Acentra HEALTH

Assertive Community Treatment

Service Implementation

Provider Education 2023

Agenda

- Introduction
- Assertive Community Treatment
  - Overview
  - Criteria
- Requesting Prior Authorization
  - Tips
  - Submitting a request
  - Authorization Types
  - Timelines
  - Process
- Pended Reviews
- Denials & Reconsideration
- Appeals
- ANG Provider Portal
- Resources
- Questions and Answers

Introduction

- Acentra Health (formerly Kepro and CNSI) is the Utilization Management/Quality Improvement Organization (UMQIO) for the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Fee For Service Medicaid program. We have been providing services for SCDHHS since 2012.
- We are a team of experienced leaders, caring clinicians, pioneering technologists, and industry professionals who come together to redefine expectations for the industry.
- We provide:
  - Medical necessity reviews for multiple services
  - Level of Care reviews
  - Post-Payment reviews

CMS-Certified Solutions

CMMI Level 4 Appraisal

URAC Accredited

HITRUST Certified

Assertive Community Treatment (ACT)

- ACT (H0040) is an intensive non-residential treatment and rehabilitative mental health service for adult members (age 18+) with a severe mental illness who require a higher level of community support.
- Goals are to
  - ↑ increase community living skills
  - ↓ decrease psychiatric hospitalizations
  - ↓ decrease criminal justice involvement

[Rehabilitative Behavioral Health Provider Manual]

ACT

ACT services will require prior authorization and will be covered for members who have a severe and persistent mental illness

The covered treatment must be medically necessary for meeting specific preventative, diagnostic, therapeutic and rehabilitative needs

ACT Eligibility

Diagnosis

- Primary diagnosis must reflect a serious and persistent mental illness as defined by the most current edition of the Diagnostic and Statistical Manual (DSM).
  - Schizophrenia
  - other psychotic disorder (ex. schizoaffective disorder)
  - Bipolar disorder
- Other psychiatric illnesses may be eligible depending on the level of long-term disability. Documentation of needed service must be provided. Supporting documentation may include, but is not limited to:
  - Psychiatric evaluations and updates
  - Biopsychosocial assessments and updates
  - Inpatient hospital assessment and discharge summaries
  - Referral and transfer documentation from lower levels of care (LOC)

- Members with any of the following as a **primary** diagnosis are **not** eligible for ACT
  - Substance use disorder
  - Intellectual developmental disorder
  - Borderline personality disorder
  - Traumatic brain injury

ACT Criteria for admission reviews

Members must have significant impairment as demonstrated by **at least one** of the following:

- Significant difficulty maintaining a safe living situation
  - e.g., repeated evictions, loss of housing or utilities
- Significant difficulty consistently performing routine tasks required for basic adult functioning in the community or persistent or recurrent difficulty performing daily living tasks without significant support from others
  - e.g., personal business affairs, obtaining appropriate medical, legal or housing services, nutritional needs, personal hygiene
- Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty carrying out head-of-household responsibilities
  - e.g., meal prep, budgeting, childcare tasks, etc.

Admission Review continued

In addition, the member must have **one or more** of the following challenges, which are indicators of continuous high service needs:

1. High use of acute psychiatric hospitalization (2 or more admissions in the past 12 months) or psychiatric emergency services
2. Intractable severe psychiatric symptoms (e.g., affective, psychotic, suicidal, etc.)
3. Coexisting mental health and substance use disorders of significant duration (more than 6 months)
4. High risk or recent history of criminal justice involvement (e.g., detention, incarceration, probation, frequent contacts with law enforcement)
5. Significant difficulty meeting basic survival needs: residing in substandard housing, homelessness or imminent risk of homelessness
6. Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive service are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively using traditional office-based outpatient services

ACT Criteria for Continued Stay reviews

The desired outcome or level of functioning hasn't been restored, improved, or sustained over the time frame outlined in the treatment plan

OR

Member continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains

Continued Stay review continued

One of the following must apply:

