



**Welcome to the  
2007 NC Medicaid and  
NC Health Choice  
Provider Seminar**

*Jane Harris, LCSW  
Provider Relations Director, PSD*

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**AUTHORIZATIONS:  
"How to Make it Work  
for You"**

*Jane Harris, LCSW  
Provider Relations Director, PSD*

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**Agenda**

- VO Authorization Experience in NC
- Confirming the Basics
- Outpatient Services
- Inpatient/Expanded Services
- TCM/CAP Services
- Authorization Time Lines
- Crisis Services
- Appeals Process
- Provider Relations Unit
- NC Health Choice



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**VO Authorization Experience in NC**

Number of faxes received per week?  
**7000 – 9000** Usually with multiple requests attached to them

Number of auth requests returned to providers weekly?  
**10% - 15% per week (appr. 1200/week)**

Why?  
**Incomplete or missing information**

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**Confirming the Basics**

- Prior authorization is required for all services
- Exceptions (“Unmanaged Visits” or “Pass Through”):
  - TCM gets 32 units (8 hours) the first month
  - Community Support will also have 32 units 8 (8 hours) to complete the Introductory PCP prior to requesting any additional services.
- If a consumer transfers to your agency and has already had the pass through units for CS or TCM, you need prior authorization (PA) before delivering services.
- The pass through is a **once in a lifetime event.**

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### When Completing a Request for Authorization

#### Level of Care –

Write it out! Make sure that we know what you are asking for.

Please do not use abbreviations!

#### Member's Medicaid Number –

This is critical. We cannot authorize services if we don't have the Member's correct information.

Please check for accuracy & eligibility!



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### When Completing a Request for Authorization

#### Provider's Medicaid ID Number –

Does it match with the level of care being requested?

The provider must include the appropriate **ALPHA Suffix** with the Medicaid ID – to verify approval to provide that service at that location

For example: 83#####B for Community Support

If you are billing through an LME, it must be the LME's Medicaid ID number

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### When Completing a Request for Authorization

- Check for completeness, accuracy and clarity
  - If we have to call you to get clarification, it will slow down the process.
- Diagnosis – there must be at least one valid diagnosis per authorization request.
  - Use diagnosis code and name of dx.
  - Information on Axis I – IV is preferred
  - MH/SA - minimum Axis I or Axis II diagnosis
  - DD – minimum Axis I, Axis II or Axis III



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### When Completing a Request for Authorization

- Specify “units”, “hours”, or “days” for each service
- Specify the duration requested – Start date and End date
- Include PCP that identifies the need and purpose of each requested service
- Make sure the Service Order is signed by approved discipline

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### Sending Authorization Requests to VO

MAIL:  
PO BOX 13907  
RTP, NC 27709-3907

FAX:

MH/SA: 919-461-0599  
CAP/TCM: 919-461-0669  
Resi/TFC & EPSDT: 919-461-0679



PHONE:

1-888-510-1150

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### Viewing Authorization Letters

- Go to [www.ValueOptions.com](http://www.ValueOptions.com)
- Select Provider  
Select Provider Connect Log-In Site
- Use your Medicaid ID Number to register the first time you visit the site
- If you bill through an LME, you can not use this application
- Call 1-888-247-9311 if you have problems



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**Viewing Authorization Letters**

**Coming Soon...**

ValueOptions is testing an option to allow providers to complete the various authorization forms on line!!



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**Reminders**

- **Piedmont Cardinal Health Plan**  
If Medicaid eligibility is in Cabarrus, Rowan, Stanley, Union or Davidson counties, please call:  
Piedmont Behavioral Health\* at 1-800-939-5911
- All other questions, call ValueOptions at:  
1-888-510-1150

**\*Piedmont does not authorize NC Health Choice.  
Call ValueOptions' Health Choice  
Toll Free Line: 1-800-753-3224**



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**Forms and Where to Find Them**

- [www.ValueOptions.com](http://www.ValueOptions.com)
- Select Providers
- Select *Network Specific*
- Select NC Medicaid or NC Health Choice
- Forms are available in PDF or Word
- Instructions were last updated on 3/30/07



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**Outpatient & Mobile Crisis Authorization Requests**

- Use ValueOptions ORF2 form and instructions
- SEE ORF2 FORM AND INSTRUCTIONS



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**Outpatient Changes for NC Medicaid**

- Non-licensed, provisionally licensed and licensed staff who bill "H" codes will need to include the modifiers with their authorization request
- VO will no longer provide authorizations to H0004 without the appropriate modifier. (except for Individual)
- You will submit your billing with these same modifiers.
- Request the number of units you need for each service: Individual, Family w/child, Family w/o child, and/or Group.



