Q&A on FY 2011 DHS/DMH Utilization Management Program

	Comment/Question	DMH Response
Timeline for UM program		
1.	What is the timeframe for services for the FY11 UM program?	The dates of service are January 3, 2011 through June 30, 2011.
2.	Is there any flexibility in the start date? Because of the holidays there are very limited workdays coming up before Jan 3. I anticipate that this will require some training of staff, maybe altering the mental health assessment or the treatment plan. So I'd like to hear some response to that.	DMH has not changed requirements as far as what's required within the mental health assessment or the treatment plan with this program. It has always been a requirement of Rule 132 that medical necessity be demonstrated in the documents. We do not anticipate that anybody is going to make an authorization request on January 3. January 3 is when the clock starts for the ten hours of therapy and the 200 hours of PSR. So we don't expect people to actually be making authorization requests early in January but we do expect agencies to be tracking the services being provided to individuals starting January 3.
3.	Since this is being implemented halfway through a fiscal year would we expect that in fiscal year '12 that these limits would be roughly twice this amount?	No.
4.	My question has to do with what happens July 1 at 2011. Do these counters for the ten hours and so many units of PSR start over again for a consumer?	These thresholds described are for FY11 UM DMH will continue to do data analaysis and may determine different thresholds for FY12.
Who the UM program covers		
5.	Does the utilization management program apply to consumers who have Medicaid?	This utilization management program only applies to individuals enrolled in Medicaid because at this point in time those are the only individuals for whom DMH is reimbursing the services that the Utilization Management Program is focused on.
6.	For children and adolescents who have medical cards, we will need to do the authorization process on?	You only need to do the authorization process if they reach the threshold for services.
7.	Do SASS services fall under this UM program?	No they don't. SASS is a separate funding stream and has its own requirements and guidelines.
8.	How will the authorization process work for clients who have private insurance as their	This UM program applies to services reimbursed by DMH for individuals with

	primary, and Medicaid as a secondary insurance?	Medicaid. Authorization would be required for any individual for whom the provider has already requested reimbursement for the number of units to meet the threshold.
9.	How does the authorization process impact people that have Medicare and Medicaid?	The DMH authorization processes are limited to services that are reimbursed by DMH, which is Medicaid. Medicare is a federal program.
10.	In regards to the utilization management program and the benchmarks, do adolescents in residential placement funded by ICG or 19D funds, are they also included in that and for the services that come as part of the residential care?	No. ICG has separate eligibility determination and separate processes which we already monitor pretty closely how those services are utilized so they are not a part of this utilization management program.
11.	And that would be true for the adolescents funded by 19D funds as well? 19 D is a classification of the residential program. It's - and I'm not sure exactly what 19D stands for either. I just know that the number's on the contract.	The Utilization Management Program is for individuals whose services are reimbursed through Medicaid funds. You are talking about encounter claims for ICG, which is different.
12.	We do the community portion of ICG that is closely monitored by the Collaborative. So I'm assuming that that portion would not be under this particular authorization process. Is that correct?	Correct. Anything that's funded through ICG has its own kind of management already going on.
13.	We're going to be a part of the Integrated Care Project where people who only have Medicaid will be picking a managed care company. They'll be required to as of January 1. And how is authorization going to Work with this? Do you guys collaborate with those managed care companies? Are they going to respect the 200 hours that you guys give up front for PSR and community support? And will we have to do - how will the reauthorization work when we have a managed care company we're working with.	The managed care companies are not part of this authorization process. This process is only for DMH funded services. The ICP pilots or programs are through Healthcare and Family Services. We have shared with them the work that we've done. They're aware of it, but it's completely separate and it's not under DMH control.
14.	Their billing will go to the managed care company not to you guys and so we're at their mercy even though you see this 200 hours as being important for people with this level of medical acuity? And our billing is going to be going to them not to you. So whatever billing we do to them won't count against those 200 hours that you have for them.	They're developing their own set of guidelines and their own set of policies. DMH has shared with them our plan and how we intend to do things and our plan is to continue to work with them as they develop their policies. For individuals that are in that pilot. Yes you won't - it won't have anything to do with DMH. However, individuals in the pilot will not be eligible for reimbursement of Medicaid services by DMH, as their services

		will be reimbursed by the managed care companies contracted by HFS.
15.	If we have a Medicaid client that also has Medicare, we always bill Medicare first. The balance paid by Value Options in some cases has been only $1.83. How many units will the client have applied towards their threshold? Is it based on the cost Value Options would have paid for a 15 minute increment?	The threshold is based on the number of UNITS reimbursed by DMH, not the dollar amount reimbursed.
16.	If our clients are on SSDI, do we have to seek authorization for continued treatment?	Authorization will be required for any individual for whom DMH Medicaid reimburses care who has reached the threshold established for that service.
17.	Beginning in July of 2011, Medicaid billing shifts to HFS. How will this change the system with the collaborative or will it exist or how will it look or do we know yet?	The billing will as you said, shift to HFS, and there is currently a considerable amount of work going on in preparation for that. HFS will not be processing authorizations for DMH. So any services that require authorization as a DMH policy, that work will continue to be done as it is being done now. Those authorizations then will be sent into the HFS system so that HFS knows to pay the provider. So the claims will go to HFS and the authorization will go to HFS and they'll pay the claim.
18.	I noticed that one of the exclusion criteria for PSR is that the individual requires more intensive contact. If a client resides in a community support residential setting are they still eligible to receive PSR services since CSR is more intensive?	Receiving residential services would not preclude someone from PSR services, so long as other medical necessity criteria are also met for the PSR service.
19.	Does the required authorization process for community support group and counseling/therapy pertain to CILA clients?	The authorization process applies to any individual for whom reimbursement of services by DMH Medicaid reaches the specified threshold of units for that service.
20.	Are we required to obtain authorization for CSG and Therapy/Counseling for consumers who receive these services through Supervised Residential or Crisis Residential programs?	Yes, if the consumer meets the threshold for authorization.
Thresholds for UM program		
21.	If a closed case is reopened in the same fiscal year will they get to use the balance of the units or will they get a new set of units?	If it's an individual whose received services from your agency within the fiscal year and they come back to your agency then they would start wherever they left off. So if

