CMHRS Provider Webinars- FAQ

December 5-7, 2017- Afternoon Sessions

ABA Behavior Therapy:

Q1: Under the Initial service authorization form it asks for NPI of clinical supervisor, Service coordinator, licensed staff if we are billing under the group NPI can we use the Group NPI or is it only the Individual NPI?

A: This question is specific to ABA Behavior Therapy services. Billing under the group NPI can occur if your agency is contracted with the MCO. In this case however, the MCOs still require the individual therapist to credential with the MCO.

Q2: Will EPSDT Behavioral Therapy services be authorized under the clinical supervisor or will they be authorized under the organization?

A: The organization- if your agency was contracted with the MCO as an organization. See response Q1.

Q3: For EPSDT Behavior Therapy/ABA Therapy, do we only need to complete that specific Initial service authorization form? Or does the CMHRS form need to be completed as well?

A: No. Just the ABA Therapy form for Initial and use the Continued Stay Request form for concurrent requests.

Q4: Will a signed physician's letter need to be submitted in addition to the initial and/or continued stay forms?

A: No, not to the CCC Plus MCOs. The attestation verifies its completion.

Q5: Does a prescription serve the purpose of the letter of referral for EPSDT services?

A: No. The program rules have not changed. From the EPSDT Supplement/ Behavioral Therapy Provider Manual requires that … *The need for behavioral therapy must be identified by the child's physician, nurse practitioner, or physician assistant through an inter-periodic/problem-focused visit or an EPSDT screening/well-child visit. The physician, nurse practitioner, or physician assistant does not need to be*

enrolled with DMAS, a Medicaid MCO or the BHSA. A prescription would not comply with the requirement.

Q6: Is a formal referral required for EPSDT Behavioral Therapy, or will a physician/nurse practitioner/physician assistant signature on our Assessment and letter of medical necessity suffice? Is this form is taking the place of the EPSDT form?

A: Yes it is still required. A signature on the initial service authorization request would not comply with the requirement set forth in the EPSDT Supplement/ Behavioral Therapy Provider Manual (see above Q5). The attestation on the authorization request forms do not take the place of the referral documentation requirements.

Q7: For EPSDT Behavioral Therapy, the BHSA currently requires an updated Letter of Medical Necessity with each authorization extension in conjunction with the DMAS regulations. Is appears that this is not a requirement for the MCO forms. Can you confirm? We were under the understanding that the MCOs had to operate in alignment with the DMAS regulations. Instead of a doctor's letter - the referral needs to be sent directly from the source to the MCO?

A: The signed attestation verifies medical necessity. An updated letter is not required to be submitted with the authorization request.

Q8: The DMAS regulations state that an EPSDT Behavioral Therapy provider can be an agency that employs an LBA. We have been successfully billing under the group NPI for services. Will all 6 MCOs require that these services be billed and authorized under the individual LBAs?

A: See response to Q1.

Q9: What happens if a family requests EPSDT services and does not go through their MD? Do we need to direct them to get the referral first?

A: Yes

Q10: Are the approved assessments for ABA staying the same?

A: Yes. The program rules will not change.

Q11: I'm not seeing the current code for EPSDT assessment H0032-UA anymore. Additionally, previously authorization was not needed if less than 5 hours but we had trouble getting the assessment claims to pay. Will a new assessment now fall under the H2033 code?

A: The rules for conducting and billing assessments has not changed. Since this training session focused on service authorization, the assessment code was not included in this training as it does not require prior authorization. You will continue to bill using the same assessment code.

Q12: For the Assessment for ABA Therapy do we need to get authorization for them before seeing the patient

A: No. Providers bill for the initial assessment under service code H0032 with a UA modifier. There is a limit of two assessments per member per provider per year. A year is defined as the time period between July 1 and June 30 of the following year. Units are billed in 15 minute increments and there is a limit of 20 units per assessment. Initial assessments do not require service authorization. Only initial assessments and assessments performed after an interruption in services are billed under service code H0032. Subsequent reassessments during service provision are billed as part of service code H2033.

Q13: the aba authorization form indicates that the person performing service coordination must have an NPI number. This indicates that this person is a LBA or LaBA. Please confirm. That is not required under current DMAS manual.

