ValueOptions® Presents:
The Colorado Medicaid Community Mental Health Services Program: Covered Diagnoses, Covered Services and Concurrent Review Processes

Presenters:
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Agenda

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- Welcome and Introductions
- Behavioral Health Organization Partnerships
- General Authorization Information
- Covered Diagnoses
- Common Uncovered Conditions
- Resources for Uncovered Services/Diagnoses
- Covered Services
- Concurrent Review Processes

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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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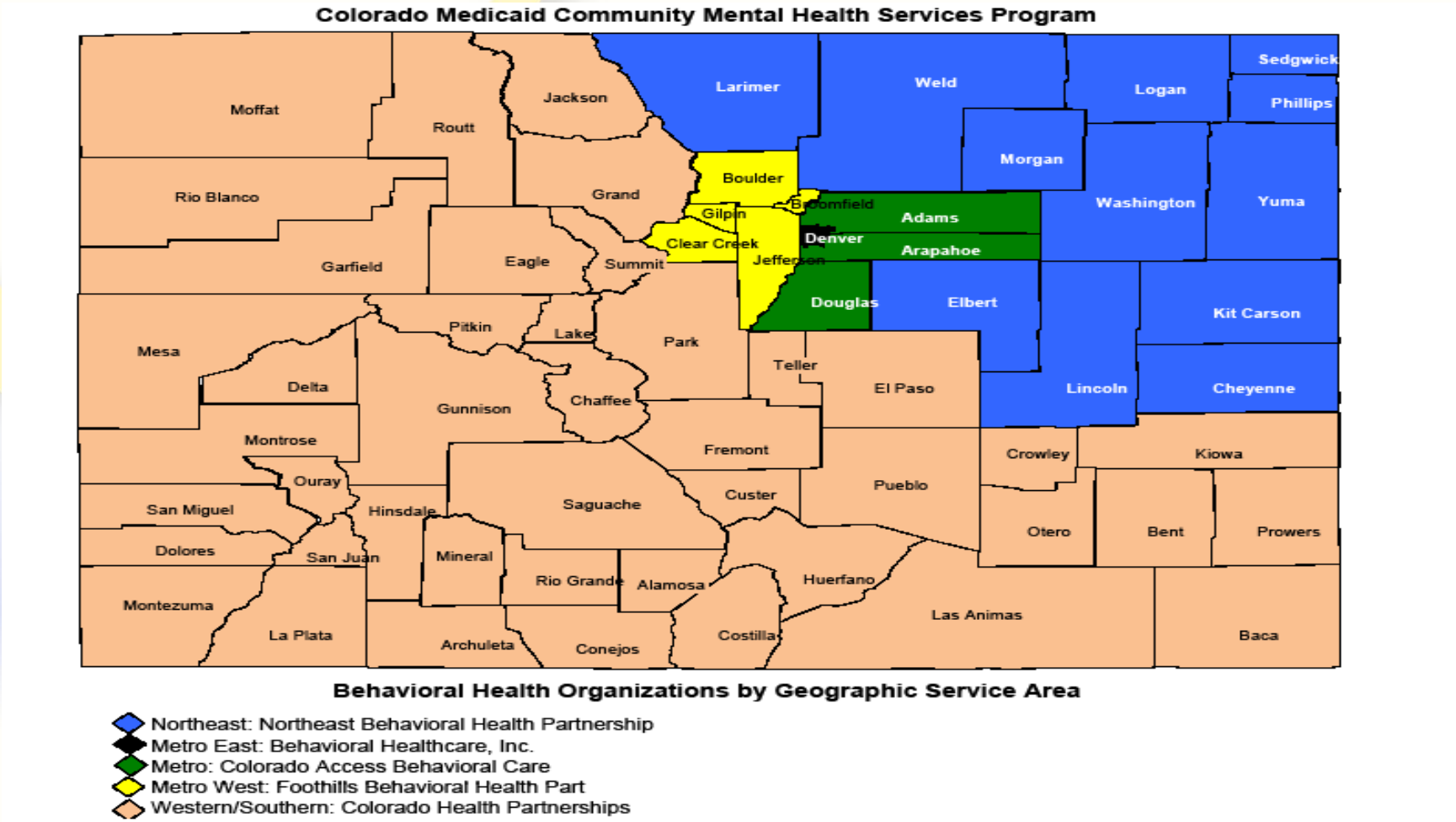
Behavioral Health Organizations by Geographic Area



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VO Clinical Department – Contacts

Amie Adams, LMFT, Clinical Director 719 538 1441

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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

Outpatient: 35 individual sessions

Inpatient: 45 days

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

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Outpatient Authorizations

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Outpatient authorizations expire 6 months 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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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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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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Authorization Outcomes: Denials/Appeals

- Note: If a clinical denial is issued, a letter will be sent to your hospital, and to the member (or guardian). There are no letters for administrative denials
- For CO Medicaid, the member holds the appeal rights, there is not provider appeal option. Formal appeals need to be requested by the member. They have 30 days from the date of the denial to request an appeal
- A hospital MAY request an appeal only if a member signs a form making the hospital their Designated Client Representative, which means you can then request an appeal on their behalf.

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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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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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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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Covered Diagnoses

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Covered Diagnoses

- Why is diagnosis important?
- HCPF defines list of covered diagnoses for Medicaid beneficiaries who are enrolled in the behavioral health managed care program.
- The list of covered diagnoses is a specific subset of all DSM-IV-TR diagnoses.
- The list is included in the provider handbook and can also be found on each of the BHO websites or on the HCPF website.
- BHO Covered Diagnoses
  - http://www.coloradohealthpartnerships.com/provider/handbook/Section13.4_CoveredDx.pdf

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Uncovered Diagnoses

- Any diagnosis that is not on the list of covered diagnoses is excluded.
- Some of the most common excluded diagnoses include the following categories:
  - Autism Spectrum Disorders (Autistic Disorder; Asperger's Disorder; Pervasive Developmental Disorder)
  - All Substance Abuse, Intoxication, Withdrawal and Dependence conditions
  - Dementia and other organic conditions, including mood and behavioral disorders related to traumatic brain injury or a general medical condition
  - Mental Retardation and Learning Disorders
  - Sexual Disorders
  - V codes or Diagnosis Deferred (799.9), except for evaluation

Resources for Uncovered Diagnoses

- Assessment and treatment of educational issues may be covered by the member's school district.
- Issues related to family safety or family preservation may be covered by the Department of Human Services.
- Issues related to crime victimization may be covered by the department of justice or other law enforcement agencies.
- Issues related to medical concerns may be covered by fee-for-services (Medical) Medicaid.
- Issues related to employment may be covered by employer sponsored treatment programs, such as EAPs.

Covered Services

- Continuum of Care
  - Inpatient and Crisis Services
  - Alternative Treatment Units (ATU)
  - Partial Hospitalization
  - Clinic and community-based Intensive Outpatient Services
  - Day Treatment Services
  - Peer Directed Services
  - Vocational Services
  - Evaluation and Psychological Testing

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Billing Codes

- Know your contract!
- Uniform Service Coding Standards Manual—2012
  - Service Description
  - Credentials of Provider
  - Allowable Places of Service
  - Documentation Requirements
  - Applicable Age Populations
  - Unit Duration

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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 (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 (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

Questions and Answers

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Thank you!

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