	If they had used six hours of therapy counseling and then we closed them because we're done with their services with us, but they came back again with medical necessity, would they get the four hours that are the balance or would they get a new set of ten?	they'd already received six hours of therapy counseling and you wanted to provide additional therapy counseling, you would be able to seek reimbursement for four before you'd need to seek the authorization.
22.	Would they have had the same kinds of limits, the ten hours and the 40 hours or 400 sessions or 400 units sorry, PSR limits that you talked about? Would they have had similar limits?	There are no limits. We're talking about a point in time at which the service needs to be authorized. The ten hours of therapy is very consistent across the nation from what we've been told from the data that was gathered by our consultants.
23.	So say that we have a client who we provide initial services to and then we want to reauthorize some services for them and they move out of our catchment's area to another mental health center, Would the client then start over in terms of their cumulative hours or how would that work?	The hours are tracked by provider, so if someone comes to your agency, you do not need to be concerned from a tracking standpoint about whether they've received units of service at another agency.
24.	If somebody is hospitalized are the thresholds reinstated?	No. It stays at wherever it was at before they went into the hospital.
25.	Is there ever a time that there is an episode of care ending where the client comes back to the agency and gets another 10 individual sessions of therapy /counseling that don't need to be authorized?	Not for FY11.
26.	So every fiscal year the clients in our agency get 10 hours of therapy/counseling that don't need to be authorized?	That is the threshold for FY11. The UM program for FY12 has not yet been determined.
27.	Is a consumer allowed 10 hours of individual therapy/counseling, 10 hours of group therapy/counseling and 10 hours of family therapy/counseling, or 10 hours combined?	The 40 unit threshold is for all modalities of therapy combined.
28.	Is a consumer allowed 800 units of CSG AND 800 Units of PSR or 800 units combined?	The 800 units is a combined amount for PSR and CSG, not 800 units for each service.
29.	Also, the UM Program overview states for PSR, CSG 800 units are allowed. Is Community Support INDIVIDUAL also included in the 800 units or is there a separate threshold for CSI?	There is no threshold and no external authorization for CSI during FY11.
30.	Does PSR individual count toward the 200 hours?	Yes.
	DMH Policy considerations	
31.	Is DMH thinking yet about how often you would be supplying information to the agencies regarding our utilization pattern, and also any information that you're gathering on the LOCUS and Ohio scale scores even by region. Is that something you're looking at?	The division is certainly interested in providing reports and information to our providers and have ongoing discussions with our Regions about best ways to do that. Please send any suggestions to your Regional Contract Managers for consideration.

32.	What percent of the 25%, you know, that you said 75% received of that threshold, what percent of that 25% do you expect will be not authorized and do we expect that that amount of savings then would be cost effective to pay for this entire process?	We do believe that there is some over utilization within some providers. We believe that there are other providers where the amount of service is going to be very easily documented to be medically necessary. We do consider it to be cost effective from the numbers that our fiscal people have put together.
33.	Early on in the presentation it was mentioned that the Medical Necessity Criteria Guidance Manual came from looking at a number of states, which state in particular or which states in particular was it based on?	We worked with our consultants, Parker Dennison who work with a number of other states and have access to a wide variety of state medical necessity criteria. This included among others, Georgia, North Carolina, Texas. We looked at a number of different states so that we were consistent with the practices within other states.
34.	Is the authorization format patterned after a particular state or is that patterned off of Value Options used in another state? And if so which state?	That was developed by the Division of Mental Health, and the collaborative then put it into their system. The division develops all of the policy and directs the Collaborative and the Collaborative develops things based on DMH specifications.
35.	I was curious then, has it been piloted anywhere with any of the providers? Will the form be piloted before it goes live with everybody January 1?	No it will not be piloted. The forms follow the same basic format to what is already in use with our ACT and CST authorizations. They were modified for information related to the specific services that we will be authorizing after January.
36.	Could you speak to the credentialing and the community mental health experience of those who created this and those who will be doing the review. I want to know if those who are doing the reviews have worked in a community mental health setting, and would be able to pull all this off themselves. Does that make sense to you?	The individuals who worked on creating the medical necessity criteria documents do have clinical experience working in community settings.
37.	How can you do an ongoing data analysis if the whole reauthorization process is going to skew the data?	DMH has done analysis of assertive community treatment and community support teams utilization both preauthorization and post authorization. We will continue to do analysis of the services that are requiring external authorization and looking at that data. Certainly we would expect to see some change in utilization over time. If we don't see any changes, and in fact

		every single person who was identified as an outlier continues to get authorized for the same amount of services as they did prior to the authorization process being put in place, then that would tell us that every person who is an outlier was receiving medically necessary services.
38.	If at post payment review an auditor sites exclusion criteria and/or service initiation criteria related to a billed service, will that bill be disallowed even if the continuing service authorization was in place at the time of service?	No
39.	Providers would like guidance on how to proceed in situations where CILA residents are denied reauthorization for PSR and CSG, the agency is unable to provide CSI to the resident, the resident is unable to obtain or maintain employment and the resident has no interest in pursuing educational opportunities. Historically, these individuals participate in PSR and CSG.	PSR is intended to be an intensive, time-limited service focused on skill-building, and CSG is intended to assist individuals in transferring such skills to natural settings. DMH realizes that there may be individuals for whom additional resources/activities are needed which are NOT Medicaid services. We are interested in working with stakeholders on developing such natural supports within communities.
40.	Will the Division consider establishing different initial authorization levels for clients with higher level of needs to severe mental illness?	We will be monitoring the authorizations for any trends and expect that the process will evolve and change as new data emerges.
	Authorized Units	
41.	If an encrypted email address is provided, will an automatic email be generated regarding the authorization decision?	No, the provider can obtain the answer via ProviderConnect. They will also receive written notification via letter.
42.	If we request additional hours and get an authorization based on an estimated start date for those hours, but then the consumer misses an appointment so they end up only having received nine hours by the time that the authorization date arrives, will we lose that 10th hour?	No.
43.	If we use all of the requested and authorized units, and the person continues to need the service, then we have to do another authorization?	Yes.
44.	Is the decision all or nothing? If you ask for ten extra sessions, is it either ten approved or denied, and it – approved it ten or denied it at zero or is it may be authorized at five?	The Collaborative has been instructed to approve what amount is demonstrated as medically necessary.
45.	Are there 40 units for each or is that 40 units for all of those say if an LPHA is using a combination of those or has authorized a combination of those?	It's 40 units total. When you request the authorization you would want to take into account that they're continuing both individual and group and how many hours total they would need.