A: Please contact MCO network teams directly to determine how your agency or individual LBA will be identified in the authorization form, the network teams can be contacted using the information here:
◆Updated MCO Contracting/Credentialing Contacts

Q14: For ABA therapy under the initial service authorization, what are examples of other interventions that have been tried?

A: Outpatient psychiatric and medical care, speech therapy or occupational therapy in outpatient settings, medication management are examples.

Q15: Can you please explain for ABA SA there is NPI of licensed staff delegating authorization to the unlicensed staff? Can this can be completed by the LABA under the supervision of an LBA?

A: No, refer to Q 13 for more information.

Q16: For ABA on page 19 asking about the staff what if there is more than one supervisor on the case or if the supervisor changes do we need to submit a new form with the new staff

A: Not a new form, but indicate any changes on the next concurrent authorization form.

Q17: Can a LMHP-E complete an ABA assessment? if it's within their competency. Do they need a separate NPI #

A: No they cannot complete the ABA assessment. Please review the program rules in the EPSDT Manual for Behavior Therapy. The assessment must be completed by the LMHP, LBA or LABA under supervision of LBA.

Q18: For ABA, under which section do we include requested hours for data analysis/ graphing and for preparation of communication materials as allowed by DMAS?

A: yes, under hours needed for clinical supervision and direct services by the licensed professional with description and detail provided in the treatment goals section.

Q19: Can a RBT provide parent training

A: All clinical services and training must be under the supervision and delegation of the LBA, if the LBA is able to delegate such activities then it would be allowed based on the board of medicine regulations governing the practice of Applied Behavioral analysis.

Attestation and Signatures

Q20: Authorization signature lines indicate LMHP. Is this a new requirement? Previously we have been advised that someone credentialed to provide the service can complete the SRA as long as the required assessment/SSPI has been completed by a license-type staff.

A: That is correct. The attestation made by the LBA/LMHP (or Supervisee, Resident, etc.) verifies that a properly completed assessment/SSPI was performed (on the Initial Service Authorization request form). The attestation on the Continued Stay Authorization form verifies that an SSPI has been completed according to current policy requirements set forth in the CMHRS provider manual and that the member continues to require the service and meets medical necessity criteria.

Q21: Is licensed eligible an accepted type for LMHP to sign off on the CMHRS authorization request? Does LMHP type refer to individuals who are in the process of working toward licensure under the supervision of an LMHP?

A: Yes, LMHP type includes the LMHP-Resident, LMHP-Supervisee, or LMPH-Resident in Psychology. The definition of LMHP is found in 12VAC30-50-130 and the CMHRS manual, Chapter 4: "Licensed Mental Health Professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

Q22: If the LMHP-type does the required SSPI/assessment, can they co-sign the Authorization form as an attestation but the QMHP or qualified service provider complete the remainder of the form?

A: Yes.

Q23: Does an LMHP need to complete authorization requests?

A: No they are not required to complete the entire authorization form. They shall be available to speak about the request if the MCO contacts the agency with questions about the request.

Q24: For the continued stay authorization, you are still requiring the LMHP type attestation. However, not all services require a new SSPI to be completed except at 6 months or annually depending on the service. Why is the LMHP type still required to attest? Is this just to say that this has happened on the timeframe outlined by the regulations or for each continued stay authorization?

A: Yes, that it occurred in the timeframes outlined by DMAS manual and regulation. The LMHP type is attesting that the member continues to require the service based on MNC set forth in DMAS manual and regulation.

Q25: Does a follow up Service Specific Provider Intake need to be done for each continued stay? If so, are all of these Intake updates billable?

A: See also response to Q24. The SSPI for CMHRS services must be conducted annually per the CMHRS Manual Chapter 4. Regulations set forth that for some services such as Psychosocial Rehabilitation and Mental Health Skill Building - for services that continue more than 6 months, the LMHP (or Resident, Supervisee, etc.) must document the need for continued services. These rules have not changed. The attestation on the continued stay form is verifying that the SSPI has been completed and the member

continues to need the service and meet the MNC. The attestation is not adding a requirement that a new SSPI be conducted each time a continued stay request form is submitted.

