Illinois Department of Human Services
Carol L. Adams, Ph.D., Secretary

Illinois Department of Human Services Division of Mental Health Presents

The Illinois Mental Health Collaborative for Access and Choice Authorization Training

January 14, 2008

Agenda

- Introductions
- Overview of Learning Objectives
  - Who is the Collaborative Clinical Staff?
  - What Needs to be authorized starting 1/31/08?
    - ACT
    - CST
  - What do I send in for a request for authorization?
    - The Request Form
    - The Treatment Plan
    - The Crisis Plan
  - How do I send in my requests for authorization?
  - When will I hear back from the Collaborative?
- Questions

Introductions

- Illinois Department of Human Services/Division of Mental Health (DHS/DMH)
  - Jackie Manker, LCSW, Community Service Development Manager
  - Bryce Goff, M.A., Certified Recovery Support Specialist
  - Patricia Reedy, LCSW, Chief Social Worker
  - Amy Starin, LCSW, Administrator Child and Adolescent Services
  - Tanya Anderson, MD, Dep Dir Child and Adolescent Services
  - Linda Bollensen, M.A., Medicaid Coordinator
  - Richard Barton, Ph. D., Licensed Clinical Psychologist
  - Rusty Dennison, M.A., MBA, Parker Dennison and Associates
  - Lee Ann Slayton, M.S., Parker Dennison and Associates

- The Collaborative Clinical Team
  - Dee Durant, MSN, CNS, Director National Clinical Operations
  - Sandy Potter, LCSW, Vice President, Operations, Public Sector Division Texas
  - Steve Holsenbeck, M.D., Chief Medical Officer

Presentation Online

Today's presentation will be available online

http://www.IllinoisMentalHealthCollaborative.com/providers/Training/Training_Workshops_Archives.htm

Be sure to share this information with your staff!

The Collaborative Clinical Staff

- The following clinical staff will support the Collaborative:
  - The Medical Director will:
    - Provide oversight for all clinical functions
    - Assure that physician advisors support providers in the review process
    - Be available for consultation
    - Be licensed in Illinois

Collaborative Clinical Staff (cont.)

- The Clinical Director will:
  - Ensure that clinical staff are knowledgeable about the DMH service taxonomy and associated rules/regulations
  - Provide oversight and monitoring of the day to day operations
  - Respond to issues/concerns promptly
  - Ensure excellent customer service
  - Be licensed in Illinois

Collaborative Clinical Staff (cont.)

- The Care Manager will:
  - Work with providers to inform them about the authorization standards and processes
  - Authorize services to ensure that they are appropriate to client's needs
  - Engage with providers in clinical dialogue focused on developing a plan to best meet the consumer's needs
  - Work collaboratively to identify alternative or additional services as needed
  - Submit service request for review by the physician advisor if alternative suggestions are not agreed upon
  - Be licensed in Illinois

Overview of Clinical Management

- The following are key elements of clinical management that are central to determining the appropriateness of care:
  - Consumer goals clearly stated in the treatment plan
  - Evidence-based practice or best practice components
  - Expected timeframes based on clinical need not calendar based - Medically necessary
  - Concurrent reviews timely
  - Continuity of care evident

Authorization in a nutshell

- Who – any individual receiving CST or ACT
- When – Authorization for services is required after 1/30/08
- What – Authorization request form with a treatment plan and a crisis plan (3 documents)
- How – Submit documents by fax, electronically through ProviderConnect, or by phone

What Needs to be authorized?

- New ACT and CST admissions after 1/30/08
- Reauthorization requests after 1/30/08

How do I submit an Authorization?

Provider contacts the Collaborative for Requests

- www.IllinoisMentalHealthCollaborative.com
- Telephone 866-359-7953 - open in January 2008
- Fax – 1-800-839-6276

What do I send to request an authorization?

Information Required

- The Request form
  - includes the LOCUS scores for adults
- Treatment plan with measurable goals
- Crisis plan (consumer driven)

The Request Form

- There are two forms
  - ACT
  - CST
- Indicate on the Form the type of request
  - Initial
  - Reauthorization

The Request Form (continued)

