**Section 3**

# PROVIDER ASSISTANCE & REFERRALS

| **For access to care and any other member related services, please call:** | |
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| **Provider Relations Needs:** | 1-800-804-5040 |
| **Clinical Authorization and Claims Needs:** | |
| Colorado Health Partnerships(CHP) | 1-800-804-5008 |
| Foothills Behavioral Health Partners (FBHPartners) | 1-866-245-1959 |
| Northeast Behavioral Health Partnership(NBHP) | 1- 888-296-5827 |

**CLINICAL OPERATIONS DEPARTMENT:**

Clinical Care Managers (CCM) are available 24 hours a day, 7 days a week for:

- Pre-authorization for inpatient, ATU, Residential Treatment and any higher level of care
- Utilization review
- Consultation
- Member referrals
- Concurrent reviews and continued authorizations. Providers may also call the Clinical Operations Department to consult with a CCM regarding a Member's treatment needs related to:
    - Medication management referral
    - Psychological testing (prior authorization required)
    - Aftercare (in preparation for program/facility discharge) with an outpatient therapist or structured program.
    - Referral to a different level of care, including discharge
- Authorization of outpatient services when you have been unable to successfully use the TeleConnect or ProviderConnect systems (Authorization must be made within 30 calendar days after initial session.)

**CUSTOMER SERVICE DEPARTMENT:**

Representatives are available from 8:00 a.m. to 5:00 p.m. (**MST**), Monday through Friday. They are responsible for:

- Verification of Medicaid eligibility
- Verification of member eligibility
- Claims inquiries
- Written inquiries
- Benefit explanations
- Prevention, Education, and Outreach referral information
- CCAR Inquiries

**NETWORK CREDENTIALING DEPARTMENT:**
Provider Relations/Credentialing staff are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. The Network Credentialing staff is responsible for:

- Credentialing and re-credentialing
- Network monitoring
- Network management
- Application status
- Updating provider demographic data

**PROVIDERCONNECT OR TELECONNECT**
Outpatient providers are required to use ProviderConnect or the TeleConnect systems to register outpatient therapy. These systems are available twenty-four hours a day. Please follow the instructions below for using the TeleConnect.

**USING TELECONNECT 1-888-556-6211 (TOLL-FREE)**

**PLEASE HAVE READY WHEN YOU CALL:**

1. Provider Number
2. Member Medicaid Number
3. DSM Diagnosis Code
4. Member Date of Birth
5. Number of Sessions
6. Requested/Dates of Service for Claims Questions
7. Access to Care Monitoring: Through the member registration process, ValueOptions may collect information on routine appointment availability. When a provider contacts ValueOptions to authorize care for a member (either telephonically or through ProviderConnect) following the initial intake appointment, please be prepared to respond to the following questions:

- What was the date the member called to request an initial appointment?
- What date did you offer the appointment?
- If the appointment offered was outside of the seven business day timeframe, you will be asked to select a reason.

Call within 30 calendar days of initial appointment to register outpatient care. For authorizations other than outpatient, call the ValueOptions Access to Care Line. *Authorization is not required for medication management services.*

**INSTRUCTIONS FOR LETTER ENTRY FOR TELECONNECT:**
You may enter your alpha character anytime during the message. Please enter the alpha character in the member's ID as follows: An "A" would be entered by pressing the 2 on your touch-tone keypad followed by the pound (#) sign. "B" would be entered by pressing the 2 on your touch-tone keypad twice followed by the pound (#) sign. "C" would be entered by pressing the 2 on your touch-tone keypad three times followed by the pound (#) sign. All alpha characters on each of your touch-tone keypads would be accessed the same except for the letters

"Q" and "Z". To enter the letter "Q", press the number 1 on your touch-tone keypad followed by the pound (#) sign. To enter the letter "Z", press the number 1 on your touch-tone keypad two times followed by the pound (#) sign. Your entry will be verified after you enter the pound sign and you will be given three tries to enter the correct letter before you will error out. Instructions will also be provided on the telephonic menu. If you are familiar with entering information, you may bypass the instructions by simply entering the required information.

