ValueOptions® Presents:
The Colorado Medicaid Community Mental Health Services Program: Clinical Authorizations

Presenters:
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Agenda

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Agenda

- Welcome and Introductions
- Behavioral Health Organization Partnerships
- General CO Medicaid information
- Authorizations:
  - Outpatient
  - Inpatient
  - Day Treatment
  - Residential

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Behavioral Health Organization Partnerships

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Behavioral Health Organization Partnerships

- Colorado Health Partnerships (CHP)

- Foothills Behavioral Health Partners (FBHPartners)

- Northeast Behavioral Health Partnership (NBHP)

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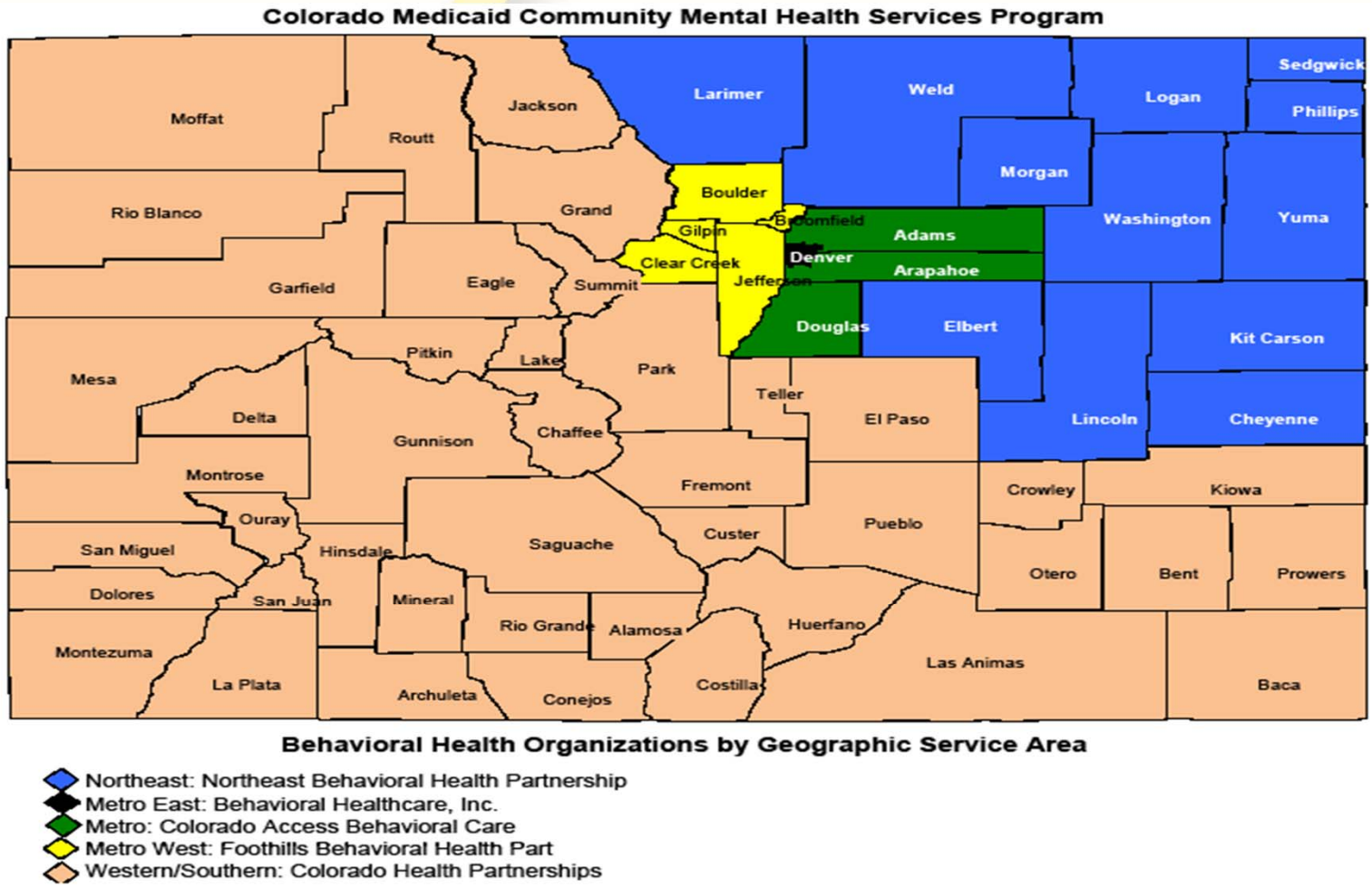
Behavioral Health Organizations by Geographic Area