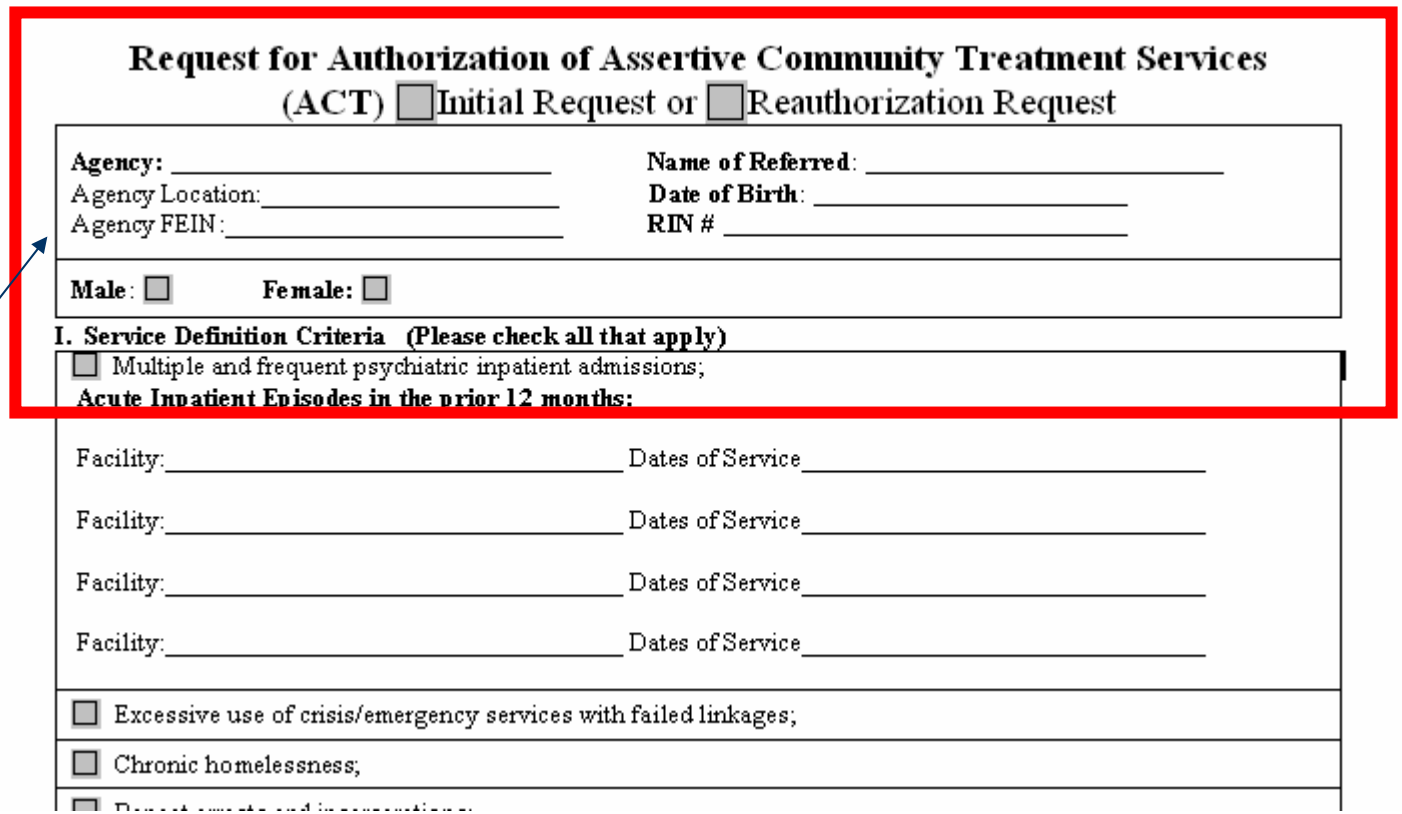
- The forms have been developed to summarize the clinical need for the requested service.
- The forms should represent the most current clinical presentation that is documented in the clinical record.

The Request Form includes:

The request for authorization form also includes an attestation that:

- The information on the form is a recommendation of medical necessity by an LPHA
- It is based on an assessment
- In the case of ACT it is based on a comprehensive assessment completed by the ACT team
- The assessment is part of the consumer's clinical record

Request Form ACT



Request for Authorization of Assertive Community Treatment Services
(ACT) ☐ Initial Request or ☐ Reauthorization Request

Agency: _____ **Name of Referred:** _____
Agency Location: _____ **Date of Birth:** _____
Agency FEIN: _____ **RIN #** _____

Male: ☐ **Female:** ☐

I. Service Definition Criteria (Please check all that apply)

☐ Multiple and frequent psychiatric inpatient admissions;
Acute Inpatient Episodes in the prior 12 months:

Facility: _____ Dates of Service _____
Facility: _____ Dates of Service _____
Facility: _____ Dates of Service _____
Facility: _____ Dates of Service _____

☐ Excessive use of crisis/emergency services with failed linkages;
☐ Chronic homelessness;

Request Form CST

Request for Authorization of Adult Community Support Team Services (CST)

☐ Initial Request or ☐ Reauthorization Request

Agency: _____	**Name of Referred:** _____
Agency Location: _____	**Date of Birth:** _____
Agency FEIN: _____	**RIN #** _____

Male: ☐ **Female:** ☐

I. Service Definition Criteria (Please check all that apply)

- ☐ Multiple and frequent psychiatric inpatient admissions;
- ☐ Excessive use of crisis or emergency services with failed linkages;
- ☐ Chronic homelessness;
- ☐ Repeat arrests and incarcerations;
- ☐ History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing.
- ☐ High use of detoxification services (e.g., two (2) or more episodes per year.)
- ☐ Clinical evidence of suicidal ideation or behavior in last three (3) months.

