

PROVIDER ALERT

Alert #: PA 2011-22
Issued: September 2011
To: CT BHP Providers
Subject: Revised Procedure - Temporary Member Certification

Dear Provider,

The CT Behavioral Health Partnership issued a Provider Alert (PA 2011-12) in June 2011 that outlined a process for obtaining service authorizations for pending eligible members. While the intention was to continue a process previously established with providers, the volume of requests for temporary authorizations has been substantial and it has become apparent that these methods are not sustainable for the CT BHP provider network and the administrative service organization staff. In an effort to further streamline this process, we have worked closely with providers, the Departments of Social Services, Children and Families and Mental Health and Addiction Services to develop the following revised procedure.

EFFECTIVE OCTOBER 1ST, 2011

- The **CT BHP WILL** continue to create temporary member records **ONLY** for inpatient psychiatric, inpatient detoxification, partial hospitalization, free standing detoxification, residential rehab, adult group home, 23 Hour OBS, and CARES.
- The **CT BHP WILL NO LONGER** create temporary member records for all other levels of care

EFFECTIVE OCTOBER 1ST, 2011, for inpatient psychiatric, inpatient detox, partial hospitalization, free standing detoxification, residential rehab, adult group home, 23 Hour Observation, and CARES:

When the provider verifies with the DSS automated eligibility system that the member is not currently eligible, the provider:

- Assists the member in submitting an application for benefits to the DSS,
- Secures authorization to disclose Personal Health Information to CT BHP, and
- Contacts CT BHP at 877.552.8247 to request authorization for "Pending Eligible" member.

ValueOptions Customer Service will:

- Search the eligibility file,
- Create a Temporary ID, if the member is not showing as eligible,
- Certify treatment, if the request meets medical necessity,
- Reconcile the temporary ID with the Medicaid ID, on a weekly basis,
- Create an authorization and authorization letter, once the member is granted benefits, and
- Submit the authorization to HP.

NOTE: Certification and/or authorization should not be considered a guarantee of payment. Payment may be made only to eligible providers who meet all program eligibility requirements at the time services are rendered and submit a clean claim within timely filing. The authorization letters have been updated to reflect these changes.

EFFECTIVE OCTOBER 1ST, 2011, for Intensive Outpatient, Extended Day Treatment, Home Based Services (MST, MDFT, FFT), Outpatient, Psych Testing, Methadone Maintenance, Ambulatory Detoxification services, and all other levels of care except IICAPS and Home Health (see below)

Only after a provider verifies with the DSS automated eligibility system that the member has been made retroactively eligible:

- Provider will submit an *abbreviated* retrospective review form* to the CT BHP within thirty (30) days of the eligibility determination date (date the members eligibility date was determined*)
- CT BHP will review the request and verify that member's eligibility has been retroactively granted
- CT BHP will create an authorization and authorization letter and will submit the authorization to HP

*** The abbreviated review form for retroactive eligible clients will be distributed to providers and available on the CT BHP website (www.ctbhp.com) by October 1, 2011.*

EFFECTIVE OCTOBER 1ST, 2011, for Home Health (behavioral health) and Home Based (IICAPS) services:

Only after a provider verifies with the DSS automated eligibility system that the client has been made retroactively eligible:

- Provider will submit the *complete* medical record to the CT BHP within thirty (30) days of the eligibility determination date (date the members eligibility date was determined*). Complete Medical Records can be faxed or mailed to:
 - Fax: 1-860-263-2037 Attn: Compliance Department
Re: Retroactive Eligibility Review
 - Mail: CTBHP
500 Enterprise Dr., Suite 4D
Rocky Hill, CT 06067
Attn: Compliance Dept.
- CT BHP will review the request and verify that member's eligibility has been retroactively granted
- CT BHP will create an authorization and authorization letter and will submit the authorization to HP

If you have any questions or concerns, please do not hesitate to contact the CT BHP Call Center at 1-877-552-8247.