Q26: If we re-create the authorization forms in our EHR system, may the LMHP/LMHP-type/LBA sign the attestation electronically versus a physical signature? Will an electronic signature be accepted if there is a date/time stamp that the LMHP signature is connected with it? Would the MCO's accept password protected signatures that are embedded in our EHR *systems?*

A: All Plans will allow

Q27: What about an LaBA Licensed Assistant Behavior Anslyst's signature on those forms?

A: No. The signature must be by a LMHP, a LMHP type, or LBA.

Q28: Does the LMHP that did the assessment have to be the same person that attests?

A: No, but the LMHP who is attesting to the assessment completed by someone else is taking responsibility for the authorization request.

Authorizations/Registrations

Q29: What is the difference between the registration and authorization again?

A: Registration is a means of notifying the MCO that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Registrations notify the MCO of service delivery. A review of medical necessity criteria is not included in the registration process. At the expiration of the registration period, a new registration will need to be submitted to the member's MCOs. The frequency that this occurs can vary across the CCC Plus MCOs.

Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid enrollment, and ongoing medical necessity for the service.

Q30: For each service, is there a maximum amount of service that can be requested? (ex. 3 months, 6 months, 12 months) Since there won't be routine authorization periods, what should we request on the forms.

A: No. You will request the number of units you believe meet the individual's needs based on the goals you have identified in the ISP. The CCC Plus MCOs are not relying on routine authorization periods but will work with providers during the authorization process to ensure the individual receives the necessary services that meets their individualized needs. Your authorization request should support the units requested -- clearly explaining what the planned goals are and what interventions you will provide to meet make progress towards those goals.

Q31: Will the MH CM registrations still default to 1 year or will those be individualized as well? How often will a "Continued Stay Registration" be completed?

A: It will be individualized. The MCOs will not have default authorization or registration periods. Since they are not relying on clinical information, they will provide an individualized registration period based on the member's claims and authorization history.

Q32: For crisis intervention services, now we register for 76 units and start date (ex. 12/6) end date (ex. 12/7). So that if this client bounces to another CSB we do not have to "discharge" in order for them to complete a registration. On the new form there is no units box and no end date. How will this work with CCC Plus?

A: The MCOs will provide a registration period. Now that members have a care coordinator assigned to them, providers can notify the care coordinator if members "bounce" to another provider. Each of the plans have protocols in place so that care coordinators and utilization management staff can coordinate care in these types of scenarios.

Q33: Is Crisis Intervention still limited to 7 days? Or are we allowed to request more time since it's individualized by the severity of the Crisis situation/symptoms. Currently we use a registration every 7 days for Crisis Intervention. Is this process changing?

A: You will request the number of units you believe meet the individual's needs. The CCC Plus MCOs are not relying on routine authorization periods but will have registration processes for registered services. This may vary across the MCOs.

Q34: ICT and MHCM services are often needed for years. After the initial authorization, are all subsequent renewals done via registration, even over a course of years?

A: ICT is initially registered and subsequent authorization requests must be made using the continued stay request form. MHCM is always registered.

Q35: In terms of individualizing the unit requests based on need, for MHSS are we still working with the 560 units total for the year? or is there no longer a max amount of units we can request?

A: See Response Q30. Service limits will be removed in compliance with Mental Health Parity rules.

Q36: To clarify, if a member is currently in services, will they keep the same authorization number, or will they receive a new authorization number with the new MCO?

A: The MCO will issue and notify you of a new authorization and number after January 1, 2018 for those CCC Plus members who are currently in services.

Q37: What does it mean to be denied for administrative reasons?

A: Administrative reasons for denial can include: incomplete service authorization request, duplicate request, or continued authorization request submitted too soon (outside of MCO timely submission).

Q38: When faxing in service authorizations can we fax multiple service authorizations at one time, or do they need to be faxed individually?

A: Multiple authorizations can be faxed at one time, however the MCOs recommend that faxes be sent individually to avoid mix ups.

Q39: Will each MCO require that the authorization number be included on the claim, or will there be a system in place to match up the member/provider/service to determine if an appropriate auth exists?

A: Including the authorization number is not required, but is recommended for easier processing.

Q40: If a client is staying with their current MCO (their MCO is participating in CCC Plus) will their authorization numbers also change? Will an initial request form need to be submitted?

A: No, an initial request form will not need to be submitted for members currently receiving services; only for new services that begin on or after January 1, 2018.   If the member remains in their current MCO, there may be authorization updates to reflect the CCC Plus program. MCOs have procedures in place to notify all providers of new CCC Plus authorizations as of January 1, 2018.