46.	Will the pending (or final) authorization number need to be submitted as part of the billing process.	No. Providers can refer to the 837 guide for details on required fields.
47.	Is there a maximum allowance of for example the therapies that you can request in the authorization?	There is not a maximum that you can request. But it should be logical to the person reviewing it. The determination will be based on what you are reporting to the clinical care manager is needed for that individual person.
48.	So we've been told to request a reasonable time for reauthorization - so is it reasonable to say six months is realistic that the treatment plan is valid for six months?	You need to estimate how many units of service you think you need in order to achieve the goals of the individual. While a treatment plan is valid for six months per Rule 132, that does not mean that every person for whom the treatment plan is written today is going to still be in service six months from now, or going to be in the same service six months from now.
49.	Will providers be held to the estimate of how many days until anticipated service termination or transition to alternative services that's required to be entered in the actual authorization especially if this is a significant length of time away that you anticipate them terminating.	There will be a start date and an end date to the authorization. If circumstances change and additional time is needed, then you would need to explain that in a new authorization request.
50.	So is there a code or anything to put in the 837 (unintelligible) number like another 40 sessions or something.	You'll get an authorization when you submit the request you'll get a pended authorization number.
51.	Is when we put in an authorization and suppose the authorization is for a (max) 200 units and we get denied. The question I have is will we get denied for the 200 but you'll say maybe it's medically necessary for 100?	That's a possibility if the clinical care manager believes that medical necessity is shown for a shorter period of time that's a possibility. If medical necessity just isn't there at all then there could be denial.
52.	Okay so we don't have to resubmit for the lower 100 hours - or 100 units	No
Services involved in UM program		
53.	Will individual and family therapy fall under this authorization process?	Any therapy/counseling service that is paid for with DMH Medicaid funds would fall under the UM program guidelines.
54.	Community Support Residential - I just want to be very clear that that's not included in Community Support Group.	No, it is not.
55.	There are medical necessity criteria for Community Support Individual, but no threshold amount for CSI for authorization?	DMH has not planned any external authorization of CSI at this point. Medical necessity criteria was issued because DMH expects providers to be considering medical necessity as they're providing all services, not just the high levels of service. Providers should consider that criteria when doing a treatment plan and including CSI. But there is not a point in time during this current

		utilization management program where CSI would require external authorization.
56.	After January 3rd, you're starting with a brand-new client and so you have to complete a mental health assessment and treatment plan in order to get the authorization but then would we get reimbursed for the time spent doing the mental health assessment and treatment plan before we were able to do the authorization?	Except in the existing authorization processes for ACT and CST, you are not going to do an authorization at the time that someone initiates services. You're only going to seek authorization if they've received enough service to reach that threshold.
57.	Let's say the LPHA recommends that the parents attend this evidence-based parenting skills program, and that the program is 20 weeks two hours each session. Will that be covered under Community Support Group, you know, given that all the medical necessity and everything else is there?	In your example, that is 40 hours, or 160 units, which is below the threshold for CSG, so authorization would not be required.
58.	Are mental health assessment and treatment plan services considered under therapy counseling or are those additional services that wouldn't be part of the ten sessions or the ten hours?	Mental health assessment is a distinct service as is treatment plan development. So those are not considered within those 40 units of therapy counseling. It's only the therapy counseling units that are counted for reaching that threshold.
59.	The authorization is for therapy solely correct? And we - working as a clinician, working with children and adolescence do a lot of client centered consultation with other providers. And I'm assuming that doesn't count towards the therapy those initial - that threshold.	Correct. Correct.
60.	Does counseling by a case manager or other staff with a consumer, and they bill the state as a counseling service, count against the 10 hrs of therapy/counseling available for the year?	Any therapy/counseling service provided at the agency and submitted for reimbursement from DHS/DMH will be counted towards the 40 unit threshold for therapy/counseling.
	Submission of Authorization Requests	
61.	Once we see that a consumer is getting up to almost the ten hours of therapy and we need to request reauthorization how far ahead of time can we submit that?	You can submit it as far ahead of time as you feel comfortable being able to show that this service remains medically necessary.
62.	So if the initial process to get somebody reauthorized takes 7 business days and the appeal process can take up to 15 business days, it's realistic that we have to give ourselves 22 business days considering worst case scenario if someone is denied. Which is a month and a few days. So we'll be requesting authorization a little over a month in advance, correct?	Yes.
63.	From the demo it seemed like you needed to have at least 3 Axis I and 3 Axis II diagnosis. Even if	You must enter "no diagnosis" for any of these fields for which that applies.