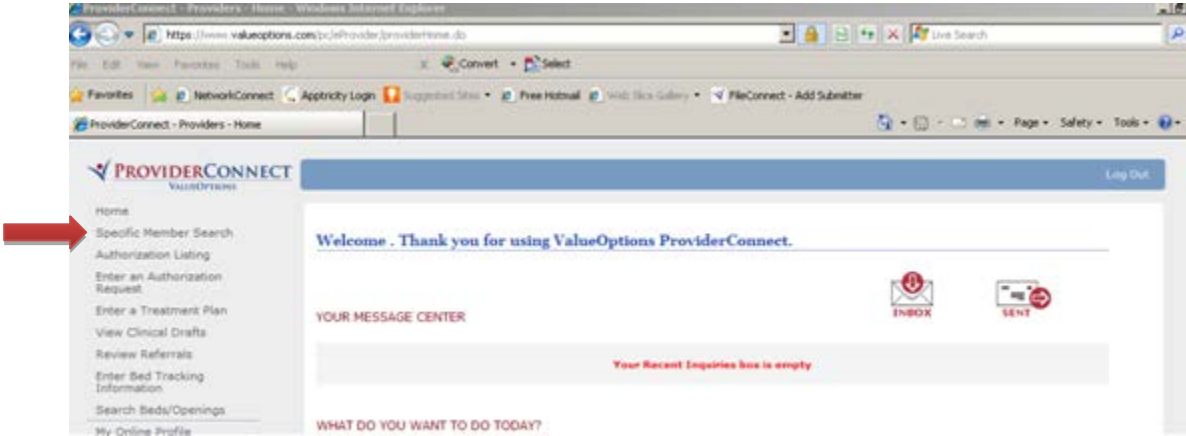
Provider Relations
CT Behavioral Health Partnership

Encl: Attachment: *Instructions for how to view the eligibility determination date
Attachment: **Abbreviated Retrospective Review form – Web Registered Services

CT BHP Retrospective Eligibility Updated Temporary Member Certification Procedures

To View Eligibility Determination Date:

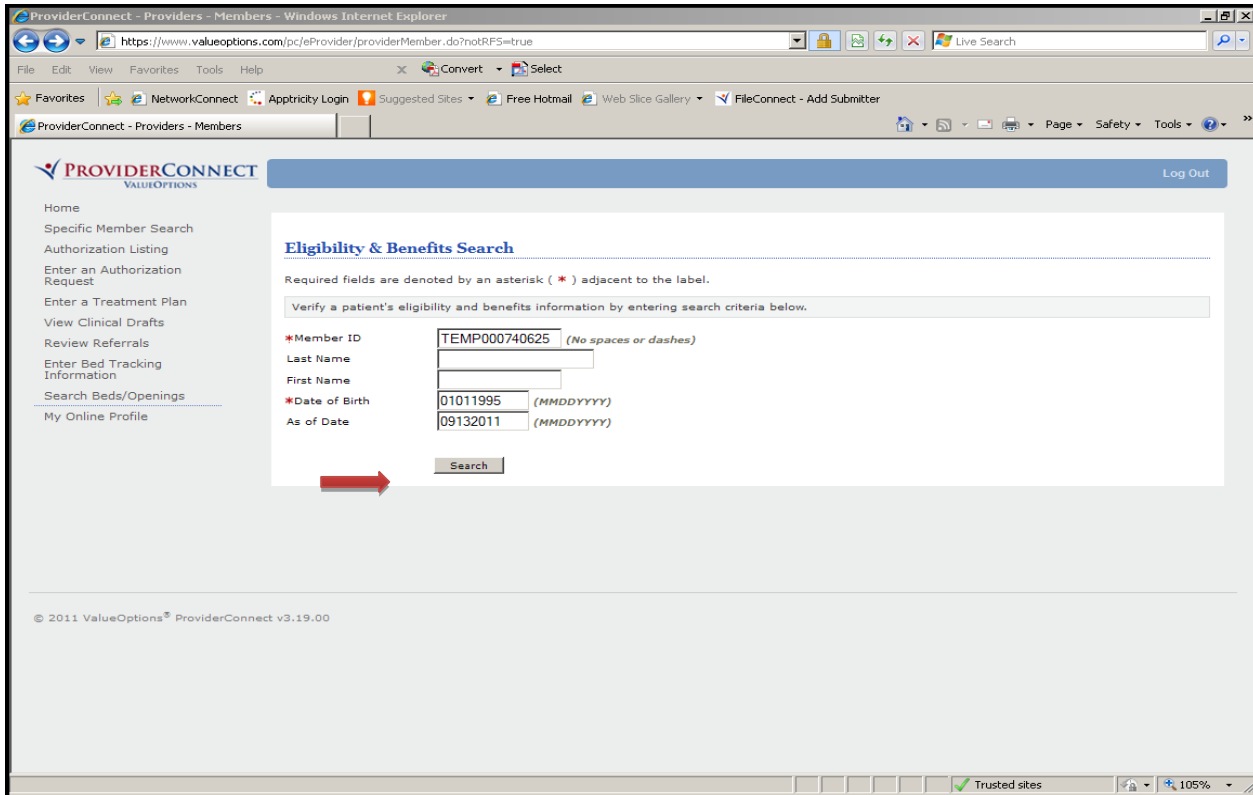
- 1) Enter ProviderConnect Home Page and click on Specific Member Search



