

Residential Rehabilitation Provider Information

Prior Authorization from DSS

General information about obtaining prior authorizations and reauthorizations from DSS can be found in chapter 8 of the Connecticut Medical Assistance Program Provider Manual. It can be found online (and downloaded) at: www.ctmedicalprogram.com. Once to the website, go to Publications > Provider Manuals> View Chapter 8 and then select PNMI Mental Health Group Homes from the drop down menu for Chapter 8. (Note that there are DCF PNMI as well as mental health group homes. Only the sections about Mental Health Group Homes apply to Residential Rehabilitation providers.)

When do I have to request authorization from DSS for residential rehabilitative services for clients?

There are two types of prior authorization given by DSS: one for preadmission authorization (see below) and another for reauthorization. For both types of authorization, the request must be received by DSS **prior** to the dates of service covered in the request.

Preadmission authorization:

Preadmission authorization is required for Mental Health Group Home Rehabilitative Services. To receive reimbursement from DSS, a Mental Health Group Home provider must comply with all prior authorization requirements. DSS has sole discretion to determine what information is necessary to approve a prior authorization request.

What form do we use for preadmission authorization and reauthorization?

The Authorization Request for Professional Services Form, W-626 is required for obtaining both preadmission authorization and for reauthorization from the Department of Social Services.

Where do we get the form?

Mental Health Group Home providers can obtain the Authorization Request for Professional Services Form, W-626 by telephoning the EDS Provider Assistance Center at 1-800-842-8440 (in-state toll free) or 860-832-9259 between the hours of 8:30 a.m.-5:00 p.m., Monday through Friday or by writing to the following address: EDS Provider Assistance Center, P.O. Box 2991 Hartford, CT 06104.

How do we complete the form?

Providers should refer to Page 8-2-7 and subsequent pages for detailed instructions for completing the Authorization Request for Professional Services, W-626. See sample in appendix.

What else do I need to send to DSS with the form to get preadmission authorization for a client?

In addition to the W-626 form, you need to submit a diagnostic assessment and an initial treatment plan from the LMHA which includes an order for the residential rehabilitation level of care.

What does an “order for the level of care” look like?

The Master Treatment Plan (or initial treatment plan from the LMHA) should clearly state that the client *requires* residential rehabilitation. The diagnostic assessment and the master treatment plan should make clear why this client must receive these services in a 24/7 staffed residential environment, rather than in another setting.

Where do we send the form and additional materials?

Mail to:

Utilization Review Unit
Department of Social Services,
25 Sigourney Street, 11th Floor
Hartford, CT 06106-5033.

Keep a copy for your records.

What if someone is being admitted directly from the hospital? How do I get a prior authorization?

When it is known that someone will be discharged from the hospital directly to the Mental Health Group Home, the LMHA should work with the hospital to obtain a diagnostic assessment that clearly indicates that the client needs this level of care, and that outlines the medical necessity for placement in a mental health group home offering Residential Rehabilitation services. This can serve as the initial master treatment plan until the LMHA can develop their own diagnostic materials and treatment plan. When it is possible, the LMHA should work with the hospital so that LMHA staff can assess the client in the hospital (or on the day of discharge) and develop a preliminary master treatment plan that orders Residential Rehabilitation in a mental health group home. (The group home then has 30 days from the client’s admission to develop the residential rehabilitation plan.)

If necessary, the Group Home can use the procedures for obtaining an emergency prior authorization. These are outlined as: *“In an emergency situation where a Mental Health Group Home provider must admit a client and provide residential rehabilitation services without prior authorization, the provider must fax the Authorization Request for Professional Services, W-626 form to DSS on the day of admission.”*

What about reauthorizations? What should I send?

To obtain a reauthorization, you need to send the Form W-626 along with enough clinical information to indicate that the client continues to need and benefit from this level of

care. **The form and supporting documentation must be received prior to the dates of service covered in the request.** In general, you should send:

- ◆ A copy of the most recent Master Treatment Plan, signed by the LMHA, that includes a clear “order” for Residential Rehabilitation in a mental health group home.
- ◆ A copy of any updates to the current Master Treatment Plan.
- ◆ A copy of the current Residential Rehabilitation Plan that builds on the goals outlined in the Master Treatment Plan, and spells out the objectives this client is working on for the next 90 days.
- ◆ Copies of each of the monthly progress notes since the last registration/authorization. The progress notes should specifically outline the client’s progress toward goals and objectives in the residential rehabilitation plan and any progress toward meeting the discharge criteria.