Q41: Is authorization to complete an assessment now required? or do we still get a set number of units for the initial assessment?

A: No authorization required for CMHRS SSPI. Also, there are no changes with assessment requirements for ABA Behavior Therapy.

Q42: When submitting a continued stay SRA there does not necessarily have to be a diagnostic assessment completed. Will the MCO reimburse for services without their being an assessment procedure being billed in their system since the assessment procedure code was billed to Magellan (BHSA)

A: The MCOs will have service authorization and claims history files sent to them from the BHSA that will show the member's service history including the assessment procedure code.

Q43: Referring to Slide 9 - Reauthorizations or registrations can't be submitted prior to or after the number of days listed, correct? If submitted after, will an initial authorization be required?

A: Initial authorization requests are only for the initiation of new services. Lapses/delays in reauthorizations or registrations can result in denied claims for the services rendered during a lapse in authorization/registrations.

Q44: What happens if a person utilizes more units than requested in the authorization? Will MCOs deny payment, would we charge the individual, or would we have to turn them away? (re: PSR)

A: Providers are prohibited from charging the individual. Providers who believe their client requires more services than authorized, providers need contact the members care coordinator who can work to ensure the member receives necessary services. Provider will need to clearly describe the rationale and plans for the additional services.

Q45: It seems that providers are not able to submit re-authorization requests earlier than 14 business days prior to the end of the existing authorization (7-14 business days, depending on the MCO). If each MCO has 3-5 business days to make a determination, this may mean that we have 2 days or less to discharge a client if the authorization is denied. Will the MCOs consider allowing providers to submit re-authorization requests earlier in order to ensure appropriate time to prepare the client for discharge?

A: Best practices are that preparations for discharge should being at admission. The MCOs are committed to ensuring members are and continue to receive all medically necessary services. If services are denied, the MCO can coordinate alternative services that will meet the member's needs. At this

time, the MCOs are not considering changing the timelines. Providers and members are afforded appeal rights for any adverse decision.

Q46: Will notifications of approval/denials be faxed and/or mailed to the address listed on the authorization/registration form or to the fax/address included with the credentialing information?

A: Notifications will be made using the credentialing information. The plans have loaded this information and use it to generate automatic authorization/registration notifications.

Q47: One of the eligibility requirements for PSR is "Requires long-term services to be maintained in the community." In recognition that those with SMI maintain stability through regular participation in programs such as PSR (evidenced based practice), will MCO's recognize this component when considering the length of time for authorization approval?

A: The MCOs will be utilizing the DMAS medical necessity criteria for PSR, including the portion referenced in your question (described below), to make authorization decisions. The requirements for PSR set forth that the individual must MEET ONE of the following criteria:

1) Have experienced long-term or repeated psychiatric hospitalizations; or
2) Experience difficulty in activities of daily living and interpersonal skills; or
3) Have a limited or non-existent support system; or
4) Be unable to function in the community without intensive intervention; or
5) Require long-term services to be maintained in the community.

Q48: If a member needs an increased level of services during an authorization period due to increased stressors/unplanned event, how do we go about requesting increased unit authorization?

A: You would reach out to the care coordinator.

Q49: What is the process to end an authorization/registration when a member is discharged from services?

A: To notify the MCO of a discharge, Providers would contact the member’s care coordinator for assistance and instruction and also to facilitate transfer or discharge from services.

Magellan	**UHC**	**Anthem**	**Aetna**	**VaPremier**	**Optima**
800-424-4524	877-843-4366	1-855-323-4687 Press #4	1-855-652-8249 press #1 and ask for CC.	1-877-719-7358 select option for Care Management	757-552-8398 OR Toll Free 866-546-7924

Q50: Since providers are not required to complete an initial authorization for members at the expiration of the current service authorization, will individuals currently enrolled in ICT only need a registration? If a client has a current continued stay authorization with ICT that has an end date of 12-31-17, on 1/1/2018 will we submit an Initial or a Continued Stay authorization to the CCC Plus MCO?

A: A registration request would be required for continuing ICT services. Only new services as of 1/1/2018 would require an initial authorization request.