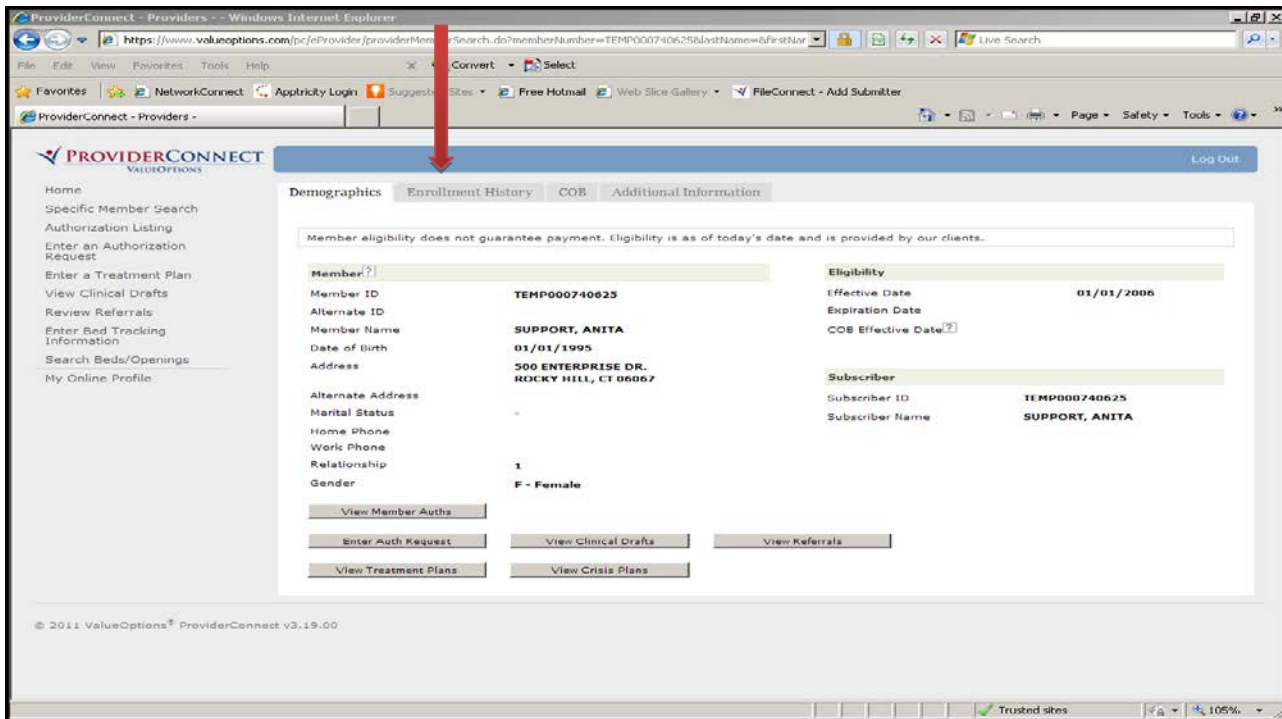
- 2) Enter Member ID and DOB

The screenshot displays the 'Eligibility & Benefits Search' form. The form includes a search criteria section with the following fields: 'Member ID' (with a red arrow pointing to it), 'Last Name', 'First Name', 'Date of Birth' (with a red arrow pointing to it and the value '09132011'), and 'As of Date'. A 'Search' button is located below the fields. The footer of the page indicates '© 2011 ValueOptions® ProviderConnect v3.19.00'.