What should the Master Treatment Plan (from the LMHA) include?

- ◆ The Master Treatment Plan (MTP) should clearly indicate the medical necessity for a client receiving care in a 24-hour, residential facility. A summary of the clinical formulation or the current diagnostic functioning can support the order for residential rehabilitation in a mental health group home. Listing a problem of “housing” is not sufficient to justify medical necessity.
- ◆ The Master Treatment Plan should clearly indicate (order) that the person needs Residential Rehabilitation in a mental health group home. This can be as simple as listing the level of care as Residential Rehabilitation in a mental health group home. (The service being purchased from Medicaid is Residential Rehabilitation, so those words should be used in the MTP.)
- ◆ Long range goals for the client that are related to the client’s psychiatric disability, and that can be addressed by rehabilitation services in a mental health group home.
- ◆ At least annually, the LMHA assessment should reflect the client’s progress toward discharge from this level of care.

How do we document that the client meets medical necessity for this level of care?

Medical necessity is documented in several ways:

- ◆ The diagnostic assessment is clear that the client’s psychiatric illness is interfering with his or her life to the extent that they need a residential setting for rehabilitation.
- ◆ The Master Treatment Plan “orders” residential rehabilitation in a mental health group home as the level of care required to assist this client meet the goals and objectives. It is clear from reading this plan that the client could not accomplish those goals in a less intensive setting.
- ◆ The Residential Rehabilitation Plan outlines objectives and interventions based on the Master Treatment Plan.
- ◆ Monthly Progress Notes outline the client’s progress (or lack of progress) toward meeting objectives and toward meeting discharge criteria.

In general, these documents must make the case that this client requires a 24/7, staffed residential setting to achieve rehabilitation goals and objectives at this time.

If a client is admitted during the last week of the month, how do we get all the information available in order to bill for that month?

The first step for the group home is to obtain the Preadmission Authorization (see sections above.) As soon as you receive the number for the Authorization, you will be able to bill for the month in which the client was admitted. (Remember, you have up to one year to submit your claim for services.)

What are some of the more common issues that are requiring DSS to request more information from providers?

- ◆ Master Treatment Plan does not order Residential Rehabilitation in a mental health group home.
- ◆ Master Treatment Plan does not indicate why the client needs to work on the stated goals in a 24-hour, staffed environment, rather than a supervised apartment or other less, intense living situation,
- ◆ The residential rehabilitation plan is not related to the Master Treatment Plan.
- ◆ Monthly Progress Notes are either not included, or do not specifically outline how the client is making progress toward the goals and objectives as a result of the residential rehabilitation services.

Billing and Payment Issues

EDS is the company that processes claims for Medicaid in Connecticut. Providers are encouraged to access the EDS website (www.ctmedicalprogram.com) for answers to many of their questions. The Provider Services tab offers contact information for both EDS and DSS, information about claims cycles and payments, mailing addresses for claims as well as information about provider workshops. The Publications tab allows you to view the policy and procedure manual for group homes and other provider types, billing examples, copies of recent provider bulletins and newsletters, and claims processing information. You can search the bulletins for topics of interest such as remittance advice or claims cycles. The Hot Topics tab offers information about current issues of interest to many providers such as electronic remittance advice, eligibility verification and electronic funds transfer.

What are the dates that EDS processes claims?

EDS sends out a provider bulletin twice a year to all providers indicating the claim cycle dates for the next two calendar quarters. If a provider wants to obtain a duplicate copy of this bulletin, it can access it on the EDS website, www.ctmedicalprogram.com. From that home page, go to Publications, then Provider Bulletins and look for the Title: "Electronic Claims Submission Schedule". The bulletins are sent out (and posted to the website) in December and June of each year.

If our claim clears on a Thursday, when can we expect the electronic deposit and the EOB (Explanation of Benefits)?

EDS sends out a provider bulletin twice a year to all providers indicating the dates checks will be mailed and electronic funds transferred. These can be accessed at the EDS website. Look for the bulletin entitled “Connecticut Medical Assistance Program Remittance Advice, Check and EFT Dates.” The bulletins are sent out (and posted to the website) in December and June of each year.