**PROVIDERCONNECT**

ProviderConnect provides an online alternative to telephonic services, giving providers a 24/7 available, easy-to-use tool for completing everyday service requests. The system will allow users to access the following features:

- Eligibility Status
- Claims Search (for specific member(s) and view details of claim such as claim status, paid date, check number)
- Electronic Claims Submission (both Batch and Single Claim)
- View and Print Correspondence including Authorizations and Provider Summary Vouchers
- Access Your Provider Practice Profile (lookup demographic information, validate and submit changes online)
- Submit Inquiry to Customer Service (send a question to ValueOptions online and get a response in the manner you choose)
- Benefit Status
- Register Outpatient Care

**PROVIDER AVAILABILITY FOR MEMBER ACCESS TO CARE**

Federal regulations prohibit discrimination against Medicaid covered individuals. Any practice which selectively excludes members from available treatment services/appointments may be in violation of those regulations. A statement by your scheduler or voicemail that you are "not currently accepting Medicaid clients" constitutes discrimination.

All ValueOptions Colorado providers must have appointments available for Medicaid members as specified below, according to State/Federal regulation and the provider contract:

1. **ROUTINE ACCESS:** A routine appointment must be available within seven (7) business days of a member's request. Under the Colorado Medicaid provider contract, providers are required to offer a routine appointment within seven business days. If a provider offers a member a routine appointment within seven business days and the member declines and chooses an appointment outside of seven business days, the access requirement is met. Members must be offered the same hours of availability as all other insurance members.

2. **ROUTINE OUTPATIENT APPOINTMENTS FOLLOWING AN INPATIENT OR RESIDENTIAL DISCHARGE:** A routine appointment must be available within seven (7) business days after discharge from an inpatient psychiatric hospitalization or residential facility.

3. **URGENT ACCESS**: Urgent care (appointments) shall be available within twenty-four (24) hours from the initial identification of need.

   **Urgent Definition:** A request from a member or designated member representative for situations or circumstances for which there is the potential for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR Potential for serious impairment to bodily functions without treatment, OR Potential for serious dysfunction of any bodily organ or part without treatment. The appointment should be scheduled within 24 hours of the initial request.

4. **EMERGENCY:** Emergency services shall be available by phone, including by TTY accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.

   **Emergency Definition:** A member or designated member representative requests mental health services that include conditions, situations or circumstances for which there is the risk for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR for serious impairment to bodily functions without treatment, OR for serious dysfunction of any bodily organ or part without treatment.

A regional CBHC emergency services team should be consulted prior to inpatient hospital admission or higher level of care. These teams provide assessments at most local emergency rooms. Independent network providers typically do not have emergency room privileges. Thus it is impractical to require IPN providers to conduct emergency evaluations in hospital ERs.

5. Inpatient and Residential Treatment post-discharge follow-up appointments: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

6. Providers who serve only Medicaid members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees ~~or comparable to Medicaid fee-for-service~~. Minimum hours of Provider operation shall include Covered Service coverage from 8:00 a.m. to 5:00 p.m. Monday through Friday and emergency coverage 24 hours a day, seven days a week. Providers are encouraged to offer flexible appointment times or after regular business hours appointments to members whenever possible.

7. Extended hours of operation and Covered Service coverage must be provided at least two days per week at clinic treatment sites which should include a combination of additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.

8. Evening and/or weekend support services for members and families should provide access to clinical staff, not just an answering service or referral service staff.

**EXPECTATIONS OF PROVIDERS FOR EMERGENCY ACCESS:**

In order to comply with emergency access standards under the provider's contract, our expectations for IPN providers are:

1. If an independent provider is contacted by a member in crisis, the provider will conduct an assessment to determine whether the member's situation can be handled outside of the emergency room. This assessment should follow the standards as indicated in item 4, Emergency Access, above.

2. If the member goes directly to the ER, or if the provider determines the member in crisis is best assessed in the ER, the provider will be available to the CBHC emergency services team to provide background information, diagnosis and other pertinent details on the member in crisis. This will assist the CBHC emergency services clinician in conducting the member's evaluation, and may result in the most appropriate disposition for the member.

3. Providers are requirement to give contact information to members on their voicemail to include one of the following: the provider's pager, the provider's cell phone number, or how to reach a covering clinician with whom the provider contracts with to provide coverage when the treating provider is not reachable.

4. Quarterly test calls are performed at random by the ValueOptions quality improvement staff to monitor provider compliance with these standards. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider's non-response to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services. Outpatient providers are expected to offer 24-hour personal emergency access to their members or have formal arrangements for emergency coverage by another practitioner. An answering service/machine which refers all callers to an emergency room, community behavioral health center, crisis or other agency is **not acceptable unless the provider has established a formal contract for emergency coverage with**

**the agency**. **In all cases, providers must obtain prior authorization for inpatient care by calling the Access To Care Line 24 hours a day, seven days a week, at 1-800-804-5008**.

