

## PROVIDER NOTICE

**Notice #:** PN 2011- 06  
**Issued:** September 2011  
**To:** CT BHP Residential and Group Home Providers  
**Re:** ProviderConnect Residential and Group Home Discharge Procedure

Dear Provider,

This notice is being sent to clarify the discharge process for DCF Residential and Group Home Providers. The goal of the CT BHP is always to insure and manage the appropriate use of resources while improving the consistency in program delivery as well as reduce the administrative burden of providers.

In our effort to become more dependent on our electronic system, effective October 1, 2011, we are asking that DCF Residential and Group Home Providers now complete discharge information through the ProviderConnect application.

A step by step tutorial with accompanying screen shots from the ProviderConnect application has been included with this notice. Please share with appropriate staff members. Additionally, a template of the discharge form will also be available for those facilities in which clinical staff may want to document the required information that an administrative or non-clinical staff may be entering into the ProviderConnect application.

If you have any questions, please feel free to contact the CT BHP Call Center at 1-877-552-8247.

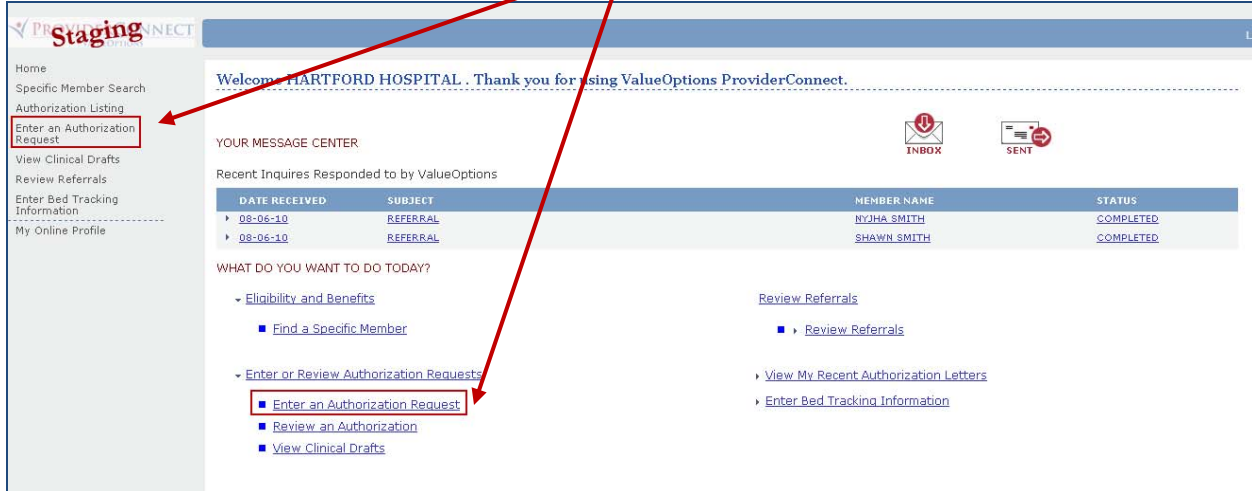
Provider Relations Department  
Connecticut Behavioral Health Partnership

**Please Note:** ProviderConnect users must complete their last MTPPR before completing the electronic discharge. If the discharge is completed first, the user will no longer have access to the member in their system. Discharges should also be completed within a reasonable timeframe, within 24-48 hours from the actual discharge.

*Encl: Discharge Function Tutorial*

## Discharge Function – ProviderConnect

- 1) On the ProviderConnect homepage, click on the “Enter an Authorization Request” link either on the left navigation sidebar or the main body of the page.



The screenshot shows the ProviderConnect homepage. On the left sidebar, the 'Enter an Authorization Request' link is highlighted with a red box and a red arrow. In the main content area, under 'WHAT DO YOU WANT TO DO TODAY?', the 'Enter an Authorization Request' link is also highlighted with a red box and a red arrow. The message center shows recent inquiries with columns for DATE RECEIVED, SUBJECT, MEMBER NAME, and STATUS.