	you only have a single Axis I diagnosis you must enter None for the other 5 fields. Can just one suffice?	
64.	We here offer a service called Sparks. It's a 16 session treatment modality evidence-based for adolescents. It's kind of like DBT for adolescents and it's 16 sessions. If we already knew that we were going to put a client through that should I submit that request at the beginning or wait until closer to the tenth session?	You are welcome to submit it as early as you think you've got the documentation that shows that there's medical necessity for it and they're benefiting from it. We do know that many of the evidence-based therapies are longer than ten sessions, and this information is being included in the training of the CCMs who will complete the authorizations.
65.	Will we have the option of submitting that ahead of time before we even started them in getting authorization for those 16 sessions?	Part of the authorization criteria is showing that they are benefiting from the treatment. So you might not want to submit before they have the first session, but once they are involved and you see and can document that they're benefiting from it you can certainly submit it and not wait until the eighth session for instance. The other piece of that is you wouldn't be requesting the entire 16 hours either, since the first 10 do not require authorization.
66.	Can I request 10 hours of each modality of therapy counseling, or only 10 hours total.	You don't have to request increments of 10 hours for the authorization. When you put in the number of hours that you're requesting to be authorized you want to request the number that you expect to provide.
67.	Can we request a reauthorization for more than 10 hours of therapy and/or more than 200 hours of PSR if we believe that it is medically necessary for this consumer? That is, if we can provide clinical evidence/documentation to support the medical necessity of an additional 500 hours of PSR based on the progress demonstrated by the consumer over the first 200 hours allowed, would we be able to request for this much additional time? Or are we limited to only asking for 200 hours of PSR or 10 hours of therapy at a time?	There is no set number of hours or units that can be requested at the time of authorization. The clinician should use their best judgment in estimating the number of hours necessary to obtain treatment goals for the individual.
68.	Since PSR and CSG services are combined for the determination of the 200 hour initial service provision, when we seek reauthorization do we need to individually request these services (with a separate line item and separate start/end date and number of units for each service) or can the form filled out on-line under "Services Requested" which says "Service Name:" list both PSR and	PSR and CSG are separate requests within ProviderConnect. The same supporting documents can be securely attached to both requests. However, if a provider is faxing the additional documentation and want it to be considered for both requests, this must be indicated (along with the Consumer RIN/Name) on the fax cover sheet.

	CSG with a combined number of units for both?	
69.	If a service is delivered in the community Therapy/Counseling,CSG) what site do we use as the site being authorized?	You should use the site in which the clinician is based.
70.	Is the L the only person that can do the authorization because we have a lot of clinicians that are masters level but are not Ls but they're supervised by Ls?	On the Collaborative side of the authorization, the Clinical Care Managers must be Ls. There is no such requirement on the provider side for the clinician requesting the authorization.
71.	Okay so the clinician is a Q. They can submit this on their own then, a masters level Q?	Yes. Some of the documents they'll be submitting of course per Rule 132 have to have the L signature, but as far as if an individual clinician is a Q and they're doing therapy certainly they can make that request, DMH just requires that the person reviewing the medical necessity be an L
72.	Can we talk to a collaborative case manager to make as sure as possible that it would be covered?	What I would recommend is that you actually talk with your regional staff who can involve other people within the division if necessary. But that's really where you would take questions about specific programs. If after speaking with your contract manager, you determine that submitting an authorization request is what is the next step for you, and you are questioning the documents that you need to send, you can certainly contact a CCM for technical assistance regarding any documentation.
73.	I guess I'm wondering if it would not be something to consider maybe some technical support kinds of things put into place with the clinical case managers initially in the first number of months that this program has started. So that everyone can expedite a process that can take 30 days, 15 days and 30 days for an appeal before a person can get services. Maybe some kind of a technical support kind of component for initially for this program to kind of help the centers get up to speed and kind of figure out what we need to do to minimize those kinds of situations.	Certainly the clinical care managers will provide technical assistance as needed. It is important to note that DMH will continue to reimburse a provider for services during any period of time where there is a request for reconsideration or appeal. Certainly what we hope is that the appeal process or the reconsideration process will be a very rare occurrence.
74.	On Page 35 of the slide the middle dot point says and the provider LPHA deems additional hours are medically necessary. Does that mean an LPHA has to be the one that asks for the additional hours, or does that mean you want LPHA signature, what does that mean?	What that means is that an LPHA is always the person who according to Rule 132 is determining medical necessity. It does not mean that the LPHA is necessarily the actual treatment provider.

75.	So on yesterday's call it was indicated I don't think it was a final decision that if we electronically submitted the MHA and ITP we just needed one signature of the case manager. Does that have to be an LPHA for the authorization to be accepted?	It was the electronic signature of the staff person. So if you're a person completing the treatment plan that your agency your plans are done online and there is an electronic signature on your treatment plan that's required when you submit it.
76.	And if it's not the LPHA is that okay? Will you accept that?	For authorization purposes, yes.
77.	Is the start date the date of the last mental health assessment or the original, you know, start date, maybe they started in '08 but they've obviously had a new mental health assessment done more recently? So which would be the start date?	The requested start date is actually the date you're seeking authorization for.
78.	There was another section that said that the date that the client started in treatment.	Yes that would be the date they started in treatment.
79.	If multiple people on our team are providing service to one person when you say provider specific that means any staff working at the agency location that you're referring to is that correct? So within our team if one person submits the authorization but they happen to be out sick we have other people cover each other and we submit is that okay?	Yes.
80.	Is there a limit to how many staff we can add to requests authorizations?	There is no limit on user names and passwords for staff at an agency.
81.	Logins - given the clinical nature of the authorizations we may need to provide additional logins to staff. Is there a way to limit these logins to specific portions of the system? Is there a maximum number of logins?	There is no limit on user names and passwords for staff at an agency. There is no way to block other applications in Provider Connect. Claim submission requires a separate box to be checked on the paper form, so if the provider did not want the user to have access to this functionality, they would leave it blank.
82.	Why is it that if we are required to fill in the client's diagnosis, LOCUS scores, Devereaux scores, Columbia Scale scores, etc. for a registration, that we must re-enter all of this information every time we have to get an authorization? This will make additional "paper work" for clinicians, when they could be using this time to help the client. It seems like there could be a way to automatically fill in the information from the registration.	The requirement to supply this information at the time of the authorization request is to ensure that the Clinical Care Manager making the authorization determination has the most up to date information on the individual receiving the service. Because functional scores are likely to change with treatment, the scores entered at the time services were initiated may not be reflective of an individual's current status.
83.	Multiple Sites. Authorizations are provided at specific sites. A question was raised what happens if a client shows up at another site? As a follow-up - sometimes we need to transfer our clinicians	They would submit the request under the primary service provision site, but as long as it is the same provider, they would not require a separate auth request for each

