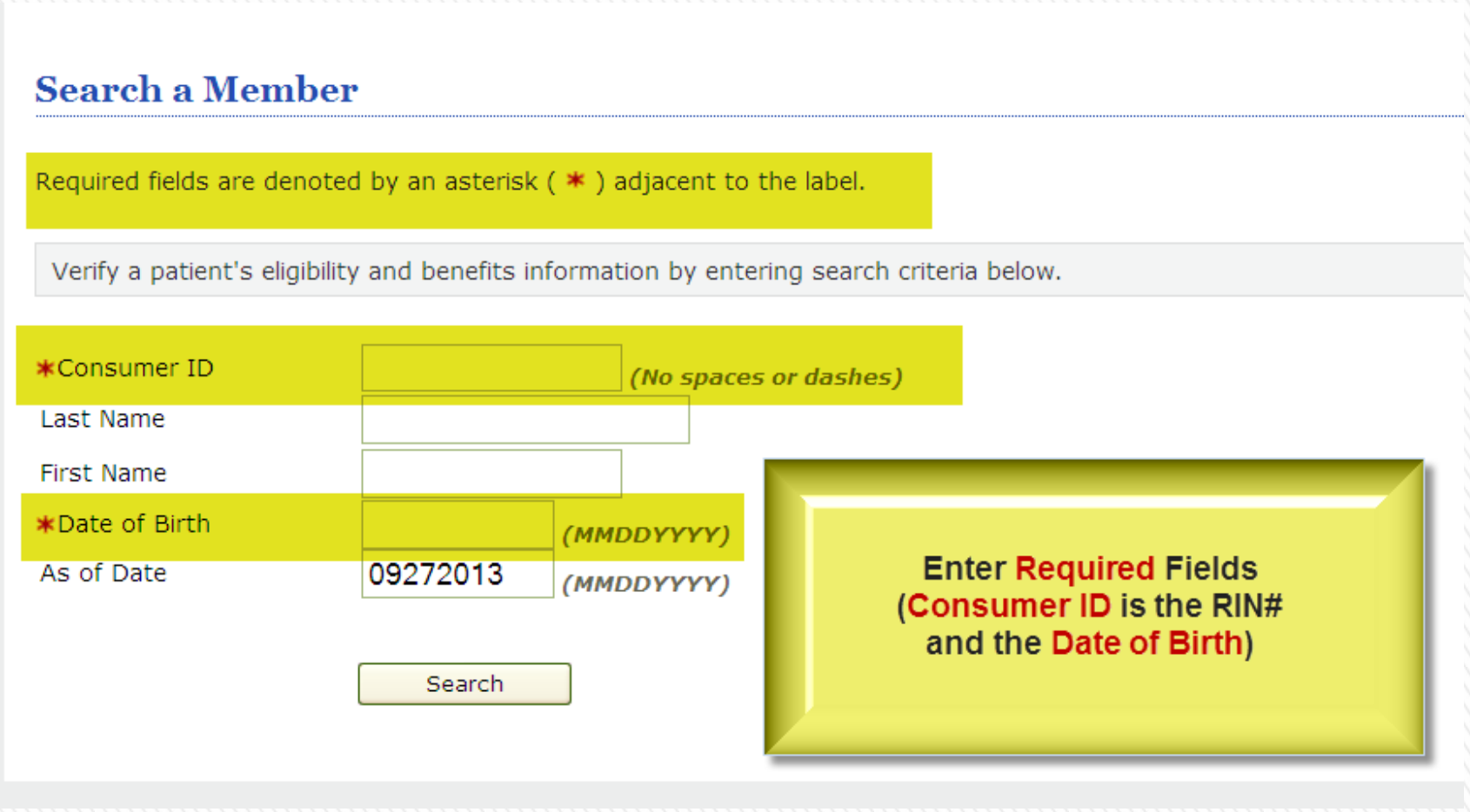
Authorization Request



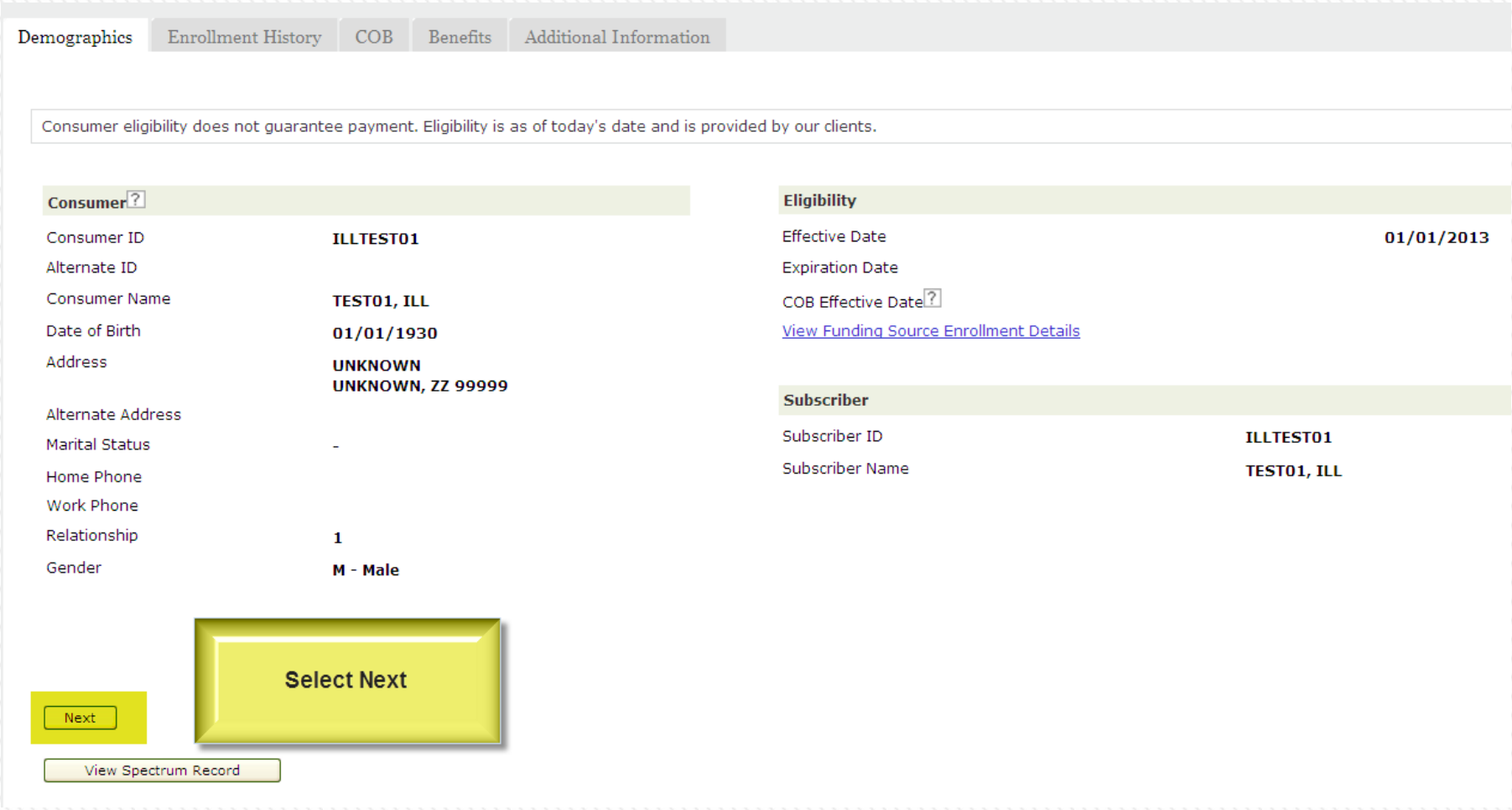
Disclaimer


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

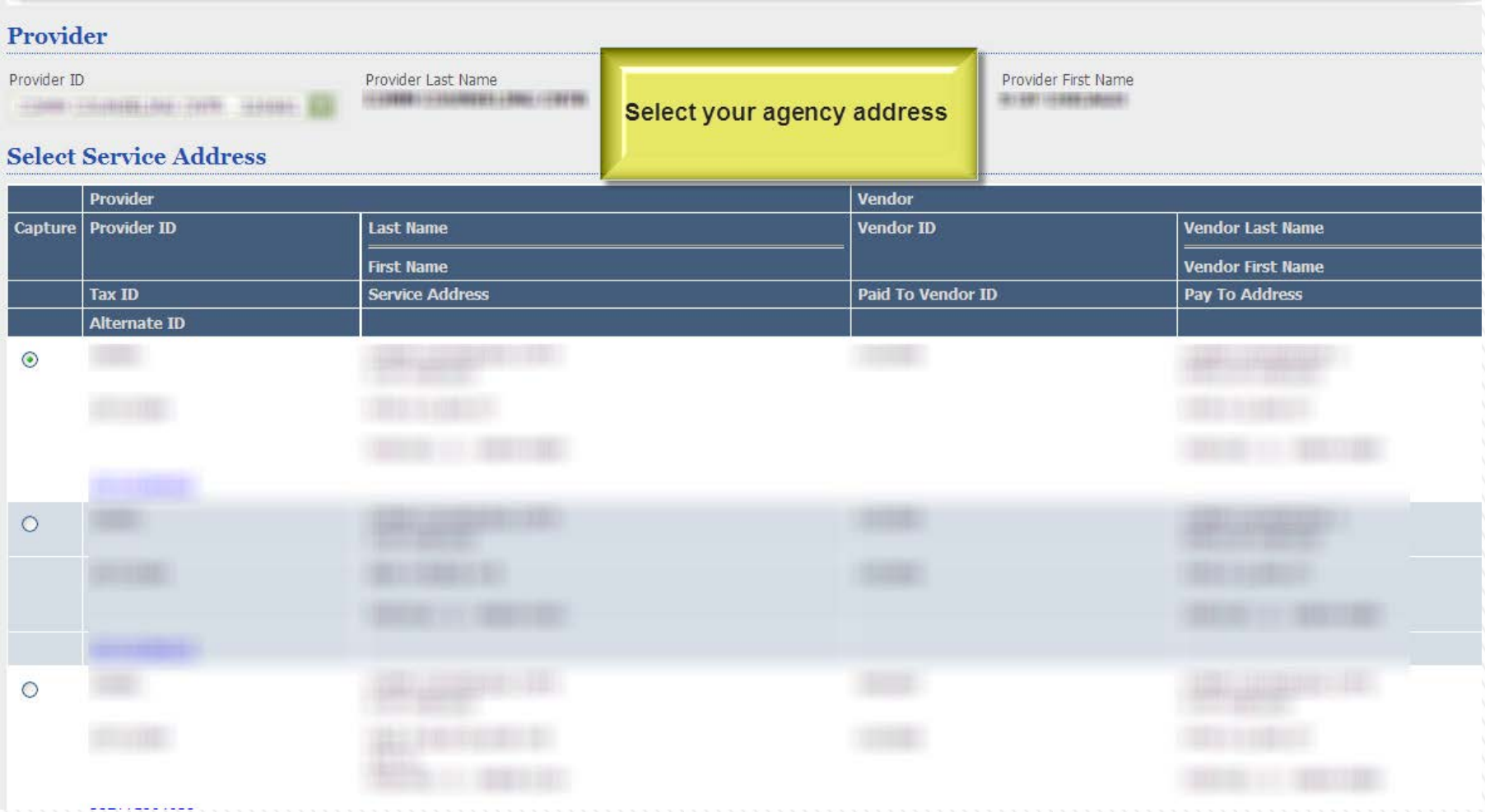
Member Search



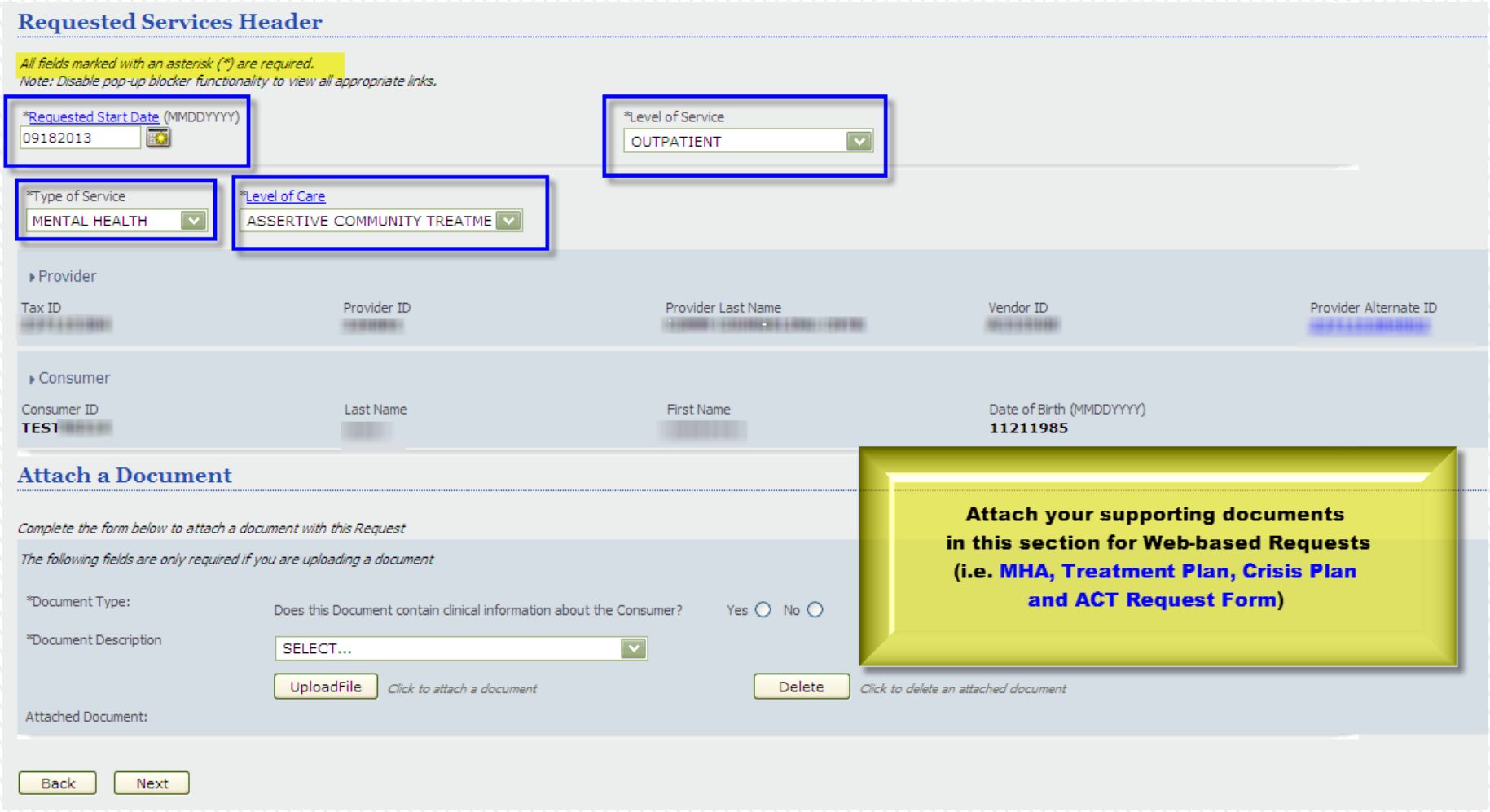
Member Demographics



