ValueOptions® Maryland Tips for Submitting Authorization Requests through ProviderConnect

September 2009

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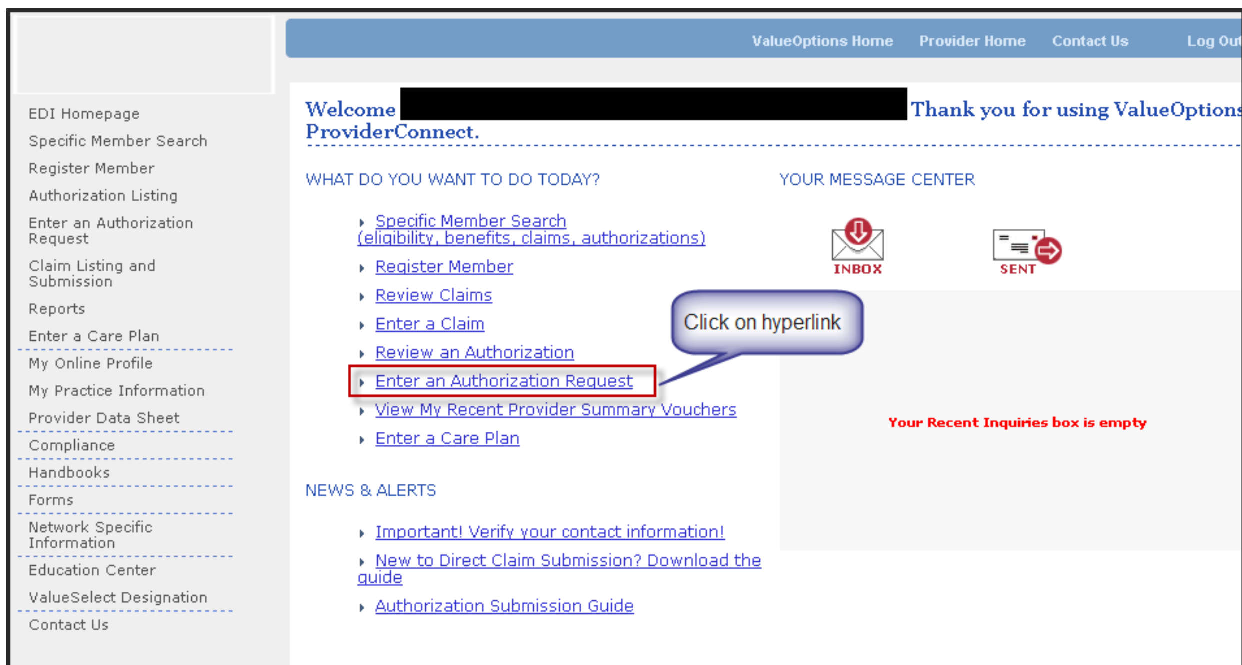
Tips for Submitting Authorization Requests through ProviderConnect

After logging in, providers will initially view their home page. Authorization Requests are started by utilizing the ***Enter an Authorization Request***:



After selecting ***Enter an Authorization Request*** providers will be directed to a disclaimer page and then to a ***Search a Member*** page where **Member ID** and **Date of Birth** are required elements. The system defaults to the current date for "**As of Date**" but can be changed as needed. The Consumer ID can be the Medicaid ID, the MAPS-MD or ValueOptions® Maryland assigned Uninsured ID, or the ValueOptions Consumer ID.

ProviderConnect Home

Search a Member

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 09082009 (MMDDYYYY)

Search

Providers will be offered a page to confirm the consumer information.

Next, the provider must select the correct service address on the ***Select a Service Address*** page. This address needs to be a match to the primary location where the consumer will receive services, and is the key to successful navigation through the request process. Funding streams, program codes and OMS provider types are linked to this selection.

ProviderConnect Home

Provider

Provider ID | Provider Last Name | Provider First Name

Select Service Address

If provider has more than 1 active servicing address - these will all display

Capture	Provider ID / Tax ID / Alternate ID	Last Name / First Name / Service Address	Vendor ID / Paid To Vendor ID	Vendor Last Name / Vendor First Name / Pay To Address
		ST SALISBURY, MD 21801-4921-		

Back Next

The next page is the ***Requested Services Header*** page. The selection on this page is the key to ensuring the correct forms display and the correct authorization request is placed in the system. Refer to the appendix at the end of this document for information regarding correct selections. The ***Requested Services Header*** page will refresh and redisplay depending on the options selected. Examples of Inpatient and Higher Levels of Care and Outpatient Services are displayed below:

Requested Start Date/OMS... is key to what the effective date will be on authorization request and what the reviewing care manager will see on the request.

Selecting Inpatient Level of Service results in Level of Care and Type of Care offering selected options and will dictate screens to follow in flow. Admission date must also be entered

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/OMS Interview Date (MMDDYYYY): 09082009

*Level of Service: INPATIENT/HLOC

*Type of Service: MENTAL HEALTH

*Level of Care: INPATIENT

Type of Care: INPATIENT MENTAL HEALTH- ACUTE

*Admit Date (MMDDYYYY): 09082009

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID	Provider Alternate ID

Consumer

Consumer ID	Last Name	First Name	Date of Birth (MMDDYYYY)

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 Consumer? Yes No

*Document Description: SELECT...

UploadFile *Click to attach a document* Delete *Click to delete an attached document*

Attached Document:

Back Next

Once all info is entered click **Next** - you will be prompted on whether or not you wish to attach a document - this is last chance to attach documents to the request - but they are not required. Continue with options to move forward.

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Requested Start Date/OMS... is key to what the effective date will be on authorization request and what the reviewing care manager will see on the request.

Selecting Inpatient Level of Service results in Level of Care and Type of Care offering selected options and will dictate screens to follow in flow. Admission date must also be entered

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/OMS Interview Date (MMDDYYYY): 09082009

*Level of Service: INPATIENT/HLOC

*Type of Service: MENTAL HEALTH

*Level of Care: INPATIENT

Type of Care: INPATIENT MENTAL HEALTH- ACUTE

*Admit Date (MMDDYYYY): 09082009

Provider

Tax ID | Provider ID | Provider Last Name | Vendor ID | Provider Alternate ID

Consumer

Consumer ID | Last Name | First Name | Date of Birth (MMDDYYYY)

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 Consumer? Yes No

*Document Description: SELECT...

UploadFile Click to attach a document Delete Click to delete an attached document

Attached Document:

Back Next

Once all info is entered click Next - you will be prompted on whether or not you wish to attach a document - this is last chance to attach documents to the request - but they are not required. Continue with options to move forward.

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Complete the clinical information, as applicable, for the type of service being requested. These screens vary between Inpatient/HLOC and Outpatient/Community Based services.

Tips for successful submission/navigating screens include:

- ProviderConnect works best with Internet Explorer 6 or IE7 for your browser – if you are having issues with the screens not displaying or pop ups not working correctly, you may be using a newer version of IE or using Fire Fox. If you are using IE8, you can follow the below steps to help with the issue:
  - Click on the **Tools** menu at the top of your browser
  - Click on **Compatibility View Settings**
  - Type in: valueoptions.com, and click the **Add** button
  - Click the **Close** button
- Do not use the browser **Back** button – use the **Back** button on the screen itself – using the **Back** on your browser can result in errors and loss of data.
- Required fields are indicated by **"*"**. These fields must be completed each time an authorization is requested. Some fields are dependent on other fields – a positive or negative response to a question may result in other fields being required – Example: If

the response to the question ***"Is this Consumer a Veteran"*** is "Yes" a second field will appear asking the provider to select the most recent war, if any,

- Use of hyperlinks to search with pop ups – entering partial information in a field may assist in narrowing search for desired information. However, if the information is known and the field allows free text, the information can data entered. Example: ***Axis 1 Diagnosis Code***.

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Requested Services Header

Requested Start Date 09/08/2009 | Level of Service INPATIENT/HLOC | Type of Request INITIAL

Note: Disable pop-up blocker functionality to

Diagnosis

Please indicate primary diagnosis.

Axis I

* Diagnosis Code 1: 296 | Description

Diagnosis Code 2 | Description

Diagnosis Code 3 | Description

Axis III

Select Diagnosis Code - Microsoft Internet Explorer

CLOSE WINDOW

Code	Description
296	AFFECTIVE PSYCHOSES
296.0	MANIC DISORDER SINGLE EPISODE
296.00	BIPOLAR 1 DISORDER, SINGLE MANIC EPISODE, UNSPEC
296.01	BIPOLAR 1 DISORDER, SINGLE MANIC EPISODE, MILD
296.02	BIPOLAR 1 DISORDER, SINGLE MANIC EPISODE, MODERATE
296.03	BIPOLAR 1 D/O,SINGL MANIC EPIS, SEV W/O PSYCH FTRS
296.04	BIPOLAR 1 D/O, SNGLE MANIC EPIS, SEV W PSYCH FTRS
296.05	BIPOLAR 1 D/O, SINGL MANIC EPIS, IN PRTL REMISSION
296.06	BIPOLAR 1 D/O SINGL MANIC EPIS, IN FULL REMISSION
296.1	MANIC DISORDER RECURRENT EPISODE
296.10	MANIC DX- RECURRENT- UNSPECIFIED DEGREE
296.11	MANIC DISORDER RECURRENT EPISODE MILD DEGREE
296.12	MANIC DISORDER RECURRENT EPISODE MODERATE DEGREE
296.13	MANIC DX-RECURRENT-SEVERE W/O PSYCHOSIS
296.14	MANIC DX-RECURRENT-SEVERE W/PSYCHOSIS
296.15	MANIC DX-RECURRENT-PARTIAL/UNSPECIFIED REMISSION
296.16	MANIC DISORDER-RECURRENT EPISODE-FULL REMISSION
296.2	MAJOR DEPRESSIVE DISORDER SINGLE EPISODE

- Drop-downs are available throughout the authorization request to standardize responses whenever possible
- Help Text is available as hover text or pop up on several screens – moving the cursor over the field or double clicking may provide with additional information
- For fields where response does not match the options offered, there is usually an "other" option which will allow you to enter information in a free-text box. Example: ***Psychotropic Medications***, if the drug prescribed is not found, the provider may indicate "other" and enter the name of the drug, etc, in the free text box that will appear.