DATE RECEIVED	SUBJECT	MEMBER NAME	STATUS
08-06-10	REFERRAL	NYJHA SMITH	COMPLETED
08-06-10	REFERRAL	SHAWN SMITH	COMPLETED

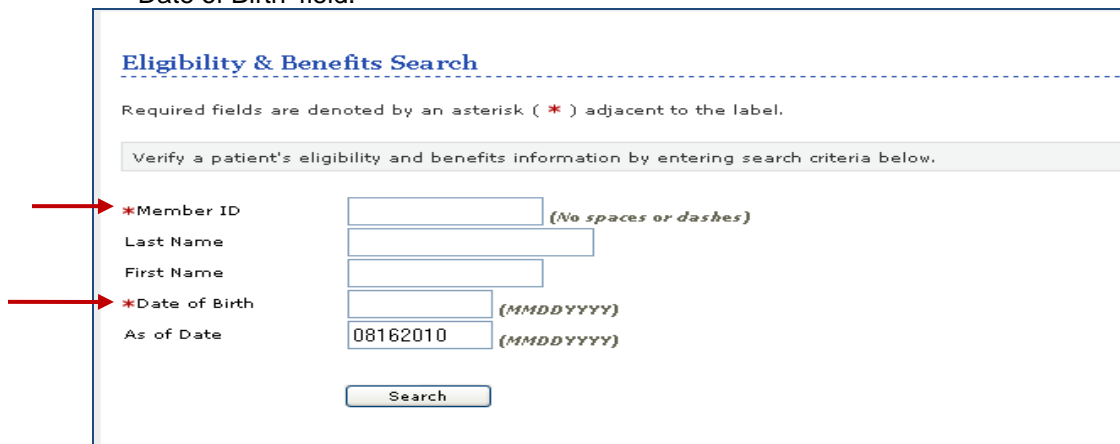
- 2) A “Disclaimer” box will pop up warning that only completed and submitted requests will be reviewed. Click the “Next” button.



The screenshot shows a disclaimer box with the following text: "Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for authorization. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the 'Enter an Authorization Request' process, you will receive a screen noting the pending or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions." A red arrow points to the 'Next' button at the bottom left of the box.

- 3) On the ‘Eligibility & Benefits Search’ page, search for the member by entering the member’s 9-digit Medicaid ID number in the “Member ID” field. In the “Date of Birth” field, enter the member’s date of birth in MMDDYYYY format. Then click on the “Search” button.

**Example:** If the member’s date of birth is January 1, 1995, then enter “01011995” in the ‘Date of Birth’ field.



The screenshot shows the 'Eligibility & Benefits Search' form. It includes a 'Search' button and several input fields. Red arrows point to the 'Member ID' and 'Date of Birth' fields. The 'Date of Birth' field contains the example value '08162010'.

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Member ID  (No spaces or dashes)

Last Name

First Name

\*Date of Birth  (MMDDYYYY)

As of Date  (MMDDYYYY)

08162010

Search

- On the 'Demographics' page, click the "Next" button on the bottom of the page.

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member ID	TEMP000700074	Eligibility	
Alternate ID		Effective Date	02/04/2010
Member Name	WOODSIN, LAMONYNE	Expiration Date	
Date of Birth	02/28/1995	COB Effective Date	
Address	500 ENTERPRISE DR ROCKY HILL, CT 06103	Subscriber	
Alternate Address		Subscriber ID	TEMP000700074
Marital Status		Subscriber Name	WOODSIN, LAMONYNE
Home Phone			
Work Phone			
Relationship			
Gender	M - Male		

Next

- On the 'Select Service Address' page, click on the radio button next to the appropriate Provider Service Address and then press "Next"

### Select Service Address

Provider	Vendor
Capture	Vendor
Provider ID	Vendor ID
Last Name	Vendor Last Name
First Name	Vendor First Name
Tax ID	Paid To Vendor ID
Service Address	Pay To Address
Alternate ID	
<input checked="" type="radio"/> CBHP002120	TEMP PROVIDER
500 ENTERPRISE DR OTP STE 4D ROCKY HILL, CT 06067-3913-	VC8003159
TEMPFAC	TEMP PROVIDER
<input type="radio"/> CBHP002120	VC8005769
500 ENTERPRISE DR STE 4D ROCKY HILL, CT 06067-3913-	TEMP PROVIDER
999999999	500 ENTERPRISE DR STE 4D ROCKY HILL, CT 06067-3913-
999999999	

Back Next

- On the 'Registered Services Header' page, enter the date that services were started for the member in the "Requested Start Date" field. For ease of use, click on the calendar next to this field and select the appropriate start date to automatically put the date into this field.

### Requested Services Header

All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.