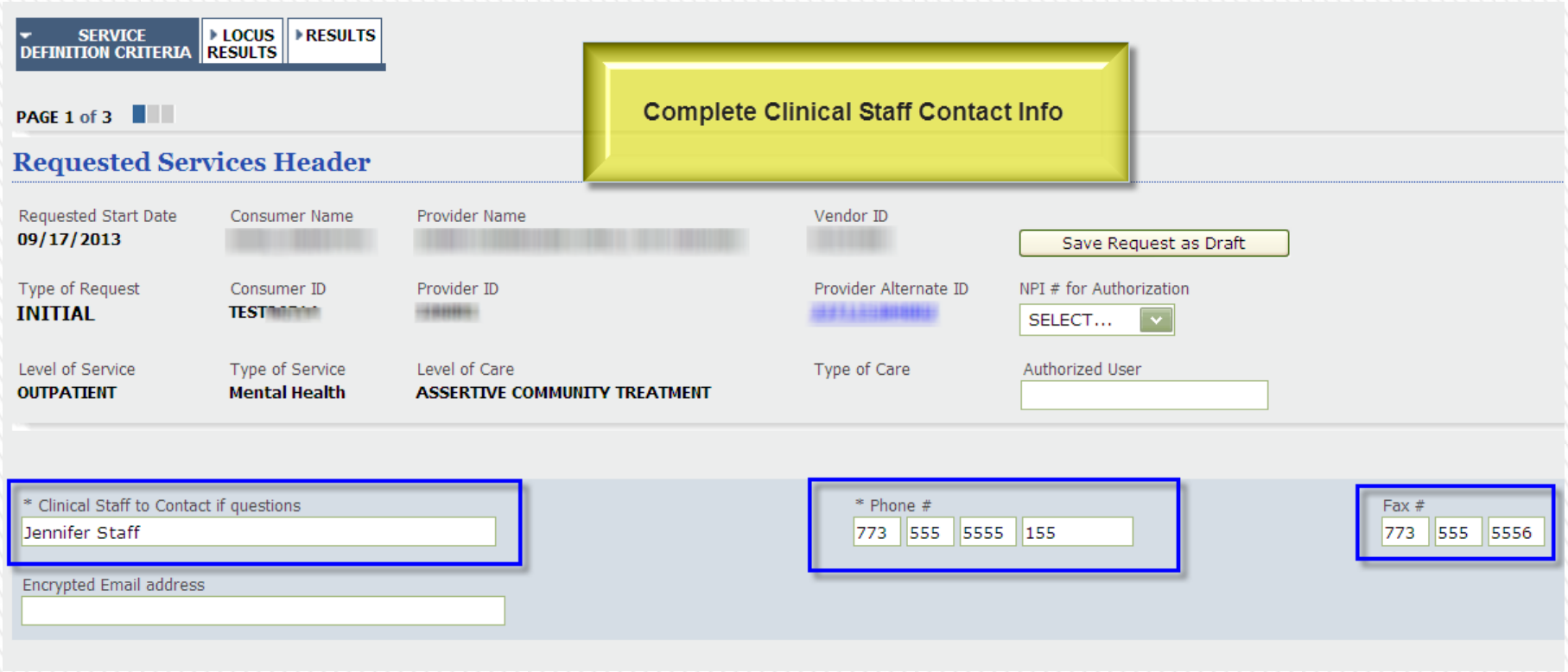
Provider Location



Request Services



Requested Services Header



Service Definition Criteria

Service Definition Criteria

Check all that apply

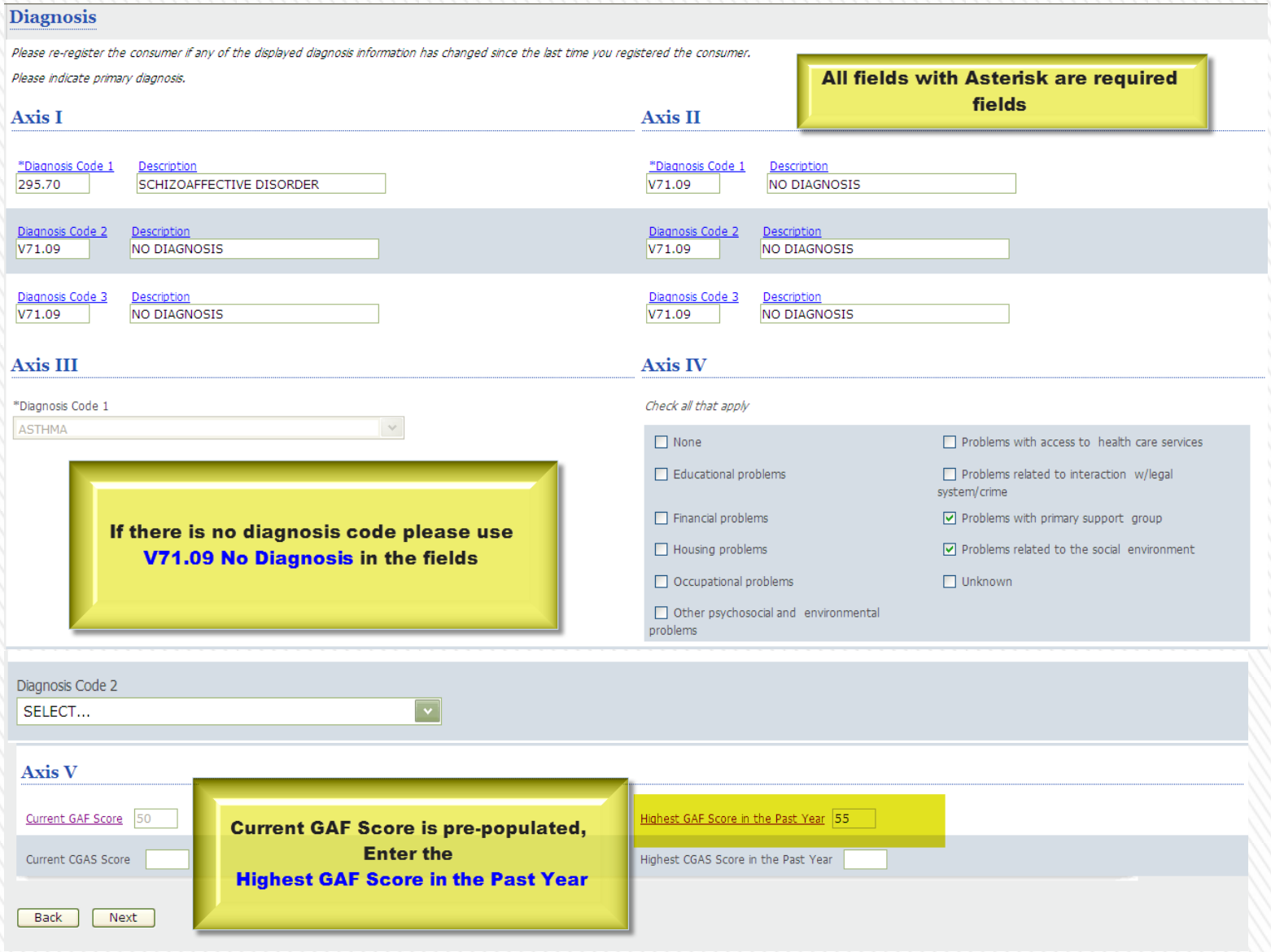
- [x] Excessive use of crisis/emergency services with failed linkages
- [ ] Chronic homelessness
- [ ] Repeat arrests and incarcerations
- [x] Multiple and frequent psychiatric inpatient admissions
- [x] Person has multiple service needs requiring intensive efforts to ensure coordination among systems,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