Authorization/Registration Timelines

Q51: Approvals for initial authorizations...will they follow same timeline?

A: Yes, all MCOs will rely on Contract Standards for turnaround time-3 business days or up to 5 business days if additional clinical information is required

Q52: On the slide about timeframes for submission of authorization requests, you indicated that the authorization must be submitted with 7 or 14 days prior to the authorization ending; I am assuming that this is only for continued stay and that any individual newly starting services after 1/1/18 should have the authorization request submitted prior to or at the start of services for approval? (slide 9)

A: Correct

Q53: So are we no longer submitting 30 days in advance and only submitting within the 7 to 14 day time frame?

A: The 30-day timeframe is used by Magellan of Virginia (the BHSA). The MCOs will utilized either 7 or 14 day timeframes for concurrent request submissions. From Slide 9:

Timeframes for Submission and Turnaround (Concurrent)	CMHRS Services (excluding CI/CS)	CI/CS	MCO UM Decision Turnaround
Aetna	7 business days	48 hrs.	All MCOs will rely on Contract Standards- 3 business days or
Anthem	14 business days	48 hrs.	
MCC	7 business days	48 hrs.	

Optima	7 business days	48 hrs.	up to 5 business days if additional clinical information is required
United Healthcare	14 business days	48 hrs.	
Virginia Premier	14 business days	48 hrs.	

Q54: Are you saying that we will no longer be able to submit continued stay requests up to 30 days in advance, only 7 or 14 days before their authorization will be running out?

A: Correct. These 7/14 day timeframes apply to CCC Plus members and their MCOs only.

Q55: We currently have 2 business days following the date of the assessment to submit the initial MHCM, CI & CS registration. Is this allowable with the MCOs? Do we still only have two days after the face-to-face assessment session to submit the registration? And, do we still have the full month before the registration runs out (usually the 11th month) to turn in the continuing stay registration request?

A: The MCOs have not indicated they will follow the BHSA submission timeframes. Once the MHCM assessment is completed, you need to submit the registration request and include the requested start date. For CI/CS, you have 48 hours to submit the initial registration request. For all others follow the guidance as documented here:

CCC PLUS ELIGIBILITY TRACKING, AUTHORIZATION AND CLAIMS PROCESSES FOR CMHRS

- CMHRS Provider Reference-Doing Business with CCC Plus MCO's

Q56: Is the 7/14 day timeline how early we can submit or is that a you must submit no later than 7/14 days prior to end of authorization?

A: Please refer to the information in the website under:

CCC PLUS ELIGIBILITY TRACKING, AUTHORIZATION AND CLAIMS PROCESSES FOR CMHRS

- CMHRS Provider Reference-Doing Business with CCC Plus MCO's

Care Coordination/Trauma Informed Care

Q57: If a client already has a case manager, is the MHSB or PSR worker also supposed to coordinate with the PCP?

A: Yes. There are no changes to the program requirements.

Q58: For what reason is the compilation of the care coordination/other services the individual is involved in not the responsibility of the MCO's Care Coordinator?

A: The rules for care coordination within CMHRS program rules has not changed. Members in CCC Plus have complex care needs and are likely to have multiple service providers. It is essential that providers know what other services their clients are receiving. They can reach out to the Care Coordinator to "fill in the gaps" for services that the member may not have reported.

Q59: What is the ratio of care coordinators to individuals served?

A: See chart below

CCC Plus Care Coordination Staffing Ratios by Population			
High-Risk Populations			**Moderate to Low Risk Populations**
CCC Plus Waiver Populations	**Nursing Facility Populations**	**Other High-Risk Populations**	**Emerging High-Risk**
1:70	1:175	1:100	1:400
CCC Plus Waiver including Technology Assisted and Standard levels of care; Section 5.1.1(a).	Nursing Facility including Specialized Care and Long-Stay Hospital Section 5.1.1(b).	Individuals with Serious Mental Illness (SMI) Individuals (duals and non-duals) with complex or multiple conditions who are identified by the plan or self-identified as having conditions that are not well managed, e.g. multiple ED visits, multiple inpatient admits, or have a lack of medication adherence, etc.	All other individuals (duals and non-duals) not already identified in the high-risk population groups; includes populations (duals and non-duals) with complex or multiple conditions who are well managed. Populations listed in 5.1.1, (d-o), including DD Waiver individuals are included unless they meet high-risk criteria.