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**Inpatient/Residential/Substance Abuse Expanded Service Authorization Requests**

SEE ITR FORM & INSTRUCTIONS  
on the VO website



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**Inpatient/Residential/Substance Abuse  
Expanded Service Authorization Requests**

Use the ITR for These Services

- Inpatient
- Residential – all levels
- Substance Abuse Services
- Multisystemic Therapy
- Intensive In-home
- Psychosocial Rehab
- Partial Hospitalization
- Community Support
  - Adult
  - Child/Adolescent
  - Team
- ACTT
- Day Treatment

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**Community Alternative Program (CAP)/Targeted Case  
Management Authorization Requests**

SEE CTCM FORM & INSTRUCTIONS  
on the VO website



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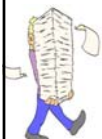
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**Community Alternative Program (CAP)/Targeted  
Case Management Authorization Requests**

The CTCM form is used to request:

- Plan of Care (POC) Initial Review
- Continued Need Review (CNR)
- Targeted Case Management (TCM)
- Discreet Services
- Plan Revisions



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**Community Alternative Program  
Discreet Services**

Discreet Services are those services which are provider-specific (not equipment or modifications) and include:

- Home and Community Supports
- Residential Supports
- Respite
- Personal Care
- Day Supports
- Supported Employment



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**Community Alternative Program  
Discreet Services**

**When an authorization request is submitted for any Discreet Service, the following apply:**

- A separate CTCM form must be submitted for each service IF different providers are delivering the services. If the same provider delivers multiple services, up to 3 requests can go on one form.
- The Case Manager submits the original or initial request along with Plan of Care.



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**Community Alternative Program  
Discreet Services**

- The Provider can submit JUST the CTCM for the concurrent request if there are no changes.
- In these cases, the POC is not required to be resubmitted.





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### CTCM Authorization Requests

Also, use the CTCM form for submitting a Plan of Care (POC) or Continuous Need Review (CRN).

With each request, include:

- Plan of Care
- Service Order, properly signed by QP unless a physician order is required.
- MR2 form
- Supporting Assessments
- SNAP score
- Cost Summary

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### CTCM Authorization Requests

Targeted Case Management (TCM) is also authorized using the CTCM form.

With each request for a **Non-Waiver recipient submit:**

- Person Centered Plan (PCP)
- Service Order, properly signed QP until new TCM definition is approved then one of the approved four disciplines will need to sign the PCP for non-Waiver consumers.
- Requests must be submitted no less than every 90 days. See Timeline Grid

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### CTCM Authorization Requests

With each request, for Waiver Recipients, submit:

- For TCM, a request will be submitted with your annual CNR (**starts with November birthday month requests**)
- Service Order, properly signed and
- CTCM must be submitted
- This will be an annual authorization.
- If all units are used prior to the next CNR, you should submit a Revision Request using the CTCM

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**CTCM Authorization Requests**

- CAP-MR/DD Waiver TCM
- Annual authorization 240 units/year
- UR guidelines TCM based on an average of 5 hours/month or 20 units/month
- Requests for additional units prior to next CNR require POC submission with documentation to support additional units.

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**Authorization**



**Timelines**

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**PCPs**  
**Introductory**

- Action Plan (goals)
- Crisis Prevention/Crisis Response (second page of the Crisis Plan)
- The signature page with signature from appropriate discipline.
- Submitted with initial requests for those services where a consumer enters directly (refer back to Access Flow Chart)

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**PCPs**  
**Introductory**

- Intro PCP is for NEW consumers to the system only. A new consumer is one who has never had any services before or who has been discharged from **ALL** services for at least **60 days**.
- For those who have been discharged for 60 days or more, an Intro PCP can be completed. However there is no additional pass through allowed.

