

Services Management Communication Bulletin #6 (12/10/04)

Dear Providers:

Here are a few updates on some important issues:

### **Standard Care Grids**

For your information, we have fully implemented the use of the standard care grids. To reiterate, you should request all medically necessary services the consumer needs on a SAR. But if the consumer's needs fall within standard care, your SAR will be automatically approved by an authorization technician.

Recently, we have had some inquiries about SARs that were approved but for fewer units. When a SAR exceeds the amount of service on the grid, we will automatically reduce the approved amount to the amount in the grid, unless there is a reasonable justification for the larger amount. Please remember to write a justification.

### **SAR Form**

We still receive old SAR forms. Since the old SAR forms do not have all the information we need, we will administratively deny these requests. Please use the new form. It is posted on the Western Highlands Network website.

### **Adding Additional Units to an Already Approved Authorization**

For example, if you have 8 events of 90800 approved from 7/1/04 – 9/30/04 and need 6 more, submit a SAR requesting it. In the justification, note that you want additional units added to an existing authorization. We will change the existing authorization by adding units to it.

### **Extending the End-Date of an Already Approved Authorization**

For example, if you have 8 events of 90800 approved from 7/1/04 – 9/30/04 and don't need more units, but simply want to extend the end-date, submit a completely new SAR with a start-date of 10/1/04, asking for as many units as you need per the new time-frame. Any authorization with a lapsed end date is no longer valid, even when some authorized units have not been used.

### **Medicaid Consumers' Unmanaged Outpatient Sessions Beginning January 1, 2005**

Even though Value Options (VO) has an unmanaged period (8 sessions for adults and 26 sessions for children) beginning January 1, Western Highlands Network (WHN) requires that ALL outpatient services be authorized, in order for claims submitted to WHN to be paid. It is the provider's responsibility to know when an OTR must be submitted to WHN in order to also get a VO authorization. When WHN authorizes a service, your Letter of Authorization (LOA) will state that the authorization is contingent upon "the submission of an OTR, if applicable, per Value Options requirements."

The requirements for submission of an OTR are as follows:

- Track the number of outpatient sessions (adults are allowed 8 unmanaged sessions—with group therapy counting as ½ session in the unmanaged period only, and children are allowed 26 unmanaged sessions, with group therapy counting as 1 session)
- Make sure all lines on the OTR are completed and the information is accurate
- Submit the OTR to the WHN Services Management Department with a SAR
- Submit the OTR to WHN a couple of sessions before the unmanaged sessions expire

If we don't receive an OTR with your SAR, we will assume that the request falls in the unmanaged sessions. Please do not send an OTR before the unmanaged sessions are about to expire, since this will trigger an unneeded review by VO.

If you are a directly-enrolled Medicaid provider, you should submit service authorization requests directly to VO.

#### **Services NOT Requiring a Service Authorization**

Non-case responsible providers have been calling us about why they have not received an authorization for room and board, therapeutic leave, and therapeutic leave room and board. These services no longer require authorization, so case managers are not requesting these services. Non-case responsible providers may simply bill for the services. Remember that therapeutic leave is limited to 15 days per quarter.

We also continue to receive SARs for medication checks (90862). You do not need an authorization for this service.

#### **H-Codes and OTRs**

Apparently, some clinicians feel that H-codes are not subject to review by Value Options, and therefore, are not submitting OTRs. For Medicaid eligible consumers H-codes are no different than CPT codes; both require approval by Value Options after the unmanaged period. You need to submit an OTR.

#### **ACTT**

SARs for ACTT should be for one calendar-month only, requesting 4 units for each month. You may ask for multiple months but please make discrete 4 unit requests for each month.

#### **Notification of Out of Home Community Placement for Children/Adolescents**

Last year, the NC Legislature passed a law which requires the completion of the "Notification of Out of Home Community Placement for Children/Adolescents" form when a child is placed out-of-home. Originally, Western Highlands Network required the submission of this form to the Services Management Department when a request for residential placement was reviewed. At the request of providers, we relaxed this requirement and simply asked providers to complete the form and we would check compliance during provider reviews. We have been advised informally at the State-level that generally the forms are not being completed statewide. Additionally, our initial provider reviews have found a pattern of non-compliance in completing the form. Therefore, effective immediately, we are re-instituting the requirement that the provider must send us the form when requesting residential services, so that we know it has been sent to the appropriate officials, per the requirements stated on the form. No residential service will be authorized without the submission of the "Notification of Out-of-Home Community Placement for Children/Adolescents" form.

Although you are required to submit the form the WHN, the provider is responsible for sending the form to all the parties who are outlined on the form.

#### **Room and Board**

We have had a number of requests from case responsible providers for residential services for youth in the CMMED target population. We can approve Level II residential services for this population, however, please know that room and board is not an allowable cost under the CMMED target population. It is, allowable under the CMSED target population.

#### **Requests for Forms**

We often get requests for forms. Please check the Western Highlands Network website. All the forms are available on the website: [www.westernhighlands.org](http://www.westernhighlands.org)

#### **SAR Overlap Errors**

When completing the start and lapse dates on a SAR, please remember to avoid overlapping the dates. We often get requests, for example, November 1 – December 1. Then, the next request is for December 1 – January 1. These requests overlap and require time to fix. The first request should be November 1 – November 30. The second request should be December 1 - December 31.

**Status of an Authorization**

We are getting many calls from non-case responsible providers asking about the status of an authorization. These calls should go directly to the case manager who is coordinating services. The case manager often can look up the status in the Management Information System. If the case manager cannot directly access the MIS, the case manager should call us if the status of an authorization is unknown.

**Medicaid Eligibility**

Many consumers who are accessing services with state funds may be eligible for Medicaid. Providers should be actively pursuing Medicaid eligibility for appropriate consumers. We will not continue to re-authorize services for state-funded consumers, month-after-month, if the consumer may be eligible for Medicaid. We will require documentation that Medicaid application has been made in order to continue approving state funds.

**Natural Support Systems**

As you know, it is State policy that Person-Centered Plans include the use of natural support systems. The public state dollar should be used last. As we re-authorize state funds for consumers, increasingly we will be looking for the use of natural supports. We will expect their use to increase over time so that state dollars for services can be reduced.

**Administrative Denial**

When we administratively deny a SAR (for example, because the PCP target dates have lapsed), you must resubmit a SAR when you send us the correction. An administrative denial removes the request from the system; you must start over. If you submit the corrected PCP without a SAR, we will not know what to do with it. Often, a very perturbed provider will call us because we have not acted on SAR. Upon investigation, it is discovered that we administratively denied the service and the provider did not resubmit a new SAR with the correction. This problem is easily solved: Remember that a denial requires a new SAR; a pending SAR does not.

**Requests for Residential Services**

Requests for residential services require a RAF and the PCP. Historically, we required a SAR, but we removed this requirement at providers' request to eliminate paperwork. Unfortunately, this means that we are not getting a justification for the placement (which was typically written on the bottom the SAR.) Therefore, instead of reinstating the requirement for a SAR, we are simply asking that you send us a brief justification, which includes a history of what has been tried and an up-to-date CAFAS score. Many providers have an internal UR process for residential services and complete a UR form to document need. If you wish, you may send us the UR form in lieu of the justification.

**ADATC**

Effective immediately, we are approving 14 days for the rehabilitation program at ADATC. ADATC will request additional days for consumers if they are medically necessary.