		Section 5.1.1 (c – n) if they meet high-risk criteria per 2 above.	
See Section 5.1.1			

Q60: Will the Care Coordinator be sharing monthly reports to providers? What information will they be sharing?

A: Monthly reports will not be sent to providers.

Q61: Does this mean incorporating Trauma-specific goals or just clinical awareness and planning?

A: As applicable, planning and incorporating TIC goals should be included.

Q62: Given the expectation that we collaborate on an ongoing basis with the care coordinators, will there be an updated list provided to us for who is acting as care coordinators for regions/general contact information. It is our understanding that some of the MCOs are assigning regional care coordinators, while others are assigning them based on the individual's needs.

A: You will be made aware of who is your CCC Plus clients' assigned Care Coordinator; they will be contacting their member's current providers. The member's Care Coordinator will be reaching out to you, inviting you to join the Integrated Care Team (ICT) as the Integrated Care Plan (ICP) is developed and when modifications are needed. The Morning Session Power Point Slide deck found on the DMAS website includes plan specific slides which include the contact phone numbers providers can use to reach out to Care Coordinator staff. (click the following link) ◆AM Session - CCC Plus CMHRS Transition Overview

Completing Authorization and Registration Forms

Q63: LaBAs are not referenced on the forms. Are they able to complete them?

A: Yes. They can complete the authorization request form but the attestation must be made by the LBA, LMHP or LMHP-Supervisee, LMHP-Resident, or LMHP-Resident in Psychology.

Q64: Does a follow up Service Specific Provider Intake need to be done for each continued stay? If so, are all of these Intake updates billable?

A: The SSPI for CMHRS services must be conducted annually per the CMHRS Manual Chapter 4. Regulations set forth that for some services such as Psychosocial Rehabilitation and Mental Health Skill Building - for services that continue more than 6 months, the LMHP (or Resident, Supervisee, etc.) must document the need for continued services. These rules have not changed. The attestation on the continued stay form is verifying that the SSPI has been completed and the member continues to need the service and meet the MNC. The attestation is not adding a requirement that a new SSPI be conducted each time a continued stay request form is submitted.

Q65: Could you clarify again whether a QMHP can complete the Service Request Authorization as long as a LMHP signs the form?

A: Yes that is correct. The LMHP's signature is an attestation that the member's SSPI/assessment was properly completed and that the member requires that level of service and meets the MNC established in regulation and in the DMAS CMHRS provider manual. It is not just a signature.

Q66: PSR was using registration instead of service authorizations, for clarity, will the registration be treated the same as a service authorization in terms of not having to submit a service authorization until the end date or 90 days from 1/1/18

A: Open registrations, issued by Magellan the BHSA, will be honored by the CCC Plus member's MCO. At the expiration of that registration for PSR, the first time you submit a request to the member's MCO, you must use the Continued Stay Authorization form.

Q67: Where can we find information on where to submit the SRA's? Fax numbers/contact names.

A: Each of the forms include this information on the last page. You can access the forms on the DMAS website. http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx

Q68: Are we required to end a TDT school day authorization and resubmit for a TDT summer authorization for children transitioning from school based to summer programs? If we are required to do this, what would that process look like?

A: Yes. This process hasn't changed as it is currently handled this way by Magellan the BHSA. You would need to submit concurrent authorization request for these transitions.

Q69: On the TDT authorization request form are you unable to select multiple codes, such as summer program and in-school TDT. If not, will all authorizations have to be completed prior to summer program and then before school starts? How about if they are attending summer school Monday-Thursday, and then summer program on Friday?

A: Multiple codes cannot be selected on the authorization form. The MCOs will need to ensure your agency is licensed for both school based non-school (summer) TDT programs. Distinct ISPs would be needed to reflect the school based and summer school program.   You will need to contact the member's MCO when atypical service provisions such as this scenario are being considered.

Q70: Can we print a list of medications from our EHR rather than writing each medication on the authorization form?

A: Please refer to the attachment on the authorization form.

Continuity of Care and Authorizations

Q71: As existing authorizations transition to the MCOs, will members receive new authorization number?