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VO Clinical Department – Contacts

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- Oversight of call center, inpatient authorization process, supervision of Care Managers, Coordination of care with partner Mental Health Centers

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- Oversight of all outpatient authorizations and Single Case Agreements
- Oversight of residential and Day Treatment services

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General authorization information

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Eligibility

The first step in the authorization process is determining member eligibility and assuring that they are assigned to our Behavioral Health Organization.

If you have any questions about eligibility, please call us to discuss. Our staff can check the CO Web Portal to determine eligibility if you have questions. Please be prepared to provide the following information about the member:
Medicaid number, SSN, DOB, First and Last Name

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CAUTION:

All authorizations are dependent on Medicaid Eligibility at the time the claim is presented for payment. Claims cannot be paid if a member is ineligible. For eligibility problems, the member would need to contact their local Department of Human Services.

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BENEFIT LIMITS

All members (age 21 and older) have the following benefit limits,per fiscal year. Fiscal year runs July 1st-June 30th

Outpatient: 35 individual sessions

Inpatient: 45 days

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Outpatient authorizations expire six month from the effective date OR when the authorized units are exhausted. Keep track of the number of units you used so you know when to contact us to request additional sessions. It is the responsibility of the provider to keep track of when additional authorization is required.

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Outpatient Authorizations

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Traditional Outpatient Services (1)

- **Fiscal Year Benefit Limit**—Adults 35 sessions per fiscal year; includes individual and brief individual therapy.
- **Covered and uncovered diagnoses**—common exceptions; see Resources
- **Retro-Authorizations**—CSAs can retro-authorize services up to 30 days; more than 30 days requires approval of Clinical Peer Advisor
- **Single case agreements**—SCAs are infrequently granted to non-network providers, when clinically justified. They must be approved by the Clinical Peer Advisor. Typical reasons for SCA approval would be: geographic access; continuity of care; clinical specialty that is not available in network and/or in member's area.
- **Members who are 5 years old or younger**—VO/FBHP/NBHP/CHP will authorize up to (4) 90801 services to allow thorough assessment of member and family; additional sessions will require the submission of a treatment plan. In most cases, treatment should include family therapy.

Traditional Outpatient Services (2)

- Enhanced Clinical Management (ECM)—The ECM process combines elements of utilization management and quality improvement. It is a way of looking at practice patterns to identify potential risks and to direct improvement.
    - ECM1—Adults with depression diagnosis, 6 months or more in treatment, no indication of medication evaluation
    - ECM2—Children and adolescents with Adjustment Disorder diagnosis, 6 months or more in treatment, no diagnosis change
    - ECM3—Youth with hospital readmission within 30 days of inpatient discharge who did not have 3 or more face-to-face contacts between admissions
- A note about audits and other expectations—It is our expectation that providers will comply swiftly and completely with any requests for clinical records; these records may be part of quality of care processes, fraud or abuse investigations, encounter verification audits, grievance reviews, etc.

Provider Authorizations - Outpatient

There are two main ways for a contracted provider to obtain an outpatient authorization for a member:

1) **Online: Provider Connect- our interactive web based authorization system**

2) **TeleConnect- our interactive voice response system**

3) **Providers encountering difficulties with Provider Connect or TeleConnect during the authorization process can opt out to talk with a VO staff person for assistance**

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Provider/TeleConnect Authorizations

- Access Provider Connect at www.valueoptions.com
- Go to the Provider Tab
- On the right hand side, you will be able to log in.
- OR: Call 888 556 6211 for TeleConnect:
- To obtain an authorization, you will need to have the following information available:
  - Your log in name and password
  - Member ID
  - Date of Birth
  - Requested start date of authorization
  - Level of Service (note- this will always be OUTPATIENT)
  - Type of Service (note- this will always be MENTAL HEALTH)
  - Answer questions about disability, treatment planning, medical conditions
  - Date member contacted you for appt and date you offered appt
  - Axis I diagnosis
  - CPT code for services to be provided and number of sessions requested
  - Place of service – where services will be provided