Acute Inpatient Episodes in the Prior 12 Months

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

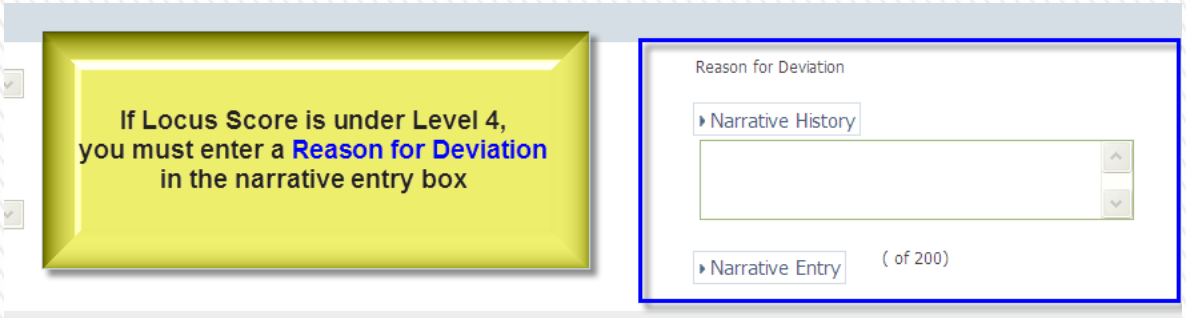
Please select all that apply

Diagnosis

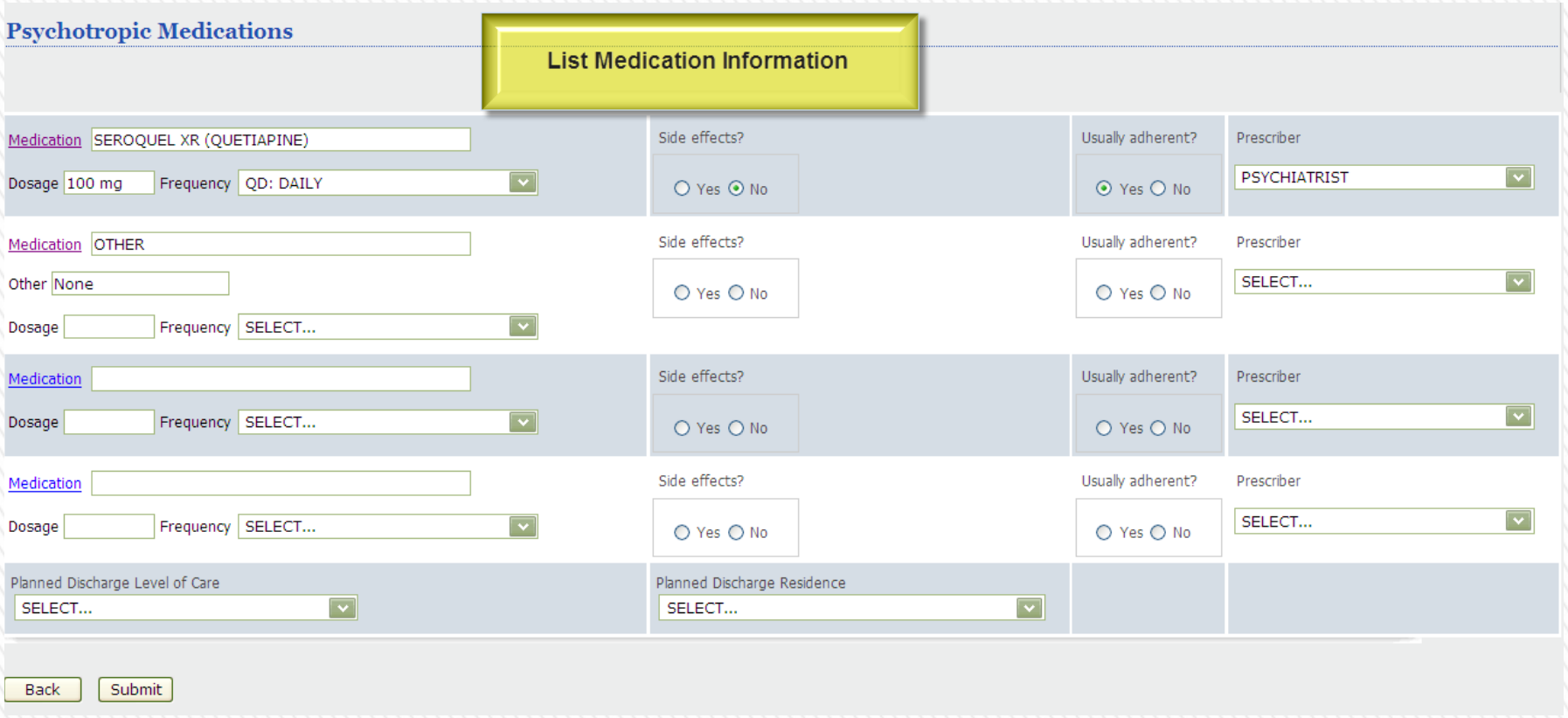

Diagnosis
Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.
All fields with Asterisk are required fields
Axis I
*Diagnosis Code 1
295.70
Description
SCHIZOAFFECTIVE DISORDER
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis II
*Diagnosis Code 1
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Diagnosis Code 3
V71.09
Description
NO DIAGNOSIS
Axis III
*Diagnosis Code 1
ASTHMA
If there is no diagnosis code please use V71.09 No Diagnosis in the fields
Axis IV
Check all that apply
None
Educational problems
Financial problems
Housing problems
Occupational problems
Other psychosocial and environmental problems
Problems with access to health care services
Problems related to interaction w/legal system/crime
Problems with primary support group
Problems related to the social environment
Unknown
Diagnosis Code 2
SELECT...
Axis V
Current GAF Score
50
Current CGAS Score
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
3
Functional Status
3
Co-morbidity
3
Recovery - Environment Stressors
3
Recovery - Environment Support
3
Recovery and Treatment History
3
Acceptance and Engagement
3
Composite score
21
LOCUS Recommended Level of Care
IV-MEDICALLY MONITORED NON-RES. SRVS (20-22)
Assessor Recommended Level of Care
IV-MEDICALLY MONITORED NON-RES. SRVS (20-22)


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

Medications



Determination Status

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
	TEST	11/21/1985		TEST

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

Shows Printing & Download Options

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
			N/A

Attached Documents

Document Title | There are no documents attached with this Authorization Request (Document Description)

Authorization Printing & Downloading Options:

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

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

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 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 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

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

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, request is authorized by 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 provider believes medical necessity is present, the CCM will forward 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

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

Log into ProviderConnect

Welcome to Provider Online Services!

