Mental Health Minute

Summer 2016

CPST Prior Authorization Requests

Permedion reviewers do their best to process provider prior authorization requests for CPST as quickly as possible. Often this process is unnecessarily delayed most frequently due to:

1) No documentation of the date the last approved hours/units expired or were used;

2) Lack of documentation to support the medical necessity for the CPST service; and

3) The individual service plan (ISP) is not individualized with goals and interventions specific to the patient receiving the services.

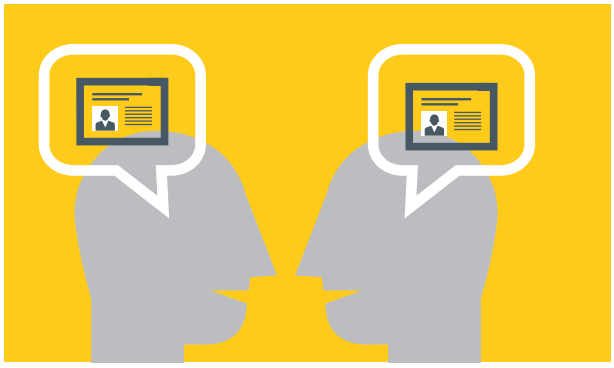
To better assist you in meeting the requirements for prior authorization, Permedion has posted information that would be helpful to the provider in understanding how you can meet the requirements. Additionally, there is a webinar and newsletter available for providers. This information can be found at hmspermedion.com, under the orange tab labeled "Contract Information" and "Ohio Medicaid: Mental Health."

Determination letters are addressed to the contact person documented on the prior authorization form in addition to the provider's billing office contact. If you put your name as the contact person, expect to receive the determination letter.

Please do not call asking for the letter if your name and contact information is not on the form (the billing office contact will automatically receive a copy). Make sure your email address is correct. We get many provider emails returned undeliverable.

Assign a clinical manager to be in charge of the CPST prior authorization requests for your agency. The manager can then review all clinical documentation prior to submission and serve as Permedion's primary contact for your agency.

Requests for peer-to-peer review vs. peer-to-peer conversation



Permedion defines peer-to-peer review and peer-to-peer conversation in compliance with URAC standards and does not offer peer-to-peer reviews. The goal of the peer-to-peer conversation is to allow the treating physician the opportunity to discuss a determination with an Ohio licensed peer-matched physician before the initiation of an appeal and outside the scope of the appeal process.

At the conclusion of the peer-to-peer conversation, no determination will be made and the treating physician will be given information on the appeal process. To schedule a peer-to-peer conversation please call 855.974.5393. Provide the name of the patient, recipient I.D. number, hospital, date of admission, contact person, and phone number.

Admission date

Sometimes inpatient pre-certification requests are entered into MITS with an incorrect admission date. Please remind your staff that the admission date on your pre-certification request should be the date the patient is admitted to the psychiatric unit and not when the patient presents in the emergency room or is placed in an observation bed. Additionally, if the patient is admitted to the psychiatric unit just after midnight, the date of admission needs to reflect the new date. If the admission date on the request is incorrect, chances are your claim will be denied by Medicaid.

Inpatient prior authorization

From time to time, Permedion nurse reviewers have questions regarding an inpatient prior authorization request or need additional clinical information. They will contact the person whose name and phone number is on the MITS prior authorization screen. The nurse reviewers are leaving voicemail messages only to find out days later that the contact person named in MITS only works on certain days or was just filling in for someone else.

A delay in receiving a return call from the contact person delays the prior authorization process and ultimately the prior authorization determination. Providing the name and phone number of a staff person who can assist Permedion's nurse reviewers with your prior authorization request in a timely manner will help to expedite the determination.

Electronic medical records

Permedion continues to review inpatient medical records from hospitals with Medicaid fee-for-service beds. Electronic medical record systems can be a challenge for behavioral health cases. So much of behavioral health documentation relies on the treatment staff's description of the patient and the patient's behaviors.

Unfortunately, checking off boxes in a pre-programmed system doesn't always give a clear indication of the patient's status and condition. It is important for the treatment staff to have the ability to enter narrative notes so that a clear, concise picture of the patient's condition and behaviors is documented. It is not enough to check off "Visual Hallucinations" or "Aggressive" and not provide further explanation and description.

Some key points to remember:

- Provide enough space for the treatment staff to document a narrative note.
- Handwritten narrative notes must be concise and legible.
- When submitting an entire medical record, be sure to copy all sections of the electronic medical record.

Faxes

Occasionally, there may be a need to fax a prior authorization request. This usually happens when there's difficulty with uploading the form to MITS. So that we may better assist you, please let us know in your cover letter the reason you're faxing the request. If you decide to withdraw a request or cancel a fax please call us at 855.974.5393.

Despite faxing the pre-authorization form, the provider still needs to enter the case into MITS. Without a case in MITS, determination letters cannot be sent and Medicaid claims will not know if the case was pre-authorized.