- Member has achieved current treatment plan goals and additional goals are indicated (as evidenced by symptoms)
- Member is making satisfactory progress toward goals, and there is documentation that supports continuing ACT will be effective in addressing the goals outlined in treatment plan
- Member is making moderate progress, but the specific interventions need to modified so that greater gains are possible (consistent with the member's pre-morbid or potential level of functioning)
- Member fails to make progress or demonstrates regression in meeting goals (reassess diagnosis to identify any unrecognized co-occurring disorders and revise treatment recommendations based on findings)
- Member is functioning effectively, and discharge would otherwise be indicated; however, it is likely regression would occur if services are withdrawn based on 1) documented history of regression or 2) Epidemiological sound expectation that symptoms will persist, and ongoing treatment is needed to sustain functional gains.

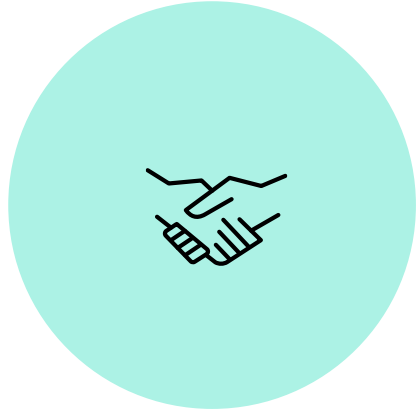
ACENTRA HEALTH

Requesting Prior Authorization

Tips for Submission

- Providers are responsible for checking member eligibility and benefit plan information **prior** to rendering services
- Please contact the appropriate Managed Care Organization for members enrolled in managed care

- Gather all pertinent clinical information, forms and the individualized plan of care to submit with the request



- Submit authorization requests to Acentra Health for all eligible Fee For Service members

Submitting a Request for Authorization

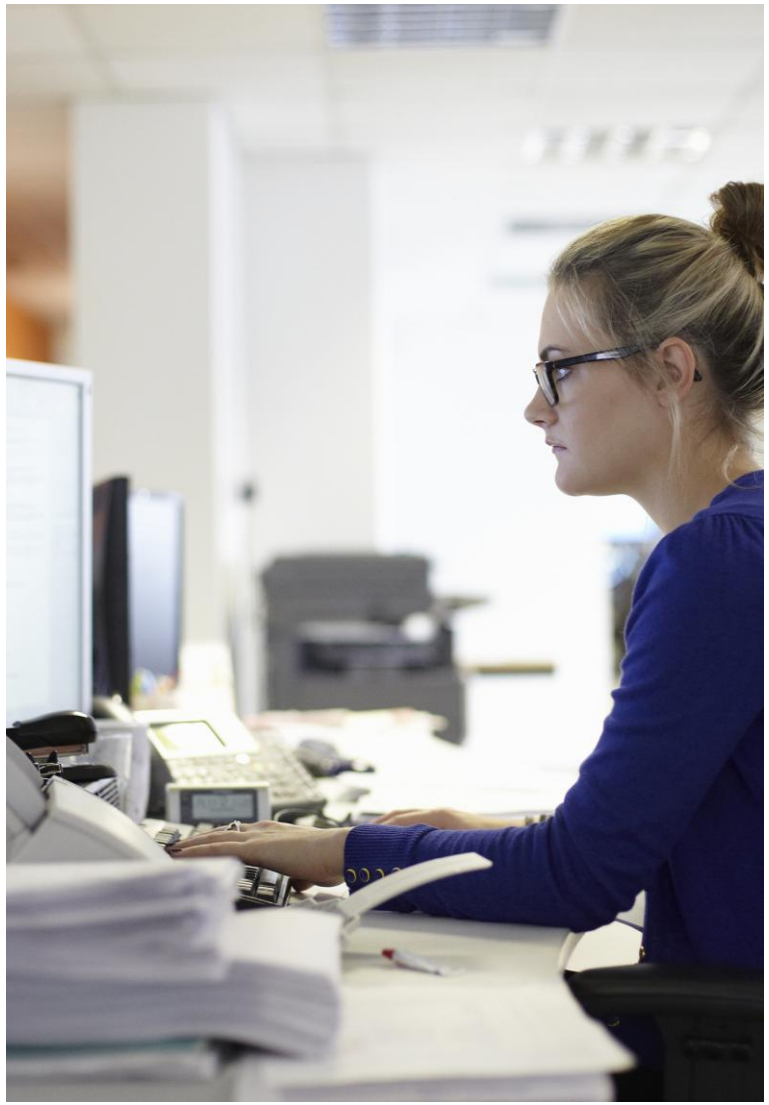
Customer Service

- Call 1-855-326-5219
- Least preferred method
- Case will be pended for additional information while we await receipt of required clinical information
- We can not begin reviewing the case until clinical information has been received.