A: Yes. The MCOs will be generating those new authorizations based on open CMHRS authorizations from the BHSA (or a member's CCC Plan) and will notify providers of those new authorization numbers. The MCOs encourage providers to be proactive and reach out to the MCO to obtain that information during the continuity of care period.

Q72: For the 90-day grace period? Is billing still being done through Magellan? Or do we bill the MCO directly even if we are still in the credentialing process?

A: For CCC Plus members, services delivered prior to January 1, 2018, billing and service authorization requests will be administered through Magellan the BHSA. For services delivered on January 1, 2018 and beyond you will bill the member's MCO directly even if you are still in the credentialing process.

Q73: When can we begin sending in continued-stay authorizations requests for clients who have authorizations with 12/31/17 end dates?

A: Any existing Magellan authorization scheduled to end between 12/16/17 and 1/10/18 will be automatically extended to 1/31/2018. If you wish you can go ahead and submit a continued authorization request with Magellan the BHSA - they will process all requests as usual submitted through 12/31/2017. Those processed authorizations that span dates beyond January 31st will override the 1/31/2018 extension made by Magellan the BHSA.

Q74: Some of our PSR authorizations with CCC plans ended their authorizations on 12/31/17 and did not give us the full 6 months. Will these have to be submitted to the new CCC Plus plan to avoid gap in authorization? If so, how soon can we submit?

A: These authorizations will not extend automatically to 1/31/18 as the BHSA authorizations. If the CCC Plus member has authorizations through Humana, those authorizations will transfer over to the member's new MCO. The MCOs will receive service authorization data (MTR data file) for their new CCC Plus members and will see these authorizations with end dates of 12/31/2017 - they will honor current those service providers during the continuity of care period. The continuity of care period will allow time for the plans to contact providers (and providers to proactively contact the member's care coordinator!) Members in Virginia Premier and Anthem are staying with those plans and they will work internally to provide their CCC Plus team their CCC authorizations.

Q75: If we have not been approved as a provider as of 1/1/18 by a MCO can we submit authorizations through them?

A: Yes, during the continuity of care period, the MCOs will maintain the member's current providers.

Q76: Some MCOs are stating that their network is closed and they are not accepting new providers such as Virginia Premier. So if we have consumers that seek services from us but we CAN'T get enrolled, are we required to discharge these consumers after the initial 90 days?

A: During the continuity of care period, please reach out to the member's care coordinator. The MCOs may choose to work out single case agreements in these circumstances.

Q77: The 90 days start 1/1/18?

A: Yes

Q78: To clarify, if we are still in the credentialing process with an MCO after 1/1, will we not be able to accept new clients covered by that MCO until we are in network?

A: Please contact MCO network teams directly, the network teams can be contacted using the information here ◆Updated MCO Contracting/Credentialing Contacts

Providers would contact the member's care coordinator for assistance and instruction and also to facilitate transfer or discharge from services.

Magellan	UHC	Anthem	Aetna	VaPremier	Optima
800-424-4524	877-843-4366	1-855-323-4687 Press #4	1-855-652-8249 press #1 and ask for CC.	1-877-719-7358 select option for Care Management	757-552-8398 OR Toll Free 866-546-7924

Q79: Service Authorizations submitted to Magellan December 28 and approved by them on Jan 10, should we send the claims for services started after Jan 1 to the client's chosen MCO?

A: Yes.

Q80: Will confirmation of previous authorization still be available for view on Magellan after 1/1/1?

A: Yes. As a BHSA credentialed provider, you will continue to have access to the BHSA portal.

Q81: Does the extension by Magellan on the 12/31/17 end dates apply to MH case management registrations also?

A: Yes.

Credentialing

Q82: Does the provider need to be credentialed with the individual MCOs?

A: Yes, Providers will need to be credentialed with the member's MCO in order to bill for Community Mental Health Services rendered to the CCC Plus member beyond the continuity of care period.