1. Medication: OTHER | Description: OTHER | Side effects? ○ Yes ○ No | Usually adherent? ○ Yes ○ No | Prescriber: SELECT...

Other: Text Field for Other

Dosage | Frequency: SELECT...

Is medication found to be effective? ○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Other Text Box only appears if Other is selected - allows free text entry of meds not available in the pop up

2. Medication | Description | Side effects? ○ Yes ○ No | Usually adherent? ○ Yes ○ No | Prescriber: SELECT...

Dosage | Frequency: SELECT...

Is medication found to be effective? ○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

- Some fields will auto populate upon concurrent review requests.
- ***Red Dot Error Messages*** are there to help providers complete all the information and to offer help

• The information you provided for Axis I Diagnosis Code I appears to be incorrect.
Please check your information and re-enter (click on 'diagnosis' to activate search).
If you believe that you have entered this information correctly, please contact ValueOptions' Customer Service.

Note: Disable pop-up blocker functionality to view all appropriate links.

Diagnosis

Decimal point is missing on Diagnosis Code 1 - must be corrected to complete request

Please indicate primary diagnosis.

Axis I

* Diagnosis Code 1 29623 | Description

Axis II

* Diagnosis Code 1 799.9 | Description DIAGNOSIS DEFERRED (AXIS 1 OR 2)

After all the data is entered, the final screens will appear based on the level of care requested. E.g. Inpatient/HLOC or Outpatient/Community Based.

- All Inpatient/HLOC will pend for further review
- Outpatient/Community Based requests will either ***Approve***

ProviderConnect Home

Determination Status: ********************* **APPROVED** *********************

Provider ID

Subscriber Name

Subscriber ID

Provider Alternate ID

Consumer Name

Consumer ID

Consumer DOB

Provider Name & Address

SALISBURY MD 21801

Authorization #
090809-1-14

Client Authorization #
N/A

Date of Admission/ Start of Services
09/08/2009

From - To
09/08/2009 - 03/08/2010

Type of Request
INITIAL

Level of Treatment
OUTPATIENT/COMMUNITY BASED

Type of Treatment
MENTAL HEALTH

Reason Code
A70

Important key elements on authorization available on page

Place of Service	CPT	Modifier 1	Service Class	Description	Units/ Visits
52		U3		OUTPATIENT/COMMUNITY BASED	5
			Total Units For Auth 090809-1-14 From 09/08/2009 To 03/08/2010	5	
			Total Units Authorized This Episode For 090809-1-14	5	

Message

A70

Claims payment is restricted to services for which the provider is contracted to deliver and is conditional upon services authorized, clinical necessity, and the enrolled consumer being eligible for services on the date of service. Clinical authorization is not a guarantee of payment.

If further authorization is required for treatment of this consumer, please submit a new request prior to the end date of the current authorization or exhaustion of the number of units.

Options to print just the ***Results*** page, the entire ***Authorization Request*** as well as ***Return to Provider Home*** page

Attached Documents

Document Title **Document Description**

There are no documents attached with this Authorization Request

Authorization Printing Options

(For the best print results, please print in 'Landscape' format)

Print Authorization Request
Click to print the entire Authorization requested

Print Result
Click to print the Results page

Return to Provider Home
Click to return to the ProviderConnect homepage

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- Or ***Pend for Further Review***

ProviderConnect Home

Determination Status: ********************* PENDED *********************

Please Note: This is NOT an Authorization for Care. The services requested require additional review. You will be contacted regarding the status of this request.

Provider ID

Provider Alternate ID

Provider Name & Address

SALISBURY MD 21801

Same key information and options on printing on a ***Pended*** request

Subscriber Name	Subscriber ID	
Consumer Name	**Consumer ID**	**Consumer DOB**
Pended Authorization #	**Client Authorization #**	
090809-1-15	N/A	
Date of Admission/ Start of Services	**Requested From**	**Type of Request**
09/08/2009	09/08/2009	INITIAL
Level of Treatment	**Type of Treatment**	**Level of Care**
INPATIENT/HLOC	MENTAL HEALTH	INPATIENT

Reason Code

P77

Message

P77

Attached Documents

Document Title **Document Description**

There are no documents attached with this Authorization Request

Authorization Printing Options

(For the best print results, please print in 'Landscape' format)

Print Authorization Request — Click to print the entire Authorization requested

Print Result — Click to print the Results page

Return to Provider Home — Click to return to the ProviderConnect homepage

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- Or offer an option for a set number of units, if approved. Accepting this will allow the provider to proceed with the request and enter details on the specific services being

requested

ProviderConnect Home

Requested Services Header

Requested Start Date 09/08/2009
Level of Service OUTPATIENT/COMMUNITY BASED
Consumer Name
Provider Name
Vendor ID
Type of Request INITIAL
Consumer ID
Provider ID
Provider Alternate ID

If your request is approved, you will receive 5 visits.
If you agree to accept this number of visits, please select "Accept". If you do not agree, please select "Reject" and you may enter your modified request.
Please be aware that if your request is above the offered number of units, it may be pended for additional clinical review.

Accept Reject

Accept these services allows the authorization process to continue and may result in auto approval or provide the reviewing staff to better understand the request.

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The provider requesting Outpatient/Community Based services, which are offered the ***Accept/Reject*** option, will then be asked to indicate the specific ***Place of Service, CPT Codes*** and ***Modifiers*** and adjustment of the units to the specific codes requested. This information allows the Care Managers and CSAs to understand the request and complete the review process. The number of units and services will be reviewed and adjusted to match the authorization process specific to that type of care. These requests may approve or pend depending on the type of services being requested.

ProviderConnect - Request Services - Request Services - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address http://pcrl1dev/pc/review/RequestORF2AcceptReject.do

PAGE 7 of 8

Requested Services Header

Requested Start Date 09/08/2009

Level of Service OUTPATIENT/COMMUNITY BASED

Consumer Name | Provider Name | Vendor ID

Type of Request INITIAL

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

Select ***Place of Serivce*** that matches where services are provided. ***CPT Code*** and ***Modifiers*** are key to correct services - particularly for Supported Employment and PRP Services. Units can be spread between more than 1 ***Place of Service, CPT Code*** and ***Modifier*** if appropriate. Care Managers and CSAs will review and adjust if necessary.

Requested Services

*Place of Service	*CPT or HCPC Code	Modifier 1 (If Applicable)	*Visits/ Units
MOBILE UNIT (OFFSITE)	h2018	u3	5
SELECT...			
SELECT...			
SELECT...			
SELECT...			

MOBILE UNIT (OFFSITE)
NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
NURSING FACILITY
OFFICE
OUTPATIENT CHEMICAL DEPENDENCY PROGRAM
OUTPATIENT HOSPITAL
PHARMACY
PRISON/CORRECTIONAL FACILITY
PRISON/CORRECTIONAL FACILITY
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (ONSITE)
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER

Done | Local intranet

Tips for Submitting PRP Authorization Requests

There are two options for providers requesting authorization for PRP services, depending on the type of PRP services requested. If the provider is requesting the Behavioral Health Screening Assessment, Community PRP, or PRP services for consumers in Supported Living (PRP, PR1, or PR2) the request is reviewed by ValueOptions® Maryland staff and the request should be submitted following the PRP flow. If the request is for PRP services provided in a residential setting (PR3 or PR4) the RRP flow should be followed (see Tips for Submitting RRP Authorizations).

When the provider has logged into ProviderConnect and selected the ***Request an Authorization*** link, they will need to search for and confirm the consumer information and identify the correct service address (see Tips for Submitting Authorization Requests through ProviderConnect). On the ***Requested Services Header*** screen the provider must provide the following information to successfully enter the PRP workflow.

- ***Requested Start Date/OMS Interview Date*** – the date the provider wishes to begin this authorization request.
- ***Level of Service*** – select Outpatient/Community Based
- ***Type of Service*** – defaults to Mental Health
- ***Level of Care*** – Outpatient
- ***Type of Care*** – Psychiatric Rehabilitation

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/OMS Interview Date (MMDDYYYY) 09102009
*Level of Service OUTPATIENT/COMMUNITY BASED
*Type of Service MENTAL HEALTH
*Level of Care OUTPATIENT
*Type of Care THERAPEUTIC BEHAVIORAL SERVICES

Documents can be attached but are not required for the request. When this information is entered the provider can select ***Next*** and begin to move through the screens that are specific to the PRP workflow.

The next screen is the ***Type of Services*** tab. These fields provide information on the consumer's demographic information and the ***Clinical Criteria*** that applies to this consumer. All the required fields will be marked with a "*". Additional field may be required based on age and responses entered in other fields. If a required field is not completed, a Red Dot Error message will appear and the provider will not be able to more to the next screen when "Next" is selected. The Red Dot Error Message will indicate which fields must be completed.

For these reviews select ValueOptions® as the agency to review the request.

Clinical Criteria must be completed. This information is accessed by double clicking on the Clinical Criteria hyperlink at the bottom of the screen – this will bring up a pop up page where criteria can be clicked off and then saved. A narrative box is also provided for documenting additional information relevant to the criteria.

Upon completion of all the required fields, select ***Next*** to continue through the authorization request. The next screen that appears is the Diagnosis screen. Axes 1-5 are available for completion. The question regarding the diagnosis on record is also required.

▸TYPE OF SERVICES | ▾DIAGNOSIS | ▸SUBSTANCE ABUSE | ▸TREATMENT PLAN | ▸INDIVIDUAL PLAN | ▸SUPPORTED EMPLOYMENT | ▸RESULTS

PAGE 2 of 7

Requested Services Header

Requested Start Date	Level of Service	Consumer Name	Provider Name	Vendor ID
09/10/2009	OUTPATIENT/COMMUNITY BASED	HALL, JAMES	WICOMICO COUNTY HEAL, TH DEPT-BEHAVIO	A342162
	Type of Request	Consumer ID	Provider ID	Provider Alternate ID
	INITIAL	M500023226	333340	932142000

- Please Provide Axis I or Axis II Information before Submitting this Request.
- If the type of care is PRP, RRP, Case Management or TBS, diagnosis on record is required

Note: Disable pop-up blocker functionality to view all appropriate links.