Fax

- Providers may use the Prior Authorization Request form
  - fax to 1-855-300-0082
- Prior Authorization request forms can be found at https://scdhhs.kepro.com/content/forms
  - Be sure to use the correct form for ACT services
- Must submit with required clinical information or case will be pended for additional information

ANG – Acentra Health's Provider Portal



- Providers are highly encouraged to use the provider portal to submit requests
- Efficient, easy access to enter and verify authorizations
- Communicate with Acentra Health staff through secure messaging regarding authorizations when appropriate
- View and print outcome letters with ease
- Reduces the "did you receive my fax" burden
- Portal.Kepro.com to register for access

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the service begins

❑ Retrospective Authorization “Retro”

Needed when services were performed before the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- Medicaid ACT Criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

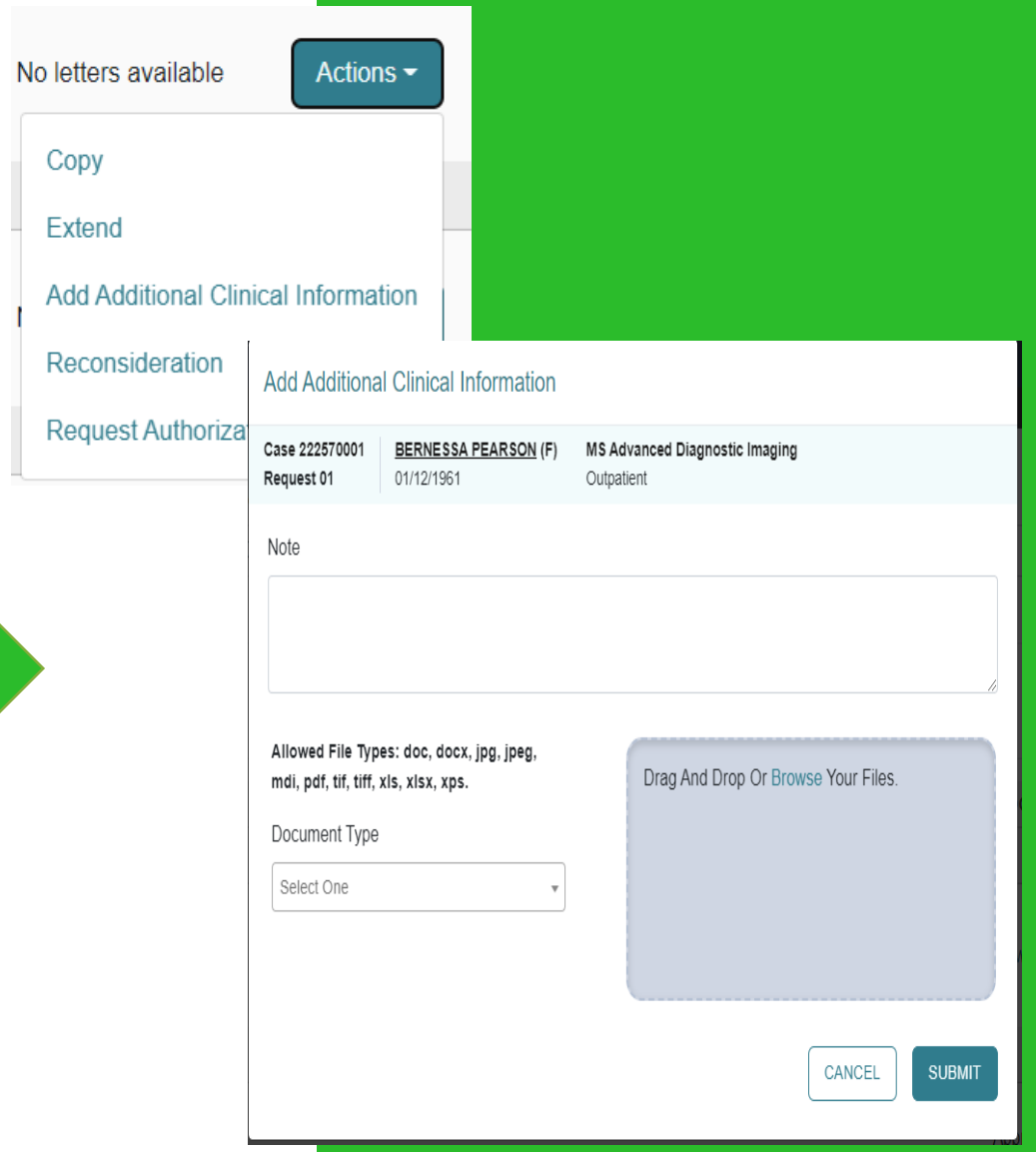
- The medical director, or another qualified physician reviewer will review the case against Medicaid criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax or web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pend, the case will move to the physician reviewer for a determination.
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information.

