ValueOptions® Maryland
Update
October 2, 2009

Crisis Bed Authorizations: Until further notice, Crisis Bed authorizations may be submitted up to 48 hours after admission. Cheryl Thompson is the ValueOptions® Maryland Care Manager assigned to Residential Crisis providers. Ms. Thompson can be reached at 1-800-888-1965, option 4, extension 214040 during business hours. Messages may be left in her voice mail box after hours.

PRP Copayment Reminder: We will be correcting our co-pay calculations for PRP and adjusting previous co-pays issues paid in error. Co-payment amounts for Psychiatric Rehabilitation Program (PRP) services remain the same and are based on the minimum services required for each PRP level of care for the authorized service. The $2 co-pay amount is based on the minimum number of required encounters provided and not on the actual number of services if that number is more than the minimum delivered in the month. The co-pay amount does not increase if services are delivered above the minimum level and does not decrease if the billed amount in any month is cascaded downwards.

Reminder – Services Authorized by the CSA: Providers are reminded to select "CSA" in the "Which agency is this request intended for?" field on the "Type of Services" screen in ProviderConnect when requesting Residential Rehabilitation (RRP), Supported Employment (SEP) or concurrent Crisis Bed authorizations. The CSA selected for the review is based on the consumer's county of residence.

PRP Authorization End Date Correction: The end date of a PRP authorization is the last day of the last month of the date span. Approved PRP services with a mid-month end date will be programmatically corrected by VO. Please note: the end date will not affect claims payment. Going forward, the ValueOptions® Care Manager reviewing the authorization request will change the end date to the last day of the last month.

OMS Clarification for "Requested Start Date/OMS Interview Date" Field: Under the MAPS system, the authorization start date was automatically determined based on the OMS interview date and following the 30/100 day rules. Under VO, the 30/100 day system rules are the same. However, providers need to use the "Requested Start Date/OMS Interview Date" field for two purposes. For the initial authorization request of 2 visits, enter the requested start date in this date field. For all concurrent OMS authorization requests, enter the OMS interview date in this date field. In both cases, the system will automatically generate the correct authorization span and ensure there is no gap or overlap in the authorizations.

Approval Process for new Individuals who are uninsured requesting Case Management Services: When a request is made for a new individual who is uninsured, providers are to submit the request to ValueOptions for authorization for case management. The case management request must meet the uninsured eligibility criteria and meet medical necessity

criteria for case management to be considered for an exception by MHA and the CSA for approval for an uninsured eligibility span for case management.
Once VO has reviewed the request, VO will pend the decision and forward the request to the CSA for review and approval.
Exceptions granted will be very limited and contingent upon the urgency of the request, such as a discharge from a state hospital, or diversion from inpatient psychiatric care, and the expectation that the provider will link the individual to the necessary benefits in order to obtain Medicaid coverage for future services.
If approval is recommended by the CSA, the CSA will request final confirmation by phone or email to MHA – Penny Scrivens, LCSW-C, Case Management Coordinator, at 410-402-8482 pscrivens@dhmh.state.md.us, or James Chambers, Director, Adult Services at 410-402-8476 jchambers@dhmh.state.md.us.. MHA will review the request and determine if funds are available and forward the decision to the CSA within 2-3 working days. If MHA approves, the CSA will enter the approval in ProviderConnect.
Providers may request courtesy reviews for those consumers who are uninsured and likely to receive Medicaid eligibility, with the caveat that there will be no retroactive uninsured eligibility if the person does not obtain Medicaid.