Diagnosis

Please indicate primary diagnosis.

If the type of care is PRP, RRP, Case Management, Supported Employment or TBS, is there a diagnosis on record? ○ Yes ○ No

What is the source of the diagnosis?

Axis I

Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis II

Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis III

Diagnosis Code 1 SELECT...

Diagnosis Code 2 SELECT...

Diagnosis Code 3 SELECT...

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 w/legal system/crime
- Problems with Primary support group
- Problems related to the social environment
- Unknown

Axis V

Current GAF Score UK

Back Next

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After completion of the ***Diagnosis*** screen, the next required screen is the ***Individual Plan*** screen. The first screen is regarding ***Substance Abuse***, the second, a screen for ***Treatment Plan.*** A message will appear stating that this is not required for PRP. Continue by selecting ***Next***. The Individual Plan screen includes free text fields for long term and short term goals, interventions and progress, consumer's strengths, expectations and responsibilities.

TYPE OF SERVICES | DIAGNOSIS | SUBSTANCE ABUSE | TREATMENT PLAN | INDIVIDUAL PLAN | SUPPORTED EMPLOYMENT | RESULTS

PAGE 5 of 7

Requested Services Header

Requested Start Date 09/10/2009

Level of Service OUTPATIENT/COMMUNITY BASED

Consumer Name Provider Name Vendor ID

Type of Request INITIAL

Consumer ID Provider ID Provider Alternate ID

Free text fields for entry of information concerning consumer's Individual Plan. Counters will indicate how much of field you have used and how much more is available. Going over character limit can result in error on screen.

Treatment/Rehabilitation/Service Plan Goals

Treatment or Rehabilitation Long Term Goals:

Narrative History

Narrative Entry (0 of 500)

Strengths (0 of 250)

Consumer Expectations and Responsibilities (0 of 250)

Goal 1

1. Short Term Goal Target Date:

Short Term Goals:

Narrative History

Narrative Entry (0 of 250)

Interventions:

Narrative History

Narrative Entry (0 of 250)

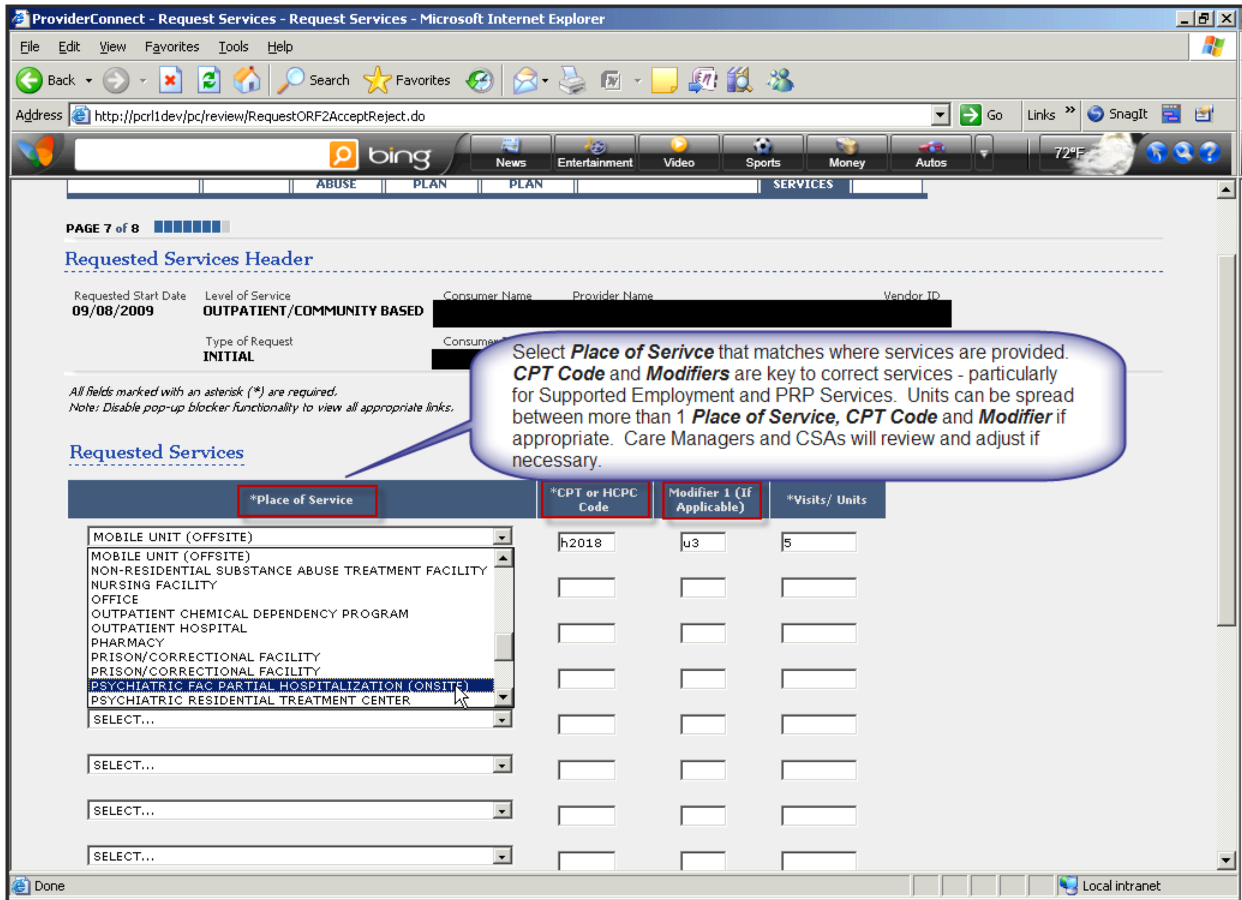
Update Progress

Narrative History

Narrative Entry (0 of 500)

After completion of this screen, when ***Next*** is selected a screen for ***Supported Employment*** will appear with the message that this is not required for this type of authorization request. Click ***Submit*** or ***Next to*** proceed.

The system will now review the request. The provider will be notified if the request is pended for further review, or if additional information is needed. The provider will be offered a preset number of units – accepting these units will allow the process to move forward. The provider will be asked to enter the specific ***Place of Service, CPT Codes*** and ***Modifiers*** and to adjust the units. The Case Manager will review and adjust the number of units requested as needed. The request may approve or pend, depending on the type of services being requested.



Codes for successful submission of PRP services are:

Place of Service	CPT/Rev Code	Modifier	Service Description
Office or Mobile Unit (Offsite)	H0002		Behavioral Health Screening PRP Assessment (7)
INDEPENDENT CLINIC (Blended)	H2018	U2	Any Combination of On-Site or Off-Site services for Community PRP client, not living independently
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (Onsite)	H2018	U2	On-Site services for community PRP Client, not living independently (minimum 2 encounters)
MOBILE UNIT (Offsite)	H2018	U2	Off-Site services for community PRP Client, not living independently (minimum 2 encounters)

INDEPENDENT CLINIC (Blended)	H2018	U3	Any Combination of On or Off-Site services for Supported Living Client, living independently (Minimum 6 encounters)
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (Onsite)	H2018	U3	Any Combination of On-Site services for Supported Living Client, living independently (Minimum 3 encounters)
Mobile Unit (Offsite)	H2018	U3	Any Combination of Off-Site services for Supported Living Client, living independently (Minimum 5 encounters)

Please Note: The Place of Service (POS), CPT Code and Modifier selection results in an authorization request for the service class. This service class allows providers to bill any of the POS, CPT Codes and Modifiers for that class, not just for the specific code noted in the request. This allows for flexibility in providing services to the consumer. If this is an initial request, a separate line for the initial assessment should be entered in addition to the units for ongoing PRP services.

All PRP services require Case Management review. When an authorization decision is made, the authorization will be updated and the information will be available on ProviderConnect.

Tips for Submitting RRP Authorization Requests

Providers requesting authorization for PRP services have 2 workflows depending on the type of PRP services being requested. If the provider is requesting the Behavioral Health Screening Assessment, Community PRP, or PRP services for consumers in Supported Living (PRP, PR1, or PR2) for the consumer the request is reviewed by ValueOptions® Maryland staff, and the request is submitted following the PRP flow (See Tips for Submitting PRP Authorization Requests). If the request is for PRP services provided in a residential setting (PR3 or PR4), with an RRP bed, the RRP flow should be followed.

When the provider has logged into ProviderConnect and selected the ***Request an Authorization*** link, the next step is to search for and confirm the consumer information, and select the correct service address (see Tips for Submitting Authorization Requests through ProviderConnect). On the ***Requested Services Header*** screen the provider must provide the following information to successfully enter the RRP workflow.

- ***Requested Start Date/OMS Interview Date*** – the date the provider wishes to begin this authorization request.
- ***Level of Service*** – select Outpatient/Community Based
- ***Type of Service*** – defaults to Mental Health
- ***Level of Care*** – Outpatient
- ***Type of Care*** – Psychiatric Rehabilitation

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/OMS Interview Date (MMDDYYYY) 09102009
*Level of Service OUTPATIENT/COMMUNITY BASED
*Type of Service MENTAL HEALTH
*Level of Care OUTPATIENT
*Type of Care RESIDENTIAL REHAB

Documents can be attached but are not required for the request. Once this information is entered the provider can select ***Next*** and begin to move through the screens that are specific to the PRP workflow.

The next screen that appears is ***Type of Services***. The fields on this screen provide the consumer's demographic information and the Clinical Criteria that applies to this consumer. All the data that is applicable to the consumer is required to move forward. Required fields will be indicated by a "*". Other fields may be required based on the responses to other questions.

E.g. the "Veterans" question, guardianship, etc. If a required field is not completed, the provider will be unable to progress to the next screen. A "Red Dot Error Messages" will appear at the top of the screen, indicating what fields must be completed. For these reviews, select the CSA as the agency to review and then select the correct CSA (by consumer county of residence) to complete the review.