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section.



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, insufficient information
- Provider may submit a new case for the service if an administrative denial is received.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted
  - Fax
  - Web portal *preferred
- A clinical reviewer will review any additional information submitted. If unable to meet InterQual® or State approved criteria, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS.

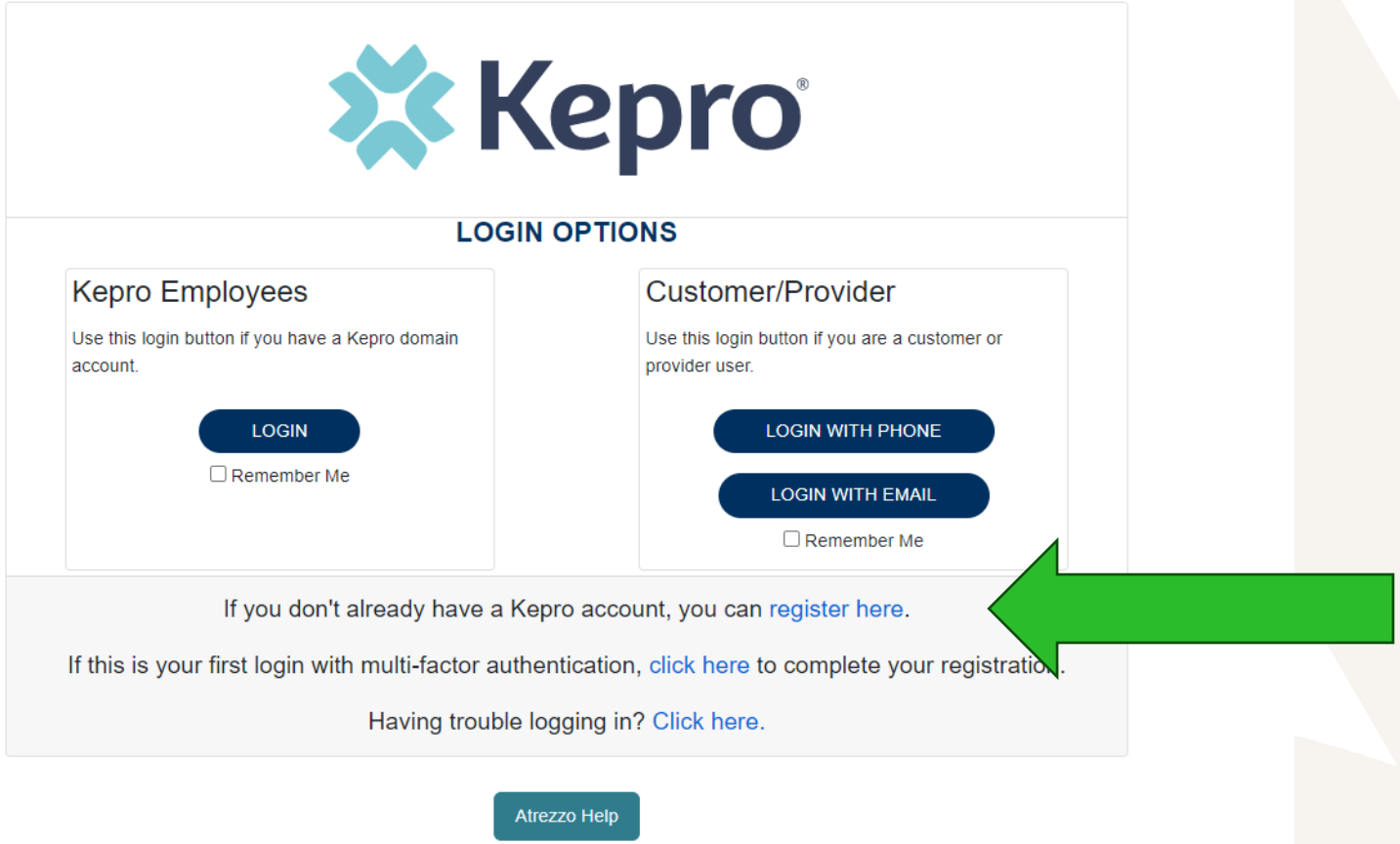
Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing
- Members may request an appeal within 30 days
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