Identifying information

Request for Authorization of Assertive Community Treatment Services
(ACT) ☐ Initial Request or ☐ Reauthorization Request

Agency: _____	**Name of Referred:** _____
Agency Location: _____	**Date of Birth:** _____
Agency FEIN: _____	**RIN #** _____

Male: ☐ **Female:** ☐

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☐ Excessive use of crisis/emergency services with failed linkages;

☐ Chronic homelessness;

☐ Repeat arrests and incarcerations;

Criteria

I. Service Definition Criteria (Please check all that apply)

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Acute Inpatient Episodes in the prior 12 months:

Facility:_____ Dates of Service_____

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Facility:_____ Dates of Service_____

Facility:_____ Dates of Service_____

☐ Excessive use of crisis/emergency services with failed linkages;

☐ Chronic homelessness;

☐ Repeat arrests and incarcerations;

☐ Individual has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;

☐ Individual exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or

☐ Individual has persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate.

Diagnosis

☐ Individual exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or

☐ Individual has persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate.

II. DIAGNOSIS

DSM Diagnosis *All 5 Axes must be completed*	**Diagnosis (Code)**	**Rank (Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF)	Highest Last Year:	Current:

III. FUNCTIONAL IMPAIRMENT (Fill out all domains from the LOCUS tool)
Domain Scores: Risk of Harm: _____ **Recovery Environment – Environmental Stressors:** _____
Recovery Environment – Environmental Support: _____ **Functional Status:** _____
Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS

III. FUNCTIONAL IMPAIRMENT (Fill out all domains from the LOCUS tool)
Domain Scores: Risk of Harm: _____ Recovery Environment – Environmental Stressors: _____
Recovery Environment – Environmental Support: _____ Functional Status: _____
Co-morbidity: _____ Recovery and Treatment History: _____ Acceptance and Engagement: _____

Agency: _____	Name of Referred: _____
Date of Birth: _____	RIN # _____

LOCUS RECOMMENDED LEVEL OF CARE: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if Applicable)
Explain:

Clinical staff to contact with any questions (print) _____

Phone: (_____)_____ Fax Number: (_____)_____

Encrypted email address: _____

Please attach the following to this request form:

1) The current treatment plan ☐
2) The consumer's crisis plan ☐

TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

This section is for instances in which utilization of ACT is recommended as part of a transition plan.

Please describe the clinical need for the transition to less intensive services or more intensive service.

Describe contacts already made to facilitate the transition

Describe issues that need to be addressed before transition can occur etc.

FOR REAUTHORIZATION REQUEST: The medical necessity for this Request for Authorization and the attached Treatment Plan is recommended by an LPHA and is based upon a completed Comprehensive Mental Health Assessment that is in the consumer's clinical record and available upon request. ☐ Yes

Please note that incomplete forms will be returned

Request for Authorization of Adult Community Support Team Services (CST)

☐ Initial Request or ☐ Reauthorization Request

Agency: _____	**Name of Referred**: _____
Agency Location:_____	**Date of Birth**: _____
Agency FEIN:_____	**RIN #** _____
Male: ☐ **Female:** ☐	

I. Service Definition Criteria (Please check all that apply)

☐ Multiple and frequent psychiatric inpatient admissions;
☐ Excessive use of crisis or emergency services with failed linkages;
☐ Chronic homelessness;
☐ Repeat arrests and incarcerations;
☐ History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing.
☐ High use of detoxification services (e.g., two (2) or more episodes per year.)
☐ Clinical evidence of suicidal ideation or behavior in last three (3) months.
☐ Ongoing inappropriate public behavior within the last three months such as public intoxication, indecency, disturbing the peace.
☐ Self harm or threats of harm to others within the last three (3) months.
☐ Medication resistance due to : intolerable side effects or illness-mediated interference with consistent self-management of medications

II. DIAGNOSIS

DSM Diagnosis *All 5 Axes must be completed*	**Diagnosis (Code)**	**Rank (Please rank diagnoses in Axes 1-3 in order of primacy)**

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

LOCUS RECOMMENDED LEVEL OF CARE: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if applicable)
Explain:

Other Rule 132 Services on treatment plan:

Service: _____ Provided by: _____

Service: _____ Provided by: _____

Clinical staff to contact with any questions (print) _____

Phone: (_____)_____ Fax Number: (_____)_____

Encrypted email address: _____

Please attach the following to this request form:
The current treatment plan ☐
The consumer's crisis plan ☐

TRANSITION PLAN (NARRATIVE)
This section is to be used when CST authorization is requested as part of a transition plan. (Please write legibly.)
Please describe the clinical need for the transition to less intensive services or more intensive services (such as ACT)

The Treatment Plan

TREATMENT PLAN REQUIREMENTS

- A person's individual treatment plan (ITP) is required to be submitted as a part of the authorization process
- The treatment plan submitted to the Collaborative as a part of the treatment request should comply with Rule 132, and be driven by the documented assessment.

