Illinois Department of Human Services,
Division of Mental Health/
The Illinois Mental Health Collaborative
for Access and Choice

FY 2011 REQUEST FOR AUTHORIZATION

ELECTRONIC SUBMISSION PROCESS

Agenda

Overview of the Authorization Process

Electronic Submission Process for Community Support Group (CSG) ï Live Demo

Electronic Submission Process for Psychosocial Rehabilitation (PSR) ï Live Demo

Electronic Submission Process for Therapy/Counseling (T/C) ï Live Demo

Overview of the Authorization Process

- Authorization for payment of services is required after January 3, 2011 for any consumer receiving services above and beyond the threshold hours/units of service

- Authorization request form with a Mental Health Assessment (MHA) and Individual Treatment Plan (ITP), along with any other supporting documentation to establish Medical Necessity Criteria

- Submit authorization request electronically through ProviderConnect and supporting clinical documentation either as secure clinical attachments with request or via facsimile

Necessary items for submitting an authorization

- Authorization request via ProviderConnect - All required and applicable fields completed. The Collaborative will not review requests for authorization submitted via facsimile.
- Current MHA and ITP - Securely attached with ProviderConnect request or faxed to the Collaborative (866-928-7177) within 1 business day
- Additional documentation - May be necessary if the MHA and ITP do not fully support medical necessity for the request. This information must also be securely attached with ProviderConnect request or faxed to the Collaborative (866-928-7177) within 1 business day.
- If required supporting materials (MHA, ITP, etc.) are not included with request/received within 1 business day, the Collaborative staff will contact the provider to explain the additional information that is required and the request will be closed without review. The provider must resubmit the entire request for authorization with all supporting documentation.

- If choosing to fax, rather than attach to the on-line request, the supporting clinical documentation for the request (e.g. MHA, ITP, etc.), please ensure that each consumerôs information is faxed separately.
- If choosing to fax, rather than attach to the on-line request, the supporting clinical documentation for the request (e.g. MHA, ITP, etc.), please ensure that the service being requested is noted on the fax cover sheet.

When to submit a request for authorization

Therapy/Counseling

- Eligible Consumers are able to initially receive up to 10 hours (40 units) of this service, if provider LPHA deems medically necessary, without submission of an authorization request
- If provider deems additional hours (units) of T/C are medically necessary above and beyond the 10 hour (40 unit) threshold, a request for authorization must be submitted **and** authorization must be obtained in order to be reimbursed for services

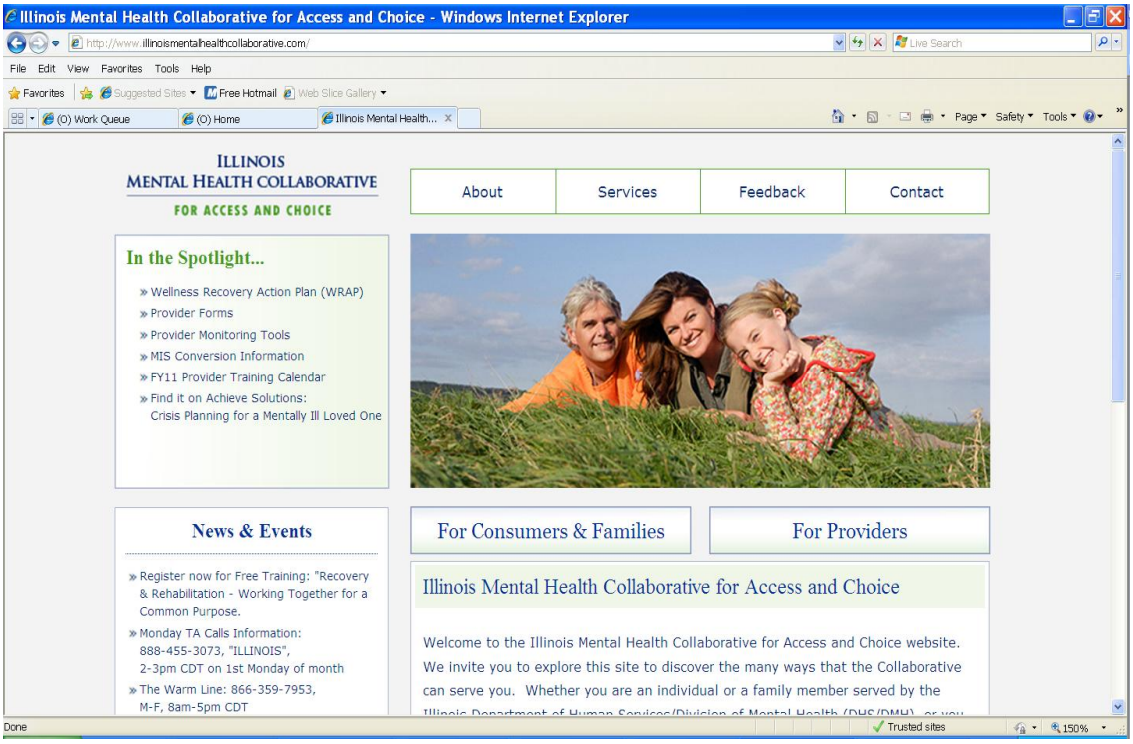
PSR & Community Support Group

- Eligible Consumers are able to initially receive up to 200 hours (800 units) of PSR, CSG, or a combination of PSR & CSG, if provider deems medically necessary, without submission of an authorization request
- If provider LPHA deems additional hours (units) are medically necessary above and beyond the 200 hour (800 unit) threshold, a request for authorization must be submitted **and** authorization must be obtained in order to be reimbursed for services

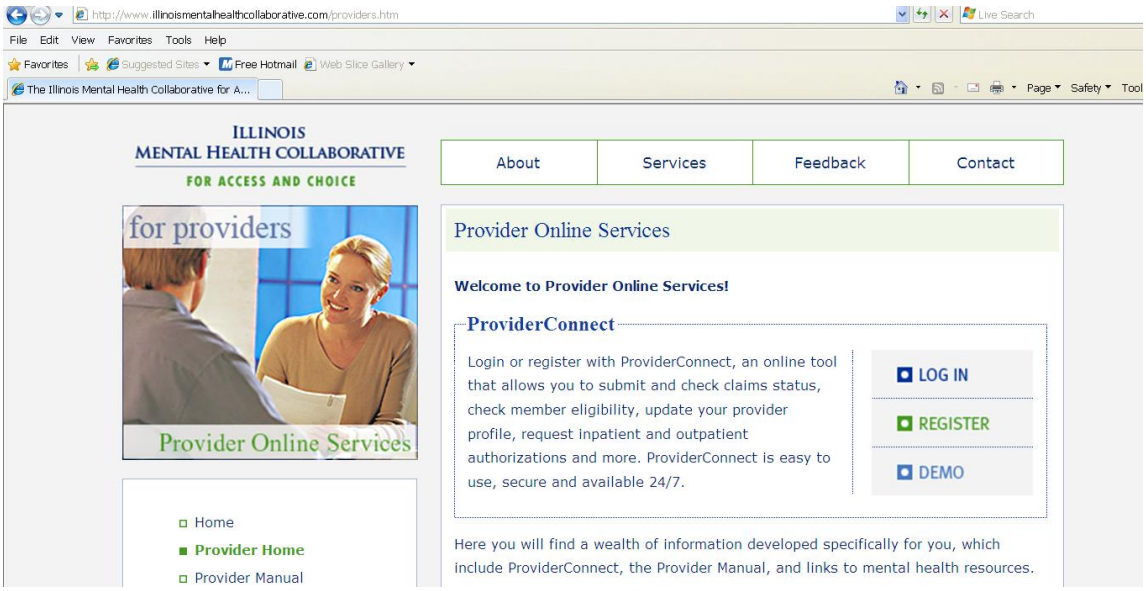
Please utilize the following ñworkflowsò to assist you in completing your on-line request for authorization submissions. Please note that there are examples provided of the of blank fields in the requests, as well as completed fields in order to demonstrate the difference in appearance.

Electronic Submission Process for Community Support Group (CSG)

1. Go to Illinois Mental Health Collaborative website:
   http://www.illinoismentalhealthcollaborative.com

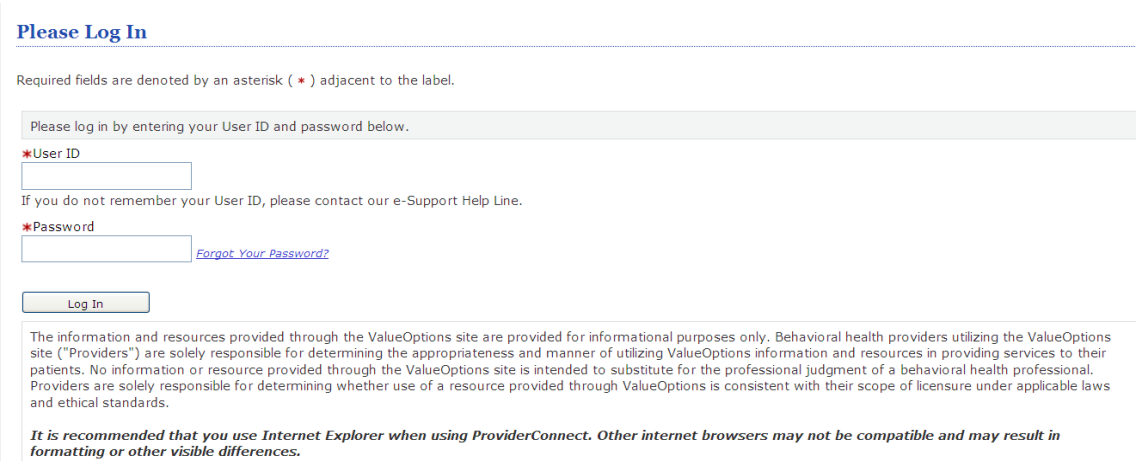


2. Once at the homepage, click the ñFor Providersòtab

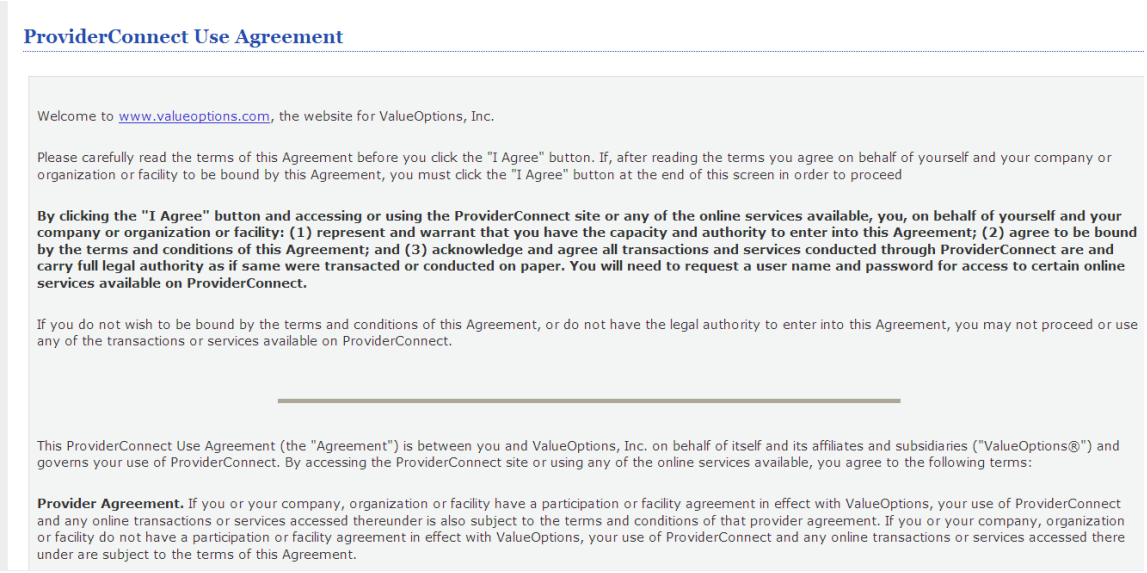


3. Click the ñLog Inòtab
4. Enter User ID

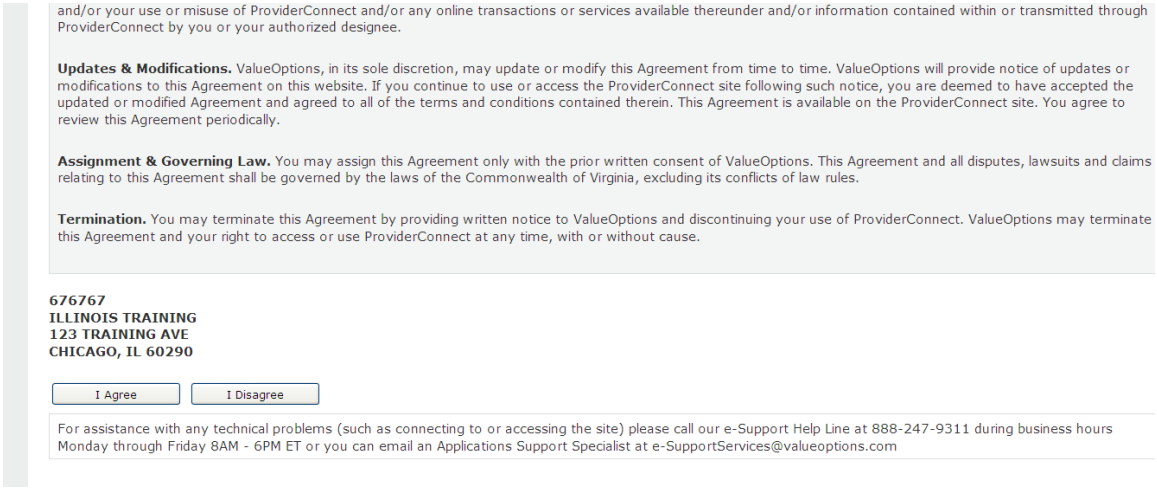
5. Enter Password
6. Click the ñLog In tabò



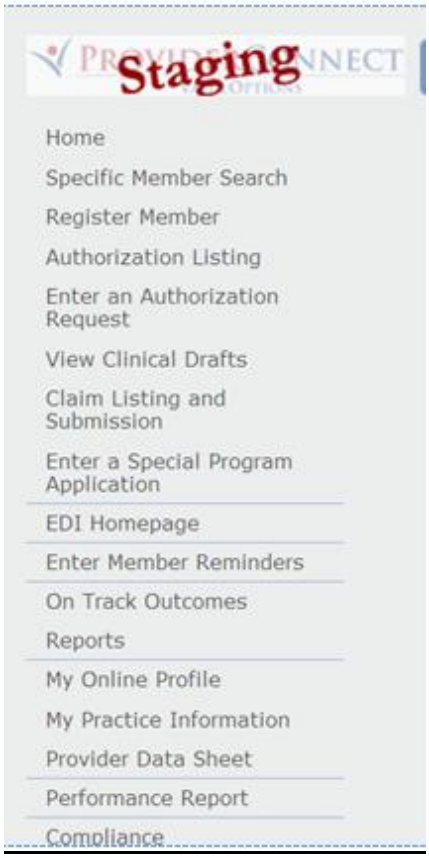
7. Provider will see the Use Agreement



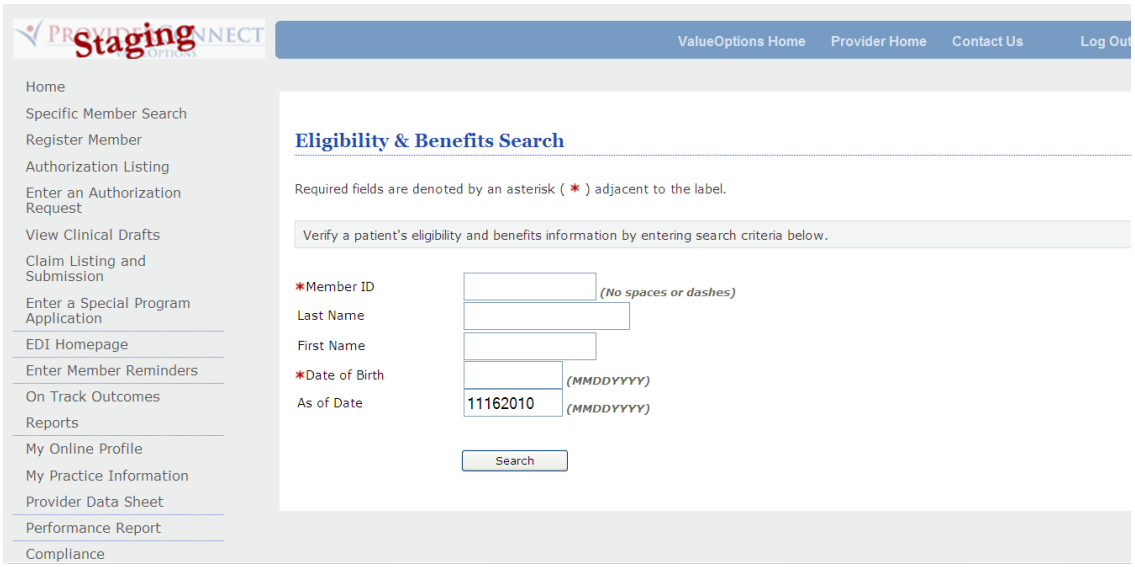
8. At the bottom of this page, provider will see tabs indicating agreement or disagreement.