3) Click SEARCH



4) Demographics screen will appear; Click the Enrollment History tab



5) View Eligibility Determination Date and Effective Date of member's retro eligibility

The screenshot shows the ProviderConnect website interface. The browser address bar displays <https://www.valueoptions.com/pc/eProvider/memberEligEnrollHistory.do>. The page has a navigation menu on the left and a main content area with tabs for Demographics, Enrollment History, COB, and Additional Information. A message at the top states: "Member eligibility does not guarantee payment. Eligibility is as of to [redacted] ts." Below this is a "Member Detail" section with a table of member information. Two callout boxes are present: one pointing to the "Effective Date" column and another pointing to the "Date Changed" column.

Subscriber ID	Member ID	Member Name	Group #	Group Name	Account #	Effective Date	Expiration Date	Date Changed
TEMP000740625	TEMP000740625	SUPPORT, ANITA	BHK001	CT BEHAVIORAL HEALTH PARTNERSH	BHK001	01/01/2006		11/23/2010

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RETROACTIVE ELIGIBILITY REVIEW TEMPLATE – WEB REGISTERED SERVICES

PLEASE COMPLETE AND FAX TO: 1-(866)-434-7681

Provider EDS/CMAP ID # (Medicaid 9-digit ID) _____

Name of clinician who filled out this form _____ Credentials/Title _____

Contact number _____ Ext: _____

Facility/Provider Name _____ Telephone Number _____

Facility/Provider Service Location _____

Member Name _____

Medicaid/Consumer ID# _____ DOB: _____ AND/OR SSN: _____

LEVEL OF CARE: Intensive Outpatient EDT Outpatient Methadone Maintenance Ambulatory Detoxification
 Home Based Services MDFT MST FFT

TYPE OF SERVICE: Mental Health Substance Abuse

PROVIDER TYPE: Comm Mntl Hlth Ctr Ind Clinic FQHC O/P Hospital Office Psych Facility – Partial Hosp

QUESTIONS: (* signifies a required field)

1. * Requested start date (EX: 09/01/2010): _____

2. **AXIS I & II:**

a. *AXIS I _____ Description: _____

b. AXIS I _____ Description: _____

c. AXIS II _____ Description: _____

d. AXIS II _____ Description: _____

3. **AXIS III (Select all that apply)**

- None Allergies Alzheimer's Disease Anemia Arthritis or Rheumatism Asthma Cancer or Leukemia
- Cardiovascular Problems Chronic Pain Chronic Obstructive Pulmonary Disease
- Circulation Problems in Arms and Legs Diabetes Disabilities or Physical Impairments (E.G., Blind)
- Emphysema or Chronic Bronchitis Epilepsy /Seizures Fibromyalgia Glaucoma
- High Blood Pressure (Hypertension) Head Injury HIV / AIDS Kidney Disease Liver Disease
- Migraine Headaches Multiple Sclerosis Obesity Parkinson's Disease Pregnancy
- Skin Disorders (Severe Burns, Leg Ulcers, etc.) Speech Impediment or Impairment
- Stomach GI Problems (E.G., Acid Reflux, Ulcers) Stroke / Effects of Stroke Thyroid or Other Glandular Disorders
- Urinary Tract or Prostate Problems Medical Condition Seriously Impacting Member's Health Unknown

4. **AXIS IV (Check all that apply)**

- None Educational problems Financial problems Housing problems Occupational problems
- Other psychosocial and environmental problems Problems with access to health care services
- Problems related to interaction with legal system / crime Problems with primary support group
- Problems related to social environment Unknown