	from one site to another and sometimes their open cases go with.	service site.
84.	Will the Collaborative provide paper authorization forms for our staff to complete and send to our billing office for submission? This is currently in place for ACT and CST.3)	Authorization requests must be done electronically through the same system all providers use to register individuals for DHS/DMH reimbursement.
85.	combine PSR/CSG requests into a single form rather than having to do it twice	A provider may request authorization for multiple services in one request, but must provide details for each requested service.
86.	Will an option for batch electronic submission of authorization requests be available? If agencies cannot submit authorizations via batch electronic submission, can some of the requested information be uploaded electronically without having to manually type it in via Provider Connect?	We are interested in ways to streamline the process, and eliminate redundancies where possible, but there are also system limitations that we are dealing with.
	Tracking need for authorization	
87.	Is there going to be something that we can just press a button and find out who's coming up for certain things? Is that going to be something that we're looking to put in place to have the same information that DHS has.	There is no way for the division to track that for individual providers, because of potential delays in claims reporting by providers. The responsibility for tracking lies within the individual providers.
88.	At some point providers will find out that we've reached our threshold for an individual, because then they're going to start rejecting the billing.	Correct.
89.	Where will we get information that a claim is rejected due to exceeding the authorization	You will receive a NAF ("No Open Auth on File") denial for the claims submitted.
90.	If we exceed the threshold, and don't realize it until we get an error in claiming, can we request an authorization be backdated and resubmit those claims?	The authorization will be effective no earlier than the date that the authorization is actually completed. It won't be backdated.
	Documents required to complete authorization request	
91.	My question has to do with the DECA both for the registration and the reauthorization do you need a base line percentage on the parent or the clinician report?	The clinician report.
92.	What kind of a measure are you using in terms of measuring improvement and reauthorizations for services versus not enough improvement and denial of services?	What we're looking for is based on what's reported in your own documentation.
93.	If we submit the initial authorization and the two documents that are mandatory which is the individual treatment plan and the mental health assessment, and from our standpoint we feel that both documents are strong - strong enough to justify authorization even though our feelings aren't 100% valid. But anyway, if initial information is required it seems like from what	If there is not sufficient information within the documents submitted to demonstrate medical necessity, then the authorization would be denied, at which time you could make a Request for Reconsideration and supply additional materials.

	was presented is that we would then have to start this process over. Am I saying that correctly, or am I wrong?	
94.	So it'll behoove us just to send as much information at the beginning as humanly possible is what you're saying right?	You should send enough sufficient information at that initial submission that you are showing the need for the service and the progress and treatment. So that the clinician can review those documents and say yes, the service is needed and yes they're making progress it makes sense to continue.
95.	In terms of submitting supporting documentation will you accept documents not written by an LPHA? It may be written by a clinician even if a LPHA signs off on it, a progress report or summarization of the progress that the client has made over time.	I don't see any reason why we wouldn't accept that as Documentation.
96.	So if we have one or two progress notes that we think really speak to what the client is currently going through and say our MHA is a little bit older because, you know, maybe it's going to be due in another month or two would you want us to include those progress notes with that initial request then?	We expect this will happen pretty frequently, that you just won't submit a treatment plan and an assessment but you'll also submit some additional documents that really help to show what's going on currently with the individual. Because our clinical decisions are based on the clinical information submitted by the provider, it would expedite the process if the provider can include anything that would help us see medical necessity is in evidence.
97.	I know the main submission for reauthorization is electronic. And if there are documents that we need to fax along with that how do we do that? Do we submit the electric portion first and then fax in the same day the additional documents?	You have a choice. You may either attach them electronically with the request, or fax them separately within 1 business day. What has worked for providers with other services when they're doing the same thing is actually submitting the fax on the same day.
98.	How does faxed information get linked to the information submitted electronically?	First, a separate fax should be sent for each consumer. This will help to ensure that the information gets linked to the right person. On the fax cover sheet for additional documentation for each request that you're sending you will want to ensure that you have noted the service being requested and for whom on that fax cover sheet. Once it reaches the Collaborative, there is a manual process of linking the faxed information to the correct electronic request. When the provider faxes something to the Collaborative, it is converted into an electronic document for the clinical care

		manager to have along with the rest of the authorization.
99.	Regarding the one additional business day to send additional documentation, I'm really concerned that it's going to be a hardship on our clinical staff to be able to copy additional progress notes or, you know, gather the kind of information that you're going to require within one additional business day and then, you know, the process will start all over again. So could you consider allowing a longer period of time for that?	DMH will certainly continue to analyze our authorization processes and make improvements where that seems to be needed. The current process was designed with respect to providers' time and a need to be as efficient as possible. Allowance of additional time results in more documents "piling up" in the system, which means a delay in responding to all requests. DMH encourages that before an authorization request is sent, that the clinician that's involved should determine whether what the collaborative care manager needs to know about this individual is reflected sufficiently in the mental health assessment and the treatment plan, or is there something else in the documentation that should be sent in that shows they've been making progress but they continue to need this service. All this information should be sent in pretty much at the same time. You may do part of it electronically and fax the rest of it, but it really all should be done within that same day so that you get a timely decision and everyone else gets timely decisions.
100.	What constitutes a current Crisis Plan? Would a WRAP plan suffice?	A WRAP plan could certainly be an example of an individual's crisis plan.
101.	Is your fax machine going to be capable of handling all of this?	Yes. And you also have another option. If you feel more comfortable you can attach all these documents securely to your online request for authorization.
102.	Yesterday on the Utilization Management call when they were talking about attaching the documents, for the mental health assessment they said the attached document that was current within the past twelve months, but for the treatment plan it said current within the past six months. Is that accurate, or could a review be used - the six month review?	Certainly the rule requires review of the treatment plan every six months. And so what we want to see is the most up to date document. If your review document sufficiently describes your treatment plan then you wouldn't need to attach the actual treatment plan as well. If there is information within the initial treatment plan document that is not in the six