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Provider/Tele Connect Authorizations

- After all information is entered, you will receive either an authorization number, with number of units authorized and the date range for the authorization

OR

- You may receive a message that the case needs further review and that you will be contacted by a staff member to review the case. You will be contacted within 1-2 business days to resolve the authorization question

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Provider Connect/Tele Connect- tips

- Authorizations may be requested for start dates 30 days prior to today's date or 30 days in the future.
- Reasons authorizations may not be given immediately or require further review:
  - Member is under age 5 (needs treatment plan reviewed prior to auth)
  - Axis I diagnosis is not covered
  - Date of requested service is outside the auth timeframe
  - Authorization is on file for another provider (you may receive 2 sessions in this case)
  - Your prior authorization for member is not yet exhausted

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ProviderConnect Overview

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ProviderConnect *(Provider Online Services)*

- **What is ProviderConnect?**
- **ProviderConnect is an online tool where providers can:**
  - Verify Member eligibility
  - View Authorizations
  - Request Authorizations
  - Submit Claims
  - View Claim Status
  - Access Provider Summary Voucher
  - Access and Print Authorization Letters
  - Submit inquiries to Customer Service
  - Submit updates to provider demographic information
  - Access and print forms
- ***Increased convenience & decreased administrative burden!***

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ProviderConnect Benefits

- **What are the benefits of ProviderConnect?**

- Free, online, secure application
- Easily access routine information 24 hours a day, 7 days a week
- Complete multiple transactions in a single sitting
- View and print information
- Reduce calls for routine information

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How to Access ProviderConnect?

- All In Network providers will be able to obtain online registration per provider ID number via the website
- To obtain additional logons for ProviderConnect – contact the ValueOptions® EDI Helpdesk at (888) 247-9311 and press option 3, Monday thru Friday, 8a.m. – 6 p.m. EST
  - The turn around time for additional logons is 48 hours

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How to Access ProviderConnect?

Access thru: www.valueoptions.com
within the provider section of
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Inpatient Authorizations

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Provider Authorizations-Inpatient

- VO partners with the local Community Mental Health Centers who must either assess member themselves prior to admit or approve VO to receive clinical information directly from the hospital to use in determining authorization

- IP hospitals- to start the authorization process, contact a VO Care Manager at:
  - **CHP: (800) 804-5008**
  - **FBHPartners: (866) 245-1959**
  - **NBHP: (888) 296-5827**
  - ***Care Managers are available 24 hours and seven days a week, including holidays***

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Provider Authorizations- Inpatient (cont.)

- The Care Manager will either:
  - Refer you to the local Mental Health Center (MHC) so the MHC can send out an evaluator . The evaluator will assess the member and call VO to obtain authorization for you. The MHC will provide you with an authorization number, or let you know if the case was sent to peer review.

OR

-- Take clinical information telephonically that you provide from your assessor, and confer with the Mental Health Center staff member to make an authorization decision.

  - Note: ** If you already have the name and phone number of your local Mental Health Center, you may call them directly to arrange for their assessor to come and evaluate the member.

    If you do this, we recommend that you still call VO to notify us of a pending admit, and that you have contacted the MHC.

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Authorization Outcomes-

- When you request an authorization, your request will either be approved and you will receive an authorization number, number of days approved, and next review date

OR

- The member may be approved for a lower level of care, and the MHC staff representative will help coordinate admission to the other level of care (such as ATU).

OR

- Authorization may be denied. Note: Clinical denials can only be issued by our Medical Director- Care Managers or MHC staff may not deny care. If authorization is denied, the VO Care Manager has reviewed the case with the M.D. They will offer you a peer to peer review- your doctor can speak with our MD within 24 hours of the initial denial decision.

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Provider Authorizations- Inpatient (cont.)

- Whether an assessor comes out to evaluate the member or the Care Manager takes clinical information telephonically from you varies from region to region. The VO Care Manager will know how this is handled for the region your member is from. The region the member is from is what dictates the process of evaluation and authorization.

- You can always call the VO Care Manager to assist you with process if you are unsure. They are available 24/7, including all holidays

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Authorizations- Inpatient- Concurrent and Coordination of Care

- Initial authorizations expire on the last day authorized.
- The hospital is responsible to call VO to request additional days on the last day authorized
- Coordination of care is required on every case, with the MHC staff member assigned to the area the member is from.
- If you are unsure who the MHC staff person is, please call VO and we can assist you.
- The MHC staff will need information about clinical needs so they can help create a successful discharge plan for our member
- The VO Care manager will use clinical information you provide to make an authorization decision for continued care.
- If Coordination of Care is not taking place as required, the VO Care manager may enter an administrative denial .