Clinical Criteria must be completed for the consumer. This information is accessed by double clicking on the Clinical Criteria hyperlink at the bottom of the screen – this will bring up a pop up page where criteria can be clicked off and then saved. A narrative box is also provided for documenting additional information relevant to the criteria.

Upon completion of all the required elements select ***Next*** to continue to the Diagnosis screen. Axes 1-5 are available for completion. Completion of "diagnosis on record" is also required.

TYPE OF SERVICES | DIAGNOSIS | SUBSTANCE ABUSE | TREATMENT PLAN | INDIVIDUAL PLAN | SUPPORTED EMPLOYMENT | RESULTS

PAGE 2 of 7

Requested Services Header

Requested Start Date	Level of Service	Consumer Name	Provider Name		Vendor ID
09/10/2009	OUTPATIENT/COMMUNITY BASED	HALL, JAMES	WICOMICO COUNTY HEAL, TH DEPT-BEHAVIO		A342162
	Type of Request	Consumer ID	Provider ID	Provider Alternate ID	
	INITIAL	M500023226	333340	932142000	

- Please Provide Axis I or Axis II Information before Submitting this Request.
- If the type of care is PRP, RRP, Case Management or TBS, diagnosis on record is required

Note: Disable pop-up blocker functionality to view all appropriate links.

Diagnosis

Please indicate primary diagnosis.

If the type of care is PRP, RRP, Case Management, Supported Employment or TBS, is there a diagnosis on record? Yes No

What is the source of the diagnosis?

Axis I

Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis II

Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis III

Diagnosis Code 1 SELECT...

Diagnosis Code 2 SELECT...

Diagnosis Code 3 SELECT...

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 w/legal system/crime
- Problems with Primary support group
- Problems related to the social environment
- Unknown

Axis V

Current GAF Score UK

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After completion of the ***Diagnosis*** screen the next screen, is the ***Individual Plan*** screen. The system will present first a screen for ***Substance Abuse***, then a screen for ***Treatment Plan***, with a message that this is not required for PRP. Continue with ***Next***. The Individual Plan screen is contains free text fields for long term and short term goals, interventions and progress, consumer's strengths, expectations and responsibilities.

TYPE OF SERVICES | DIAGNOSIS | SUBSTANCE ABUSE | TREATMENT PLAN | INDIVIDUAL PLAN | SUPPORTED EMPLOYMENT | RESULTS

PAGE 5 of 7

Requested Services Header

Requested Start Date 09/10/2009
Level of Service OUTPATIENT/COMMUNITY BASED
Consumer Name Provider Name Vendor ID
Type of Request INITIAL
Consumer ID Provider ID Provider Alternate ID

Free text fields for entry of information concerning consumer's Individual Plan. Counters will indicate how much of field you have used and how much more is available. Going over character limit can result in error on screen.

Treatment/Rehabilitation/Service Plan Goals

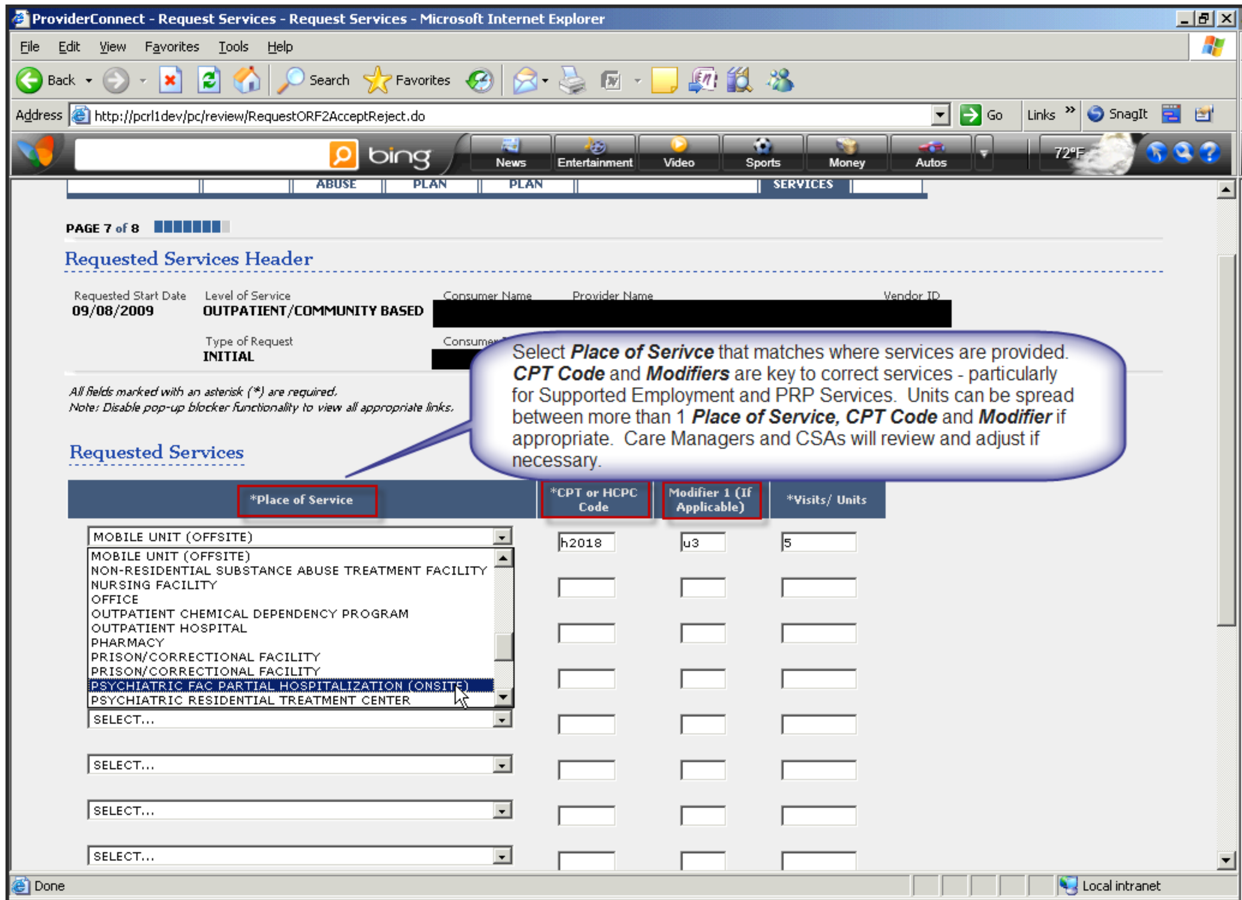
Treatment or Rehabilitation Long Term Goals:
Narrative History
Narrative Entry (0 of 500)
Strengths (0 of 250)
Consumer Expectations and Responsibilities (0 of 250)

Goal 1

1. Short Term Goal Target Date:
Short Term Goals:
Narrative History
Narrative Entry (0 of 250)
Interventions:
Narrative History
Narrative Entry (0 of 250)
Update Progress
Narrative History
Narrative Entry (0 of 500)

After completion of this screen, when ***Next*** is selected a screen for ***Supported Employment*** will appear with a statement that this screen is not required for this type of request. Click ***Submit*** or ***Next*** to proceed with the authorization request.

The system will now review the request. The provider will be notified if the request is pended for further review or if additional information is needed. The provider will be offered a predetermined number of units. Accepting these units will allow the process to move forward. The provider will be asked to enter the specific ***Place of Service, CPT Codes*** and ***Modifiers*** as well as to adjust the units for those specific codes. The Care Manager or CSA will review and adjust number of units and services. These requests may approve or pend depending on the type of services being requested.



The required codes for successful submission of RRP services are below – entering the PRP codes prior to entering the RRP codes is the preferred action. It is suggested that the provider request one unit per month for PRP, and 365 units for the RRP bed. If this is an initial request a separate line for the initial assessment should be entered in addition to the units for ongoing services. :

Place of Service	CPT/Rev Code	Modifier	Service Description	Notes/Resulting Service Class
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (Onsite)	H2018	U5	On-Site PRP services to Intensive Residential Clients (Minimum 4 Encounters)	PRP 4
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (Onsite)	H2018	U4	On-Site PRP services to General Residential Clients (Minimum 4 Encounters)	PRP3

MOBILE UNIT (Offsite)	H2018	U4	Off-Site PRP Services to RRP General Clients (Minimum 13 Encounters)	PRP3
MOBILE UNIT (Offsite)	H2018	U5	Off-Site PRP Services to RRP Intensive Clients (Minimum 19 Encounters)	PRP4
INDEPENDENT CLINIC (Blended)	H2018	U6	General Residential Combined (Minimum 17 Encounters)	PRP3
INDEPENDENT CLINIC (Blended)	H2018	U7	Intensive Residential Combined (Minimum 23	PRP4
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER, COMPREHENSIVE OUTPATIENT MEDICAL REHAB FACILITY, OTHER UNLISTED FACILITY	H0019	None	Residential Bed Hold	RRP Bed
	T2048	None	Residential Room and Board	RRP Bed

***** For PRP services see Tips for Submitting PRP Auths.

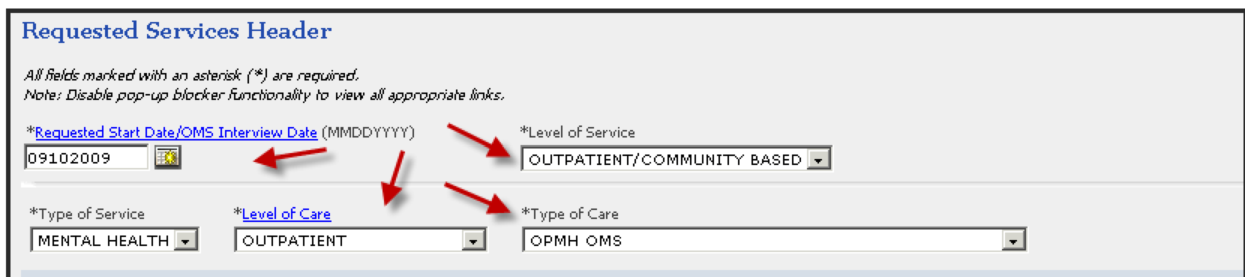
Please Note: The Place of Service (POS), CPT Code and Modifier selection results in an authorization request for the service class. This service class allows providers to bill any of the POS, CPT Codes and Modifiers for that class, not just for the specific code noted in the request. This allows for flexibility in providing services to the consumer.