ProviderConnect

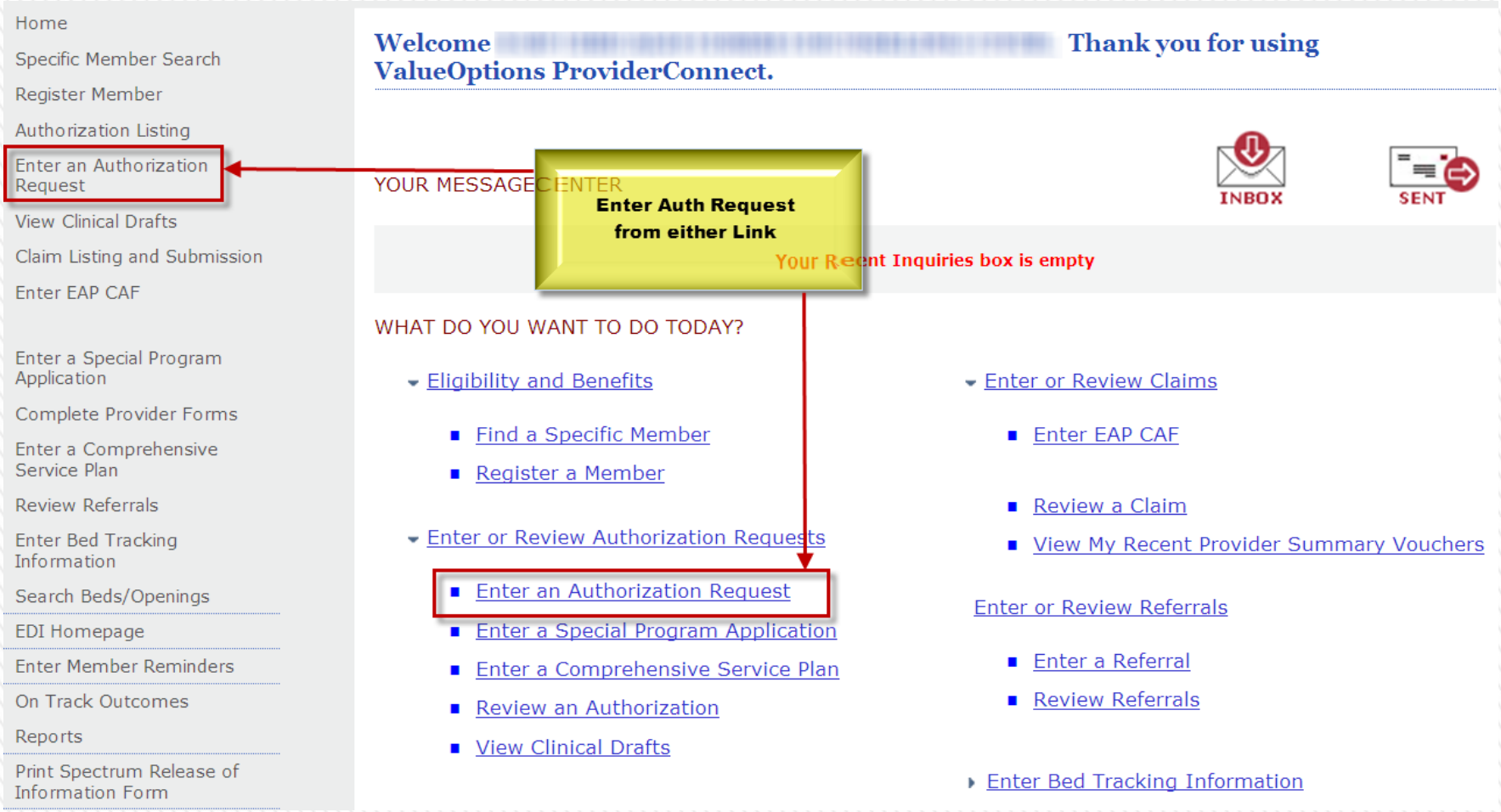
Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7.

LOG IN
REGISTER
DEMO

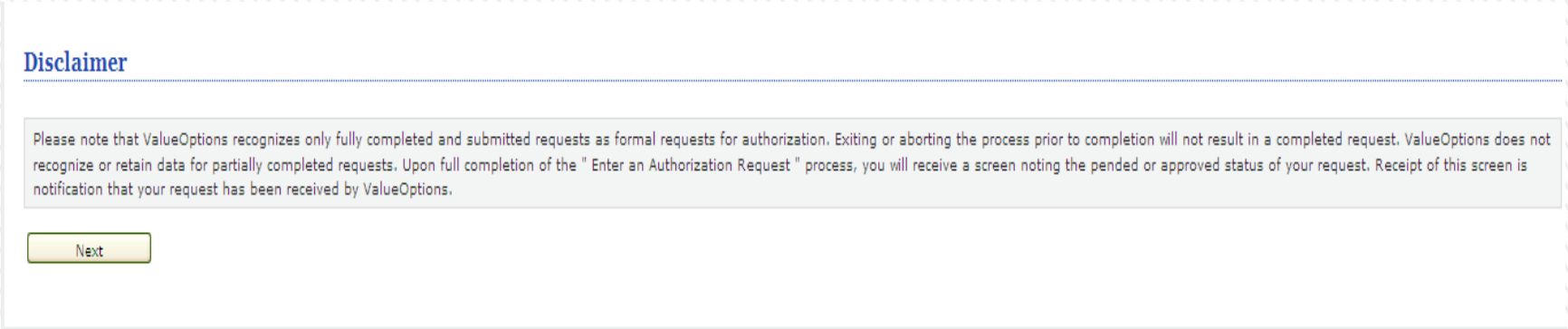
Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

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!