		month review you may want to attach both of those so that the clinicians sees all the necessary information.
103.	What constitutes a written plan to facilitate the consumers transition to alternative services. Are you looking for a separate document or can it be a continuity of care, goal, or statement within the consumers ITP?	DMH does not prescribe how you write your records. A lot of times it might be something that is within the treatment plan document itself. For example, once we attain these goals then these are the types of support that the person is going to use.
104.	Yes I was wondering if someone doesn't have a discharge summary can they still be approved for authorization? Well kind of a discharge plan.	Well there should be something in place that talks about a plan for a change in their services. The idea of medically necessary services is that you're addressing a problem and that they are going to reach a goal at some point and no longer need either that frequency or that intensity or that service; they might need something else.
105.	Must all of a consumer's medication be listed, or just the psychotropic medication? Many of our clients are on numerous medical meds so there would be much more work involved if every one of their medications must be individually listed.	The listing of medications is not a requirement for the authorization request, however it often provides useful information to the Clinical Care Manager related to diagnosis and level of functioning, which are factors for consideration in determining medical necessity.
106.	Do we need an updated MHA and ITP every time we do a reauthorization, or can we just send the current MHA and ITP as long as these, along with any additional documentation, do reflect the medical necessity of the requested services? Since Rule 132 requires review of ITPs every 6 months, if we are two months in to the last review period and we need to request reauthorization, we would not want to be rewriting an ITP every 2 months if it is not necessary/required.	You do not need to update the documents in order to complete the reauthorization. You do need to ensure that medical necessity is demonstrated in the documents submitted.
107.	On Provider Connect when you go to attach the supporting documents it said: Mental Health Assessment (current within 12 months) and then for ITP is says current within past 6 months. For Bridge applicants when we enrolled clients with the Collaborative they would not accept a 6 month review, they made us do a new complete ITP. I wanted to know if that was true in this case too. In Rule 132 it indicates that the treatment plan should be reviewed at least every 6 months, but no where does it say a treatment plan has to be done in its entirely every 6 months.	Providers should attach the mental health assessment and treatment plan in effect at the time of the authorization request. If a treatment plan has been reviewed, and the review document refers to things contained only in the original treatment plan, then both the review document and the full treatment plan should be attached.
108.	Under Transition or Service Termination the online Provider Connect authorization process does not include #5,6 or the list of barriers as	These are listed in PC in this process, but are not numbered as such. Is the provider looking at the ACT/CST screens? This may

	described in the training. Also Provider Connect does not list ITP or MHA as options when submitting electronic documents – this is highly problematic	explain why they are not seeing this. When attaching documents, multiple options are given to indicate the type of document. In PC itself, the provider will go through a "radio button" checklist to indicate whether they have attached or faxed the specific documents in question.
	Determination of medical necessity	
109.	How is that going to be determined or verified if there is no equally effective or more appropriate natural community support available?	Certainly when a clinician is doing an assessment of someone that includes assessing what supports they have available to them. So if they don't have those supports in the community then that would be part of the assessment document that those resources don't exist. One of the things to consider when submitting the documentation is that criteria, and are the documents that I am submitting answering or explaining or providing evidence for the medical necessity criteria as outlined in the guidance?
110.	Under the continuing service criteria do we need to meet all of those or one of those in terms of requesting more services?	Yes. You need to meet all the continuing service criteria.
111.	Under the additional criteria for therapy and counseling modalities it mentions the severity or complexity of the individual symptoms necessitates one on one intervention and precludes the exclusive use of group modality. And then under the service initiation criteria on the same page it says that the individual has indicated their agreement with the need for and the choice of this service modality. And I just wanted to get some clarification on your thinking regarding to client choice regarding individual therapy that if in fact we believe we can document that the client meets medical necessity and we're asking for reauthorization of individual services and we're providing an evidence-based treatment and that's what the client wants is that going to be taken into account or is there some thinking whether it's with children or adults that we're going to need to move people into groups?	Certainly individual choice always plays into decisions regarding treatment. If an individual is completely opposed to a group modality and they are in need of therapy and together you plan for individual therapy for which there is demonstrated medical necessity then they would not be denied just because there might be a group modality that would also be appropriate.
112.	If an individual is receiving therapy and	The level of care is at least a 2. This does not

	counseling and will require a LOCUS of Level 2 in order to gain authorization, how is that going to affect their authorization for PSR if they have a LOCUS level of 3? Will that affect either service modality authorization?	mean that ONLY a level of 2 would be authorized. While a 3 is indicative of more intensive services than a 2, these are guidelines and would not negate other demonstrated medical necessity.
113.	The MNC states that if a youth has an Ohio Scale score of 16 or less, but positively scores for safety parameter concerns, they may still meet criteria. How should a provider demonstrate that there are safety parameter concerns?	Providers will be required to submit additional clinical documentation to indicate this information. Examples include: the Ohio Scale Scoring Tool, progress notes indicating the safety parameters of concern, letter indicating the areas of concern, etc.
114.	Regarding the PSR medical necessity criteria for service initiation, number 3 states that the individual has a current treatment plan with specific goals, time limited objectives that can be expected to be achieved within a 90 day timeframe and a discharge or transition plan. Does that mean that there is an expectation that a treatment plan for PSR consumers requiring additional authorization would be reviewed and updated with that consumer every 90 days?	No. The 90 day timeframe in the medical necessity criteria comes from the philosophy that surrounds the PSR service and what was intended at the time it was written into the Rule, which was a very time limited, very intensive treatment modality focusing specifically on skill deficits that a person needed more almost like a classroom setting, an on-site treatment where they are focused on learning skills that they then transition to community support, not if they don't even need community support, but if they need it to generalize those skills into the community and to natural settings and to build those natural supports. For initiating services what we're really looking at is you want to make sure if you're planning to provide PSR to someone that there are specific skills that they lack that they need that they can develop in about that timeframe. And if they don't meet that general criteria then PSR services may not be what's appropriate for that individual.
115.	When we call in and get our authorization we need to ensure that the eligible diagnosis for which the proposed course of treatment is determined to be effective for that particular service. Are we going to get a list of diagnosis that are appropriate for each service?	No. We're not publishing a list of diagnosis for services. What we are expecting is that the (L) has the clinical judgment to be determining that a service is appropriate.
116.	The medication it says that was required but yesterday under the IT program medication was said it was not required. Can you	There is a field to list medications, but it is not a required field. You won't be prevented from moving through your authorization