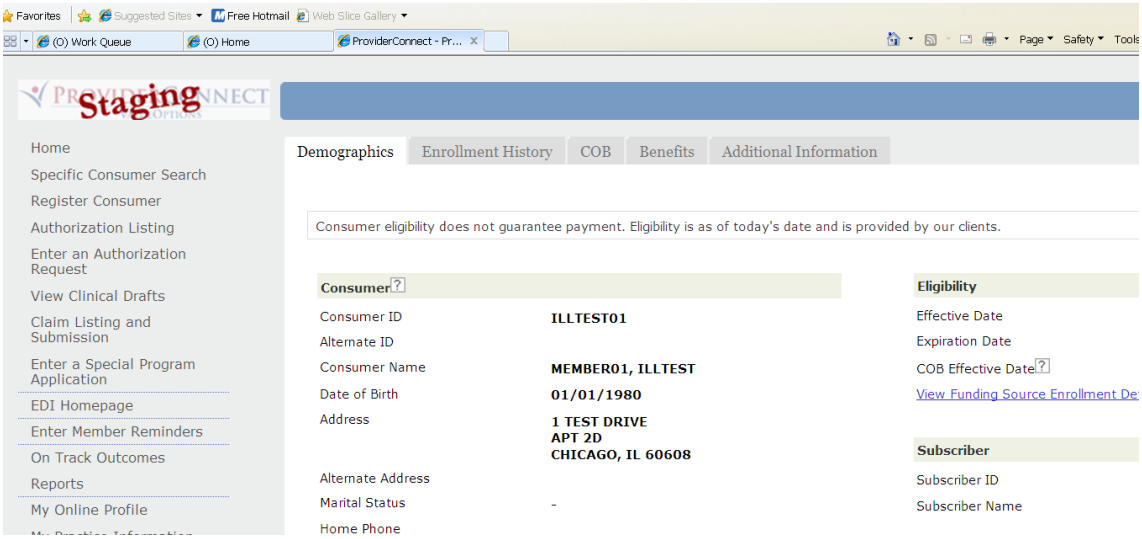
9. If provider wishes to continue with the process, provider will click the ñI Agreeò tab. The provider will be taken to the ProviderConnect home page and will select ñSpecific Member Searchòfrom the options on the left hand side of the page.



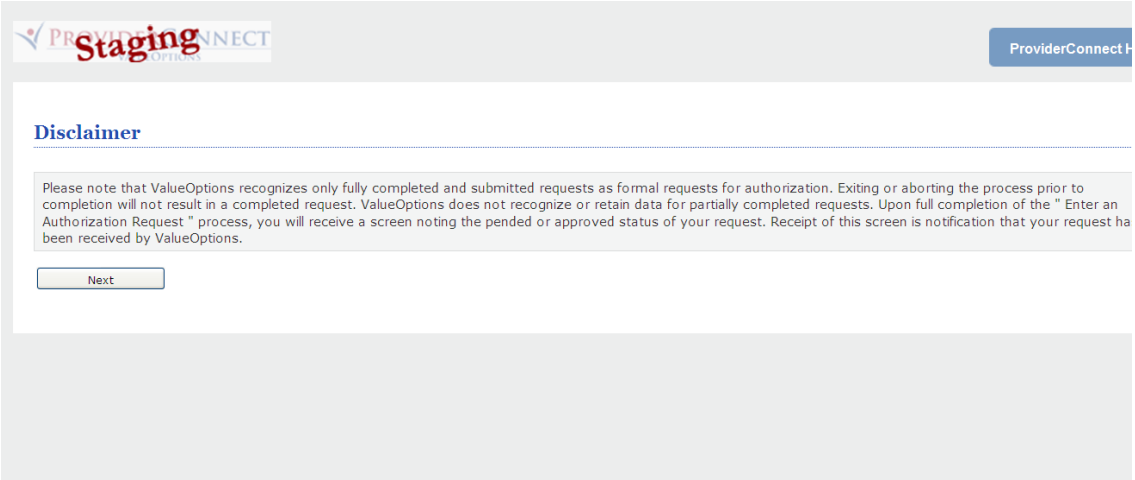
10. Provider will be taken to the ñEligibility and Benefits Searchòscreen.
11. Enter required fields: Member ID (9 digit RIN) and Date of Birth
12. Click ñSearchòtab



13. Provider will be taken to the ñDemographicsòscreen for the consumer
14. Click the ñEnter an Authorization Requestòtab at the left hand side of the screen

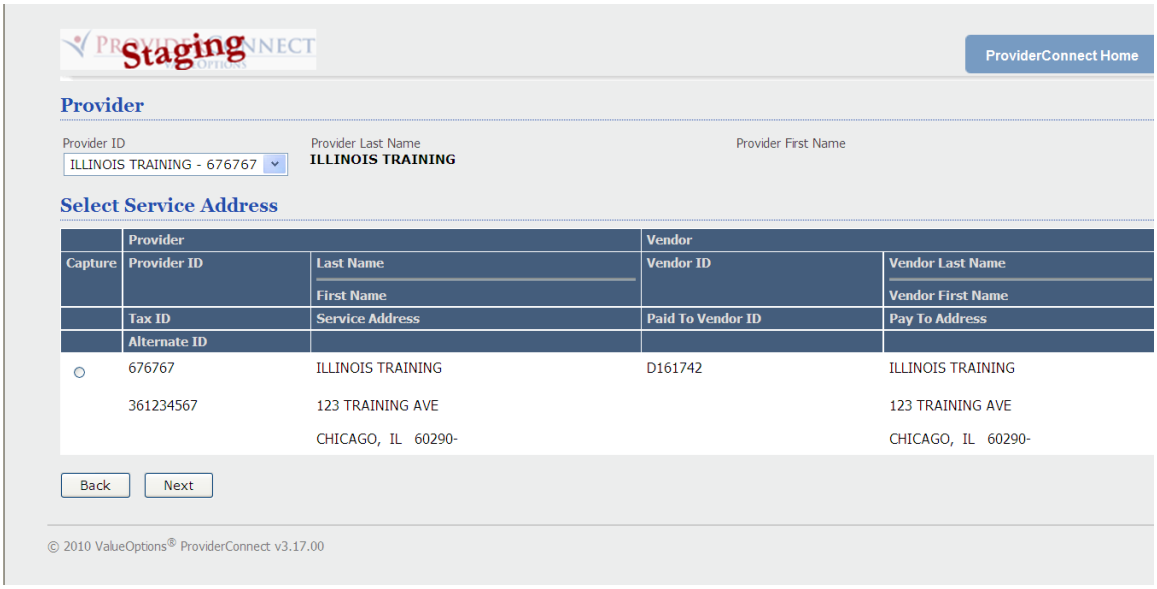


15. Provider will be taken to the ñDisclaimerò page

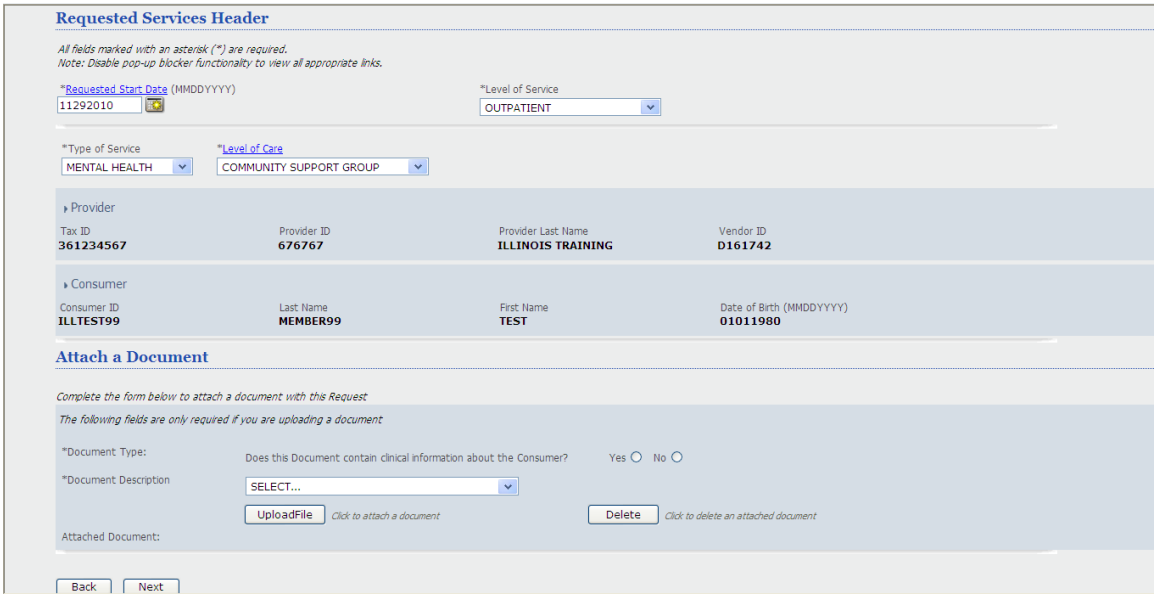


16. If provider wishes to proceed with authorization request, they will click the ñNextò tab

17. Provider will be taken to the ñProviderò screen

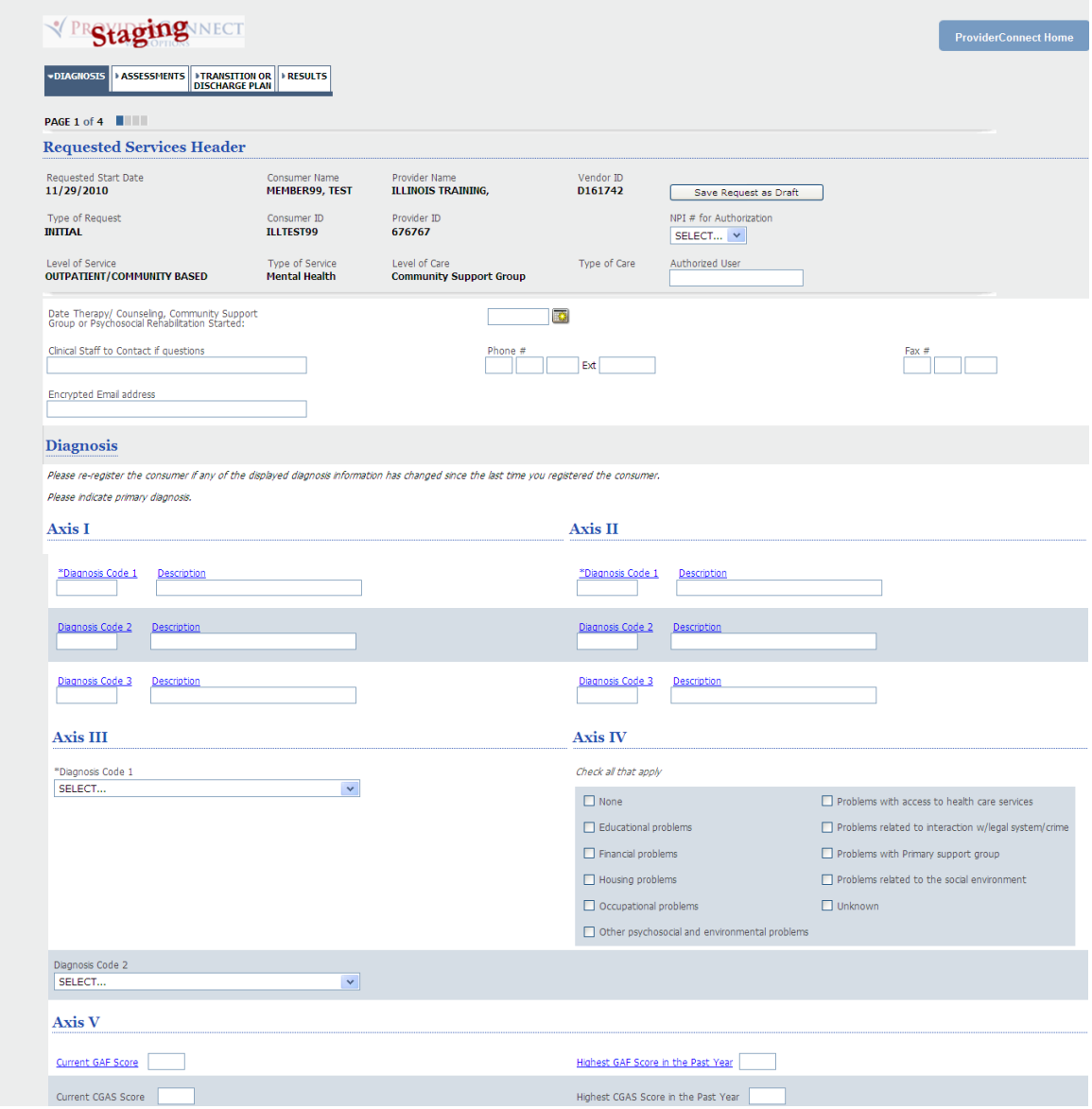


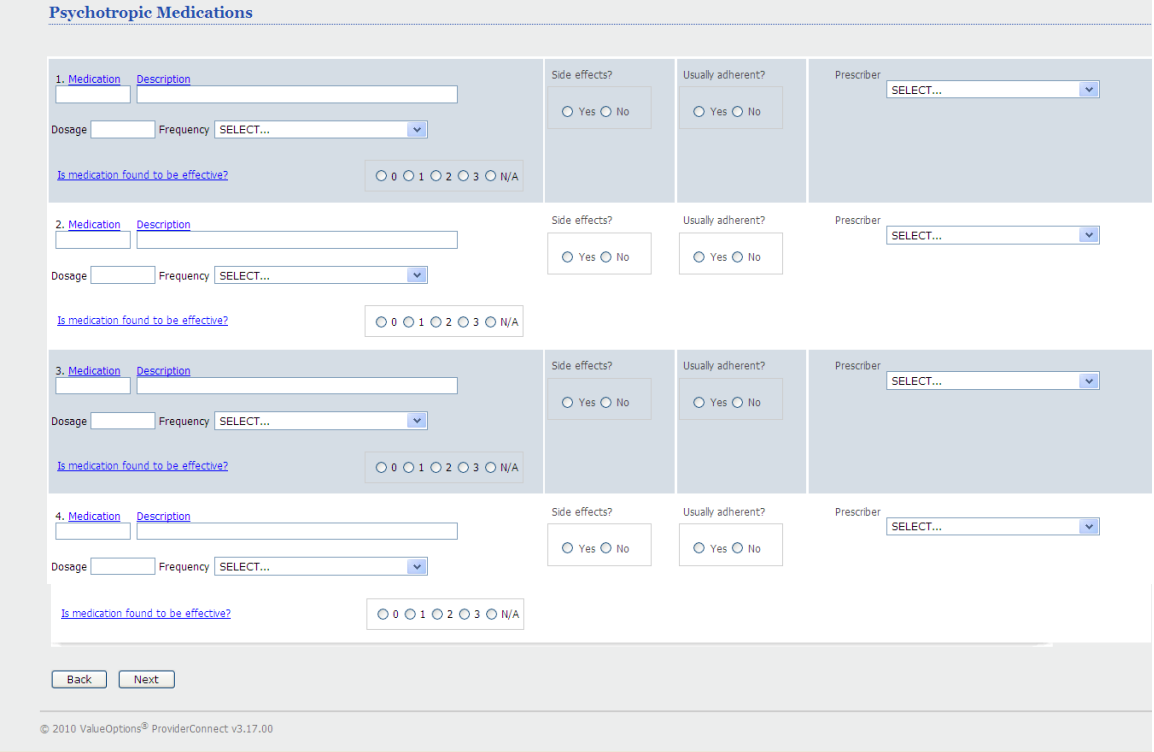
18. Select service address
19. Click the ñNextò tab
20. Provider will be taken to the ñRequested Services Headerò