The Crisis Plan

- The crisis plan is a dynamic process and not a static experience.
- A person's initial crisis plan may only have one item such as:
  - "this is how I know when I need help" or
  - "this is who to call when I need help".

Crisis Plan

- An effective tool in engagement, and
- Sets the stage for consumer choice and recovery focus
- When consumer engagement is an issue, the crisis plan can be used as an effective tool for dialogue between the clinician and the consumer.

Crisis Plan Elements

The basic elements of the Crisis plan can include:

- What I am like when I am not feeling well:
- Signs that I need help from others:
- Who to call when I need help (My support team):
- Who to not call when I need help:
- My medications are:
- I take medication to:
- My doctor or provider is:
- This is what usually works when I need help:
- Please make sure someone on my support team takes care of:

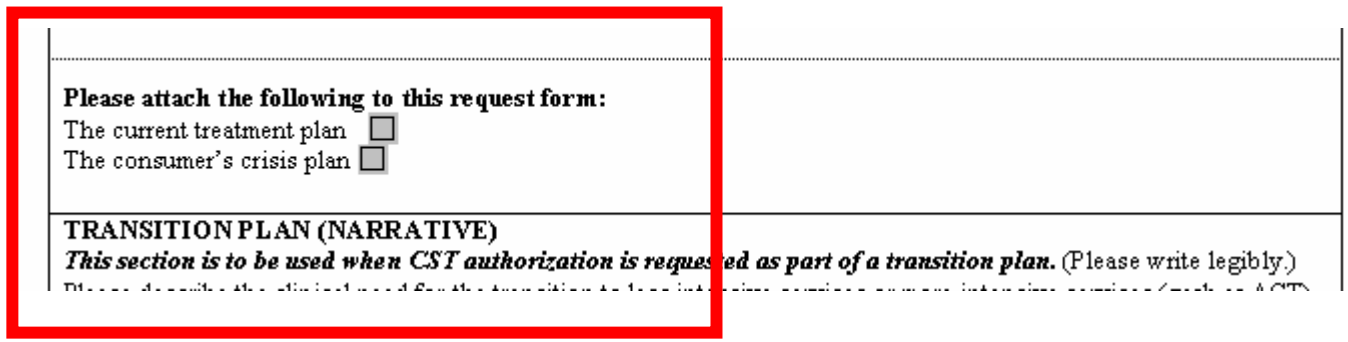
Sample Crisis Plans

Resources for Crisis Plan development are extensively available on the internet such as: http://www.mentalhealthrecovery.com.

Elements of the Authorization Request

- Request form
- Treatment plan
- Crisis Plan

On page two of the request form you are reminded:



Please attach the following to this request form:
The current treatment plan ☐
The consumer's crisis plan ☐

TRANSITION PLAN (NARRATIVE)
This section is to be used when CST authorization is requested as part of a transition plan. (Please write legibly.)

Collaborative Review Process

- The provider submits a request for authorization via one of three ways as indicated earlier in this presentation.

- The Collaborative Clinical Care Manager will:
  - Verify provider's participation status (e.g. contract with DHS/DMH, certified to provide service)
  - Verify consumer's information is available to the Collaborative.

When do I hear back from the Collaborative?

- The Collaborative will respond to requests for authorizations within:
  - One business day of receipt of a completed authorization initial request excluding holidays and weekends
  - Three business days for a completed concurrent request, excluding holidays and weekends

Collaborative Review Process

- Review request for authorization information for completeness (documents required based on request type)
  - If medical necessity is established, request is authorized and communicated to provider via e-mail.
  - If medical necessity is not established, the Clinical Care Manager contacts provider to seek clarification and offer education/consultation regarding authorization criteria

Clinical Appeals

- Prior to a denial, the Collaborative staff will support consumers and providers by offering alternative services that can meet the person's needs in the least restrictive setting
- Appeals can be requested by a consumer or by a provider on behalf of a consumer by calling the Collaborative's toll-free number
- Appeal request must be received within 60 days of receipt of the denial
- Two levels of appeals:
  - Internal Physician Advisor (PA)
    - not the same PA who issued the denial
    - not a subordinate of the original PA who issued the denial
    - Board certified and licensed in Illinois
  - External review by an independent reviewer
- Third Level of appeal to DHS/DMH per established procedures

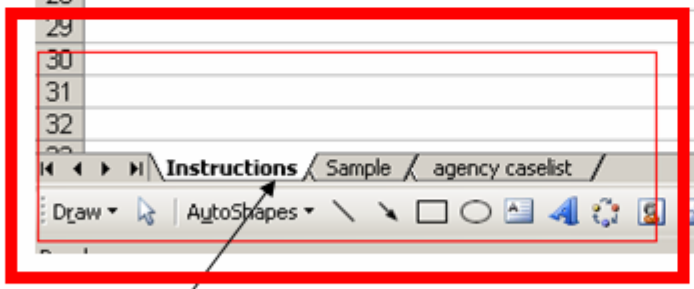
What about people who are receiving CST before 1/31/08?