All RRP & PRP services require further review. Once an auth decision is made the authorization will be updated and the information will be available on ProviderConnect.

Tips for Submitting OMS Authorization Requests

Providers requesting authorization for OMS services msut complete their request via the ProviderConnect application. Once the provider has logged into ProviderConnect and selected the ***Request an Authorization*** link, they will need to search for and confirm the consumer information, and identify the correct service address (see Tips for Submitting Authorization Requests through ProviderConnect). On the ***Requested Services Header*** screen the provider will need to provide the following information to successfully enter the authorization request.

- ***Requested Start Date/OMS Interview Date*** – the date the provider wishes to begin this authorization request. This date must match the date of the most recent OMS Interview
- ***Level of Service*** – select Outpatient/Community Based
- ***Type of Service*** – defaults to Mental Health
- ***Level of Care*** – Outpatient
- ***Type of Care*** – OPMH OMS



Documents can be attached but are not required for the request. Once this information is entered the provider can select ***Next*** and begin to move through the screens that are specific to the OMS service request. Whether this is an initial request, or a concurrent request, will dictate which screens are presented.

Initial Requests for OMS

The next screen is the ***Type of Services*** screen. This screen requests consumer demographic and diagnostic information. All data that is applicable to the consumer, based on the consumer's age as well as other factors in the consumer's history, are required to move forward. Required fields will be identified with a "*". Other fields may be required based on responses to other questions. E.g. "Veteran" question, Guardianship, etc. If a required field is not completed, the provider will not be able to move to the next screen when ***Next*** is selected and there will be "Red Dot Error Messages" at the top of the screen, indicating which fields

must be completed. For these reviews select ValueOptions® as the review agency, and leave "office" as "Select".

TYPE OF SERVICES | REQUESTED SERVICES | RESULTS

PAGE 1 of 3

Requested Services Header

Requested Start Date 09/10/2009 | Level of Service OUTPATIENT/COMMUNITY BASED | Consumer Name | Provider Name | Vendor ID

Type of Request INITIAL | Consumer ID | Provider ID | Provider Alternate ID

"Red Dot Error Messages" will appear if data is not complete.

• Educational level is required

Select ValueOptions as the agency and leave office as Select

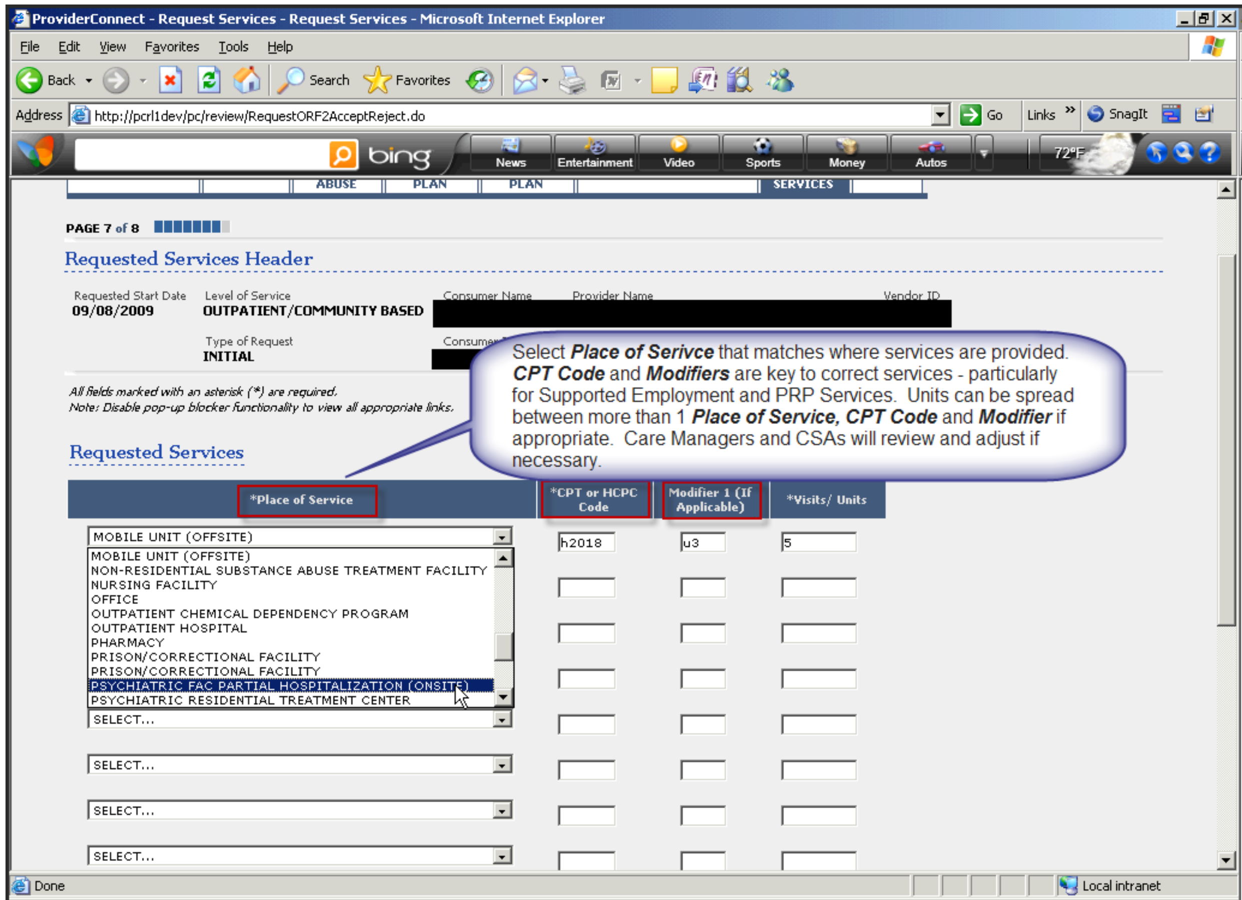
Type of Services

*Is this a courtesy review? Yes No

*Which agency is this request intended for? V-VALUEOPTIONS

If CSA, which office should handle review? SELECT...

Upon completion of all the required fields, select ***Next.*** If this is an Initial request, you will proceed directly to the screen to request an authorization for the initial 2 units. The provider will be offered a preset number of units. Accepting these units will allow the process to move forward. The provider will be asked to enter the specific ***Place of Service, CPT Codes*** and ***Modifiers*** and to adjust the units as required by the service requested. This entry of information allows the care managers to understand the request and complete the review process. These requests may approve or pend, depending on the type of services being requested and the consumer's eligibility and demographic information.



Code for successful submission of OMS services are below

Place of Service	CPT/Rev Code	Modifier	Service Description	Notes/Resulting Service Class
Office, Home, Assisted Living Facility, Outpt Hospital, Nursing Facility, Hospice, Community Mental Health Center, Comprehensive Outpatient Medical Rehab Facility, Rural Health Clinic, Tribal 638 Free Standing Facility	90801		Psychiatric Diagnostic Interview	All codes result in a TIN authorization to allow flexibility in servicing consumer & billing
	90804		Individual Psychotherapy (20-30 Minutes)	
	90805		Individual Psychotherapy with Med Eval/Mgmt	
	90806		Individual Psychotherapy (40-50 Minutes)	
	90807		Individual Psychotherapy with Med Eval/Mgmt	

	90846		Family Psychotherapy without Patient Present	
	90847		Family Psychotherapy with Patient Present	
	90847	52	Family Psychotherapy with Patient Present - abbreviated services	
	90849		Multiple Family Group	
	90853		Group Psychotherapy	
	90875		Individual psychotherapy w/ Biofeedback	
	90876		Individual Psychotherapy w/ biofeedback	
	90862		Pharmacological Management	
	Rev Codes 0910, 0914, 0915, 0916, 0917, 0918, 0919, 0510, 0513		Outpatient Services	
	90846/0982		Family Psychotherapy w/o the identified patient present	

Please Note: The Place of Service (POS), CPT Code and Modifier selection results in an authorization request for the service class. This service class allows providers to bill any of the POS, CPT Codes and Modifiers for that class, not just for the specific code noted in the request. This allows for flexibility in providing services to the consumer.

Concurrent Requests for OMS

For concurrent requests, additional information is required, including updated OMS data. Providers will again request OMS services and again complete the ***Types of Services*** Tab. Some data will be auto-populated from the previous requests but may be modified as appropriate. All auto-populated data must be reviewed to determine if it is current and accurate.

The next screens to appear is the ***Current Risks and Current Impairments*** screens. These screens are not required for OMS request. Selecting ***Next*** will take provider to the Diagnosis screen. Axes 1-5 are available for completion.

TYPE OF SERVICES | CURRENT RISKS | CURRENT IMPAIRMENTS | DIAGNOSIS | SUBSTANCE ABUSE | OMS DATA | REQUESTED SERVICES | RESULTS

PAGE 4 of 8

Requested Services Header

Requested Start Date	Level of Service	Consumer Name	Provider Name	Vendor ID
09/10/2009	OUTPATIENT/COMMUNITY BASED	PHILLIPS, PARRISH	CALVERT MEMORIAL HOS, PITAL	A383800
	Type of Request	Consumer ID	Provider ID	Provider Alternate ID
	CONCURRENT	M500192753	004295	000215100

Note: Disable pop-up blocker functionality to view all appropriate links.

Diagnosis

Please indicate primary diagnosis.

Axis I

* Diagnosis Code 1: 296.23 — Description: MAJOR DEPRESSIVE D/O-SINGLE-SEVE
* Diagnosis Code 2 — Description
* Diagnosis Code 3 — Description

Axis II

* Diagnosis Code 1 — Description
* Diagnosis Code 2 — Description
* Diagnosis Code 3 — Description

Axis III

Diagnosis Code 1: SELECT...