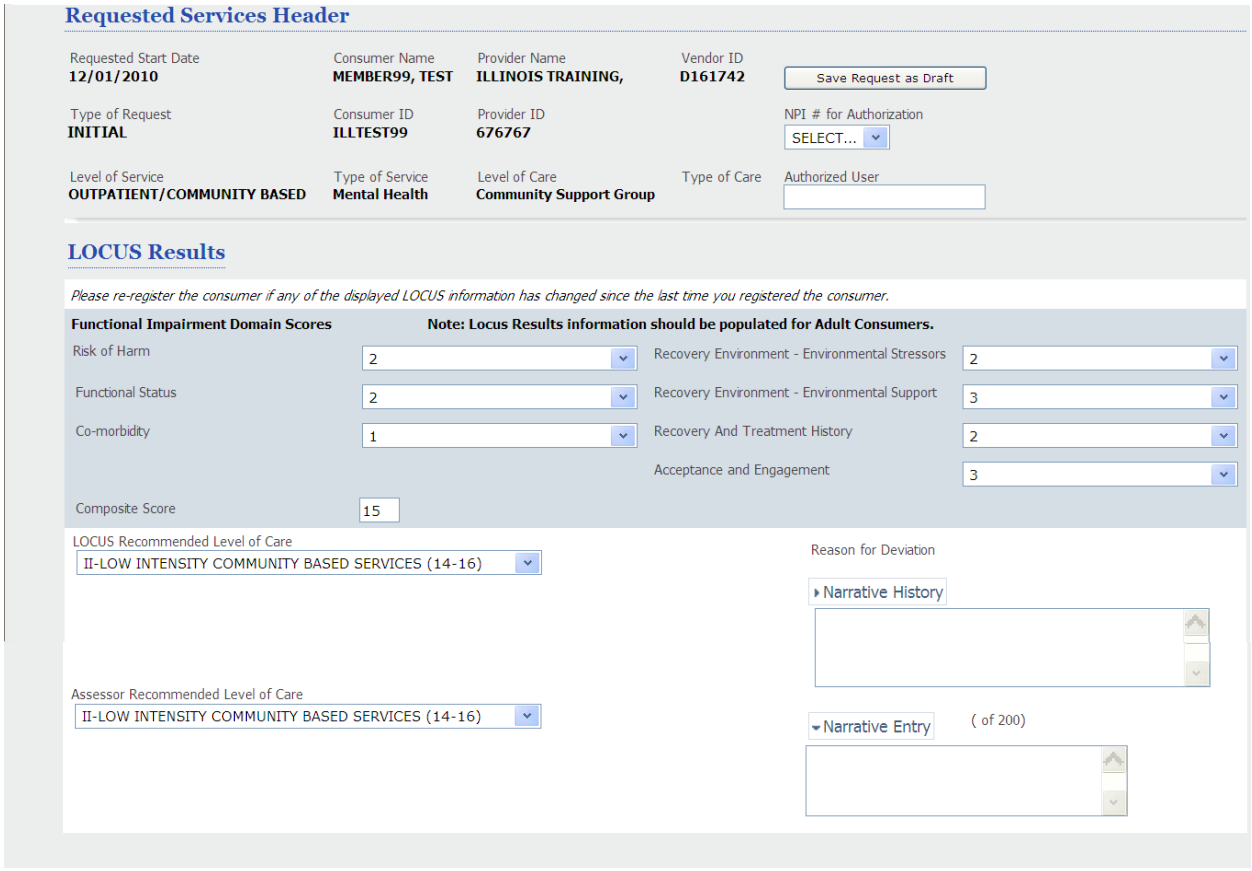
21. Enter a ñRequested Start Dateò for the start date of the authorization
22. Enter ñLevel of Serviceò = ñOutpatientò
23. Enter ñType of Serviceò = ñMental Healthò
24. Enter ñLevel of Careò = ñCommunity Support Groupò

25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the ñYesò button to the right of ñDocument Typeò
26. Select appropriate document from list in drop down menu in ñDocument Descriptionò
27. Click the ñUploadò tab
28. Upload each document following steps 25, 26, and 27
29. Click ñNextò
30. Provider will be taken to the ñRequested Services Headerò screen





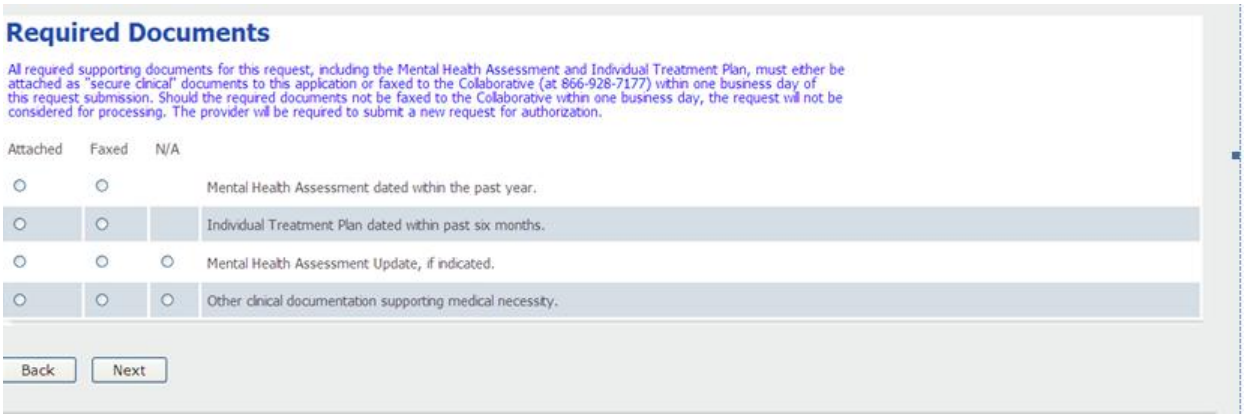
31. Provider will complete all required fields.
32. Click the ñNextòtab
33. Provider will be taken to the ñLOCUS ResultsòScreen. ***If the consumer is 18 or older, this information is required.



34. Complete ñFunctional Impairment Domain Scoresò
35. Select ñLOCUS Recommended Level of Careò
36. Select ñAssessor Recommended Level of Careò
37. Provide narrative explanation of any ñReason for Deviationòin appropriate text box

38. If the consumer is less than 18 years old, the Ohio Scale or Devereaux Scale Results must be completed.
    a. For youth ages 5-17, the Ohio Scale is required
    b. For children under the age of 5 and under, the DECA Subscale is required

39. At the bottom of the page, indicate whether the required documents will be attached, faxed, or not applicable for each item.



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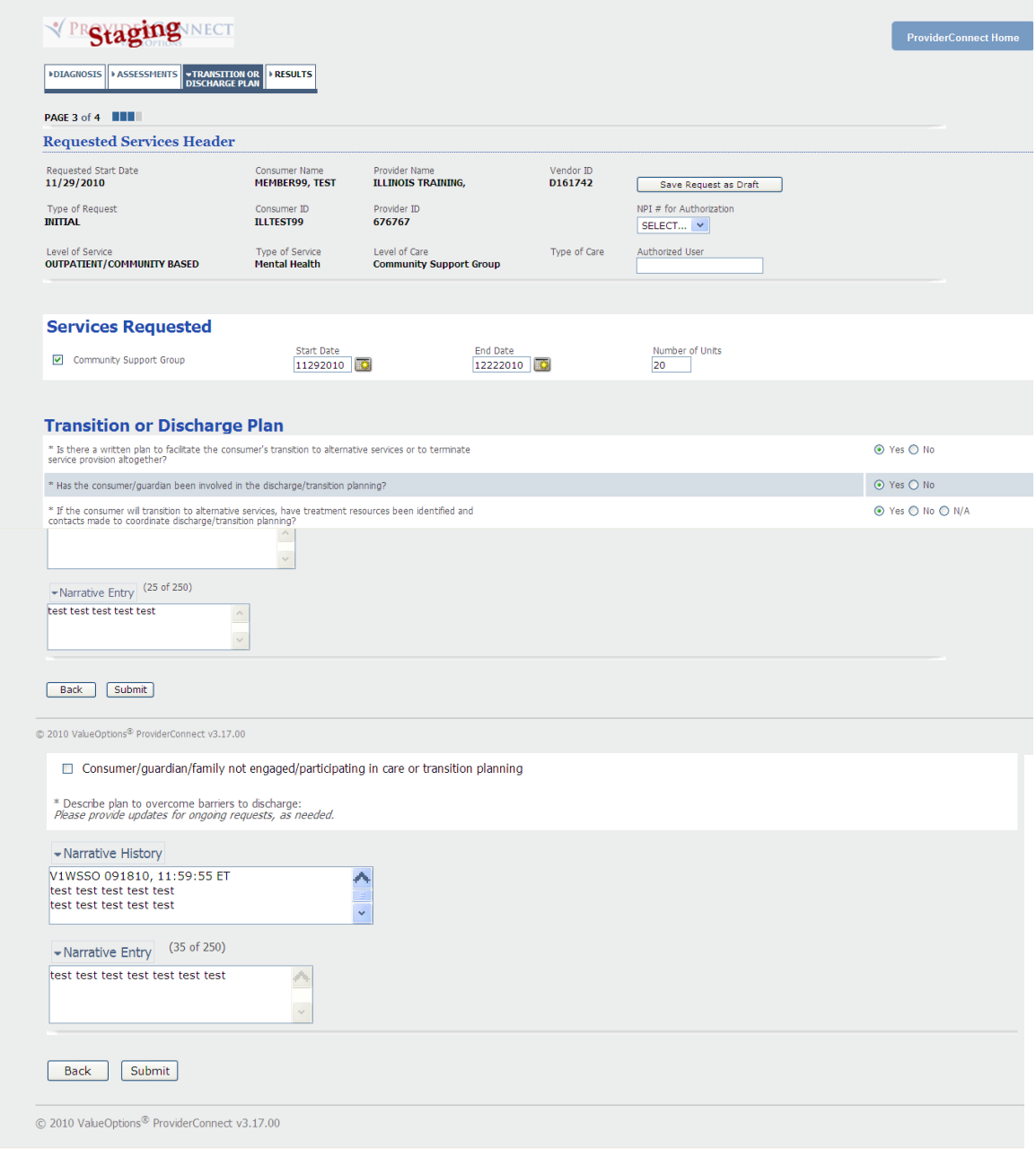
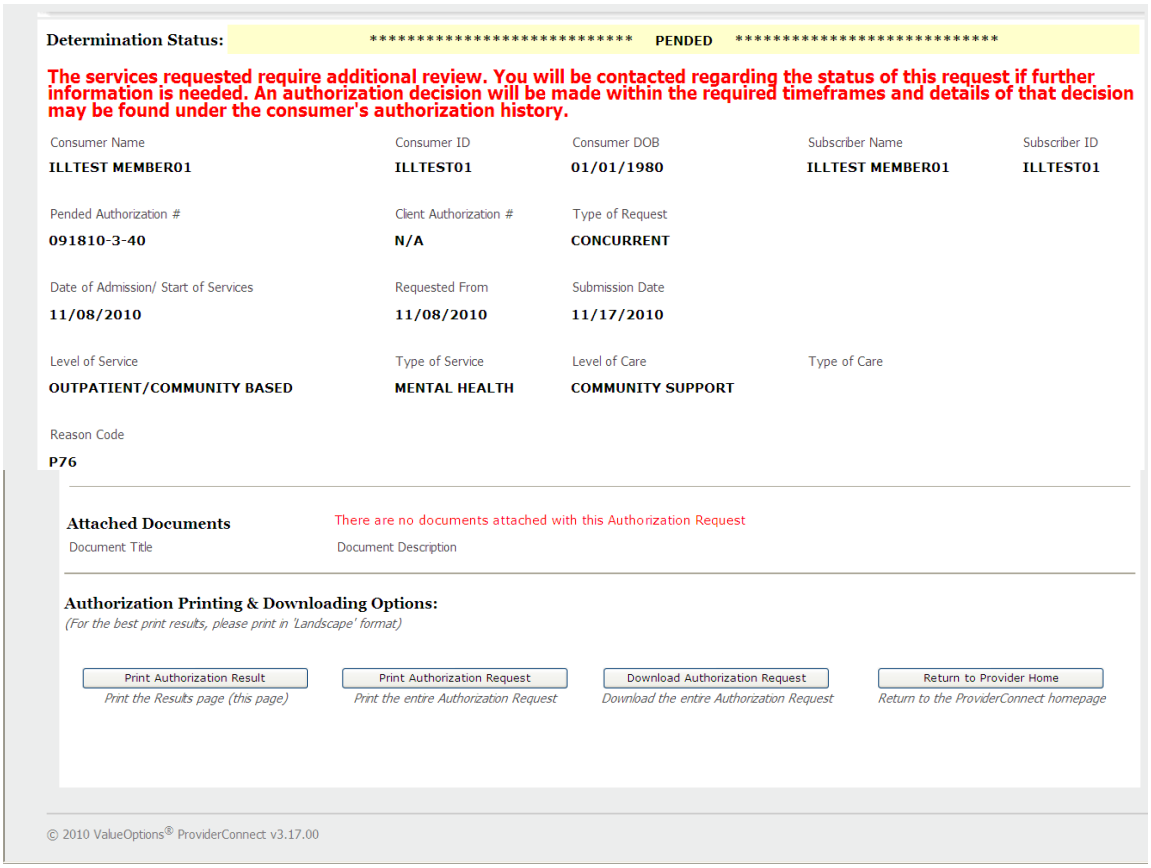


42. Indicate ñStart Dateò, ñEnd Dateò, and ñNumber of Unitsòrequested
43. Complete ñTransition or Discharge Plan Sectionò, providing required narrative.
44. Click the ñSubmitòtab
45. Provider will be taken to the ñDetermination Statusò Screen