\*Requested Start Date (MMDDYYYY)

09152011

**\*IMPORTANT! PLEASE NOTE:** The Requested Start Date **must be the same date** as the last authorized end date in order for the MTPPR request to be considered a concurrent. Users should always verify the last authorized end date on the Auth Summary tab of the member's authorization before beginning the member's MTPPR.

Example 1: The member is authorized for Residential/Group Home Services from:

11/01/10 – 12/01/10 for 30 units.

The Requested Start Date for the first MTPPR should be 12/01/2010.

- 7) In the 'Level of Service' field, select "Inpatient/HLOC". Select the 'Type of Service', 'Level of Care' and 'Type of Care' for this request. The values selected must match the values selected on the initial request.

**Requested Services Header**

All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.

\*Requested Start Date (MMDDYYYY)

\*Level of Service

\*Type of Service

\*Level of Care

Type of Care

\*Admit Date (MMDDYYYY)

- 8) Then enter the 'Admit Date' in MMDDYYYY format or by using the calendar function. The Admit Date must match the Admit Date on the initial review. Providers can verify the Admit Date on the 'Auth Summary' tab of the member's authorization.

**Requested Services Header**

All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.

\*Requested Start Date (MMDDYYYY)

\*Level of Service

\*Type of Service

\*Level of Care

Type of Care

\*Admit Date (MMDDYYYY)

- 9) The "Attach a Document" section is **not necessary**.

- 10) Click the 'Next' button. *NOTE: If no document has been attached, a pop up warning message will appear to confirm if you want to proceed without attaching a document. Click the 'OK' button to proceed.*

**Staging CONNECT** ProviderConnect Home

**Requested Services Header**

All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.

\*Requested Start Date (MMDDYYYY)

\*Level of Service

\*Type of Service

\*Level of Care

Type of Care

\*Admit Date (MMDDYYYY)

Provider  
Tax ID: 060646668

Member  
Member ID: TEMP000700074

**Attach a Document**

Complete the form below to attach a document with this Request  
The following fields are only required if you are uploading a document

\*Document Type:

Does this Document contain clinical information about the Member? Yes  No

UploadFile  Click to attach a document

Delete  Click to delete an attached document

Attached Document:

11) Click Enter Discharge Information button, and the discharge screen will display.

**Requested Services Header**

Requested Start Date <b>08/08/2010</b>	Member Name <b>TOMPKINS, JOUFU</b>	Provider Name <b>WHEELER CLINIC INC,</b>	Vendor ID <b>VCB003370</b>	
Type of Request <b>CONCURRENT</b>	Member ID <b>TEHP000700081</b>	Provider ID <b>CBHP000766</b>	Provider Alternate ID <b>004039368</b>	NRE # for Authorization <b>SELECT...</b>
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>Mental Health</b>	Level of Care <b>Group Home</b>	Type of Care <b>Group Home - 2.0</b>	

There is an existing authorization that bridges this date range.  
Is this a request for continuing care (concurrent request) or do you wish to enter Discharge information?

- 12) Complete the Required Fields of the Discharge Information Section
- a. Actual Discharge Date
  - b. Primary Discharge Diagnosis
  - c. Discharge GAF
  - d. Discharge Condition
  - e. Medication at Discharge (open text field under Narrative Entry)
    - i. Users should list Medication, Dose, Frequency and reason for treatment.

## Discharge Information

\*Actual Discharge Date (MMDDYYYY)  
08252010

\*Primary Discharge Diagnosis Description

\*Discharge GAF

\*Discharge Condition  
 Improved  No Change  Worse  Unknown

\*Medication at Discharge

▸ Narrative History

▾ Narrative Entry (0 of 250)

- 13) Complete the Required Fields of the Current Risks Section.
- a. Member's Risk to Self
  - b. Member's Risk to Others
    - i. If either rating is (2) Moderate or (3) Severe...check all that apply (i.e. Ideation, Intent, Plan, etc.)