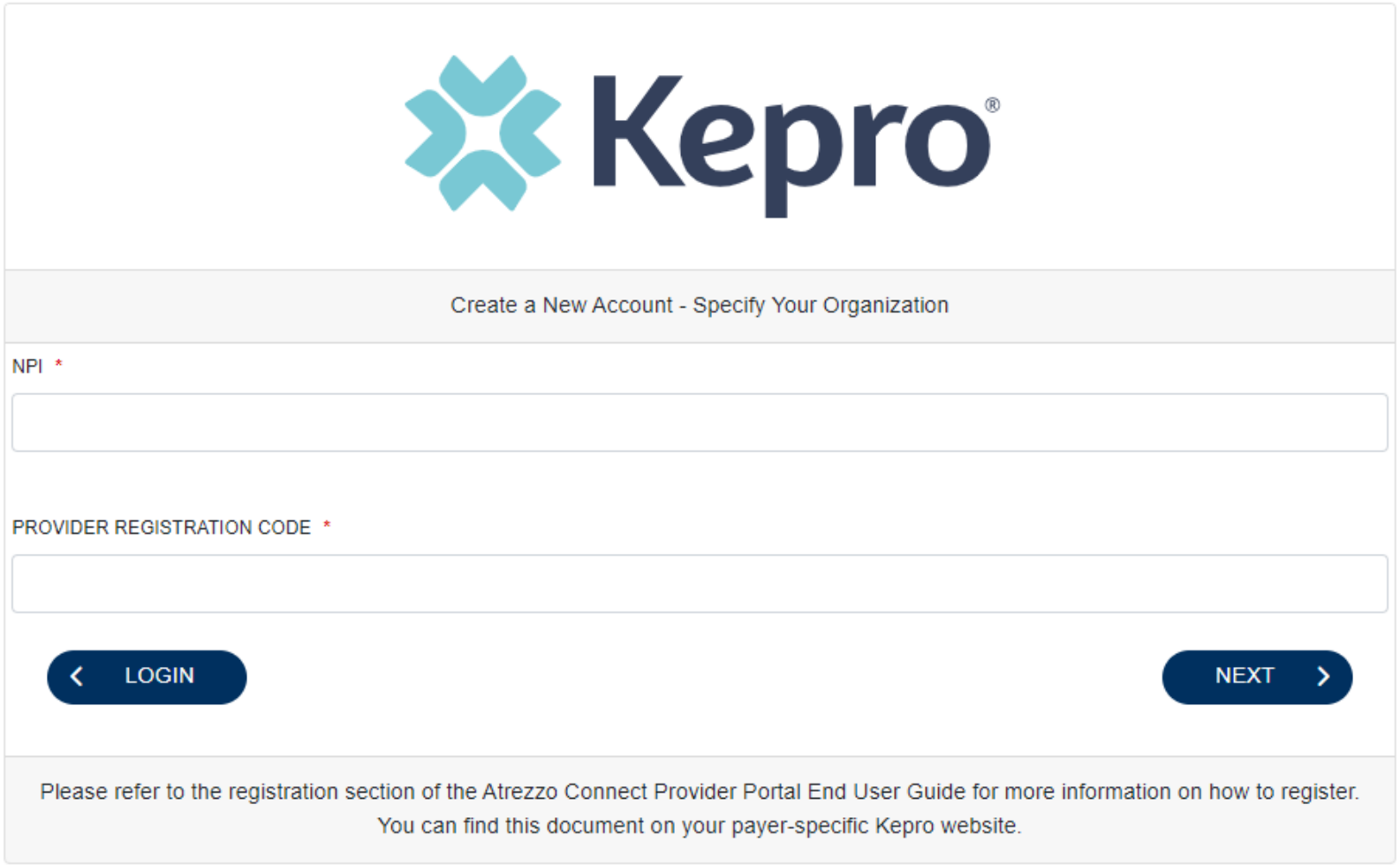
    PO BOX 8206

    Columbia, SC 29202

ANG – Registering for the Portal

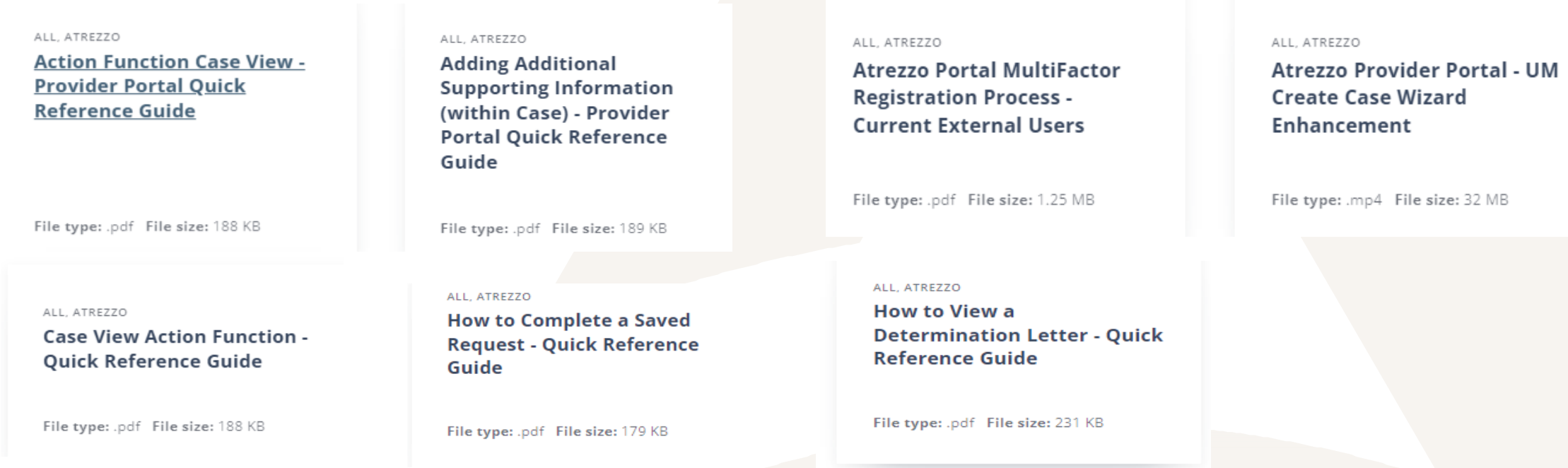


ANG Registration



ANG Training Videos

Kepro training page (https://scdhhs.Kepro.com)



** if your provider group would like individualized group training on how to submit prior authorization reviews on the secure web portal, please email wendy.fields@acentra.com

Resources and Education

- Rehabilitative Behavioral Health Services (RBHS) Manual | SCDHHS
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@kepro.com generic questions please, do not include PHI

Questions & Answers