46. Provider can choose to:
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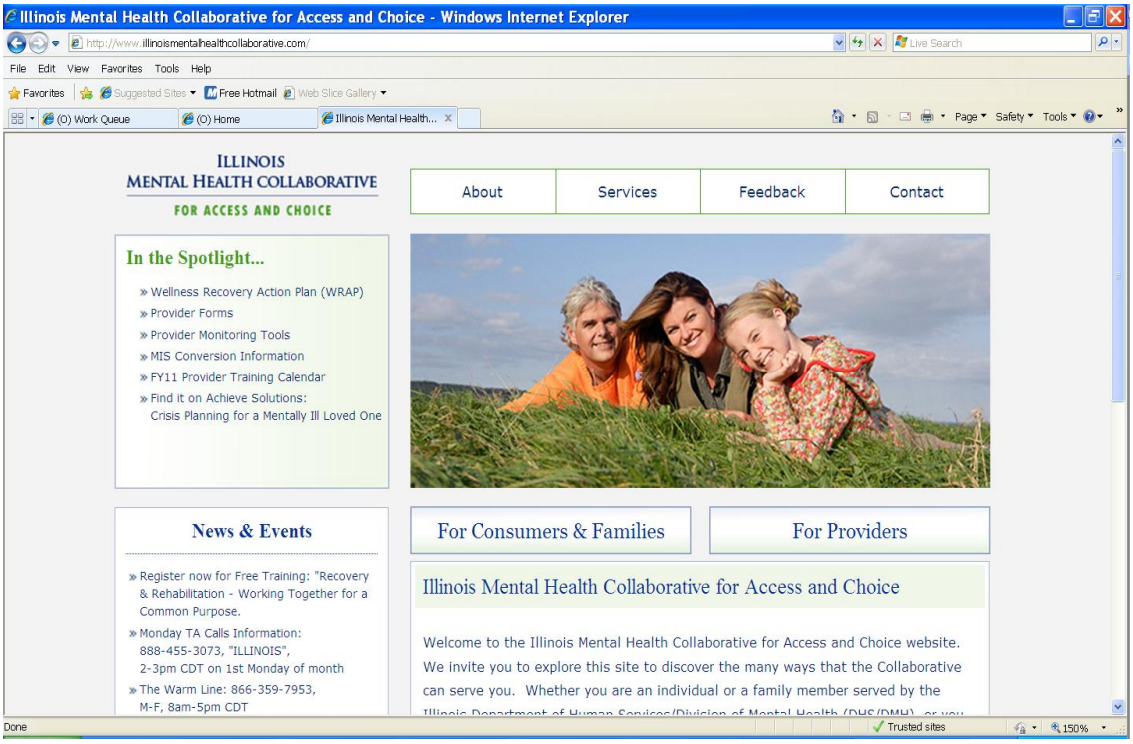

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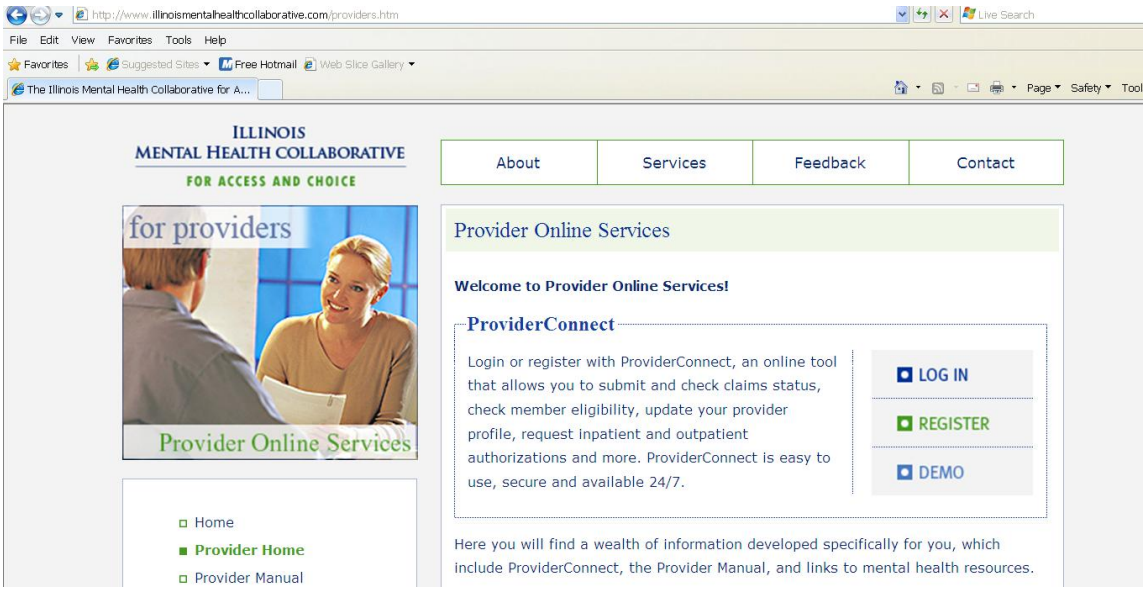

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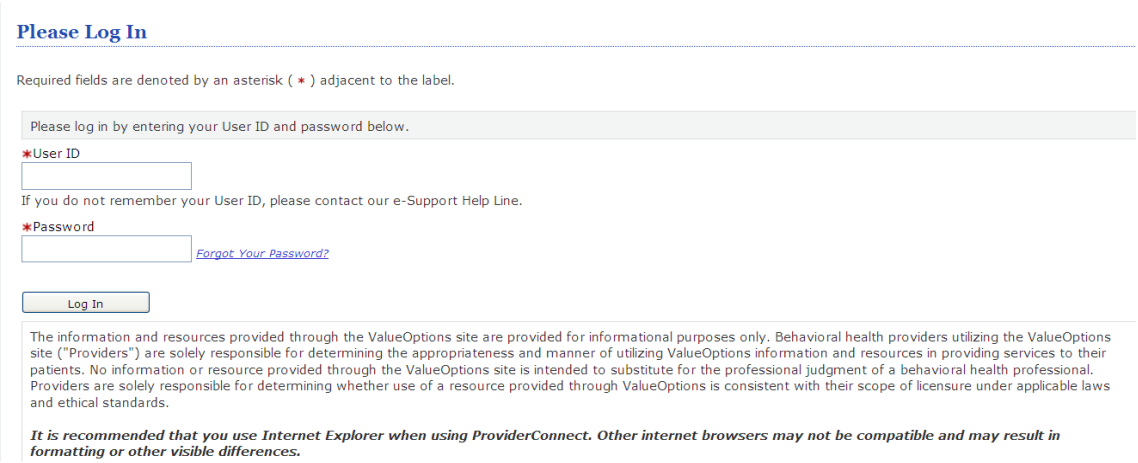

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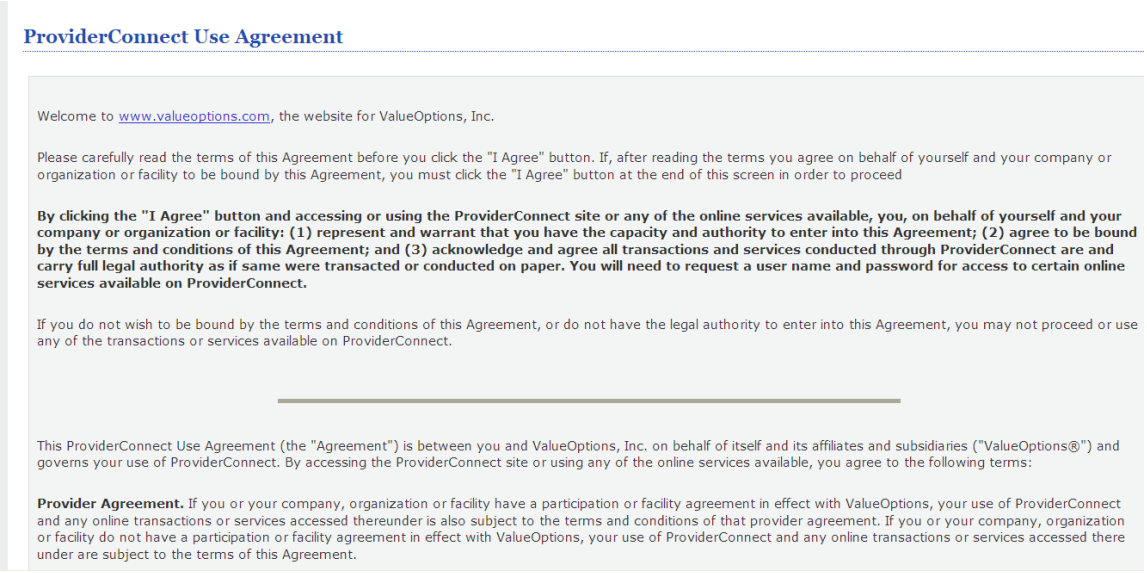

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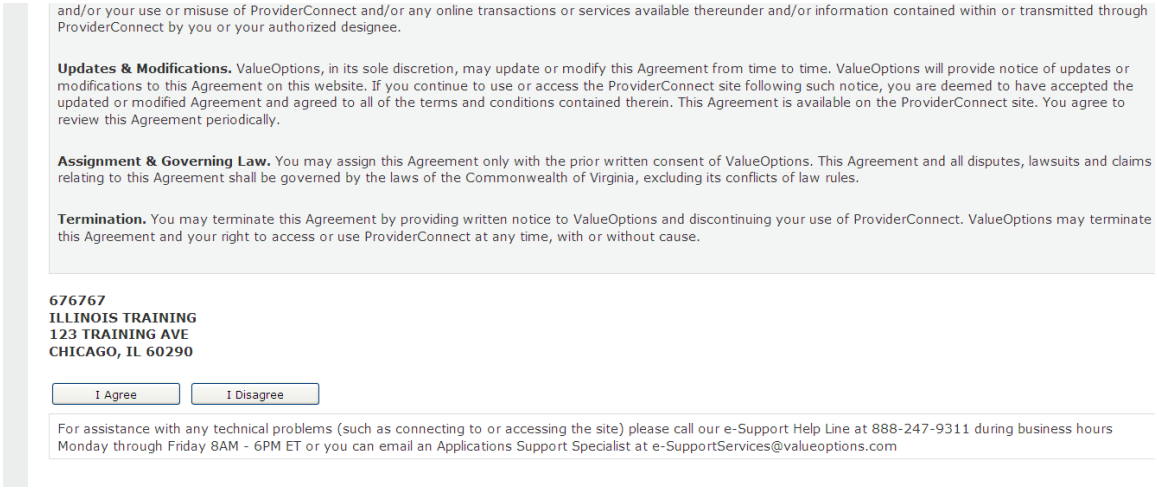

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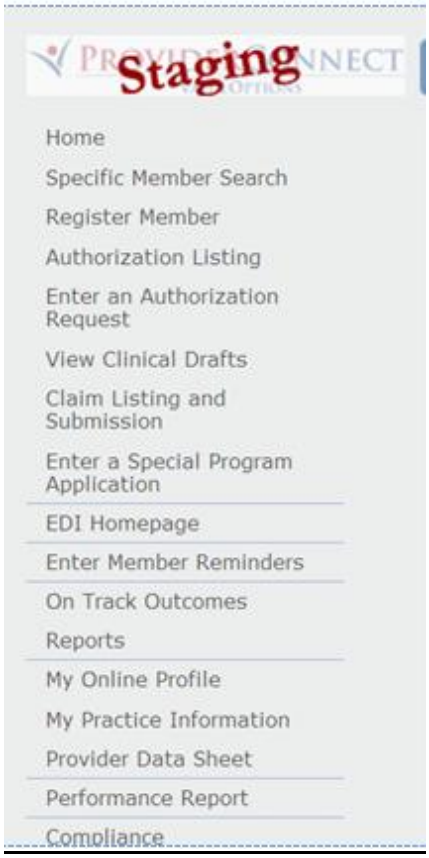

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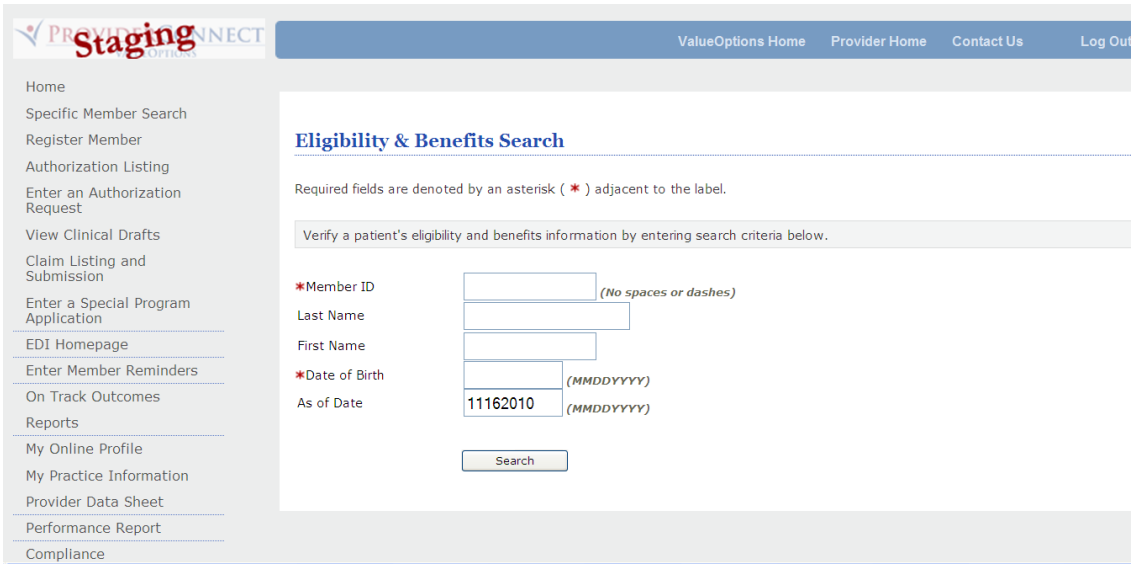

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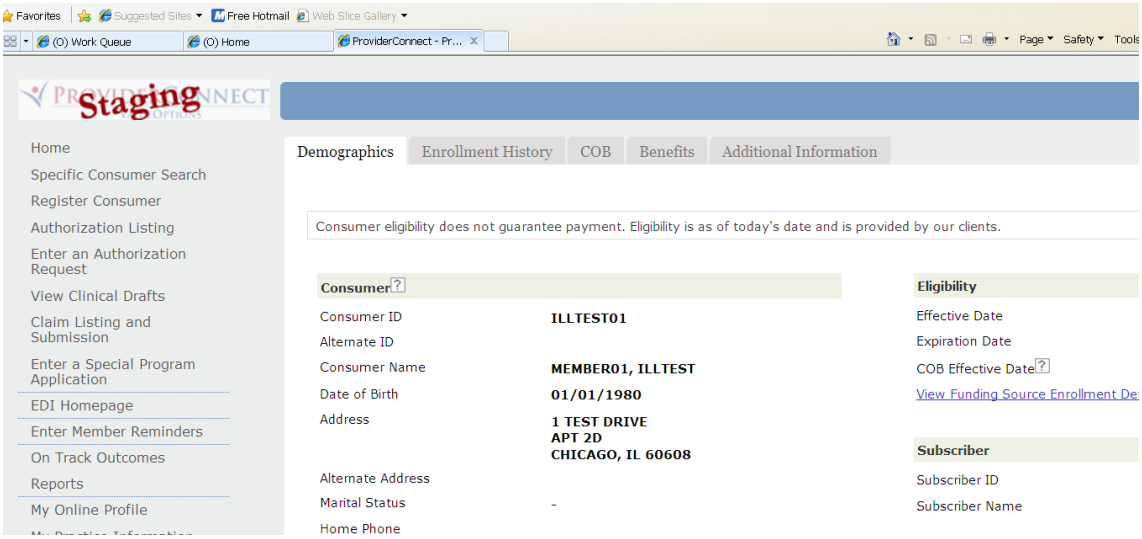