Generally, the checks and paper remittance advices are mailed the following Monday and Tuesday, funds are transferred electronically Wednesday and providers can download copies of the remittance advice on Wednesday.

What are some of the more common problems that are resulting in claims being rejected?

- ◆ Lack of authorization number or incorrect authorization number. (Inserting the hyphen in the authorization number will result in a rejection.)
- ◆ Start date and end date on the CMS 1500 claims form are different. (They must be the same date within the service month.)
- ◆ Client not Medicaid eligible.

Who to call if:

Issue	CALL	Number
We don't understand the EOB	EDS Provider Assistance Unit	860-832-9259 or 1-800-842-8440
We have questions about how to get a prior auth completed	EDS Provider Assistance Unit	860-832-9259 or 1-800-842-8440
We have questions about how to document spend down	DSS regional office serving the client	

SAMPLE FORM W-626

May 20, 2005 1:47PM MEDICAL ADMINISTRATION No. 6195 P. 2

1 W626
MAIL TOP COPY TO:
DSS
25 SIGOURNEY STREET
HARTFORD, CT 06106-2055

CONN. XIX
PROFESSIONAL SERVICES
PRIORITY AUTHORIZATION

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
AUTHORIZATION REQUEST FOR PROFESSIONAL SERVICES
This is not a Bill.
Instructions on back of form.

S-
SHADED AREAS ARE
FOR DSS USE ONLY

1. MEDICAID CASE NUMBER: 001 000 012
2. PROVIDER NUMBER: 004 088 877
3. NAME OF PROVIDER: GREGG HOME CT
4. DATE OF REQUEST OR VERBAL APPROVAL: 05/10/05
5. RECIPIENT NAME (LAST NAME FIRST): CLIENT, MARY I.
6. PROVIDER STREET ADDRESS: 29 MAIN ST
7. PROVIDER CITY OR TOWN: HARTFORD, CT
8. PROVIDER SIGNATURE: John Hancock
9. DATE OF SIGNATURE: 5/10/05
10. DATE OF BIRTH: 10/20/49
11. SEX: F
12. RECIPIENT ADDRESS/NAME OF FACILITY OR INSTITUTION: GREGG HOME CT
13. I: L
14. DESCRIPTION OF SERVICE: HH GREGG HOME SERVICES 6
15A. TOS: 2014Y
15B. PROCEDURE CODE / NDC: 06104
16. START CODE: 06/01/05
17. START DATE: 06/01/05
18. STOP DATE: 11/30/05
19. MO / DY / YR: 11/30/05
20. UNITS: 6
21. CHARGES: 6
22. TPA CHARGES: 6
23. TOWN NO. 14: 510/05
24. DENIAL REASON CODES: 510/05

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	

25. DIAGNOSIS (NEED FOR SERVICE, PROGNOSIS, ETC.): 295.30
See ATTACHED DOCUMENTATION

27. PROGNOSIS IF SERVICE IS CONTINUED

28. SPECTACLE R: OLD R Right Eye Add: NEW R Right Eye Add: 6 MONTHS

29. LENGTH OF NEED (QUARTERS, MONTHS, PURCHASES): 6 MONTHS

30. NAME OF PRESCRIBING PHYSICIAN: O. J. KESOSI

31. PHYSICIAN STREET ADDRESS: STATE: ZIP CODE:

32. PHYSICIAN CITY OR TOWN: STATE: ZIP CODE:

33. Physician Signature: _____

34. Date of Signature: _____

35. AUTHORIZING PERSON: _____

36. DATE OF AUTHORIZATION: _____

37. RECEIVED BY: _____

THIS AUTHORIZATION IS FOR MEDICAL NEED AND APPROPRIATENESS OF CHARGES SUBJECT TO ESTABLISHMENT OF PATIENT AND PROVIDER ELIGIBILITY FOR CONNECTICUT MEDICAID SIGNATURES OF PHYSICIAN AND/OR PROVIDER CERTIFY THAT THE SERVICE SHOWN ON THE FORM IS NECESSARY FOR THE HEALTH OF THE RECIPIENT.

TOP COPY -- DSS
BOTTOM COPY -- PROVIDER