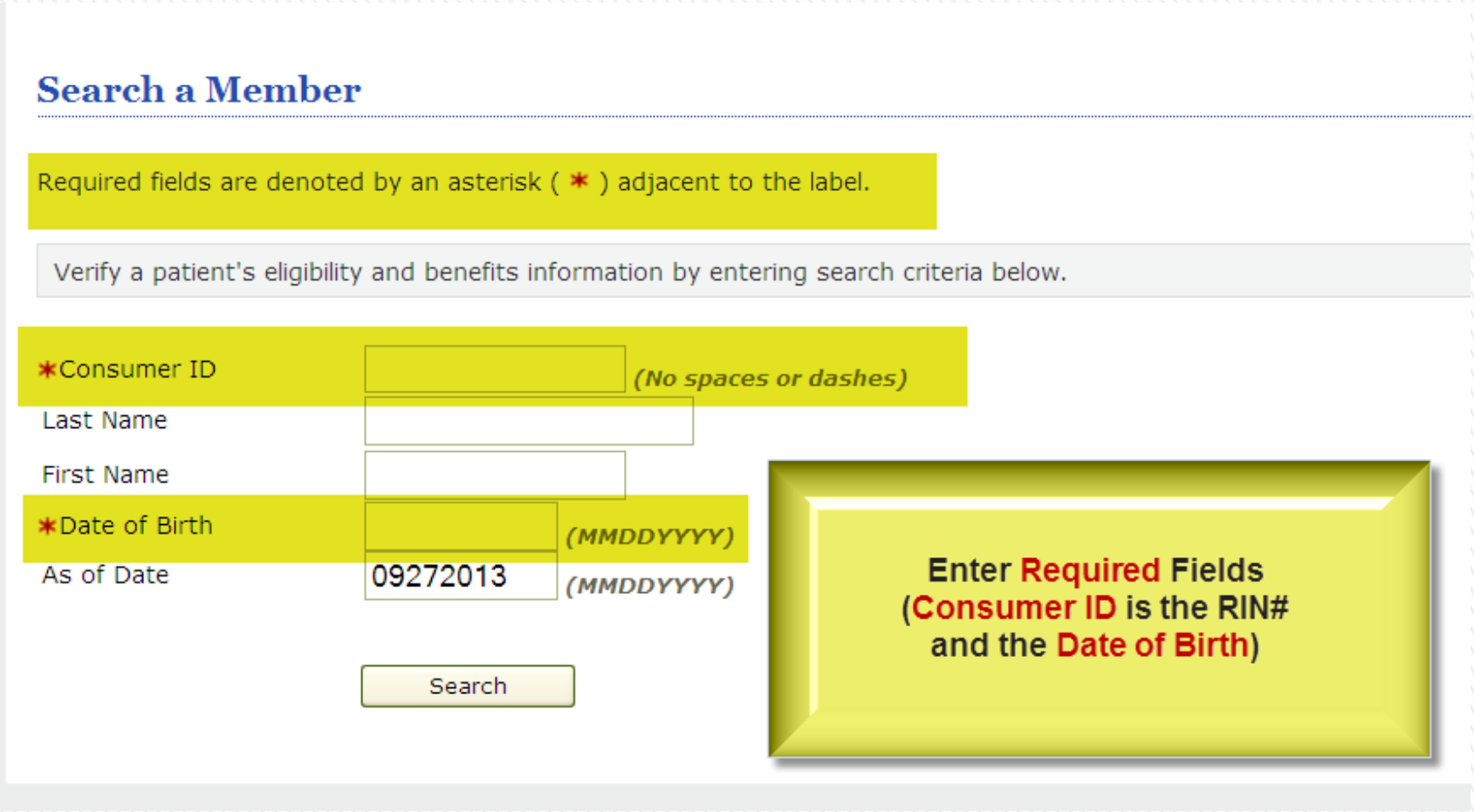
Authorization Request



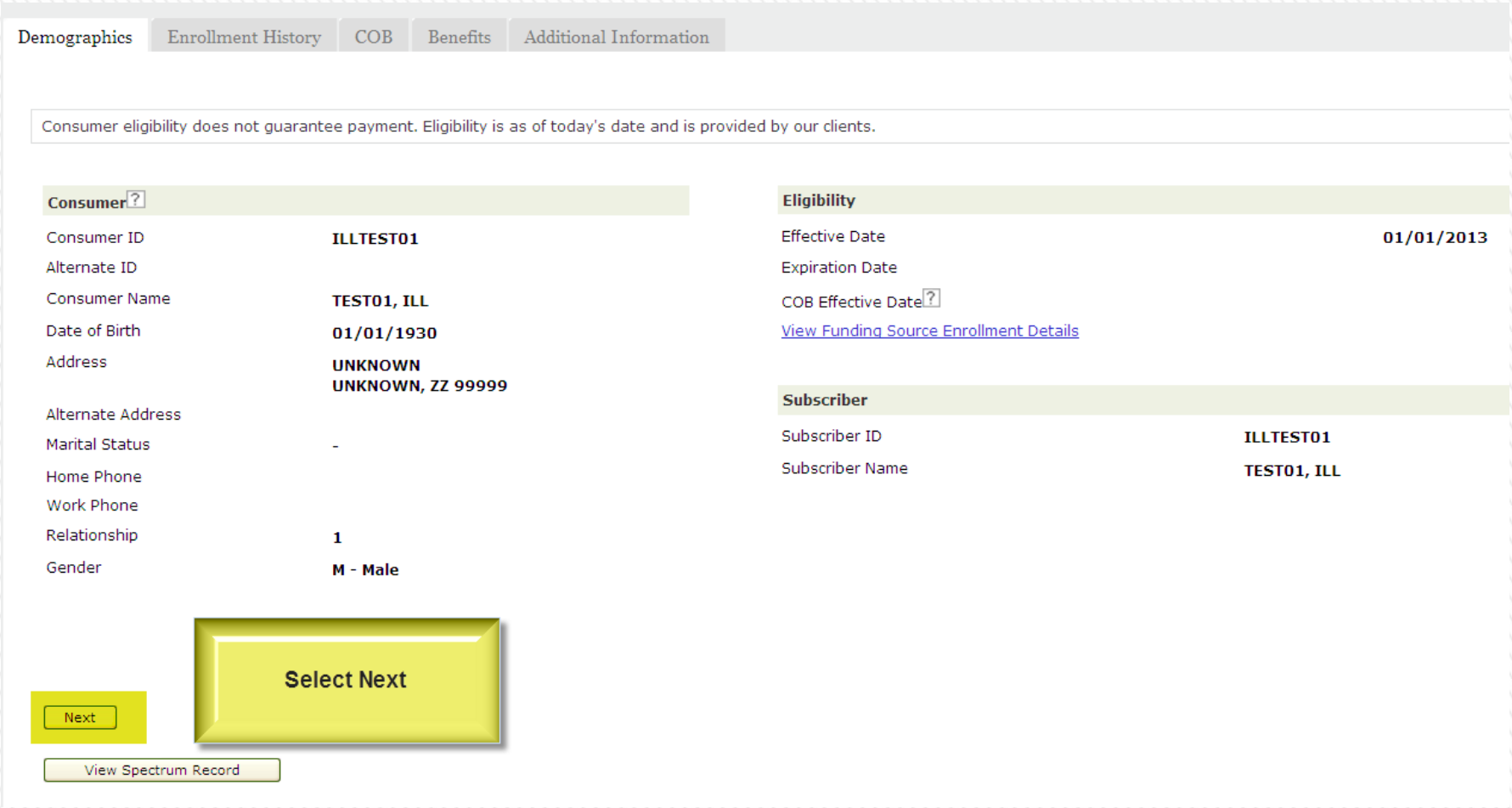
Disclaimer


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

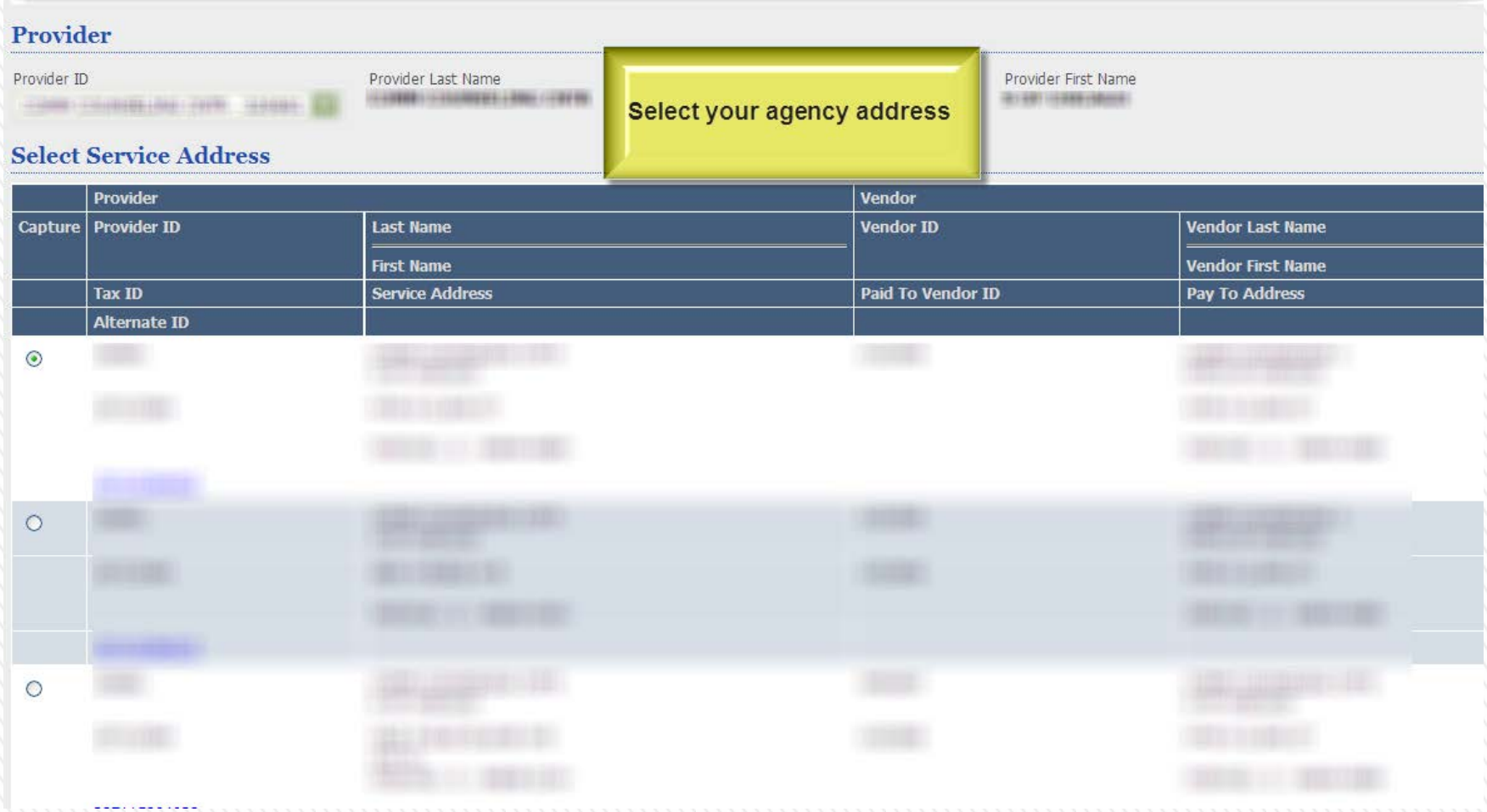
Member Search



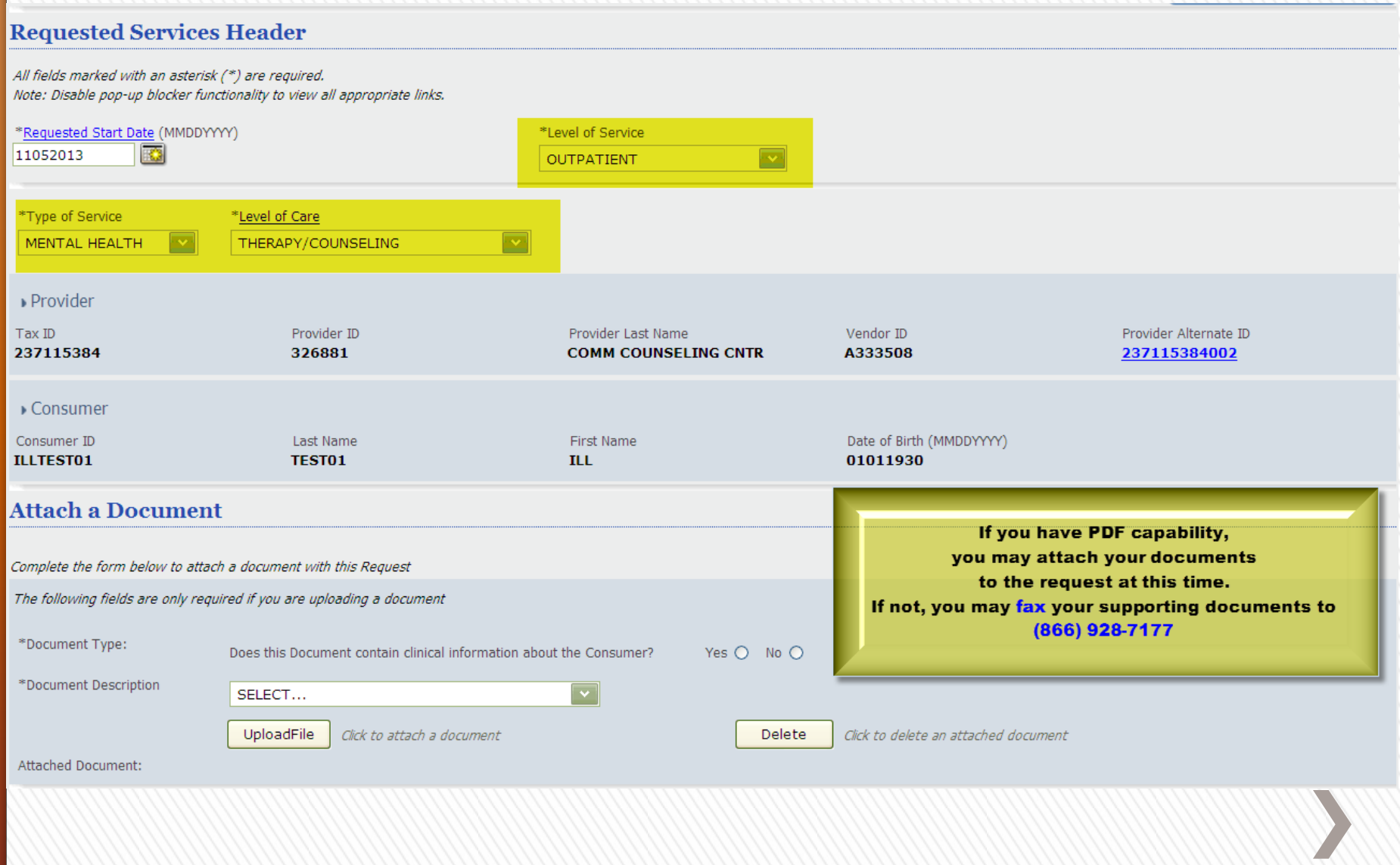
Member Demographics



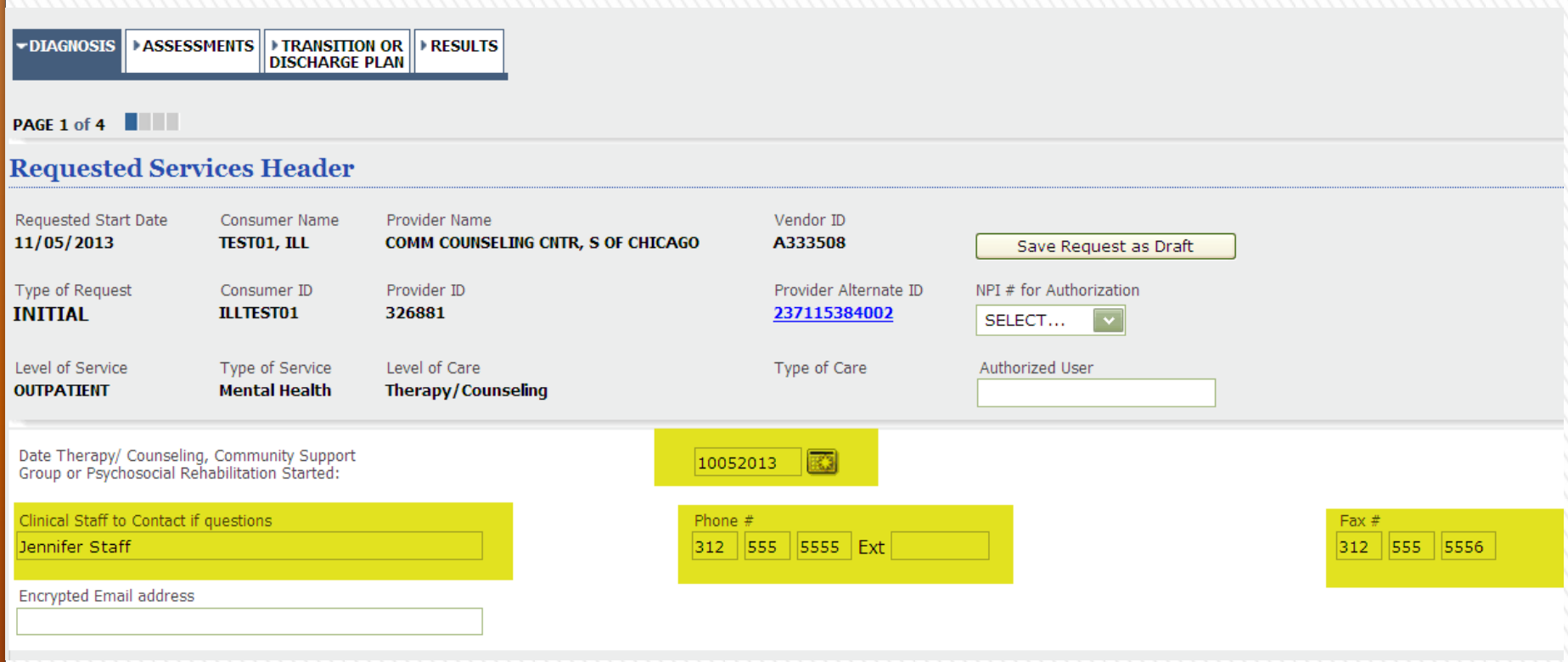
Provider Location



Requested Services Header



Request Services Continued



Diagnosis

Diagnosis

Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.

Please indicate primary diagnosis.

Axis I

*Diagnosis Code 1	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 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

DIABETES

Select V71.09 No Diagnosis for any blank codes

Axis IV

Check all that apply

- [ ] None
- [ ] Educational problems
- [ ] Financial problems
- [ ] Housing problems
- [ ] Occupational problems
- [x] Other psychosocial and environmental problems
- [ ] Problems with access to health care services
- [ ] Problems related to interaction w/legal system/crime
- [x] Problems with primary support group
- [ ] Problems related to the social environment
- [ ] Unknown

Diagnosis Continued

Diagnosis Code 2

SELECT...

Axis V

Current GAF Score 30

Highest GAF Score in the Past Year 40

Current CGAS Score

Highest CGAS Score in the Past Year

Psychotropic Medications

1. Medication	Description	Side effects?	Usually adherent?	Prescriber
ZOLOFT	Zoloft (Sertraline)	○ Yes ◉ No	◉ Yes ○ No	PSYCHIATRIST

Dosage 75mg Frequency BID: TWICE DAILY

Is medication found to be effective? ○ 0 ○ 1 ◉ 2 ○ 3 ○ N/A

2. Medication	Description	Side effects?	Usually adherent?	Prescriber
		○ Yes ○ No	○ Yes ○ No	SELECT...

Dosage Frequency SELECT...

Is medication found to be effective? ○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

LOCUS

LOCUS Results

Please re-register the consumer if any of the displayed LOCUS information has changed since the last time you registered the consumer.

Functional Impairment Domain Scores Note: Locus Results information should be populated for Adult Consumers.

Risk of Harm	2	Recovery Environment - Environmental Stressors	2
Functional Status	2	Recovery Environment - Environmental Support	2
Co-morbidity	2	Recovery And Treatment History	2
		Acceptance and Engagement	2
Composite Score	14		

LOCUS Recommended Level of Care

II-LOW INTENSITY COMMUNITY BASED SERVICES (14-16)