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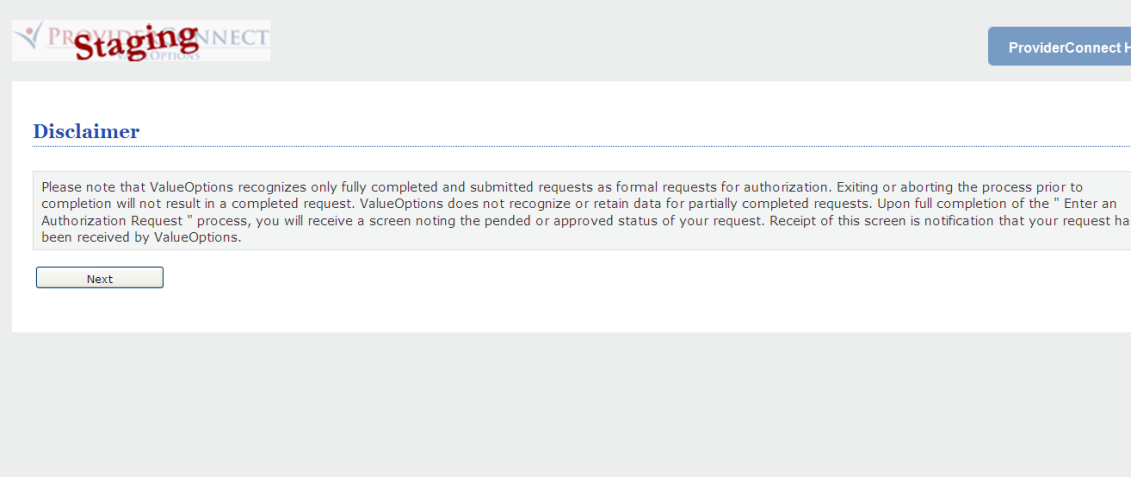

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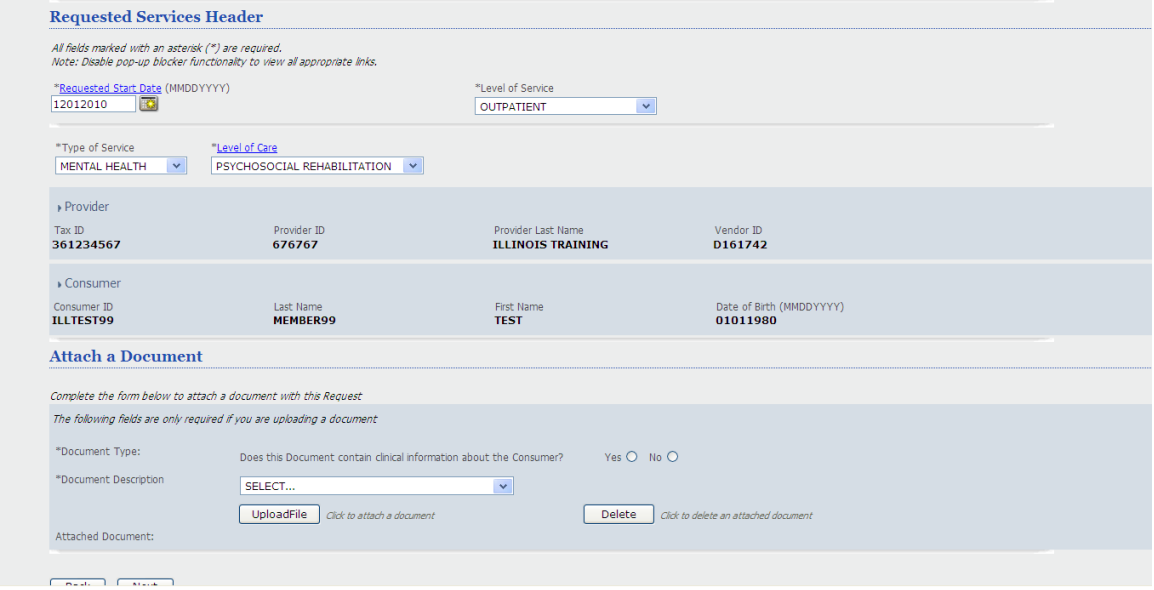

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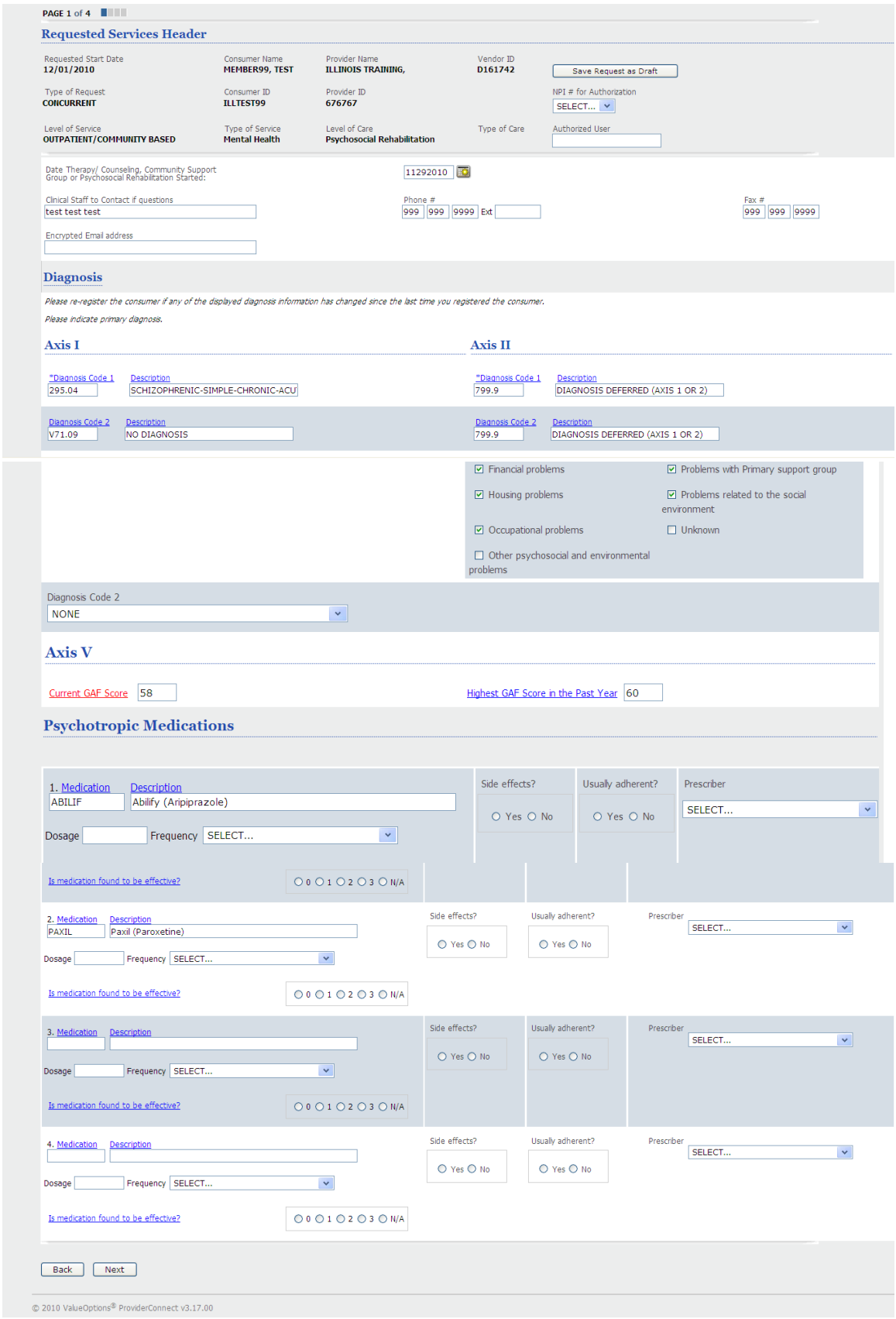
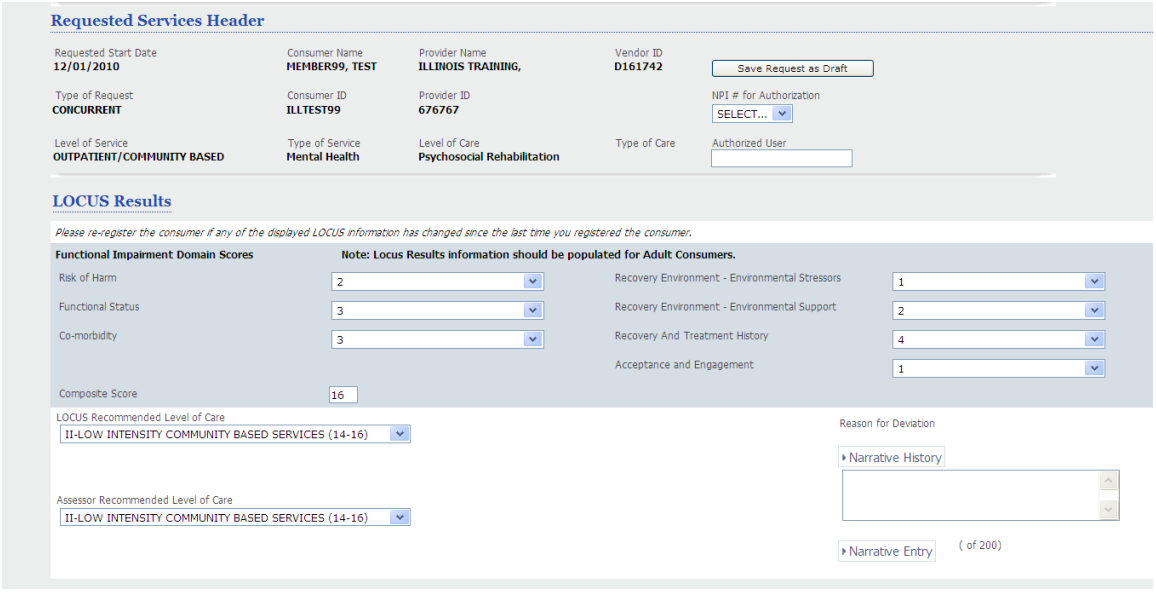

PAGE 1 of 4
Requested Services Header
Requested Start Date
12/01/2010
Consumer Name
MEMBER99, TEST
Provider Name
ILLINOIS TRAINING,
Vendor ID
D161742
Save Request as Draft
Type of Request
CONCURRENT
Consumer ID
ILLTEST99
Provider ID
676767
NPI # for Authorization
SELECT...
Level of Service
OUTPATIENT/COMMUNITY BASED
Type of Service
Mental Health
Level of Care
Psychosocial Rehabilitation
Type of Care
Authorized User
Date Therapy/ Counseling, Community Support Group or Psychosocial Rehabilitation Started:
11292010
Clinical Staff to Contact if questions
test test test
Phone #
999 999 9999 Ext
Fax #
999 999 9999
Encrypted Email address
Diagnosis
Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.
Axis I
*Diagnosis Code 1
295.04
Description
SCHIZOPHRENIC-SIMPLE-CHRONIC-ACU
Diagnosis Code 2
V71.09
Description
NO DIAGNOSIS
Axis II
*Diagnosis Code 1
799.9
Description
DIAGNOSIS DEFERRED (AXIS 1 OR 2)
Diagnosis Code 2
799.9
Description
DIAGNOSIS DEFERRED (AXIS 1 OR 2)
Financial problems
Problems with Primary support group
Housing problems
Problems related to the social environment
Occupational problems
Unknown
Other psychosocial and environmental problems
Diagnosis Code 2
NONE
Axis V
Current GAF Score
58
Highest GAF Score in the Past Year
60
Psychotropic Medications
1. Medication
ABILIF
Description
Abilify (Aripiprazole)
Dosage
Frequency
SELECT...
Side effects?
Yes No
Usually adherent?
Yes No
Prescriber
SELECT...
Is medication found to be effective?
0 1 2 3 N/A
2. Medication
PAXIL
Description
Paxil (Paroxetine)
3. Medication
Description
4. Medication
Description
Back
Next
© 2010 ValueOptions® ProviderConnect v3.17.00

31. Provider will complete all required fields.
32. Click the ñNextò tab
33. Provider will be taken to the ñLOCUS Resultsò Screen.



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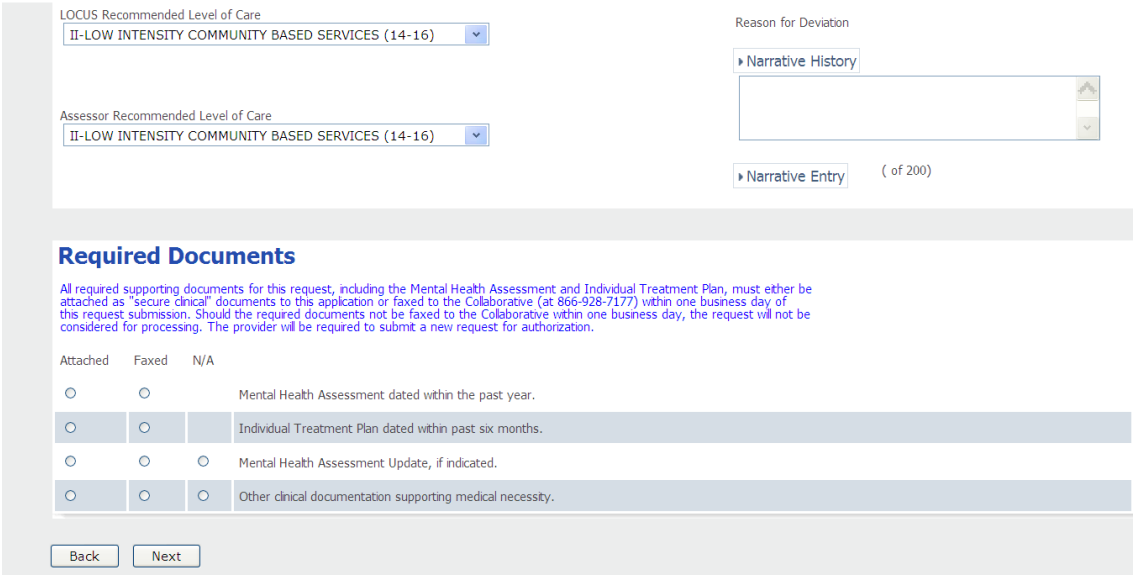

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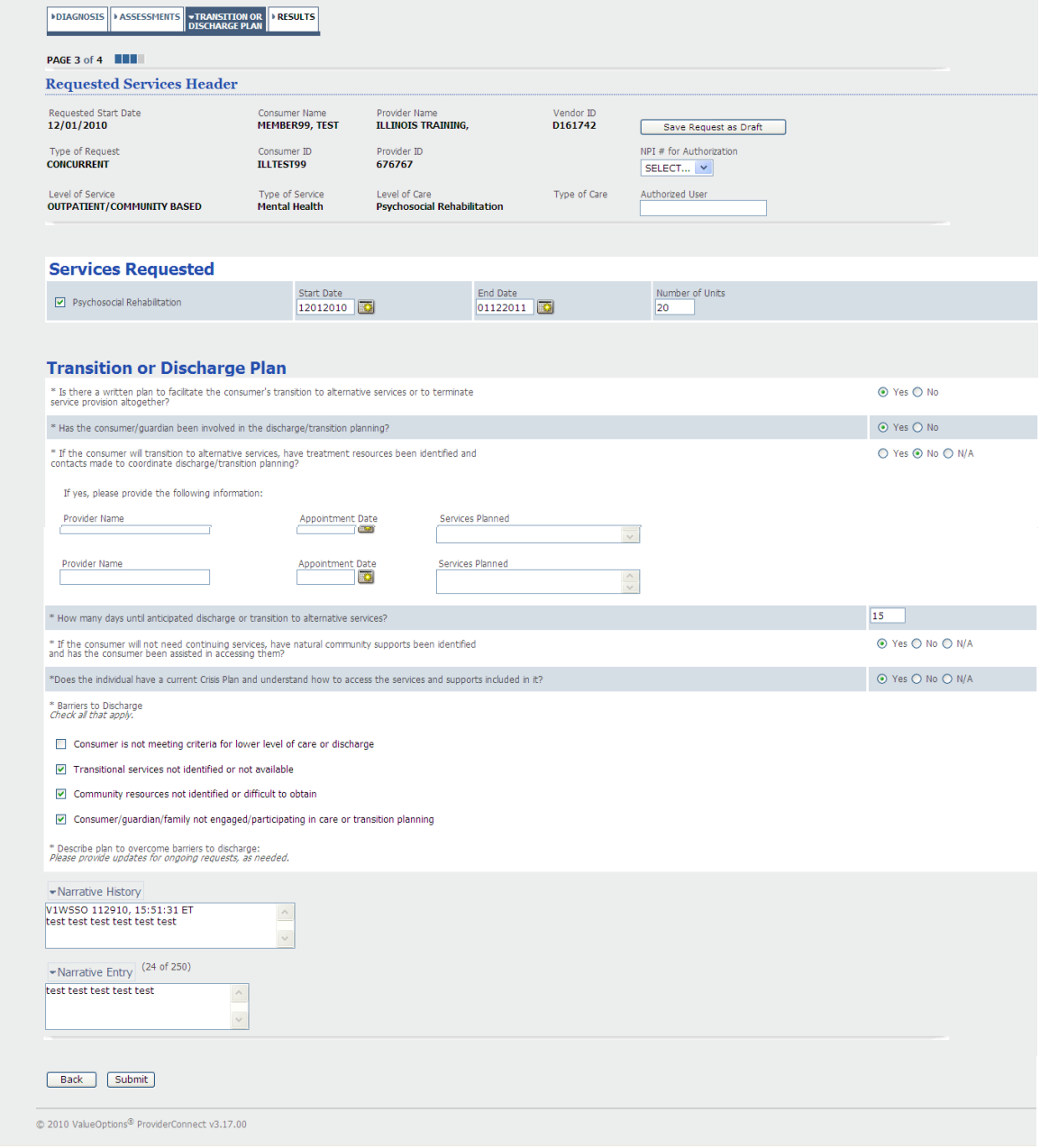