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**Final PCP**  
**Concurrent Reviews**

- All pages will be completed
- The pages completed with the introductory PCP will be included with this complete version.
- A new service order is required:
  - \* When a new service is being requested;
  - \* A new complete annual PCP is being done
- It is submitted for your first concurrent request
- It is **important** to note that on all subsequent concurrent requests an updated PCP or Revision must be submitted

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**New Consumers**

**Community Support**

- As of June 11, 2007, there is **no** 30 day pass through
- There will be a once in a lifetime pass through of 8 hours.
- This 8 hours is used to link, refer and complete the Introductory PCP
- This does not apply to NCHC  
PA is required on the first day of service

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**New Consumers**

**Community Support**

- Complete the ITR, Introductory PCP
- Complete Consumer Admission Form (send to LME not VO)
- Submit to Value Options, the ITR and Introductory PCP 
- See handout for duration of this initial authorization



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**New Consumers**

**Direct Admit Services Other than Community Support**

- Prior Authorization is Required
- During Initial session/visit:
  1. Complete Provider Admission Assessment
  2. Complete Introductory PCP
  3. Complete ITR
  4. Complete Consumer Admission Form (send to LME not VO)
  5. Submit ITR and Introductory PCP Form to VO
  6. If your information is complete, the authorization would be effective that day
  7. See handout for duration of this initial authorization



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**New Consumers**

**Before a Concurrent Request is submitted...**

- Complete the Clinical Assessment
  - \* Can be a 90801, Diagnostic Assessment, etc. (refer to list on Access Workflow)
- Previous assessments completed in last **90 days** will be accepted
- Complete the rest of the PCP
- Submit a new ITR & Complete PCP (include pages from Intro PCP) to request ongoing services and/or additional services
- See handout for duration times for authorizations:
- **Remember**, this is only a guideline, meaning it can be UP TO that amount.





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**Existing Consumers**

**Community Support Adults**

When your current authorization period ends:

1. You can request up to 780 units for up to a 90 day period
2. If you exhaust the units approved prior to or at the end of the authorization period:
  - a. Send in a new ITR and updated PCP
  - b. The revisions/update must have the QP and consumer or legally responsible person's signature. No MD signature is required unless a new service is being requested.
  - c. Remember that additional units will be authorized based solely on Medical Necessity

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**Existing Consumers**

**Community Support Children  
(up to age 21)**

When your current authorization ends:

- Submit an updated PCP/Revision with a completed ITR requesting additional units
- All authorization decisions will be made based on Medical Necessity
- Authorizations will be given for UP TO 90 days at a time
- Prior to any denial or reduction in services, the request will be reviewed under EPSDT guidelines.

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**Existing Consumers**

**Children (up to age 21)**

For services other than Community Support:

- Submit the ITR and updated PCP/Revision prior to the end of your current authorization timeline.
- The update/revision must be signed by the QP and consumer or legally responsible person. No MD signature is required unless a new service is being requested.
- See handout for authorization timelines going forward





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**Crisis Services**

**Facility Based Crisis and Mobile Crisis**

- These will be reviewed as Urgent Requests similar to Inpatient requests after July 1, 2007
- Fax these requests to 919-461-9645



- **DO NOT** fax any other requests to this line

40 VALUEOPTIONS

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**Appeals Process**

**Denials and Reductions**

- When VO denies or reduces services that have been requested the consumer/guardian and provider get a letter explaining the determination and the consumer's appeal rights
- The consumer has 11 days to respond to DMA for an informal hearing.

41 VALUEOPTIONS

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**Appeals Process (cont.)**

**Denials and Reductions**

- If the consumer does not file for an appeal, the determination by VO becomes effective on the 11<sup>th</sup> day. Providers should reduce or terminate services on that day as is stated in the letter you receive.
- The consumer still has up to 60 days to file for a formal hearing.

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### Appeals Process (cont.)