Waiting Room Time for Scheduled Member Appointments: A Medicaid Member who arrives on time for their scheduled appointment shall wait no longer than fifteen minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the Member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by reviewing the wait time policy with the Member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

## HOW MEMBERS ACCESS MENTAL HEALTH CARE

A member can access mental health care in four ways:

1. A member, family member, provider, or advocate for the member can call toll-free, seven (7) days a week for emergency or non-emergency situations, clinical assessment, and referral to the most appropriate provider.
2. The member can call or walk into any one of the Colorado Community Behavioral Health Centers (CBHC) or contact a network provider office and receive a face-to-face clinical evaluation and request services.
3. The member can be referred by their primary care physician, social services caseworker, court system or other community agency through the access points described above.
4. The member can go to or be brought to any emergency room. A face-to-face evaluation may be arranged with an area crisis evaluator. The crisis evaluator participates in disposition recommendations.

### REFERRALS TO NETWORK PROVIDERS:

All care must be authorized with the ValueOptions Service Center. Outpatient prior authorization is not required but authorization must be obtained within thirty business days following the initial appointment. All other levels of care must be pre-authorized. If authorization is not obtained for non-emergency treatment, an administrative denial or reduction of claims payment may result.

### OUTPATIENT SERVICES:

The initial authorization will define the number of sessions of psychotherapy allowed by the BHO in which the member maintains eligibility. ~~For individual BHO authorization policies and standards, please refer to the BHO Provider Handbook Addendum.~~ Data is used to monitor utilization and the provider may be requested to provide telephonic or written clinical review upon reauthorization. Psychological testing requires a separate preauthorization. ~~The Medicaid contract limits outpatient services benefit for adults to 35 individual per fiscal year. Sessions provided beyond the 35 session limit may not be covered.~~

**PRIMARY BEHAVIORAL HEALTH PROVIDER:**
The first outpatient network provider seen by the member is established as the Primary Behavioral Health Provider. The Primary Behavioral Health Provider is responsible for identifying any additional behavioral health services required by the member and conferring with the ValueOptions Service Center CCM for referrals for additional services if required. The Primary Behavioral Health Provider is **required** to coordinate all services being provided and to **document** that coordination.

**COORDINATION OF BEHAVIORAL HEALTH AND PRIMARY CARE :**
All members should have a Primary Care Physician. The ValueOptions Service Center can assist members in finding a PCP. Coordination with the PCP is necessary to promote integrated care, particularly related to medication management. Coordination with primary care is the responsibility of the Primary Behavioral Health Provider.

**FACILITIES/PROGRAMS:**
Facilities/programs receive referrals and authorizations from ValueOptions Service Center CCMs. Prior authorization is always required. ValueOptions CCMs are available 24 hours a day, 7 days a week for prior authorization.

**EMERGENCY DEPARTMENTS:**
After initial emergency department triage, authorization for further inpatient evaluation and/or treatment must be obtained from a Service Center CCM. At most hospitals, an independent assessment by a CBHC crisis evaluator will be required to assist in diversion, crisis stabilization, and referral to follow-up.

**ELIGIBILITY VERIFICATION:**
Medicaid eligibility should be confirmed before the first visit. Confirm the member's name, social security number, and Medicaid ID number, by examination of the current Medicaid card or by calling our toll-free number to verify eligibility. We recommend re-verifying eligibility at least once a month as eligibility is subject to change.

**ALTERNATIVE OR ADDITIONAL SERVICES:**
Providers must call to refer a member to another provider for a second opinion, consultation services or a new level of care. At that time, a ValueOptions CCM will review the case.

**AUTHORIZATION AND DENIAL OF SERVICES:**
A letter confirming authorization for all levels of care will be posted on ProviderConnect for providers to view and print. When there is a denial, limitation or termination of requested services or of currently authorized services, the member or legal guardian is also sent a notification letter. The letters contain instructions for filing an appeal. The BHO Office of Member and Family Affairs and the Ombudsman for Medicaid Managed Care are available to help a- member with the appeal process.

**COLLECTION OF CO-PAYMENTS/DEDUCTIBLES:**
Members covered through Medicaid are not subject to co-pays or deductibles. Collection of fees directly from a Medicaid member may result in termination as a participating provider. This includes charges for non-covered services, including missed appointments.