- The plan is detailed in the document named “Plan for Prior Auths or Services”
- Agencies will submit a complete case list of the people receiving CST prior to 1/31/08
- The agency will pick the reauthorization date for services (between 3/1/08 and 5/15/08) and evenly distribute the caseload

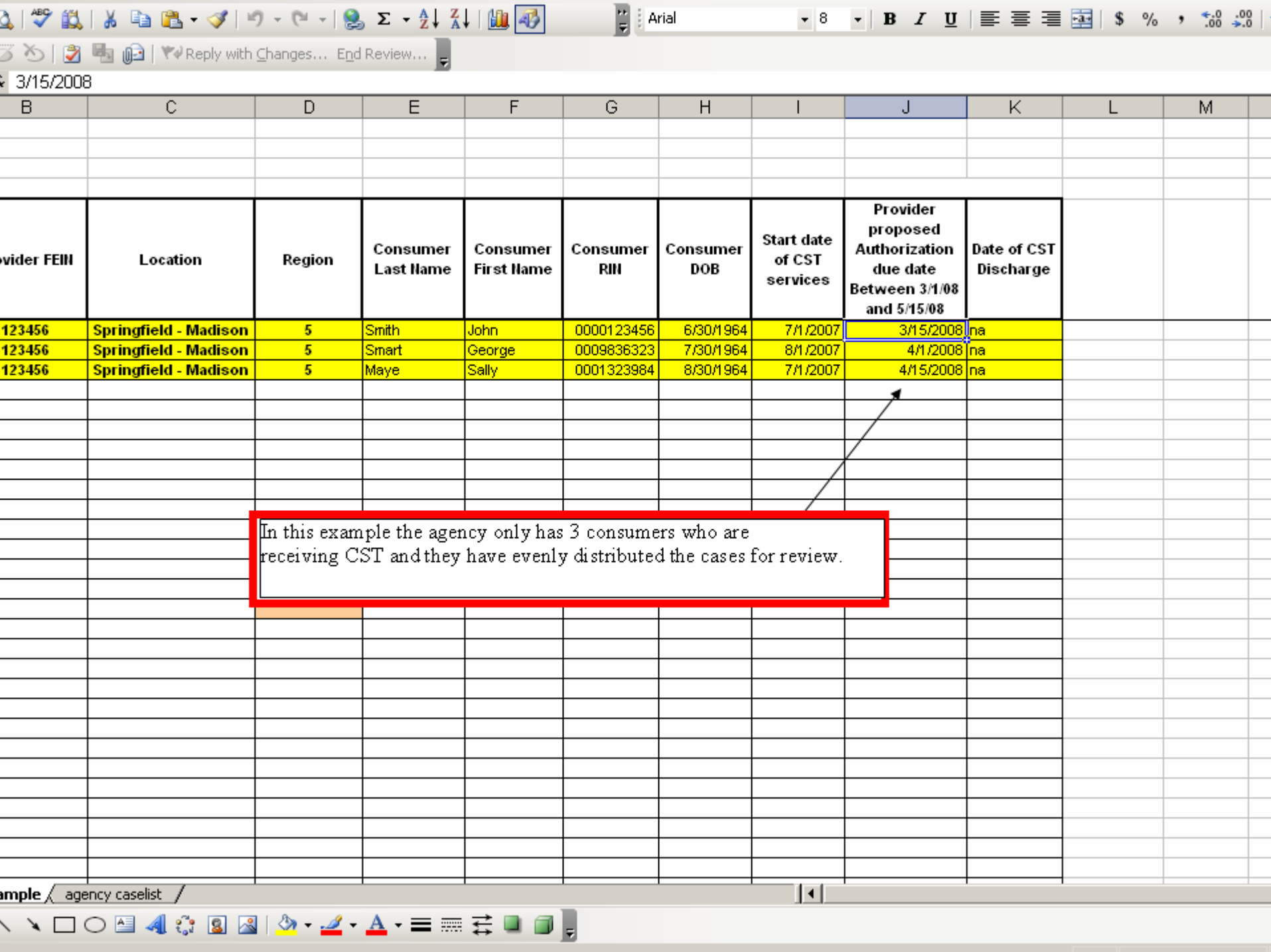
Current Services continued:

- This plan is very similar to the process which is currently underway with ACT services
- Remember to spread your work out over the entire period according to the plan

	Field Name	Instruction
14	Responsible Person	Insert name of Agency persc
15	Provider Agency Name	Insert name of Agency
16	Provider FEIN	Insert Agency's FEIN
17	Location	Insert Location of Clinic whe
18	Region	Insert Region number
19	Consumer's Last Name	Insert CST consumer's last r
20	Consumer's First Name	Insert CST consumer's first r
21	Consumer's RIN	Insert CST consumer's RIN
22	Consumer's DOB	Insert CST consumer's date
23	Start date of CST services	Insert date consumer started
24	Provider proposed Authorization due date Between 3/1/08 and 5/15/08	Insert date consumer's or pr
25	Date of CST Discharge	Insert date of consumer's dis



To open an Excel worksheet, place the mouse cursor on one of the tabs and left click on one of the tabs. The agency is required to complete the "agency caselist" worksheet and list each consumer who is receiving CST services and was receiving them prior to 1/31/08.