#### Denials and Reductions

- If the consumer does file for an appeal, services will remain in effect at the former level until the appeal is completed.
- Providers should maintain services during the appeal process. This is called Maintenance of Service.
- VO will keep an authorization in place so the Provider can get paid during this time period.

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### Appeals Process (cont.)

#### Denials and Reductions

- Maintenance of Service is required by law, so the provider should not terminate services during the appeal process.
- DO NOT send in additional requests to VO asking for more units during this time.
- Providers can submit new requests for different services during the appeal.
- If an appeal is requested, VO will send a letter to the provider requesting the medical record. You must comply with this request.

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### Provider Relations Team for the NC Medicaid Account

ValueOptions has a Provider Relations Team to address issues and questions providers may have about a variety of topics. This can include:

- late authorization notifications,
- incorrect authorizations information,
- how to complete the authorization process,
- And many other provider concerns

This team is

- dedicated to the Medicaid account.
- charged with developing and delivering trainings for providers on an ongoing basis.

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**Provider Relations Team for the NC Medicaid Account**

- If you have a need you feel can be addressed by this team, please call 1-888-510-1150, or e-mail the team at [psdproviderrelations@valueoptions.com](mailto:psdproviderrelations@valueoptions.com)
- If you have multiple authorization issues that need to be researched please complete the template found on the ValueOptions web page. Follow the directions for sending it by e-mail as a password protected document.

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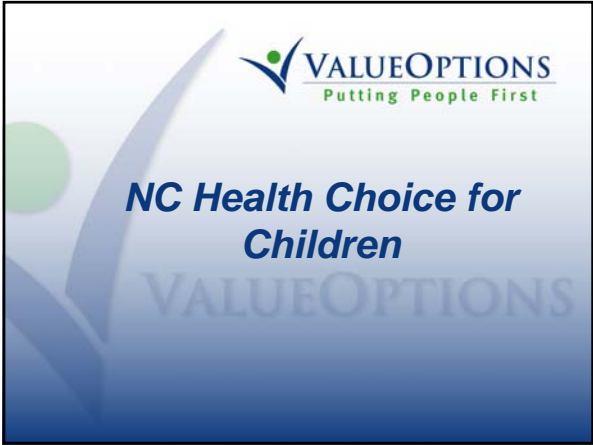
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**NC Health Choice for Children**

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**NC Health Choice Is:**

- North Carolina's Child Health Insurance Program funded by the federal and state governments.
- For children ages 6 through 18 up to 200% of federal poverty level.
- Not an entitlement program – dollars are limited.

All NC Health Choice services are authorized through ValueOptions.

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**NC Health Choice Behavioral Health Services for Children with Special Health Care Needs (CSHCN) Are:**

- Services above the core package of benefits offered by the State Health Plan
- Reviewed and approved by:
  - 1) The Behavioral Health Workgroup of the Governor's Commission on Children with Special Health Care Needs and
  - 2) The Division of Public Health
- As similar as possible to those provided through Medicaid

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**NC Health Choice Covered Services for CSHCN**

- Diagnostic Assessment
- Community Support
- Mobile Crisis
- Day Treatment
- Intensive in Home
- Multisystemic Therapy
- Residential II through IV – All Levels
- Targeted Case Management

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**NC Health Choice Core Services**

- Inpatient
- Residential Treatment Centers (like PRTF)
- Partial Hospital Programs
- Intensive Outpatient Programs
- Crisis Evaluation and Stabilization
- Outpatient Therapy\*
- Psychological Testing

\* the first 26 visits do not require precertification by ValueOptions  
\* visits are counted on the state fiscal year (July 1 – June 30)  
\* 90862 does not count toward the 26 unmanaged visits and does not require precert by ValueOptions at any time unless there is a SA diagnosis

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**NC Health Choice  
Authorization Requirements**

- The ITR form is used for requesting authorization for the following:
  - Inpatient
  - Residential Treatment Center (like PRTF)\*
  - Residential Levels II, III, and IV\* -- including Therapeutic Foster Care\*
  - Partial Hospitalization
  - Community Support\*
  - Intensive In-Home\*
  - MST\*
  - Day Treatment\*
  - IOP

\*Health Choice Addendum is also required

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**NC Health Choice  
Authorization Requirements (cont.)**

- The ORF2 form is used for requesting authorization for the following services:
  - Outpatient Services
  - Mobile Crisis
  - Diagnostic Assessment
- A current Person Centered Plan must be on file with each review request.
- Health Choice will still do telephonic reviews and may call you after you fax a request; include your phone #.