41. Indicate ñStart Dateò, ñEnd Dateò, and ñNumber of Unitsòrequested
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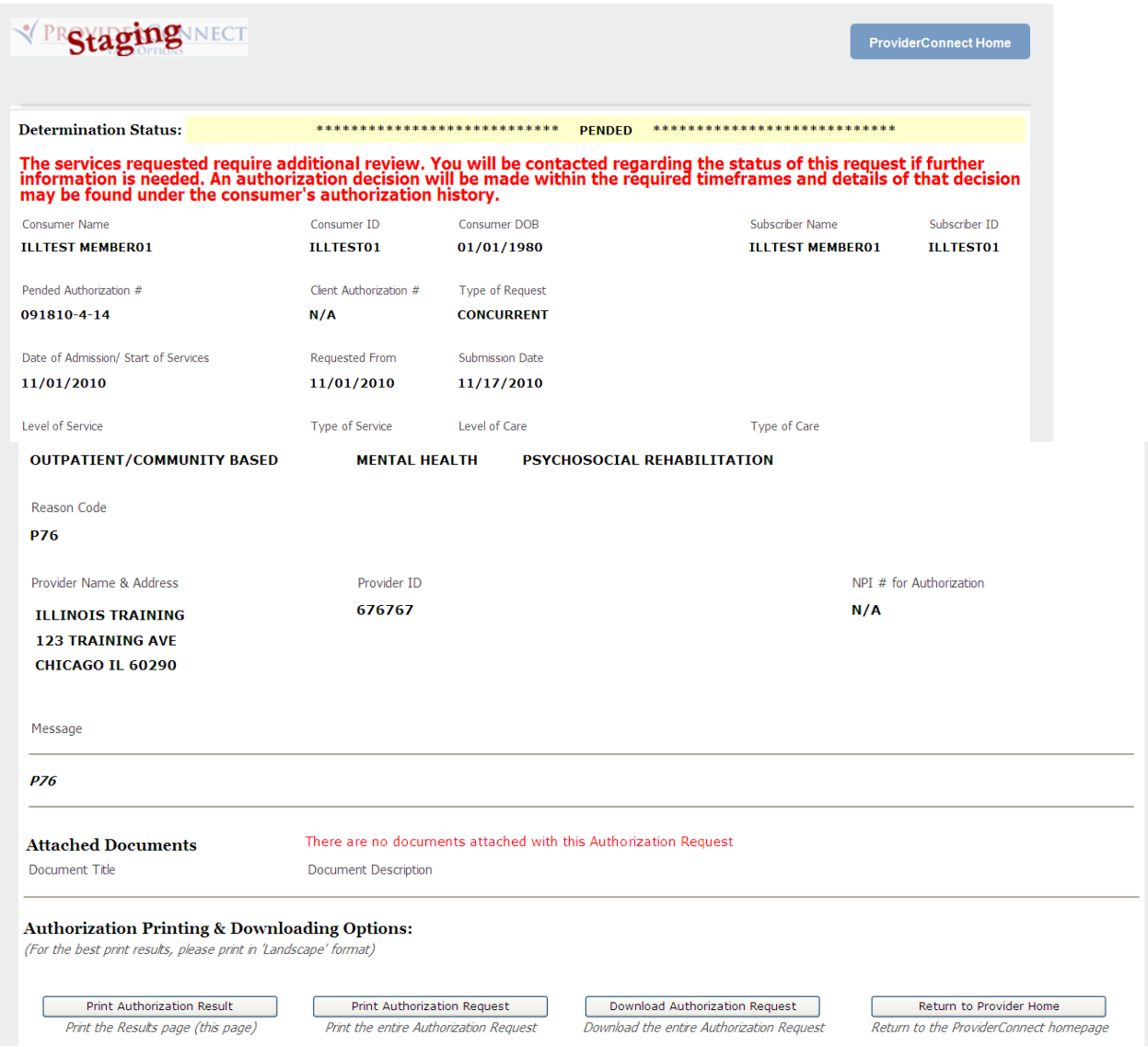

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Electronic Submission Process for Therapy/Counseling (T/C)

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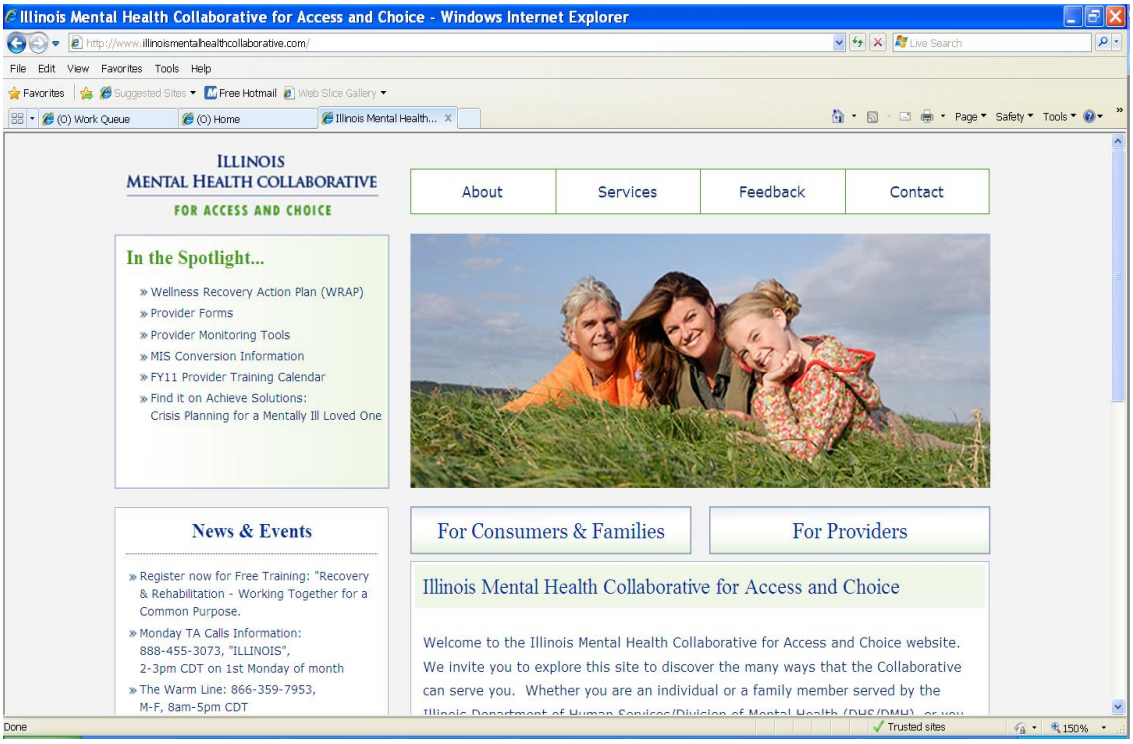

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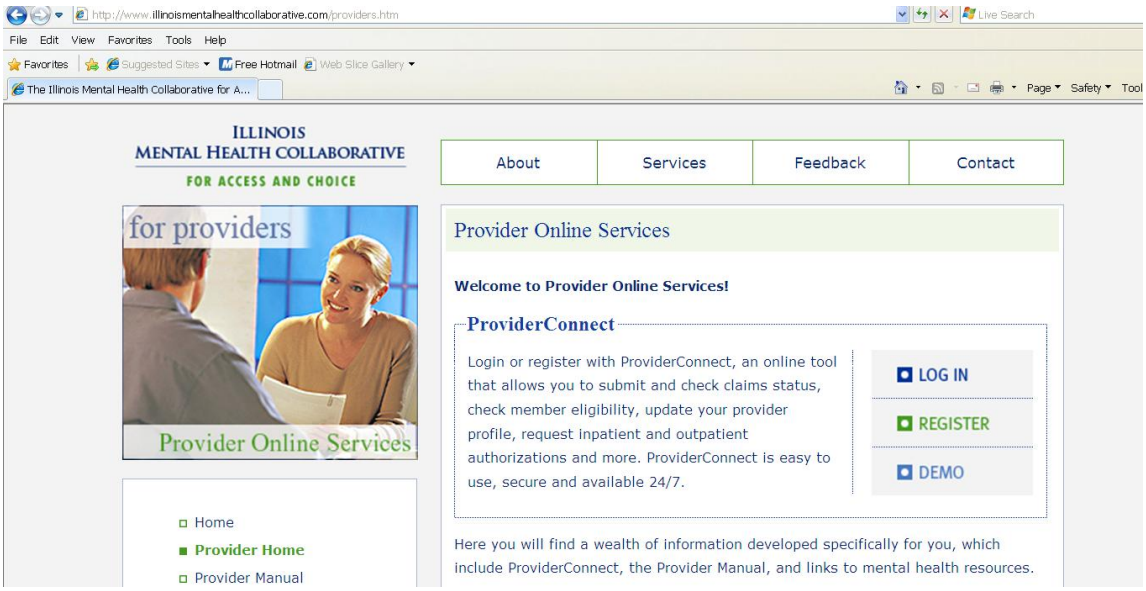

3. Click the ñLog Inòtab
4. Enter User ID

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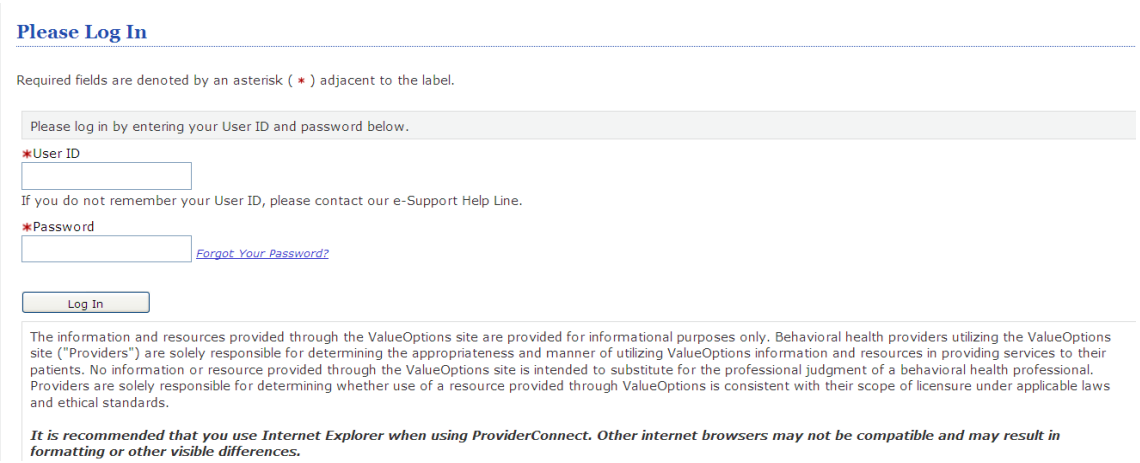

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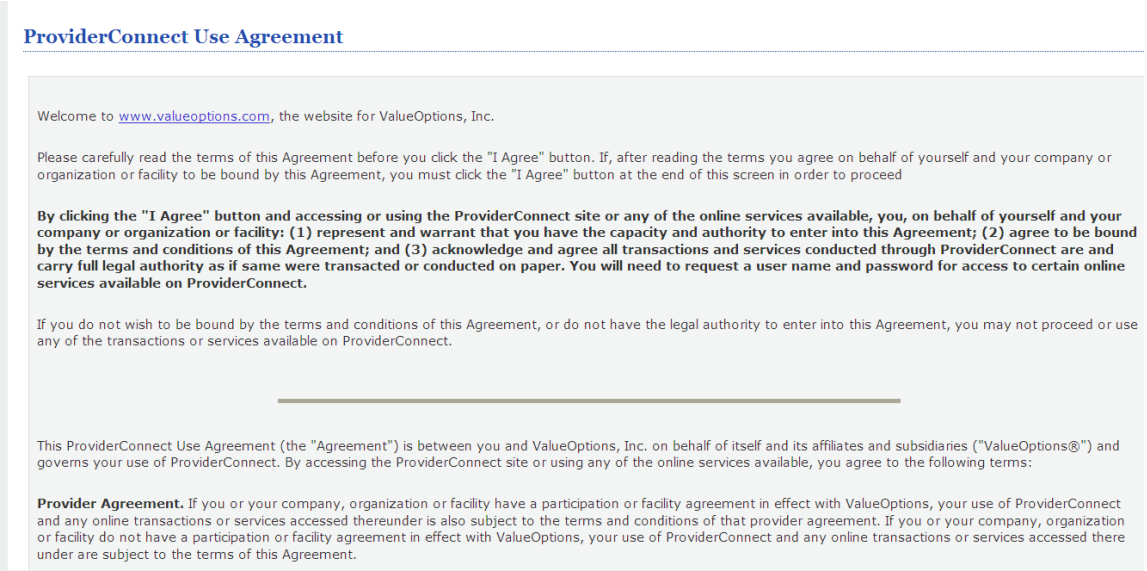
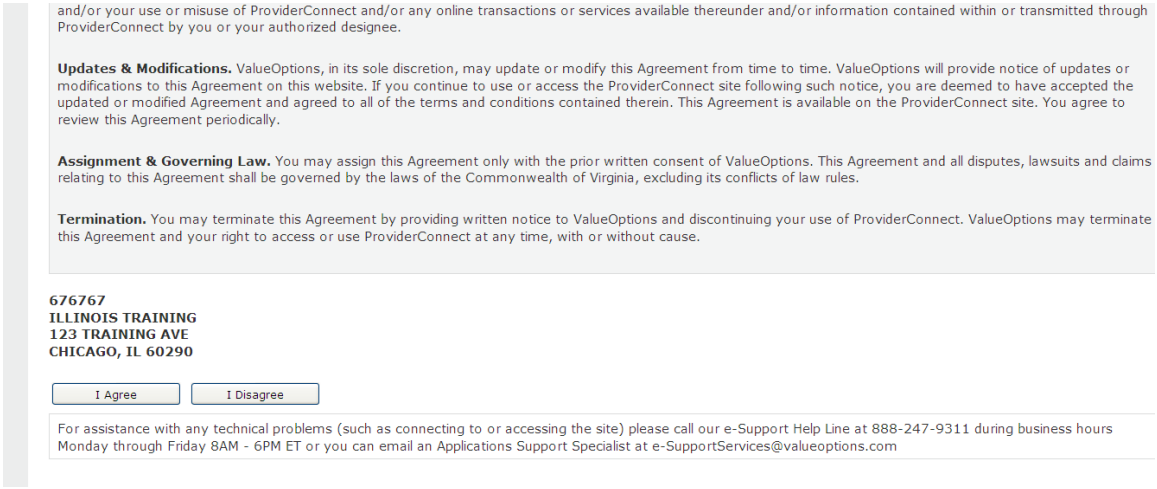
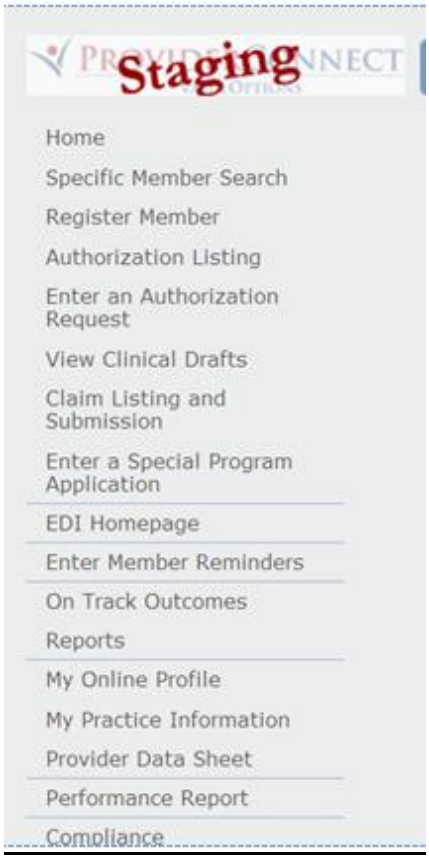