Assessor Recommended Level of Care

II-LOW INTENSITY COMMUNITY BASED SERVICES (14-16)

Reason for Deviation

Narrative History

Narrative Entry (of 200)

Ohio Scale Results

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

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

Devereaux Scale Results

DECA Subscale (For children under the age of 3)

Protective Factor Scores

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

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

Protective Factor Scores

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

Behavioral Concerns

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

Required Documents

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

Attached	Faxed	N/A	
◉	○		Mental Health Assessment dated within the past year.
◉	○		Individual Treatment Plan dated within past six months.
◉	○	○	Mental Health Assessment Update, if indicated.
◉	○	○	Other clinical documentation supporting medical necessity.

Service Requested

Requested Services Header

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

Services Requested

	Start Date	End Date	Number of Units
☑ Therapy/Counseling - Individual	11052013	06302014	200
☐ Therapy/Counseling - Group			
☐ Therapy/Counseling - Family			

Transition or Discharge Plan

* Is there a written plan to facilitate the consumer's transition to alternative services or to terminate service provision altogether?	(•) Yes ( ) No
* Has the consumer/guardian been involved in the discharge/transition planning?	(•) Yes ( ) No
* If the consumer will transition to alternative services, have treatment resources been identified and contacts made to coordinate discharge/transition planning?	( ) Yes (•) No ( ) N/A

If yes, please provide the following information:

Provider Name	Appointment Date	Services Planned
Provider Name	Appointment Date	Services Planned

* How many days until anticipated discharge or transition to alternative services?	240
* If the consumer will not need continuing services, have natural community supports been identified and has the consumer been assisted in accessing them?	( ) Yes (•) No ( ) N/A
*Does the individual have a current Crisis Plan and understand how to access the services and supports included in it?	(•) Yes ( ) No ( ) N/A

* Barriers to Discharge
Check all that apply.