	elaborate?	request if you do not enter it. For the purposes of helping us understand the clinical status of an individual consumer it would be helpful if medications were listed if an individual was being prescribed medication.
117.	In a number of the service categories you referred to an exclusionary criteria as being cognitive impairment. And I was wondering if you were going to have any further (indication) on how you will judge that?	If the record is indicating severe cognitive impairment then the clinician is going to question why there is a recommendation for therapy. We will be looking at each case individually. If you're asking what specific IQ equals cognitive impairment that's just one factor or element in the whole scheme of cognitive impairment and mental status.
118.	Will you take into consideration if a person has an Axis II diagnosis that might not in and of itself be reimbursable, but could exacerbate a reimbursable Axis I diagnosis, making it harder to treat/longer to treat/require more sessions to treat?	Certainly an individual's entire clinical picture is considered at the time that a determination is made of medical necessity.
119.	How is it determined whether that's enough progress, how much is enough progress to continue services? And how much would not be enough progress that would warrant I'm assuming a shift in an intervention when you're trying to treat a certain disorder.	We would look at each case individually. For example, the therapy counseling continuing service criteria - we would look at each of the six elements there and if the information that you've submitted evidenced medical necessity we would authorize it. We make our decisions based on the clinical notes and materials and the auth request that you send to us. Now if there are cases where you feel additional information would be helpful to the CCM here who you're right does not work with, does not see the client that would be - that would be helpful in the process.
120.	You said that if the CCM cannot establish medical necessity the CCM contacts the provider to seek clarification and offer education consultation? And then you either reach mutual agreement or you don't. From what had been said earlier it seemed like if they call us it's basically going to be to say we don't have enough information and because of that we are closing out your case and you have to reapply. So is there a point where that would actually occur without them closing out the case? They would say we need some additional information and we would be able to submit that without having to reenter the entire authorization.	When we're referring to missing information that would be for example if you've just submitted the MHA and ITP and neither of the documents contain any information regarding continuing stay criteria progress and treatment et cetera. This is more specific about the materials you submitted and it looks like there is medical necessity perhaps for a service. But we need additional clarification on what you've submitted. Or it appears that potentially something else needs to be mutually agreed upon. Then at

		that point we would be contacting the provider for those reasons.
121.	How is active participation defined?	Active participation should be reflected in the clinician's notes. If an individual is actively participating in their treatment then that is going to be evident to another clinician reading the note.
122.	One of the continuing service criteria for PSR is that "the individual cannot effectively utilize other treatment modalities, including Community Support Services or Therapy/Counseling, without the concurrent provision of PSR." Since CSG is included in the service limits for PSR, it appears that it would be unfair to deny someone PSR even if the individual could utilize Community Support Services instead, since in denying them access to more hours for PSR you also would be denying them access to the hours for CSG that they could be doing in lieu of PSR. Based on this, it seems that CSG should be separated out from PSR, or else the continuing service criteria need to be revised for PSR. Similarly, CSG will be denied if the "Individual requires the intensity of contact and range of supportive interventions only available through more intensive services and who cannot be safely or effectively treated in CS: Group modalities". However, since the more intensive services would include PSR services, which are factored in to the total allowed hours for CSG, denial of CSG would thus preclude someone from being able to use additional PSR services. Once again, it appears that the CSG and PSR should either be separated, or else the continuing service criteria and/or exclusion criteria for these two services need to be revised	CSG and PSR are separate services. As such, each has their own medical necessity criteria. Not meeting medical necessity criteria for one service does not preclude medical necessity for the other service.
123.	Does the diagnosis used for the authorization of a client have to be given by a psychiatrist?	No. The diagnosis may be given by an LPHA, according to Rule 132 requirements.
Credentials of Collaborative staff		
124.	What are the credentials for the clinical care managers?	The clinical care managers all must be LPHAs.
125.	Are the physicians reviewing the authorizations that have been denied experienced with community mental health?	Yes, and the physicians will be licensed in the state of Illinois and board certified in the specialty of psychiatry.
126.	Do the LPHAs who will be making the decisions regarding reauthorizations have a current first hand working knowledge of a dual diagnosis (MH/DD) population? As was raised in one of the	Our CCMs are experienced LPHA level clinicians who have worked with a variety of populations. Clinical decisions are made after a full and comprehensive review of all

	questions asked during the webinar, it appears that the exclusion criteria of an "individual's level of cognitive impairment, current mental status or developmental level make it unlikely for him/her to benefit from psychotherapeutic techniques" may be unfairly and subjectively applied by an LPHA who is not as well versed in the expressive therapies or behavioral techniques which tend to be much more effective in working with those with a secondary DD diagnosis of mental retardation. Some agencies such as our own specialize in this particular population and have shown significant success in providing therapy even to clients who may appear to an outside reviewer to be "too cognitively impaired to benefit" from it.	materials submitted and based on criteria approved by DMH.
127.	Will the Collaborative assign one reviewer to the agency? Will a contact person/s be assigned to this Um process? When there are delays, it is difficult to find out who is working on your authorizations when they are randomly assigned to a variety of different staff.	Specific CCMs will be designated as primary (although other CCMs may also assist) to handle authorization requests for PSR, CSG, and Therapy/Counseling. However, staff will not be assigned to a specific provider. If there are issues/concerns with delays, the provider can contact the Clinical Department at 866-359-7953 and can speak with any of the CCMs or the Supervisor. Additionally, if there are questions from the CCM and contact is made to the provider, the CCM will leave a direct number for the provider to call to reach that CCM.
128.	Do Substance Related Disorders include Fetal Alcohol Spectrum Disorders and Prenatal Substance Abuse? If so, what agency provides services for these consumers? (DMH/DD does not).	The list of eligible diagnoses for DHS/DMH reimbursement has not changed and is available in the DHS/DMH provider manual.
	Turn-around time/ notice of determination	
129.	You had mentioned that the one day turnaround was one working day. And then does that follow the state holidays then or how does that work?	Yes it is one business day, and state holidays are followed.
130.	Does that same principle apply for the seven days of response that you guys have to get back to us?	Yes. It's seven business days.
131.	The turnaround time for reauthorization - will that approval be that it’s dated and comes through the mail and you get it in the mail on the seventh business day or will we have it in our hands by email, fax, or mail on the seventh business day?	The decision will be made within seven business days. At the time the decision is made within those seven business days a letter is generated. Those letters can be viewed on Provider Connect. You can always check for an authorization and/or authorization letter on Provider Connect within those seven