### Current Risks

Key:

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

\*Member's Risk to Self

0  1  2  3  N/A

**Check all that apply** (\*Required if Risk is Moderate or Severe)

- Ideation
- Intent
- Plan
- Means
- Current Serious Attempts
- Prior Serious Attempts
- Prior Gestures

\*Member's Risk to Others

0  1  2  3  N/A

**Check all that apply** (\*Required if Risk is Moderate or Severe)

- Ideation
- Intent
- Plan
- Means
- Current Serious Attempts
- Prior Serious Attempts
- Prior Gestures

- 14) Complete the (12) Required Fields of the Current Impairments Rating Section

### Current Impairments

Key:

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

\*Mood Disturbances (Depression or Mania)

0  1  2  3  N/A

\*Weight Change Associated with a Behavioral Diagnosis

0  1  2  3  N/A

\*Anxiety

0  1  2  3  N/A

\*Medical/ Physical Conditions

0  1  2  3  N/A

\*Psychosis/ Hallucinations/ Delusions

0  1  2  3  N/A

\*Substance Abuse/ Dependence

0  1  2  3  N/A

\*Thinking/ Cognition/ Memory/ Concentration Problems

0  1  2  3  N/A

\*Job/ School Performance Problems

0  1  2  3  N/A

\*Impulsive/ Reckless/ Aggressive Behavior

0  1  2  3  N/A

\*Social Functioning/ Relationships/ Marital/ Family Problems

0  1  2  3  N/A

\*Activities of Daily Living Problems

0  1  2  3  N/A

\*Legal

0  1  2  3  N/A

- 15) Complete the Discharge Required Fields
  - a. Type of Discharge
  - b. Discharge Plan in Place
  - c. Actual Level of Care/Service Discharged To (Primary) *(drop down menu)*
  - d. PCP notified?
  - e. Actual Discharge Residence (Primary) *(drop down menu)*
  - f. Is member being discharged from RTC, GH or PRTF?
    - i. If yes, Reason for RTC, GH or PRTF Discharge *(drop down menu)*
  - g. Additional RTC, GH or PRTF Discharge Information
  - h. While not required, any additional information on reason for discharge, provider name, level of care and contact information would be extremely beneficial.
  - i. Person to Contact for Follow Up
  - j. Relationship
  - k. Phone #

<p><b>*Type of Discharge</b></p> <p><input type="radio"/> AMA <input type="radio"/> Planned</p>	<p><b>*Discharge plan in place?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><b>*Actual Level of Care/Service Discharged To (Primary)</b></p> <p>SELECT...</p>
<p><b>*Is member being discharged from RTC, GH, or PRTF?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><b>*PCP notified?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A</p>	<p><b>*Actual Discharge Residence (Primary)</b></p> <p>SELECT...</p>
<p><b>*If Yes, Reason for RTC, GH, or PRTF Discharge</b></p> <p>SELECT...</p>	<p><b>Additional RTC, GH, or PRTF Discharge Information</b></p> <p>▶ Narrative History</p> <p>▼ Narrative Entry (0 of 250)</p>	<p>▶ Narrative History</p> <p>▼ Narrative Entry (0 of 250)</p>
<p><b>*Person to Contact for Follow Up</b></p> <p>_____</p>	<p><b>*Relationship</b></p> <p>SELECT...</p>	<p><b>*Phone #</b></p> <p>____-____-____ Ext. _____</p>

- 16) Complete the Required Fields of the Aftercare Planning Section.
  - a. Does the discharge plan involve Member, Guardian and/or Parent Participation?
  - b. What CT BHP services are needed?
  - c. Other Resources/Support System to be utilized
    - i. While not required, any additional information would be beneficial.

### Aftercare Planning

<p><b>*Does the discharge plan involve Member, Guardian and/or Parent participation?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p>	<p><b>If appropriate, was MCO notified to assist in members aftercare planning?</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><b>*What CT BHP services are needed?</b></p> <p>SELECT...</p>
<p><b>Medical Aftercare</b></p> <p>▶ Narrative History</p> <p>▼ Narrative Entry (0 of 250)</p>	<p><b>Other Resources/Support System to be Utilized</b></p> <p>▶ Narrative History</p> <p>▼ Narrative Entry (0 of 250)</p>	<p>▶ Narrative History</p> <p>▼ Narrative Entry (0 of 250)</p>

- 17) Complete the last (2) Aftercare Section Required Fields
- a. Aftercare Behavioral Health Provider
  - b. Aftercare Prescribing Physician

**NOTE: Please do not use the ValueOptions Health Alert Preferences**



**\*Aftercare Behavioral Health Provider**

Not Arranged  Do Not Know  Arranged

**\*Aftercare Prescribing Physician**

Not Arranged  Do Not Know  Arranged

- 11) Click **Save Discharge Information** (btm of page) to Complete Form