3/15/2008

ovider FEIN	Location	Region	Consumer Last Name	Consumer First Name	Consumer RIN	Consumer DOB	Start date of CST services	Provider proposed Authorization due date Between 3/1/08 and 5/15/08	Date of CST Discharge
123456	Springfield - Madison	5	Smith	John	0000123456	6/30/1964	7/1/2007	3/15/2008	na
123456	Springfield - Madison	5	Smart	George	0009836323	7/30/1964	8/1/2007	4/1/2008	na
123456	Springfield - Madison	5	Maye	Sally	0001323984	8/30/1964	7/1/2007	4/15/2008	na

In this example the agency only has 3 consumers who are receiving CST and they have evenly distributed the cases for review.

ample | agency caselist

Submission Methods

- Via secure fax to 1-800-839-6276
- Submit as an inquiry online at: www.IllinoisMentalHealthCollaborative.com

Issues or concerns can also be discussed on the phone with a care manager, just call

1-866-359-7953

ProviderConnect - Online

What is ProviderConnect?

ProviderConnect is an online tool where providers can:

- View authorizations
- View and print authorization letters
- Submit inquiries to customer service
- Submit updates to provider demographic information
- Access and print forms
- Available 3rd quarter FY08

Coming Soon – July 2008:

- Verify consumer eligibility
- View the details and status of claims
- Submit single and batch claims
- Consumer registration

ProviderConnect

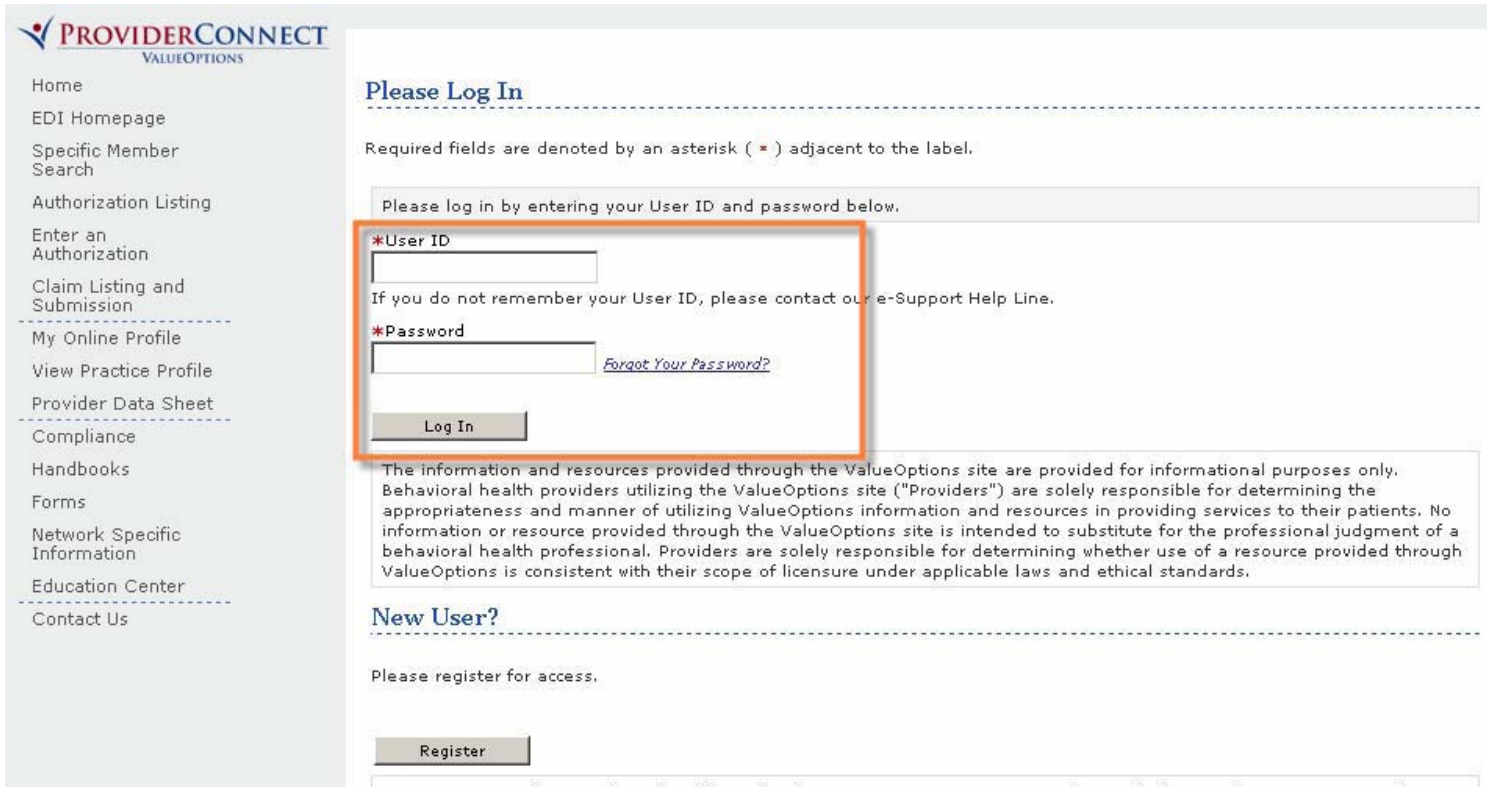
What are the benefits of ProviderConnect?