- [x] Consumer is not meeting criteria for lower level of care or discharge
- [ ] Transitional services not identified or not available
- [ ] Community resources not identified or difficult to obtain
- [ ] Consumer/guardian/family not engaged/participating in care or transition planning

* Describe plan to overcome barriers to discharge:
Please provide updates for ongoing requests, as needed.

Narrative History

Narrative Entry (15 of 2000)

Enter Info Here

In the Narrative, please enter the following:

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

(Per Rule 132 Medical Necessity Criteria)

Determination Status

Determination Status: ********** **PENDED** **********

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

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

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

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

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

Reason Code

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**

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

Administrative Denial

If the consumer does not have Medicaid:

You will receive a call from the clinician that is processing your request for services, informing that your request has been administratively denied due to not having Medicaid enrollment in our system. At that time you will be instructed to re-submit the request with a Medicaid eligible RIN.

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

Requests 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
- Appeal request must be received within 30 days of receipt of the denial
- Two levels of appeals:
  - Internal Physician Advisor (PA)
    - not the same PA who issued the denial
    - not a subordinate of the original PA who issued the denial
    - Licensed to practice in Illinois
  - External review by an independent reviewer
- Third Level of appeal to DHS/DMH per established procedures.

DMH Director's Review

DMH Director's review:

- **If the provider, consumer, or designated representative disagrees with the outcome of the Reconsideration request, an Appeal may be filed within 5 days of receipt of the outcome of the reconsideration request.**

- **This review shall not be a clinical review, but rather a 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 ???

Thanks for your participation