Q83: Is there a link for the credentialing? It's been a struggle getting applications even when asking via emails and phone calls

A: Go to the DMAS website to find an *Updated Contracting/Credentialing Contacts* document. http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx

Individualized Treatment Planning Section

Q84: All of the SRAs indicate that they would like the goals, objectives and interventions typed into the form. The form for an initial SRA must be submitted within a short timeframe in order for the service to be authorized; however, we have anywhere from 3-30 days to have a comprehensive ISP developed once the client is admitted to the service. Therefore, the fully developed plan is not likely to be present at the time an initial SRA is required to be submitted. Previously, we have been able to upload a copy of the SSPI/medical necessity documentation to support the request. Will this be a possibility? If not, is it possible to upload a copy of the initial ISP that is created with the client (as we have been doing with Magellan) rather than having to re-type the goals, objectives and interventions in another document? Additionally, on the Continued Stay SRA, is it possible to submit a copy of the current/updated ISP that outlines the goals, objectives and interventions rather than having to re-type the information

A: Providers can utilize the initial service plan which is required at admission and there needs to be a plan in place to follow and guide the initial provision of care. If you include a copy of the ISP, you need to ensure that it includes all requested information from the authorization form. You also need to ensure that you include a reference on the authorization form to any attached documentation.

Q85: Clarification Question: Does the comprehensive ISP need to be completed at the time of the assessment in order to complete the Initial Authorization?

A: No. The program requirements associated with ISP timelines is not changing.

Q86: On the Initial SRA, slide 32 indicates "Please demonstrate that the individual is benefiting from the service as evidenced by objective progress ... " if this is the INITIAL SRA, the service has not started or is just starting; how are we supposed to show that there is progress being made when the service has not yet started?

A: This can be used to establish a baseline from which progress can be measured for subsequent authorization requests; please note that you will be asked how you will measure progress.

Q87: Do you still need to include the signed ISP moving forward?

A: No, the CCC Plus authorization process does not require sending in the actual signed ISP.

Q88: The TDT authorization, in section IV: Individual Treatment Goals indicates “what specific counseling and behavioral interventions will be provided to address this goal?” for Goal #1 but for Goal #2 and Goal #3 it indicates “what specific counseling (LMHP type) and/or behavioral interventions will be provided to address this goal?” Was this an oversight or error as TDT services can be provided by a QMHP?

A: “Counseling” services as defined in the DMAS CMRHS Provider Manual can only be rendered by the LMHP type.

Q89: We currently have individuals in PSR that have monthly goals. With the way the authorization form is set up to break down into hours per week, should we change our goals to match this? Other suggestions?

A: Providers should clearly state what types of activities are planned and their benefit that is targeted in the weekly program structure on the service authorization form.

Q90: In section IV of the authorization for many services, there are only 3 places for goals/objectives. There are typically many more goals/objectives. Are we to choose the most important ones or are we to just have 3?

A: You can add an addendum if there are additional goals and objectives to include. You will just need to indicate on the authorization form if additional documentation has been attached.

Q91: Do the MCOs want providers to discuss only 3 goals on the continued stay form? We have many more then 3 goals per client. Do you want us to discuss both current goals and goals that were mastered during the last authorization period?

A: You should discuss all the goals. See response to Q89.

MCO Web Portals

Q92: Can you receive notifications via web?

A: Credentialed providers who are registered with the specific MCO’s web portal will have access. Anthem has stated that non-credentialed providers will have access during the continuity of care period.

Q93: Where would we find the portal for SA submission?

A: The Morning Session Power Point Slide deck found on the DMAS website includes plan specific slides which include the contact phone numbers providers can use to reach out to Care Coordinator staff. Click the following link: ◆AM Session - CCC Plus CMHRS Transition Overview

When to use Magellan of Virginia, the BHSA

Q94: So are we no longer having to go through the BHSA for approvals starting in January?

A: CMHRS coverage for Medallion 3.0 members remains covered through Magellan of Virginia (the BHSA) until the implementation of Medallion 4.0. CMHRS for members in GAP will also remain covered through Magellan of Virginia (the BHSA). But for your clients who are enrolled in CCC Plus, CMHRS will be administered by the member’s MCO effective January 1, 2018.

Q1: Will there be any consideration for Magellan BHSA to use the newly approved standard form for Authorizations that will be used for the CCC+ program so that providers are not having to create/use multiple forms based on an individual's insurance coverage?

A: No. DMAS does not require Magellan the BHSA to use the CCC Plus Authorization forms.

Q2: So if we mostly go through the BHSA Magellan of VA is this information not for us?

A: If you have members enrolled in CCC Plus, this is for you. This presentation addresses the processes for your clients that are enrolled in CCC Plus.