- Easily access routine information 24 hours a day, 7 days a week
- Use the same web address: www.IllinoisMentalHealthCollaborative.com
- Complete multiple transactions in a single sitting
- View and print information
- Reduce calls for routine information

How to Access ProviderConnect

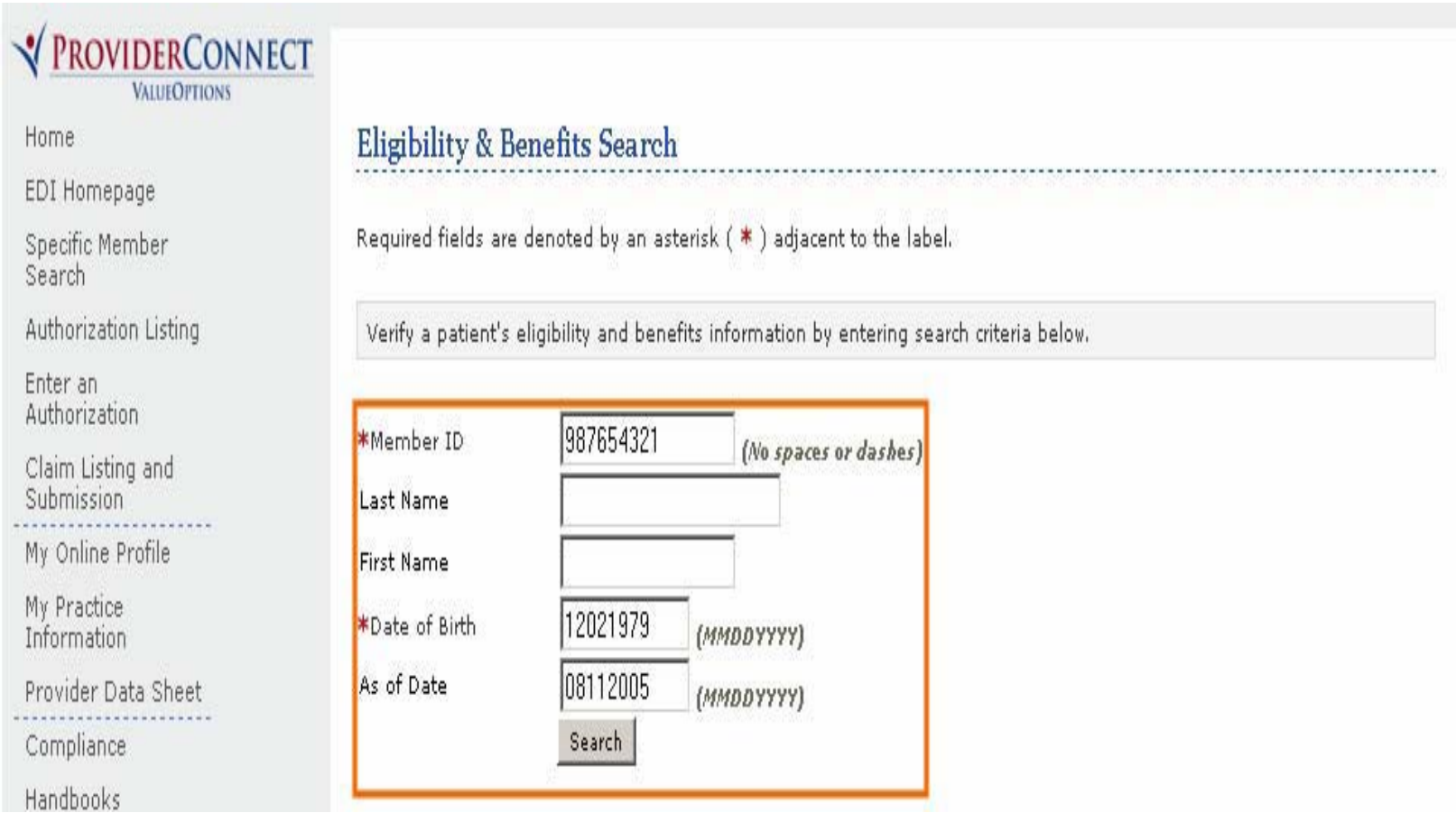
- All Providers will be able to obtain one online registration per provider ID number via the Web site
- To obtain additional logons for ProviderConnect – contact the ValueOptions® EDI Helpdesk at 888-247-9311 and press option 3, Monday through Friday, 8 a.m. – 6 p.m. EST
- Available after Provider Data Collection Process – 3rd Quarter FY08