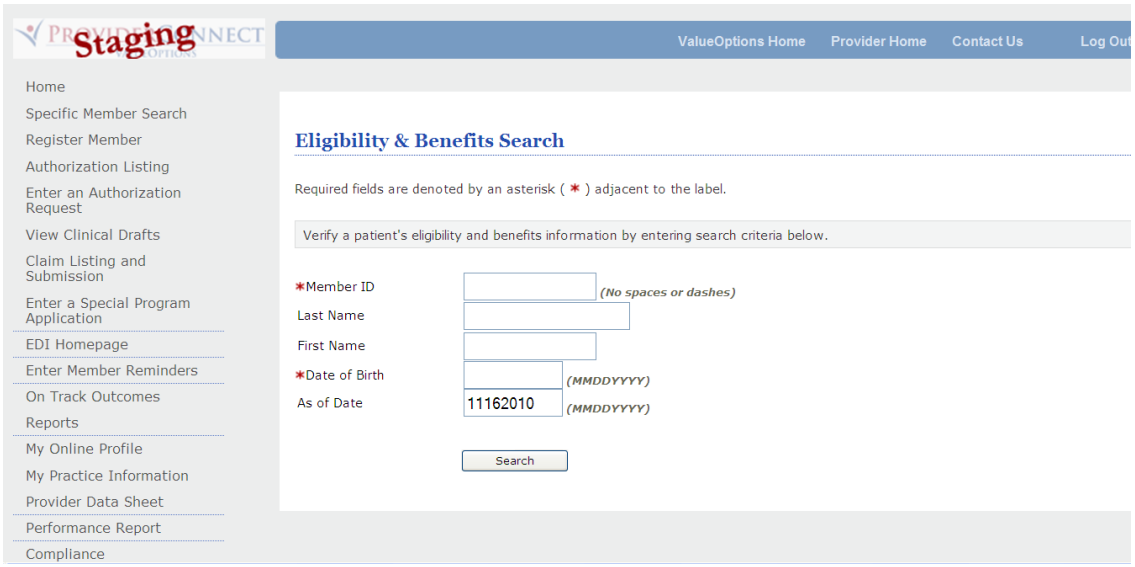
8. At the bottom of this page, provider will see tabs indicating agreement or disagreement.



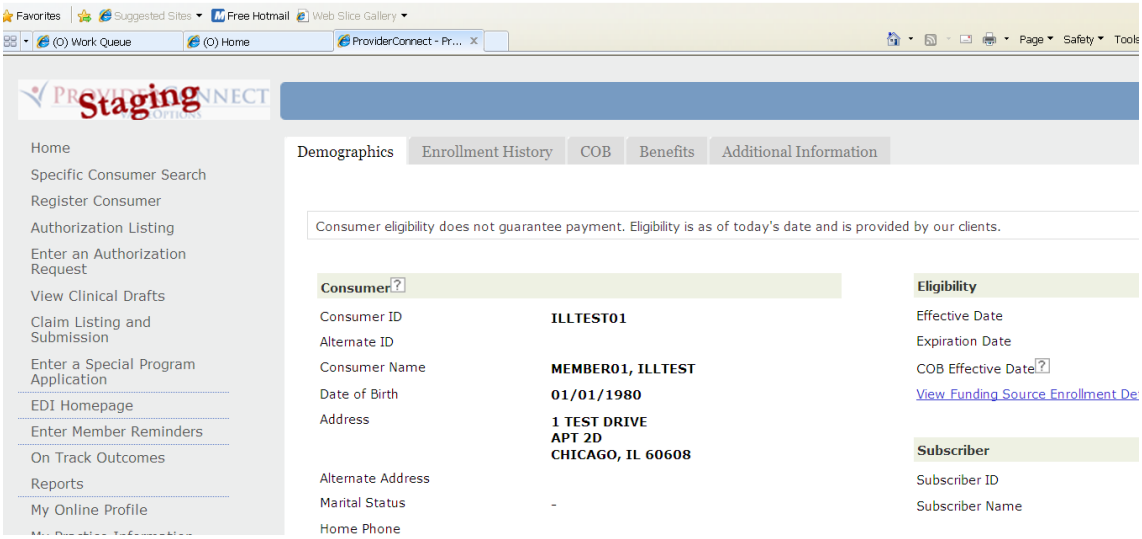
9. If provider wishes to continue with the process, provider will click the ñI Agreeòtab. The provider will be taken to the ProviderConnect home page and will select ñSpecific Member Searchòfrom the options on the left hand side of the page.



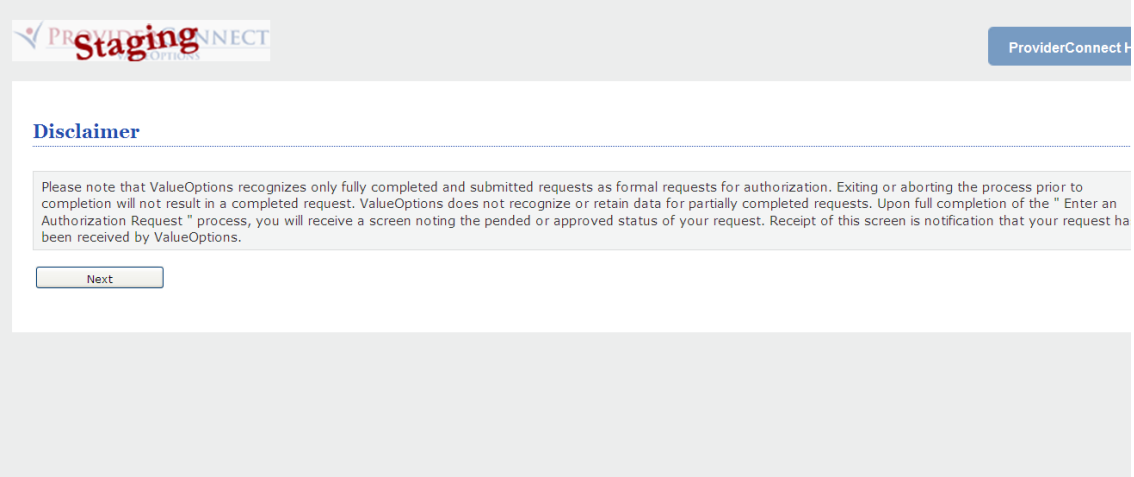
10. Provider will be taken to the ñEligibility and Benefits Searchòscreen.
11. Enter required fields: Member ID (9 digit RIN) and Date of Birth
12. Click ñSearchòtab



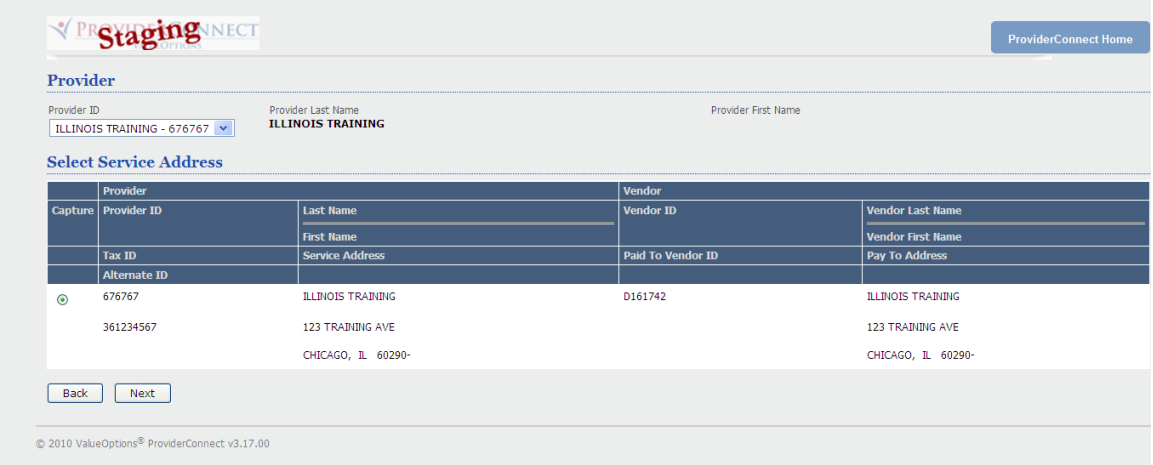
13. Provider will be taken to the ñDemographicsòscreen for the consumer
14. Click the ñEnter an Authorization Requestòtab at the left hand side of the screen



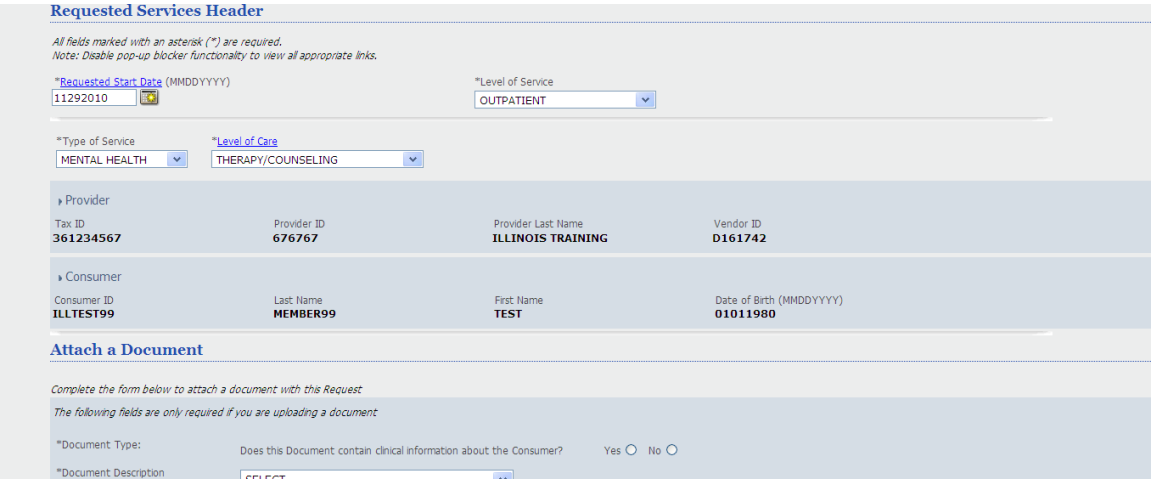
15. Provider will be taken to the ñDisclaimeròpage



16. If provider wishes to proceed with authorization request, they will click the ñNextò tab
17. Provider will be taken to the ñProviderò screen

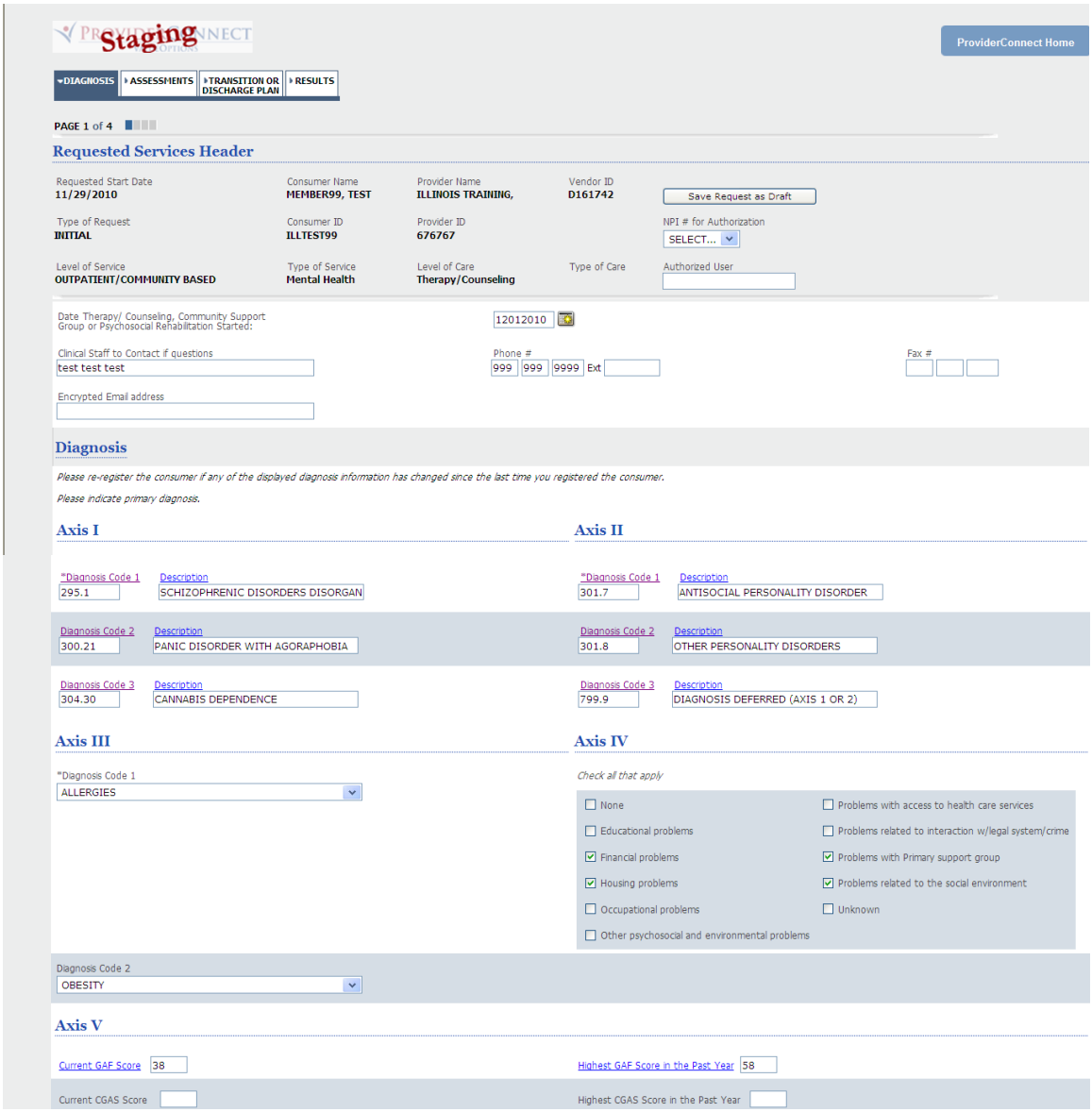


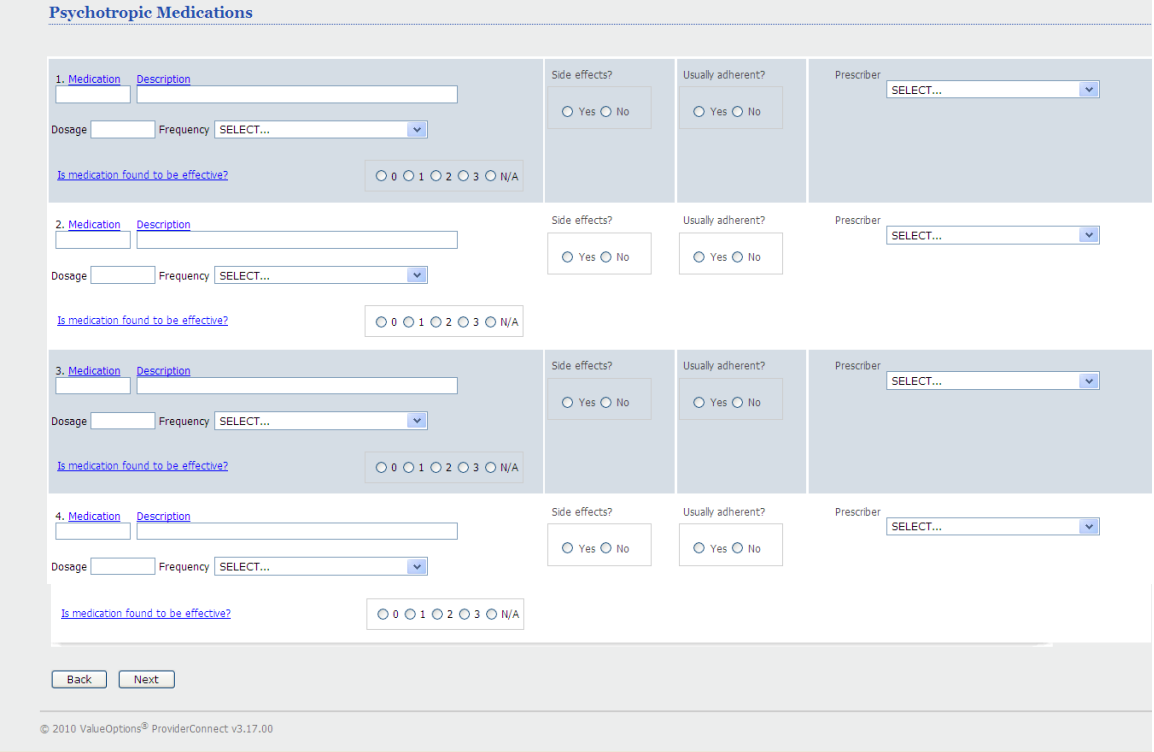
18. Select service address
19. Click the ñNextò tab
20. Provider will be taken to the ñRequested Services Headerò