5. **AXIS V (Indicate GAF Score 1-100)** _____

6. Current Risks

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

A. *Members Risk to Self 0 1 2 3 N/A

B. *Members Risk to Others 0 1 2 3 N/A

7. Current Impairments

A. *Mood Disturbances (Depression or Mania)
 0 1 2 3 N/A

C. *Anxiety
 0 1 2 3 N/A

D. *Psychosis / Hallucinations / Delusions
 0 1 2 3 N/A

F. *Thinking/Cognitive/Memory/Concentration Problems
 0 1 2 3 N/A

H. *Impulsive/Reckless/Aggressive Behavior
 0 1 2 3 N/A

J. *Activities of Daily Living Problems
 0 1 2 3 N/A

L. *Impairments Related to Loss/Trauma
 0 1 2 3 N/A

B. *Weight Changes Associated with Behavioral Diagnosis
 0 1 2 3 N/A

For 2 or 3 rating:
 Weight Gain Loss N/A
 Past 3 mos _____ Lbs N/A
 Current Wt _____ Lbs N/A
 Height _____ Ft _____ In N/A

E. *Medical / Physical Conditions
 0 1 2 3 N/A

G. *Substance Abuse / Dependence
 0 1 2 3 N/A
 For 2 or 3 rating: Check all that apply
 Alcohol Illegal Drugs Prescription Drugs

I. *Job/School/Performance Problems
 0 1 2 3 N/A

K. *Social Functioning/Relationships/Marital/Family Problems
 0 1 2 3 N/A

M. *Legal
 0 1 2 3 N/A
 For 1, 2 or 3 rating: Check all that apply
 Juv Jus Probation Parole Other Court

Treatment Plan

- 15. *Is psychiatric medication evaluation or medication management visit indicated? Yes No
- 16. *Do family members or sig. others actively participate in the members treatment or recovery? Yes No
 If yes, are any of the family members/significant others receiving their own MH or SA treatment? Yes No
- 17. *Treatment plan was developed with member (or guardian) and has measurable time limited goals. Yes No
- 18. *Does a documented goal oriented treatment plan exist? Yes No
- 19. *Anticipated / Target Date for achievement of current treatment plan goals _____

Discharge Information (if applicable)

- 20. * Anticipated Discharge date (EX: 09/01/2010): _____
- 21. * Actual Discharge date (EX: 09/01/2010): _____
- 22. *Type of Discharge AMA Planned
- 23. *Actual Level of Care/Service Discharge To (primary)
 Community Support Team Outpatient Targeted Case Management Inpatient 23 Hour CSU
 PHP RTC Group Home Halfway House Day Services IOP/SOP Alternative Community Support
 Day Treatment Foster Care In-Home & Family Services Placement Services PRTF
 Residential Child Care Respite Specialty Children's Programs Subacute Other Assertive Community Treatment
 Facility Based Crisis Intensive In-Home MST NCMC Only Ambulatory Detox NCMC Only Medically Supervised ADATC
 NCMC Only Non-Hospital Med Detox. NCMC Only SA Med Monitored Resi
 NCMC Only SA Non Med Resi Over 21 Opioid Treatment Psychosocial Rehab SACOT
- 24. * Name of Discharge Provider _____
- 25. * Date of Follow-Up - Contact Date (EX: 09/01/2010): _____

ADDITIONAL REQUIRED QUESTIONS ONLY FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

* Is the member currently maintained on Methadone? YES NO

a. If **yes**, how long has the member received Methadone services?

6 mos or less 7 mos – 1 yr 1-3 yrs 3-5 yrs 5 yrs >

b. If **no**, what has been the duration of the member's opioid use?

Less than 1 yr 1-3 yrs 3-5 yrs 5 yrs or >

*What other services are included in the treatment plan?

Community Support (AA/NA) IOP/PHP Other Behavioral Health Services Outpatient Therapy

PCP / MD Follow-up

*What is the ultimate treatment goal? Abstinence Methadone Maintenance

Ambulatory Detox

*From what substance is the member in need of detoxification? (select all that apply)

Alcohol Benzodiazepines Opiates

*Has the member had a previous detox in any setting in the past year?

YES NO

If **yes**, number of detoxes in the past year?

1 2 3 4+

*What is the identified discharge plan? (Select all that apply)

Community Support (AA/NA) IOP/PHP Methadone Services Other Behavioral Health Services

Outpatient Therapy PCP/MD Follow-up