Log In to ProviderConnect

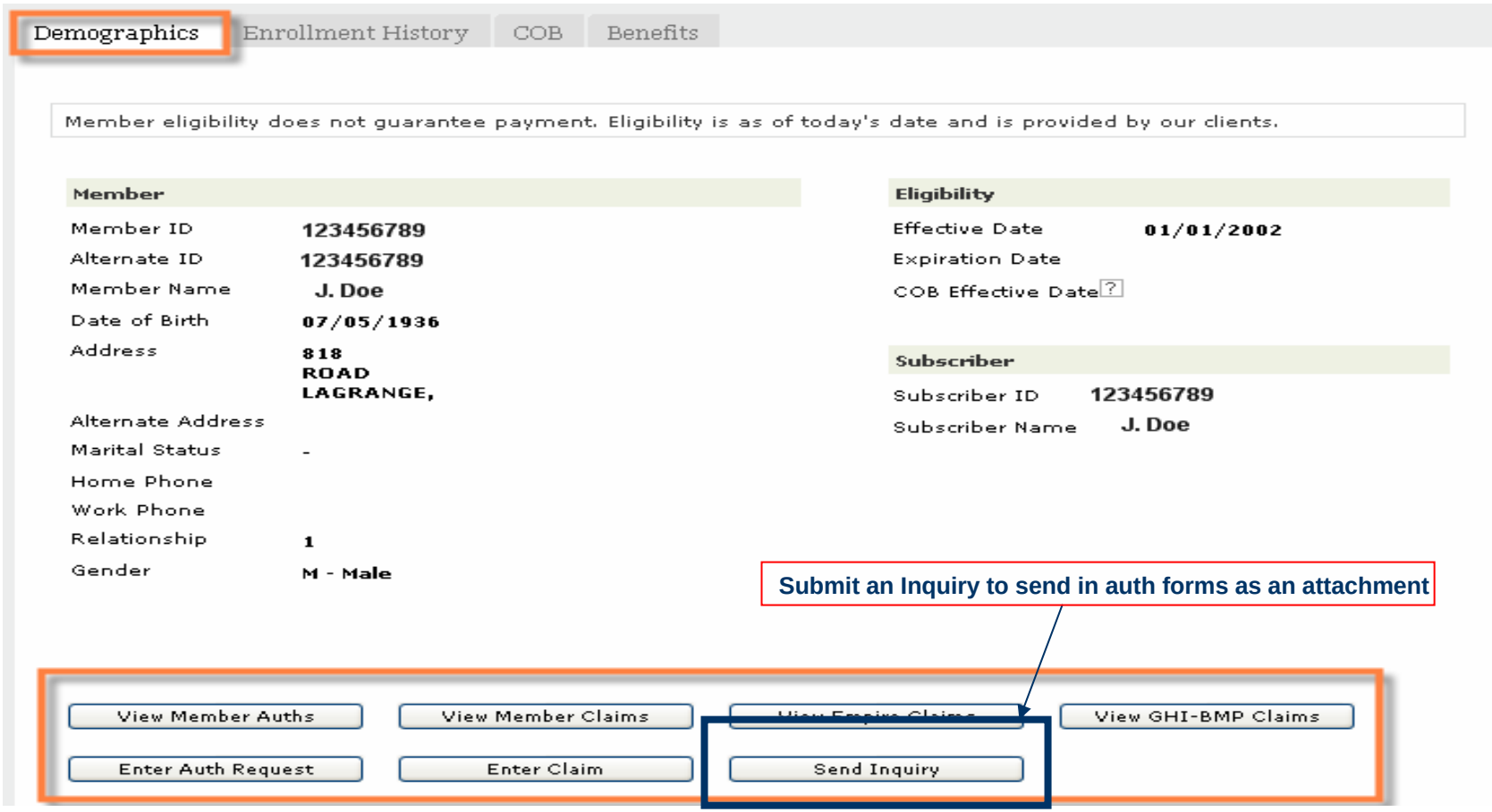


ProviderConnect Welcome Page

Eligibility



Consumer Demographics



Summary

- Summary of Learning Objectives
  - Who is the Collaborative Clinical Staff?
  - What Needs to be authorized starting 1/31/08?
    - ACT
    - CST
  - What do I send in for a request for authorization?
    - The Request Form
    - The Treatment Plan
    - The Crisis Plan
  - How do I send in my requests for authorization?
  - When will I hear back from the Collaborative?
- The plan for prior services

Questions?

Thank you!

Illinois Mental Health Collaborative for Access and Choice