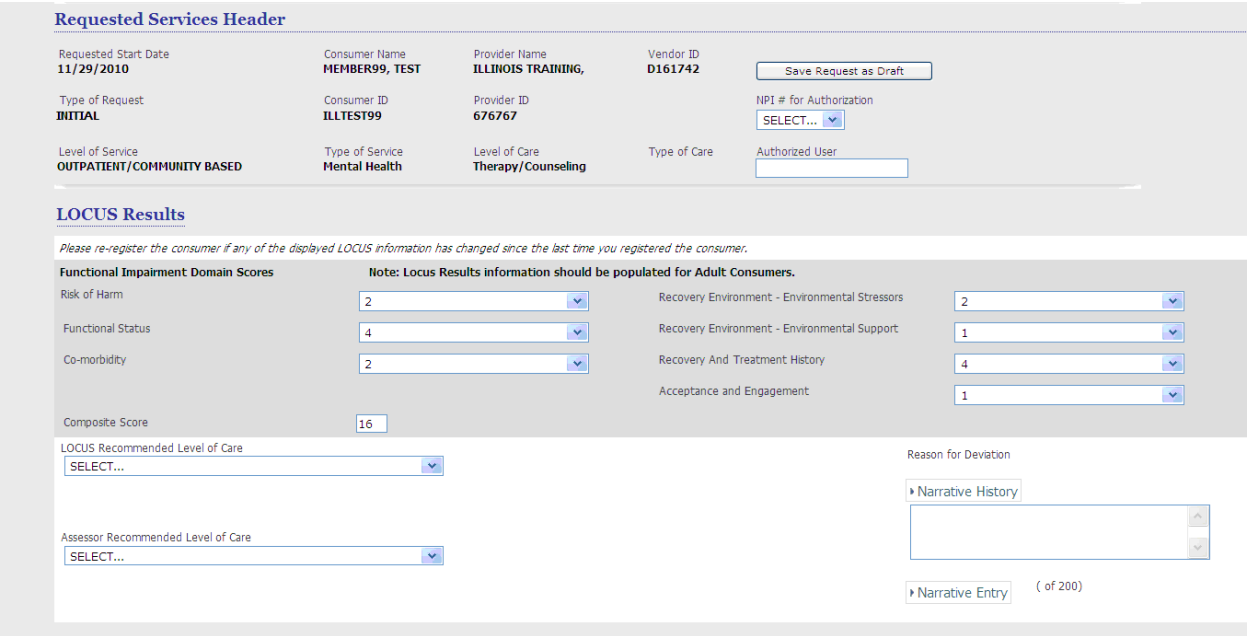
21. Enter ñRequested Start Dateòfor the start date of the authorization
22. Enter ñLevel of Serviceò= ñOutpatientò
23. Enter ñType of Serviceò= ñMental Healthò
24. Enter ñLevel of Careò= ñTherapy/Counselingò
25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the ñYesòbutton to the right of ñDocument Typeò
26. Select appropriate document from list in drop down menu in ñDocument Descriptionò
27. Click the ñUploadòtab
28. Upload each document following steps 25, 26, and 27
29. Click ñNextò

30. Provider will be taken to the ñRequested Services Headerò screen





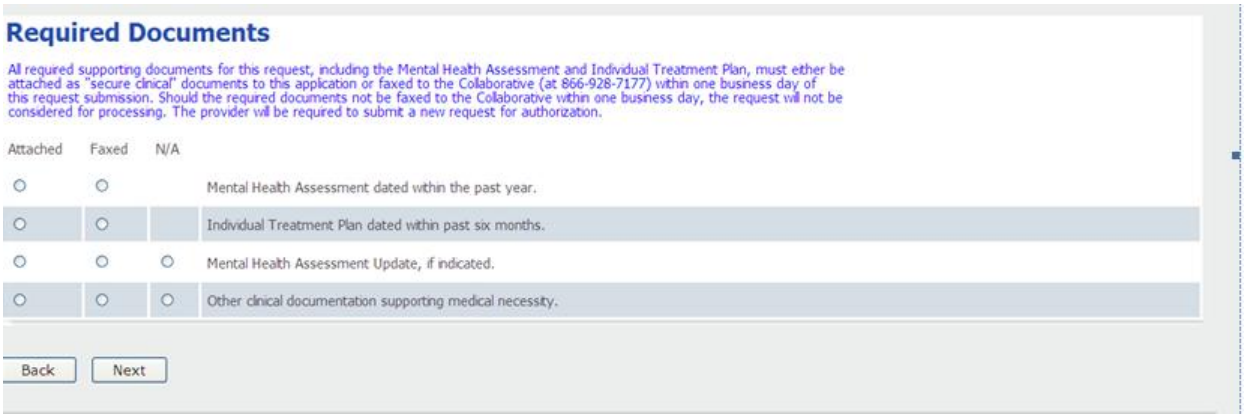
31. Provider will complete all required fields.
32. Click the ñNextòtab
33. Provider will be taken to the ñLOCUS ResultsòScreen. ***If the consumer is 18 or older, this information is required.



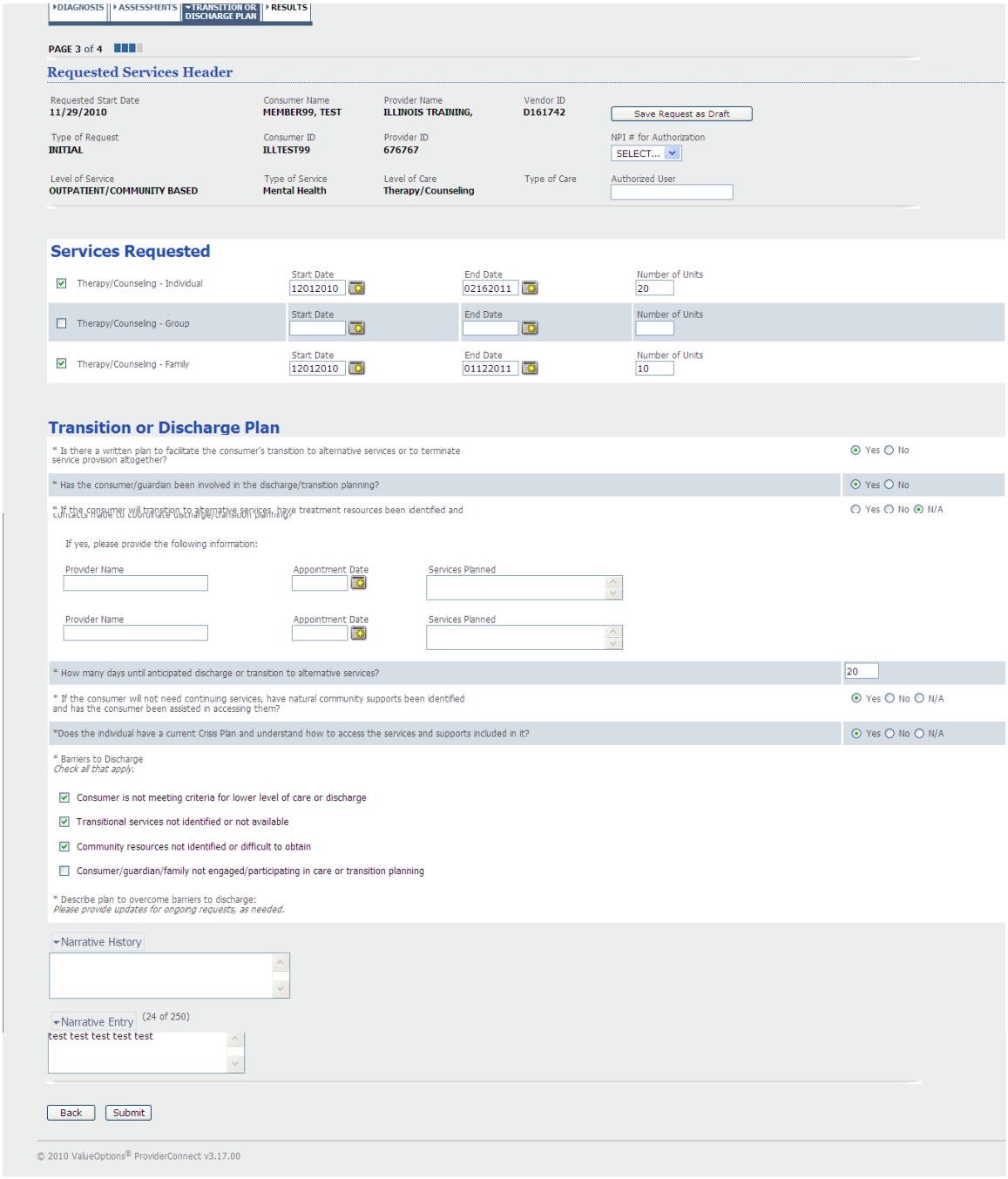
34. Complete ñFunctional Impairment Domain Scoresò

35. Select ñLOCUS Recommended Level of Careò
36. Select ñAssessor Recommended Level of Careò
37. Provide narrative explanation of any ñReason for Deviationòin appropriate text box
38. If the consumer is less than 18 years old, the Ohio Scale or Devereaux Scale Results must be completed.
    a. For youth ages 5-17, the Ohio Scale is required
    b. For children under the age of 5 and under, the DECA Subscale is required

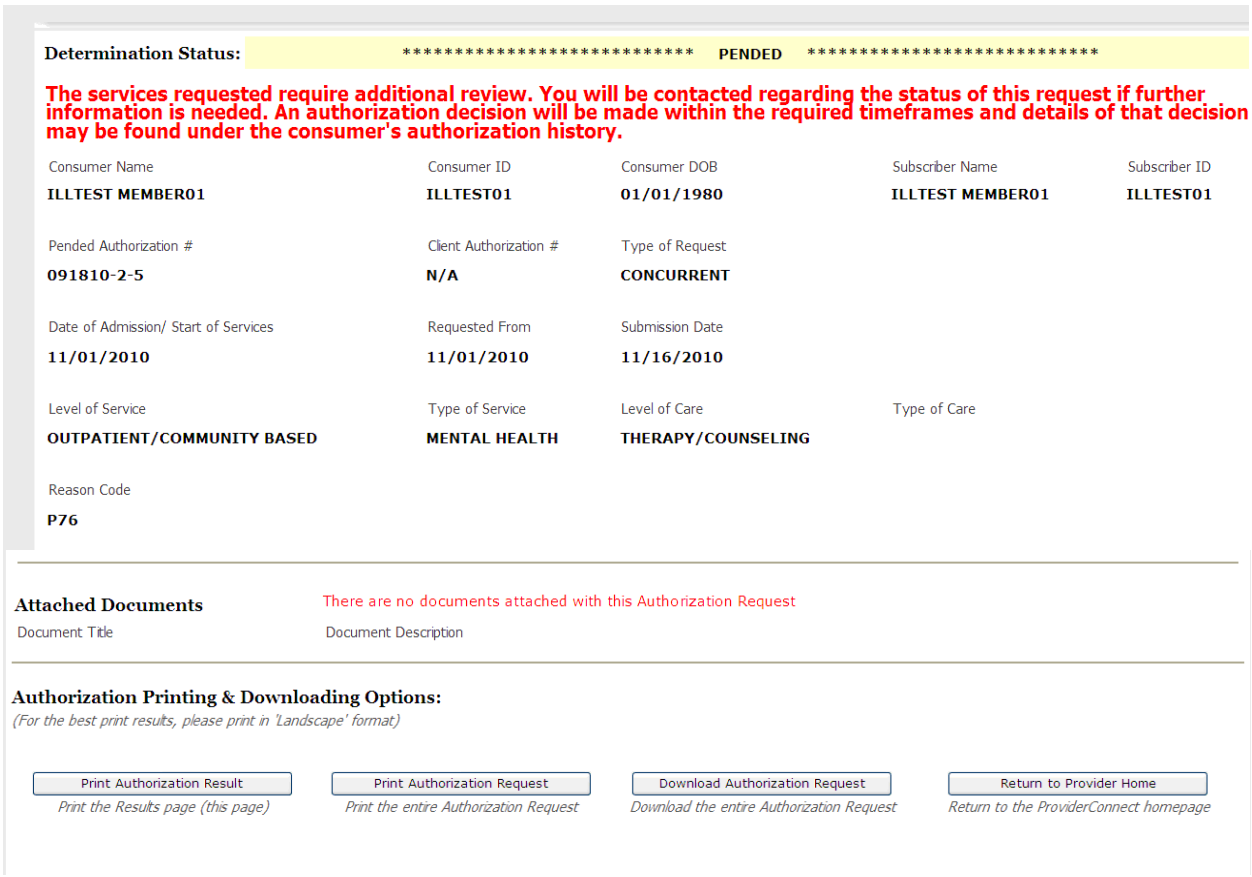
39. At the bottom of the page, indicate whether the required documents will be attached, faxed, or not applicable for each item.



40. Click the ñNextòtab
41. Provider will be taken to the ñServices Requestedòscreen



42. Check appropriate box for type(s) therapy requested (Individual, Group, Family)
43. Indicate ñStart Dateò, ñEnd Dateò, and ñNumber of Unitsòrequested for each service
44. Complete ñTransition or Discharge Plan Sectionò, providing required narrative
45. Click the ñSubmitòtab
46. Provider will be taken to the ñDetermination Statusò Screen



47. Provider can choose to:
    a. Print the Authorization Result
    b. Print the Authorization Request
    c. Download the Authorization Request
    d. Return to Provider Home

Helpful Contact Information

Collaborative Clinical Care Managers	866-359-7953
EDI Helpdesk	888-247-9311
Claims Customer Service	866-359-7953 (ask specifically for Claims Customer Service)