Diagnosis Code 2: SELECT...

Diagnosis Code 3: SELECT...

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 w/legal system/crime
- [ ] Problems with Primary support group
- [ ] Problems related to the social environment
- [ ] Unknown

Axis V

Current GAF Score: UK

Highest GAF Score in the Past Year

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After completion of the ***Diagnosis*** screen, the next required screen is the ***Substance Abuse*** screen. Selection of a substance within this screen will result in additional fields appearing for completion regarding the particular substance.

TYPE OF SERVICES | CURRENT RISKS | CURRENT IMPAIRMENTS | DIAGNOSIS | SUBSTANCE ABUSE | OMS DATA | REQUESTED SERVICES | RESULTS

PAGE 5 of 8

Requested Services Header

Requested Start Date 09/10/2009 | Level of Service OUTPATIENT/COMMUNITY BASED | Consumer Name | Provider Name | Vendor ID

Type of Request CONCURRENT | Consumer ID | Provider ID | Provider Alternate ID

Note: Disable pop-up blocker functionality to view all appropriate links.

Substance Abuse

Check all that apply.

Clicking the Alcohol check off expands section to report information on Alcohol use, date of last use, etc.

- [ ] None
- [x] Alcohol

*Total Years of Use SELECT... | *Length of Current Use SELECT... | *Amount of Use | *Frequency of Use SELECT... | Date Last Used (MMDDYYYY)

- [ ] Amphetamines/ Stimulants (diet pills, "speed", Ecstasy, Ritalin, etc.)
- [ ] Barbiturates (sedatives, "downers", etc.)
- [ ] Cocaine (crack, powder, etc.)
- [ ] Hallucinogens (LSD, mescaline, etc.)
- [ ] Inhalants (glue, gasoline, solvents, nitrites, etc.)
- [ ] Marijuana or Hashish
- [ ] Opioids (Heroin, Morphine, etc.)
- [ ] Over-the-counter Cold or Cough Medications (dextromethorpan, etc.)
- [ ] PCP (Phencyclidine)
- [ ] Pain Killers (Codeine, Demerol, etc.)
- [ ] Sleeping Pills
- [ ] Steroids
- [ ] Tranquilizers (Valium, Xanax, other anxiolytics, etc.)
- [ ] Other Prescription Drugs
- [ ] Other Non-prescription Drugs or Substances
- [ ] Unknown

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The next screen to appear is the ***OMS Data*** screen. This information is required for OMS services. The format of the screen is similar to the previous format of the OMS interview. The questionnaire is age-specific. There are required and optional questions through this section.

▸TYPE OF SERVICES | ▸CURRENT RISKS | ▸ CURRENT IMPAIRMENTS | ▸DIAGNOSIS | ▸SUBSTANCE ABUSE | ▾OMS DATA | ▸REQUESTED SERVICES | ▸RESULTS

PAGE 6 of 8

Requested Services Header

Requested Start Date	Level of Service	Consumer Name	Provider Name	Vendor ID
09/10/2009	OUTPATIENT/COMMUNITY BASED			

	Type of Request	Consumer ID	Provider ID	Provider Alternate ID
	CONCURRENT			

*Date of Current Interview 09102009

Child and Adolescent (6-17 years)

Adult (18-64 years)

INTERVIEWER: Throughout the questionnaire, you will see the following text as part of several questions "(since last interview date/in the past six months)." When this appears, you should read
the question as follows:

If this is the consumer's initial OMS interview in your program: read the question with the phrase "in the past six months" as the reference period. For example, "Have you been homeless at all in
the past six months?"

If this is NOT the consumer's initial OMS interview: say the actual previous OMS interview date when reading the question. For example, "Have you been homeless at all since October 15th?"

A companion **OMS Interview Guide** for this questionnaire is available at **www.maryland.valueoptions.com.** Included in the Guide are instructions for administering the questionnaire and
definitions for several terms as noted within this questionnaire.

The symbol (ψ) denotes a consumer opinion only question (discussion may occur but child's/adolescent's/caregiver's initial response should be recorded; see OMS Interview Guide for further
explanation).

An asterisk (*) denotes a question that is mandatory for submission.

Living Situation

I'm going to ask you some questions today about different areas of your life, such as your living situation and daily activities.

*Where are you living now? SELECT...

if Other, specify:

(INTERVIEWER: Read the answer options to the respondent)

In general, how satisfied are you with where you currently live?ψ SELECT...

Have you been homeless at all (since last interview date/in the past six months)? ○ No ○ Yes

Functioning and Symptoms

(INTERVIEWER: Read the answer options to the respondent)

Overall, how satisfied are you with your recovery?ψ SELECT...

Now, I am going to read a series of statements. For each of these statements, please indicate whether you strongly agree, agree, feel neutral (neither agree nor disagree), disagree, or strongly
disagree with these statements. [CARD #1 with response options]

I do things that are meaningful to me.ψ SELECT...

I am able to take care of my needs.ψ SELECT...

I am able to handle things when they go wrong.ψ SELECT...

I am able to do things that I want to do.ψ SELECT...

My symptoms bother me.ψ SELECT...

For the next several questions, please tell me your answer based on the past MONTH.

INTERVIEWER: (do not read aloud) For items 10-33, you must either show the designated Response Card, give the consumer a copy of the questionnaire to follow along, or read all of the
response options for each to the consumer. (Questionnaire Items 10-33 comprise the BASIS-24; ©McLean Hospital. Used and modified with permission.)

During the PAST MONTH, how much difficulty did you have ...

Managing your day-to-day life?ψ [CARD #2 with response options] SELECT...

Coping with problems in your life?ψ [CARD #2] SELECT...

Concentrating?ψ [CARD #2] SELECT...

During the PAST MONTH, how much of the time did you ...

Get along with people in your family?ψ [CARD #3 with response options] SELECT...

Get along with people outside your family?ψ [CARD #3] SELECT...

Get along well in social situations?ψ [CARD #3] SELECT...

Feel close to another person?ψ [CARD #3] SELECT...

During the PAST MONTH, how much of the time did you ...

Feel like you had someone to turn to if you needed help?ψ [CARD #3] SELECT...

Feel confident in yourself?ψ [CARD #3] SELECT...

During the PAST MONTH, how much of the time did you ...

Feel sad or depressed?ψ [CARD #3] SELECT...

Think about ending your life?ψ [CARD #3] SELECT...

Feel nervous?ψ [CARD #3] SELECT...

During the PAST MONTH, how often did you ...

Have thoughts racing through your head?ψ [CARD #4 with response options] SELECT...

Think you had special powers?ψ [CARD #4] SELECT...

Hear voices or see things?ψ [CARD #4] SELECT...

Think people were watching you?ψ [CARD #4] SELECT...

Think people were against you?ψ [CARD #4] SELECT...

During the PAST MONTH, how often did you ...

Have mood swings?ψ [CARD #4] SELECT...

Feel short tempered?ψ [CARD #4] SELECT...

Think about hurting yourself?ψ [CARD #4] SELECT...

During the PAST MONTH, how often ...

Did you have an urge to drink alcohol or take street drugs?ψ [CARD #4] SELECT...

Did anyone talk to you about your drinking or drug use?ψ [CARD #4] SELECT...

Did you try to hide your drinking or drug use?ψ [CARD #4] SELECT...

Did you have problems from your drinking or drug use?ψ [CARD #4] SELECT...

Legal System Involvement

*(Since last interview date/in the past six months) have you been arrested? ◯ No ◯ Yes

*(Since last interview date/in the past six months) have you been in either jail or prison? ◯ No ◯ Yes

(INTERVIEWER: Read the answer options to the respondent)
Some people have had a negative encounter with the police, such as being arrested or hassled by police. (Since last interview date/in the past six months), would you say you have had... SELECT...

Employment

Now let's talk a little bit about your work situation.

*Are you currently employed? ◯ No ◯ Yes

*Are you actively looking for work by doing things like filling out applications, or answering ads? ◯ No ◯ Yes

Have you been employed (since last interview date/in the past six months)? ◯ No ◯ Yes

INTERVIEWER: (do not read aloud) If the person held more than one job during the reporting period, please ask him or her to answer the following questions in terms of the most recent job.

*(Is/Was) your job competitive employment or sheltered workshop or agency employment? SELECT...

How many hours a week (do/did) you usually work? SELECT...

(INTERVIEWER: Read the answer options to the respondent)
In general, how satisfied (are/were) you with this job?ψ SELECT...

Somatic Health

Do you smoke cigarettes? ◯ No ◯ Yes

How many cigarettes do you smoke per day? [one pack = 20 cigarettes] SELECT...

(INTERVIEWER: Read the answer options to the respondent)
Would you say in general your health is:ψ SELECT...

How tall are you?(feet) (inches) (feet) (inches)

How much do you currently weigh?(pounds) (pounds;whole numbers only) SELECT...

Demographic and Interview Information

*How long have you received mental health services from this clinic? SELECT...

*Consumer involvement in interview: SELECT...

Clinician's Notes (Optional)

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Click ***Submit*** or ***Next*** to proceed with the authorization request after completion of the OMS questionnaire.

The system will now review the request for completeness and for consumer's history. The provider will be notified if the request is pended for further review, or if additional information

is needed. The provider will be offered on these requests a predetermined 150 units – accepting these units will allow the process to move forward. The provider will be asked to enter the specific ***Place of Service, CPT Codes*** and ***Modifiers*** and to adjust the units as appropriate. It is not necessary to divide up the units when submitting this concurrent request. All 150 units can be applied to the most frequently anticipated service provided to that consumer (refer to the previous grid of codes that apply to OMS services). This service class allows for flexibility in billing the services actaully provided within the service class. These requests should auto-approve or may pend for various reasons (consumer eligibility, consumer in treatement with another provider, etc.)