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**NC Health Choice  
Appeals Process**

- If the ValueOptions MD non-certifies or reduces services that have been requested the member and provider will receive a letter explaining the determination and the member's appeal rights.
- Level 1 Appeal – Request to VO must be made in writing within 60 days of the date of the non-certification letter.
- Level 2 Appeal – Request to VO must be made in writing within 60 days of the date of the Level 1 appeal decision letter.
- DOI Appeal -- Once the 2 levels of appeal have been exhausted through ValueOptions, the member or their designated representative has the right to appeal to the Department of Insurance (DOI) within 60 days of the Level 2 decision letter.

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**Retrospective Review Requests  
for NC Health Choice**

Retro-reviews are not allowed by NC Health Choice for enhanced services **except** when there is a change in eligibility that would have prohibited the provider from requesting approval **prior** to the date of service delivery.

This is at the direction of the Division of Public Health.

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**ValueOptions will honor retrospective review requests ONLY in the following cases:**

- When eligibility has changed from Medicaid (or other insurance) to NC Health Choice (NCHC) and the provider has faxed a request for NCHC authorization with the NCHC member ID number to the NCHC fax line (919-379-9035) **within 60 days of when the State determined the change in eligibility (not the effective date of coverage).**
- When eligibility has changed from Medicaid (or other insurance) to NCHC and the provider has made a request for NCHC authorization by phone using the toll-free line (1-800-753-3224) **within 60 days of when the State determined the change in eligibility (not the effective date of coverage).**

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**How to check eligibility for NC Health Choice**

Check Medicaid eligibility first if the child has been on Medicaid most recently by calling EDS at 1-800-723-4337 and follow the prompts.

OR

If no longer Medicaid eligible, contact BCBS of NC at 1-800-422-4658 and follow the prompts for NC Health Choice to speak with a Customer Service Representative about a child's eligibility.

In order to ensure that you, as a provider, are requesting authorization of the appropriate program (Medicaid or Health Choice) you must check eligibility through EDS or BCBS prior to submitting an ITR or ORF2 , but no less than monthly.

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**NC Health Choice  
REMINDERS**

- Checking eligibility *monthly is an essential step for the provider in order to request authorization from the correct program.*
- Additional information (clinical criteria, forms, etc.) is available at the ValueOptions website: [www.valueoptions.com](http://www.valueoptions.com); choose "Provider"; choose "Network Specific"; then choose "NC Health Choice".
- Requests for authorization must be faxed to the NC Health Choice line **only**;
- Be careful not to send Health Choice requests to the Medicaid line;
- Health Choice requests faxed to the Medicaid line will **NOT** be honored.

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**NC Health Choice  
REMINDERS (cont.)**

- For NC Health Choice Authorizations the **only** numbers to use are:  
**Fax: 1-919-379-9035**  
**Toll-Free: 1-800-753-3224**
- All "core benefit" services, with the exception of the first 26 unmanaged outpatient psychotherapy visits, require precertification
- There is NO pass through on Community Support, precert is required prior to the start of Community Support services.

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**NC Health Choice  
ValueOptions Contact Information**

- For Questions Call: 1-800-753-3224
- Fax Forms ONLY to: 1-919-379-9035
- Mailing Address:  
Mental Health Case Manager  
NC Health Choice for Children  
P. O. Box 12438  
RTP, NC 27709

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**NC Health Choice  
Claims Processing Contractor Information**

- Toll Free Number: 1-800-422-4658  
*for questions regarding claim status, benefit questions, and eligibility.*
- Claims Mailing Address:  
Claims Processing Contractor  
PO Box 30025  
Durham, NC 27702

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**Q & A**

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