		business days to see if the auth has been completed.
132.	The reauthorization decision can be viewed on Provider Connect?	Yes.
133.	How soon prior to running out of therapy hours should authorization be requested? What is turnaround time at the Collaborative?	Clinicians should use their best judgment in determining when to request authorization, with the knowledge that there needs to be documentation of progress in current treatment, as well as need for continued treatment in order to meet treatment goals. As stated in the training, the turn around time for the Collaborative decision on authorization is seven business days.
134.	Will authorizations be dated the same day they are requested (once approved) or will clients have to miss sessions until authorizations are received?	Authorizations will be effective on the date requested by the provider, so long as that date is not earlier than the date of approval. Assuming providers are timely in their submission of authorization requests, there should be no disruption to the reimbursement for medically necessary services for an individual.
135.	What is our recourse if a decision is not made by the 7th day? Is there a number we call or what can we do?	You can always contact 866-359-7953. And one of the clinical care managers can do some research to find out what the actual issue was.
136.	How long is the process for the first PA review if the clinical care manager and the provider cannot reach mutual agreements on the next steps?	7 business days.
End of fiscal year		
137.	Are we expected to terminate therapy at the end of the fiscal year because the authorization ends?	No.
Authorization Denials		
138.	If a client requires more service then and their authorization is denied where does the ethical liability fall if a client ends up being hospitalized, you know, or something worse?	Authorization decisions will be based on what is sent as documentation from the provider, which means that the provider needs to consider what is being sent in. There’s a great deal of responsibility in making sure that the documentation shows medical necessity for the service. The division is not telling providers what services to provide. The division is saying what services it will reimburse. A provider is certainly able to continue to provide any service it chooses to provide without DMH reimbursement.
139.	If there is a denial of re-auth request will there be explanations about what basis or what criteria it	Yes.

	was based on?	
Requests for Reconsideration/Appeals		
140.	So if we appeal this process and go through all of that we can provide services. And if the appeal eventually the last appeal that's done by the law or the judge is still denied you will still pay for those services while we're in that process.	Yes.
141.	It was asked if there would be a number or some type of consumer access for them to be able to advocate for their own service needs during this authorization process so that their voice could be heard.	DMH has held consumer calls to inform them about the authorization process. If an individual is approaching a threshold for services reimbursement and needs to get that authorization in order to continue to have their services reimbursed it is expected the clinician would be speaking with them about that, and they would be involved in a discussion about the process and would be able to provide any input that they wanted. Consumers are going to have the ability to request a reconsideration and appeal the decision.
142.	Okay so what does the individual get that tells them if they need to appeal?	Well in the letter that is sent to providers and available on ProviderConnect there is a paragraph talking about the collaborative and DMH encouraging providers to discuss adverse determination decision.
143.	How are they going to be notified and who is going to be notified when the authorization is approved?	You can always check Provider Connect – you'll be able to see the authorization approval on Provider Connect. Additionally you'll be notified after the decision has been made in writing via mail. It's sent to your agency location.
144.	When initiating a Reconsideration in writing or by phone, to whom is this reconsideration to be sent, or whom does the provider contact via phone? Do we contact customer service with the Collaborative, or is there a specific person/division that must be contacted? How will a provider know that the request for Reconsideration made either in writing or via phone has been received and that the initial denial is being reconsidered? Do we just have to wait the 15 days and see if we are contacted via phone with the results of the reconsideration?	Reconsideration requests are to be submitted in writing, as additional documentation would be given by the provider. They are sent to Illinois Mental Health Collaborative for Access and Choice; Attention: Appeals Coordinator, PO Box 06559, Chicago, Illinois, 60606. This address will also be on the denial letters. As appeals are submitted in writing, providers do not have to call the Collaborative before submitting one in writing but can contact the Collaborative with questions about the process. If the provider indicates a plan to appeal, the CCM will document the call for reference to receipt of appeal required appeal documents.

		If a provider wishes to check the status of an appeal, they can contact the Collaborative at 866-359-7953. This is also stated on the denial letter. The decision must be made within the 15 days and notification is sent out after the decision is made.
145.	Related to question above, is this 14 day period of time in which the review and notification via phone is to occur following the receipt of the reconsideration request 14 calendar days or 14 business days? To whom will this phone notification be made regarding the outcome of the Reconsideration request? The CEO? Some designated contact person at the provider agency? The person who submitted the reconsideration request?	The turnaround time is 14 days. The phone notice would be given to the clinical individual requesting the appeal.
	DMH monitoring/improvement of processes	
146.	If a provider has an electronic record there's a capability of uploading information into another system. I'm wondering if we have the capability of uploading our information into your – into the Provider Connect data field?	At this time that is not possible, although we continue to look for opportunities to enhance the system.
	Provider staff	
147.	Can you talk a little bit about how the LPHA who's doing the authorization potentially bill for that service or that use of time?	Well the LPHA will be providing services that are documented. And it will be those documents that are used to show the medical necessity.
148.	Is it possible to use case management for that in terms of accessing benefits that they may be eligible for?	Yes. One example of Case Management – Mental Health in the Service Definition and Reimbursement Guide includes helping the client access appropriate mental health services
149.	Can we bill the state under case management for doing recertification of existing consumers?	According to the Service Definition Reimbursement Guide, Case Management Mental Health includes "Assessing the need for service, identifying and investigating available resources, explaining options to the client and assisting in the application process."
	HFS Integrated Care Pilot	
150.	For agencies participating in the managed care pilot will they be required to participate in this UM process from January 3, 2011 to whenever the pilot starts? Or will they not be required to get authorizations until the pilot starts and that process is utilized?-If agencies have some sites in Suburban Cook that will participate in the managed care pilot and some in Chicago which are not participating in the pilot	The DHS/DMH utilization management program applies ONLY to individuals for whom DMH reimburses care. If a provider is seeking reimbursement from DMH for an individual, then the provider will need to follow the UM program as it applies to that specific individual.

	will the agency be required to facilitate two different UM systems?-	
Training Materials/Resources		
151.	Can we get a copy of this PowerPoint?	Yes. It is posted on the Collaborative's website, under the Clinical/Utilization Management heading. It's the very first bulleted point entry.