ProviderConnect - Request Services - Request Services - Microsoft Internet Explorer

PAGE 7 of 8

Requested Services Header

Requested Start Date 09/08/2009
Level of Service OUTPATIENT/COMMUNITY BASED
Type of Request INITIAL

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

Requested Services

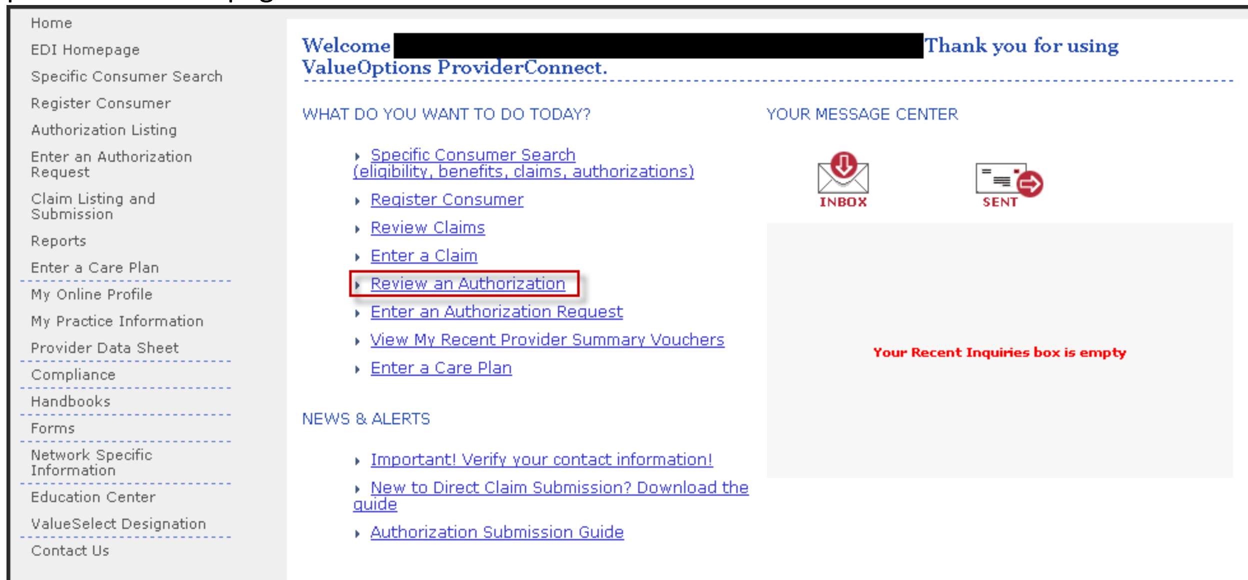
Select ***Place of Serivce*** that matches where services are provided. ***CPT Code*** and ***Modifiers*** are key to correct services - particularly for Supported Employment and PRP Services. Units can be spread between more than 1 ***Place of Service, CPT Code*** and ***Modifier*** if appropriate. Care Managers and CSAs will review and adjust if necessary.

*Place of Service	*CPT or HCPC Code	Modifier 1 (If Applicable)	*Visits/ Units
MOBILE UNIT (OFFSITE)	h2018	u3	5
SELECT...			
SELECT...			
SELECT...			
SELECT...			

MOBILE UNIT (OFFSITE)
NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
NURSING FACILITY
OFFICE
OUTPATIENT CHEMICAL DEPENDENCY PROGRAM
OUTPATIENT HOSPITAL
PHARMACY
PRISON/CORRECTIONAL FACILITY
PRISON/CORRECTIONAL FACILITY
PSYCHIATRIC FAC PARTIAL HOSPITALIZATION (ONSITE)
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER

Tips for Submitting a Discharge Review

Discharge reviews are an important component of the care review process. Discharges are most easily completed by accessing a link off of the consumer's authorization. This can be accessed from several workflows where the provider is given access to view the consumer's authorization. The easiest path to follow is by selecting the Review an Authorization from the provider's home page:



This will take the provider to the search authorizations screen where various elements can be entered to locate the authorization related to the consumer you wish to discharge. In this example the consumer's ID is entered and the ***Search*** button is selected:

Home
EDI Homepage
Specific Consumer Search
Register Consumer
Authorization Listing
Enter an Authorization Request
Claim Listing and Submission
Reports
Enter a Care Plan
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Search Authorizations

Required fields are denoted by an asterisk (*) adjacent to the label.
Please select a Provider ID below, to perform any one of the Authorization Search transactions below.

* Provider ID 001653

Vendor ID
Consumer ID
Authorization # - - (No spaces or dashes)
Client Authorization #
Effective Date 09172008 (MMDDYYYY)
Expiration Date 09172009 (MMDDYYYY)

Activity Date span cannot exceed seven (7) days.
Activity Date Range can only be entered without a value in the Effective or Expiration Date fields above (or vice-versa).

Activity Date From (MMDDYYYY)
Activity Date To (MMDDYYYY)
Delimiter Type ? Comma ',' Pipe '|'

View All | Search | Download

This will move to the Authorization Search Results where the authorization or authorizations for that consumer can be reviewed. This example has only 1 authorization to select, but depending on the number of times and settings you have treated an individual consumer in there may be additional authorizations to view:

Home
EDI Homepage
Specific Consumer Search
Register Consumer
Authorization Listing
Enter an Authorization Request
Claim Listing and Submission
Reports
Enter a Care Plan
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks

Authorization Search Results

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Next >>

Authorization		Consumer ID	Consumer Name	Consumer DOB	Provider ID	Alt. Provider ID
View Letter	Auth #					
	01- 091709- 1- 2					

Next >>

Selecting the Auth # hyperlink will take you to the Auth Summary page/tab – there are additionally Auth Details and Associated Claims tabs available to research and ensure that the provider is selecting the correct authorization to utilize for the discharge review. On this page the option to Complete Discharge Review is offered.

Home
EDI Homepage
Specific Consumer Search
Register Consumer
Authorization Listing
Enter an Authorization Request
Claim Listing and Submission
Reports
Enter a Care Plan
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Auth Summary | Auth Details | Associated Claims

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Authorization Header — Return to search results

Consumer ID
Consumer Name
Authorization # 01-091709-1-2
Client Auth # N/A
Authorization Status O - Open
From Provider
Admit Date 08/19/2009
Discharge Date

Send Inquiry | Complete Discharge Review

Clicking the ***Auth Details*** tab gives information on the type of care the authorization is for, as well as ***Dates of Service***, ***Visits/Units Requested/Approved***, ***Visits Actually Used***, etc. The ***Auth Details*** tab has link to complete discharge from as well.

Selecting the Complete Discharge Review will bring the provider to the appropriate discharge review for the type of services that have been provided. OMS services have custom discharge review screens. Other outpatient services utilize the same standard outpatient discharge screen. Inpatient and other higher levels of care have a discharge screen that is specific to the inpatient services as well. Depending on the type discharge various pieces of information from the last authorization request review will pre-populate the discharge screen. NOTE: If a consumer is being discharged from OMS services and the only authorization obtained for this consumer was prior to services being managed by ValueOptions the standard outpatient discharge screen will appear, not the OMS specific screens.

OMS Discharge Reviews

Requested Services Header

Requested Start Date 08/19/2009
Level of Service O - OUTPATIENT
Type of Request INITIAL
Consumer Name | Provider Name | Vendor ID
Consumer ID | Provider ID | Provider Alternate ID

Discharge Information

*Discharge Date (MMDDYYYY)
Type of Service P - MENTAL HEALTH
Level of Care Discharged From O - OUTPATIENT
Primary Discharge Diagnosis 296.23
Description MAJOR DEPRESSIVE D/O-SINGLE-SEVE
Discharge GAF UK
Discharge Condition
Improved | No Change | Worse

OMS Discharge Data

*Date of Last Contact with Consumer (MMDDYYYY) *Date Form Completed (MMDDYYYY)

*Date of Previous OMS Interview (MMDDYYYY)
08302009

*Was this Discharge planned? ◯ No ◯ Yes

*Was this Discharge against Medical advice? ◯ No ◯ Yes

*Reason(s) for Discharge
Check all that apply

- ☐ Consumer and provider agree that treatment is complete based upon the individual's current status, service needs, and mutually agreed upon goal attainment
- ☐ Consumer or parent/guardian withdrew consumer from care
- ☐ Consumer referred to less intensive level of care
- ☐ Consumer referred to more intensive level of care
- ☐ Consumer referred to another provider providing similar level of services
- ☐ Consumer no longer meets medical necessity criteria
- ☐ Consumer no longer eligible for services (no longer has MA/no longer meets uninsured criteria/benefits no longer cover services)
- ☐ Consumer's lack of participation in program
- ☐ Program's determination to discontinue services (because of the consumer's actions, the services are not effective or the program is unable to secure the safety and welfare of the consumer or others)
- ☐ Consumer moved from service area
- ☐ Consumer is hospitalized - psychiatric
- ☐ Consumer is hospitalized - somatic
- ☐ Consumer is in jail or prison
- ☐ Consumer deceased
- ☐ Discharge reason unknown

*Consumer/Child/Adolescent/Caregiver Participating? SELECT...

▸Child and Adolescent Questionnaire and Form (Ages 6 to 17)

▸Adult Questionnaire and Form (Ages 18 to 64)

INTERVIEWER: Throughout the questionnaire, you will see the following text as part of several questions "(since last interview date/in the past six months)." When this appears, you should read the question as follows:

If this is the consumer's initial OMS interview in your program: read the question with the phrase "in the past six months" as the reference period. For example, "Have you been homeless at all in the past six months?"

If this is NOT the consumer's initial OMS interview: say the actual previous OMS interview date when reading the question. For example, "Have you been homeless at all since October 15th?"

A companion **OMS Interview Guide** for this questionnaire is available at **www.maryland.valueoptions.com**. Included in the Guide are instructions for administering the questionnaire and definitions for several terms as noted within this questionnaire.

The symbol **(ψ)** denotes a consumer opinion only question (discussion may occur but consumer's/caregiver's initial response should be recorded; see OMS Interview Guide for further explanation).

An asterisk **(*)** denotes a question that is mandatory for submission.

I'm going to ask you some questions today about different areas of your life, such as your living situation and daily activities.

Living Situation

Where are you living now? SELECT...

if Other, specify: ______

(INTERVIEWER: Read the answer options to the consumer)

In general, how satisfied are you with where you currently live? ψ SELECT...