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Administrative Denials

- If a scheduled concurrent review is missed because a provider did not call or if an initial hospital request is made AFTER the day a member admitted, and the VO Care manager may enter an administrative denial.
- An Administrative Denial is a denial that is entered due to policies/procedures not being followed correctly by a provider. The care is denied due to an administrative problem, not related to the member's clinical presentation
- There is no appeal for administrative denials.

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Inpatient Retroactive authorizations

- (Most commonly care provided is inpatient for retro authorization)
- In some cases, due to the member's clinical presentation, they may not be able to provide you with accurate insurance information at the time care was provided, so the member may have active Medicaid on admission, but they cannot provide information, so you may not find out until after they are admitted. In these cases, we would consider a request for retroactive authorization.

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Inpatient Retro authorization-continued

- At other times, care may be provided when a member did not have active Medicaid.
- If this happens, if the member does become active with Medicaid at a later date, you may request a retro authorization for care that has already been provided
- Retro authorizations are given based on a review of the member's clinical chart
- The following details how to request a retro authorization:

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Inpt. Retro authorization- continued

- Send a letter requesting retro authorization and including:
  - Member's name, Medicaid number, DOB, and Dates of Service authorization is requested for
  - Copy of EOB from primary insurance if the member has other insurance (** Medicaid is the payor of last resort and other insurance benefits need to be used prior to Medicaid)
  - Copy of the chart- including: Admission assessments, all doctor's orders, milieu/daily case notes, treatment plan, discharge plan and summary and labwork
  - We will consider the case for retroauthorization based on the clinical information available to you at the time the care was provided.

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Day Treatment Authorizations

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Day Treatment Referrals

•Level of Care Guidelines—Please see BHO websites for current guidelines related to this level of care. These LOC guidelines specify the requirements for admission, continued stay, and discharge.
•Day treatment requires that member/student has a current IEP.
•In most cases, day treatment services are jointly funded by the child's school district and Medicaid.
•Day treatment can be requested by school, provider, or parent.
•Day treatment authorization always requires a separate evaluation that is conducted by the local mental health center.
•Referral can be made directly to the mental health center or to ValueOptions

Residential Authorizations

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Residential Treatment Services

- Level of Care Guidelines—Please see BHO websites for current guidelines related to this level of care. These LOC guidelines specify the requirements for admission, continued stay, and discharge.
- Medicaid does not pay for “room and board” services; only pays for treatment services
- RTC can be requested by provider or parent.
- RTC authorization always requires a separate evaluation that is conducted by the local mental health center.
- Referral can be made directly to the mental health center or to ValueOptions
- Clients with or without Medicaid can access RTC services through the Child Mental Health Treatment Act (CMHTA; aka, HB-1116)

Additional Resources

Resources

- Foothills Behavioral Health Partners (general; handbook; guidelines)
  - www.fbhpartners.com
  - http://www.fbhpartners.com/providers/prv_handbook.htm
  - http://www.fbhpartners.com/providers/prv_information.htm
- Colorado Health Partnerships Partners (general; handbook; guidelines)
  - http://www.coloradohealthpartnerships.com
  - http://www.coloradohealthpartnerships.com/provider/prv_hbk.htm
  - http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm
- Northeast Behavioral Health Partnership Partners (general; handbook; guidelines)
  - http://www.nbhpartnership.com/
  - http://www.nbhpartnership.com/providers/prv_handbook.htm
  - http://www.nbhpartnership.com/providers/prv_handbook_level_of_care_guidelines.htm

More Resources

- BHO Covered Diagnoses
  - http://www.coloradohealthpartnerships.com/provider/handbook/Section13.4_CoveredDx.pdf
- List of BHO Covered Services
  - http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251710359213&ssbinary=true
- List of Community Mental Health Center Partners
  - http://www.cbhc.org/about-us/mhcs/
- List of BHOs
  - http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1212398231156

Question and Answers

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Thank you!

www.chnpartnerships.com

www.fbhpartners.com

www.nbhpartnership.com

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