Have you been homeless at all (since last interview date/in the past six months)? ◯ No ◯ Yes

Functioning and Symptoms

(INTERVIEWER: Read the answer options to the consumer)

Overall, how satisfied are you with your recovery? ψ SELECT...

Now, I am going to read a series of statements. For each of these statements, please indicate whether you strongly agree, agree, feel neutral (neither agree nor disagree), disagree, or strongly disagree with these statements. [CARD #1 with response options]

I do things that are meaningful to me. ψ SELECT...

I am able to take care of my needs. ψ SELECT...

I am able to handle things when they go wrong. ψ SELECT...

I am able to do things that I want to do. ψ SELECT...

My symptoms bother me. ψ SELECT...

For the next several questions, please tell me your answer based on the past MONTH.

INTERVIEWER: (do not read aloud) For items 10-33, you must either show the designated Response Card, give the consumer a copy of the questionnaire to follow along, or read all of the response options for each to the consumer. (Questionnaire Items 10-33 comprise the BASIS-24; ©McLean Hospital. Used and modified with permission.)

During the PAST MONTH, how much difficulty did you have …

Managing your day-to-day life? ψ [CARD #2 with response options]	SELECT…
Coping with problems in your life? ψ [CARD #2]	SELECT…
Concentrating? ψ [CARD #2]	SELECT…

During the PAST MONTH, how much of the time did you …

Get along with people in your family? ψ [CARD #3 with response options]	SELECT…
Get along with people outside your family? ψ [CARD #3]	SELECT…
Get along well in social situations? ψ [CARD #3]	SELECT…
Feel close to another person? ψ [CARD #3]	SELECT…

During the PAST MONTH, how much of the time did you …

Feel like you had someone to turn to if you needed help? ψ [CARD #3]	SELECT…
Feel confident in yourself? ψ [CARD #3]	SELECT…

During the PAST MONTH, how much of the time did you …

Feel sad or depressed? ψ [CARD #3]	SELECT…
Think about ending your life? ψ [CARD #3]	SELECT…
Feel nervous? ψ [CARD #3]	SELECT…

During the PAST MONTH, how often did you …

Have thoughts racing through your head? ψ [CARD #4 with response options]	SELECT…
Think you had special powers? ψ [CARD #4]	SELECT…
Hear voices or see things? ψ [CARD #4]	SELECT…
Think people were watching you? ψ [CARD #4]	SELECT…
Think people were against you? ψ [CARD #4]	SELECT…

During the PAST MONTH, how often did you ...

Have mood swings? ψ [CARD #4]	SELECT...
Feel short tempered? ψ [CARD #4]	SELECT...
Think about hurting yourself? ψ [CARD #4]	SELECT...

During the PAST MONTH, how often ...

Did you have an urge to drink alcohol or take street drugs? ψ [CARD #4]	SELECT...
Did anyone talk to you about your drinking or drug use? ψ [CARD #4]	SELECT...
Did you try to hide your drinking or drug use? ψ [CARD #4]	SELECT...
Did you have problems from your drinking or drug use? ψ [CARD #4]	SELECT...

Legal System Involvement

*(Since last interview date/in the past six months) have you been arrested?	○ No ○ Yes
*(Since last interview date/in the past six months) have you been in either jail or prison?	○ No ○ Yes

(INTERVIEWER: Read the answer options to the consumer)

Some people have had a negative encounter with the police, such as being arrested or hassled by police. (Since last interview/in the past six months), would you say you have had...	SELECT...

Employment

Now let's talk a little bit about your work situation.

*Are you currently employed?	○ No ○ Yes
*Are you actively looking for work by doing things like filling out applications, or answering ads?	○ No ○ Yes
Have you been employed (since last interview date/in the past six months)?	○ No ○ Yes

INTERVIEWER: (do not read aloud) If the person held more than one job during the reporting period, please ask him or her to answer the following questions in terms of the most recent job.

*(Is/Was) your job competitive employment or sheltered workshop or agency employment?	SELECT...
How many hours a week (do/did) you usually work?	SELECT...

(INTERVIEWER: Read the answer options to the consumer)

In general, how satisfied (are/were) you with this job? ψ	SELECT...

Somatic Health

Do you smoke cigarettes?	○ No ○ Yes
How many cigarettes do you smoke per day? [one pack = 20 cigarettes]	SELECT...

(INTERVIEWER: Read the answer options to the consumer)

Would you say in general your health is: ψ	SELECT...
How tall are you?(feet) (inches)	☐ (feet) ☐ (inches)
How much do you currently weigh?(pounds)	☐ (pounds)[whole numbers only] SELECT...

Demographic and Interview Information

*How long have you received mental health services from this clinic? SELECT...

*Consumer involvement in interview: SELECT...

Clinician's Notes (Optional) (0 of 1000)

Return To Provider Home | Save Discharge Information

After all information is completed on the consumer the Save Discharge Information is selected and the review is saved.

Standard Outpatient Discharge Review

This discharge review will be used for all outpatient services other than OMS. This will also be the screen that presents for those OMS services that were authorized prior to 9/1/09. This discharge review consists of 3 main sections –Discharge Information, Current Risks, and Current Impairments.

Requested Services Header

Requested Start Date	Level of Service	Consumer Name	Provider Name	Vendor ID
09/17/2009	O - OUTPATIENT			

Type of Request	Consumer ID	Provider ID	Provider Alternate ID
INITIAL			

Discharge Information

*Actual Discharge Date (MMDDYYYY)

Type of Service
P - MENTAL HEALTH

Level of Care Discharged From
O - OUTPATIENT

*Primary Discharge Diagnosis: 296.23
Description: MAJOR DEPRESSIVE D/O-SINGLE-SEVERE W/O F

*Discharge Condition
○ Improved ○ No Change ○ Worse ○ Unknown

Type of Discharge
○ Planned ○ Unplanned

Discharge Reason
Check all that apply

- ☐ No further treatment
- ☐ Consumer dropped out
- ☐ Medication management follow up only
- ☐ Transfer to more intensive level of care
- ☐ Referral to other outpatient service(s)
- ☐ Consumer no longer eligible or moved
- ☐ Other

Current Risks

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

*Consumer`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

*Consumer`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

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

[Return To Provider Home] [Save Discharge Information]

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Inpatient/HLOC Discharge Review

The Inpatient/HLOC Discharge Review contains the same sections for ***Discharge Information***, ***Current Risks*** and ***Current Impairments***. The additional item that differentiates it from the Outpatient version is that it additionally has fields for indicating the aftercare needs for the consumer.

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

Legal
0 1 2 3 N/A

*Total # of Days/Sessions Used
999

*Discharge plan in place?
Yes No

*Actual Level of Care Discharged To
SELECT...

*Type of Discharge
AMA Planned

PCP notified?
Yes No

*Actual Discharge Residence
SELECT...

Member/Family Name for Follow Up

*Relationship
SELECT...

*Phone #
Ext

***Aftercare Behavioral Health Provider**
Not Arranged Do Not Know Arranged

***Aftercare Prescribing Physician**
Not Arranged Do Not Know Arranged

Medical Care Physician

Additional discharge related questions as well as ***Aftercare Provider*** information

Name

Phone #
Ext

Reason for Medical Physician Involvement
SELECT...

*Add one more behavioral health appointment? Yes No

Return To Provider Home

Save Discharge Information

Appendix for requesting various Types of Care

Services Requesting	Level of Service	Type of Service	Level of Care	Type of Care	Notes
Inpatient – Acute	Inpatient/HLOC	Mental Health	Inpatient	Inpatient Mental Health Acute	All Inpatient/ HLOC Requests will pend
Hospital Diversion	Inpatient/HLOC	Mental Health	Inpatient	Hospital Diversion	
Partial	Inpatient/HLOC	Mental Health	Partial Hospital	Partial Hospitalization	
IOP	Inpatient/HLOC	Mental Health	Intensive Outpatient	Intensive Outpatient Program	
RTC	Inpatient/HLOC	Mental Health	Residential	RTC - Routine	
Crisis Residential	Inpatient/HLOC	Mental Health	Crisis Residential	Residential Crisis	
OMS Outpatient	Outpatient/ Community Based	Mental Health	Outpatient	OPMH OMS	May auth or pend
Non OMS Outpatient	Outpatient/ Community Based	Mental Health	Outpatient	OPMH NON OMS	May auth or pend
Supported Employment	Outpatient/ Community Based	Mental Health	Supported Employment	Supported Employment	May offer units to cover Supported Employment. Will be asked to complete CPT codes and Modifier selection - All will pend for review
TBI Services	Outpatient/ Community Based	Mental Health	TBI Waiver	TBI Waiver Services	All will pend for review
PRP	Outpatient/ Community Based	Mental Health	Outpatient	Psychiatric Rehabilitation	**May offer units to cover PRP services. Will be asked to complete CPT codes and Modifier selection - All will pend for review – utilize if PRP services for PRP, PRP1 or PRP2**
RRP Beds	Outpatient/	Mental	Outpatient	Residential	**May offer units to**

	Community Based	Health		Rehab	**cover RRP bed and PRP services. Will be asked to complete CPT codes and Modifier selection - enter codes for RRP on first detail line with 356 units, PRP on second line for remaining units - All will pend for review – utilize for PRP and RRP bed for PRP3 and PRP4 – auth will be adjusted by the CSA to 1 year as appropriate**
Occupational Therapy	Outpatient/ Community Based	Mental Health	Outpatient	Occupational Therapy	All will pend for review
TBS Services	Outpatient/ Community Based	Mental Health	Outpatient	Therapeutic Behavioral Services	All will pend for review
Supported Housing	Outpatient/ Community Based	Mental Health	Supported Housing	Supported Housing	All will pend for review
Mobile Treatment	Outpatient/ Community Based	Mental Health	Mobile Treatment/AC T	Mobile Treatment/ACT	All will pend for review
Respite	Outpatient/ Community Based	Mental Health	Respite	Respite Services	All will pend for review
Case Management	Outpatient/ Community Based	Mental Health	Outpatient	Case Management	All will pend for review