Acentra HEALTH

Targeted Case Management Prior Authorization Implementation

Provider Education 2024

Partners in Healthcare – Who are we?

- 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

Medicaid Targeted Case Management (MTCM)

MTCM services are those functions and activities of care coordination which assist eligible members with access to needed medical, social, psychosocial, education, financial and other services for health-related needs. It is required to support the member's maximum, independent functioning in the community. It must be individualized, person-centered, strengths-based, and outcome-focused and provide for the direct benefit of the member. It is a shared partnership between the member and the Case Manager in all phases of the process.

Eligible Populations

- Individuals with Intellectual and Related Disabilities
- At-Risk Children
- Individuals with Serious and Persistent Mental Illness
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- At-risk pregnant Women and Infants
- Individuals with Psychoactive Substance Disorders
- Individuals at risk for Genetic Disorders
- Individuals with Sensory Impairment
- Adults with Functional Impairments

Prior Authorization Requirement as of 7/1/2024

- Effective 7/1/2024, prior authorization is required for MTCM services delivered by private providers
- T1016 and T1017
- State providers do not require prior authorization for services rendered
- Acentra Health will provide the prior authorization services for Fee For Service Medicaid Members

Prior Authorization Requests

*required forms may be found at scdhhs.gov or scdhhs.acentra.com

Authorization requests may be submitted:

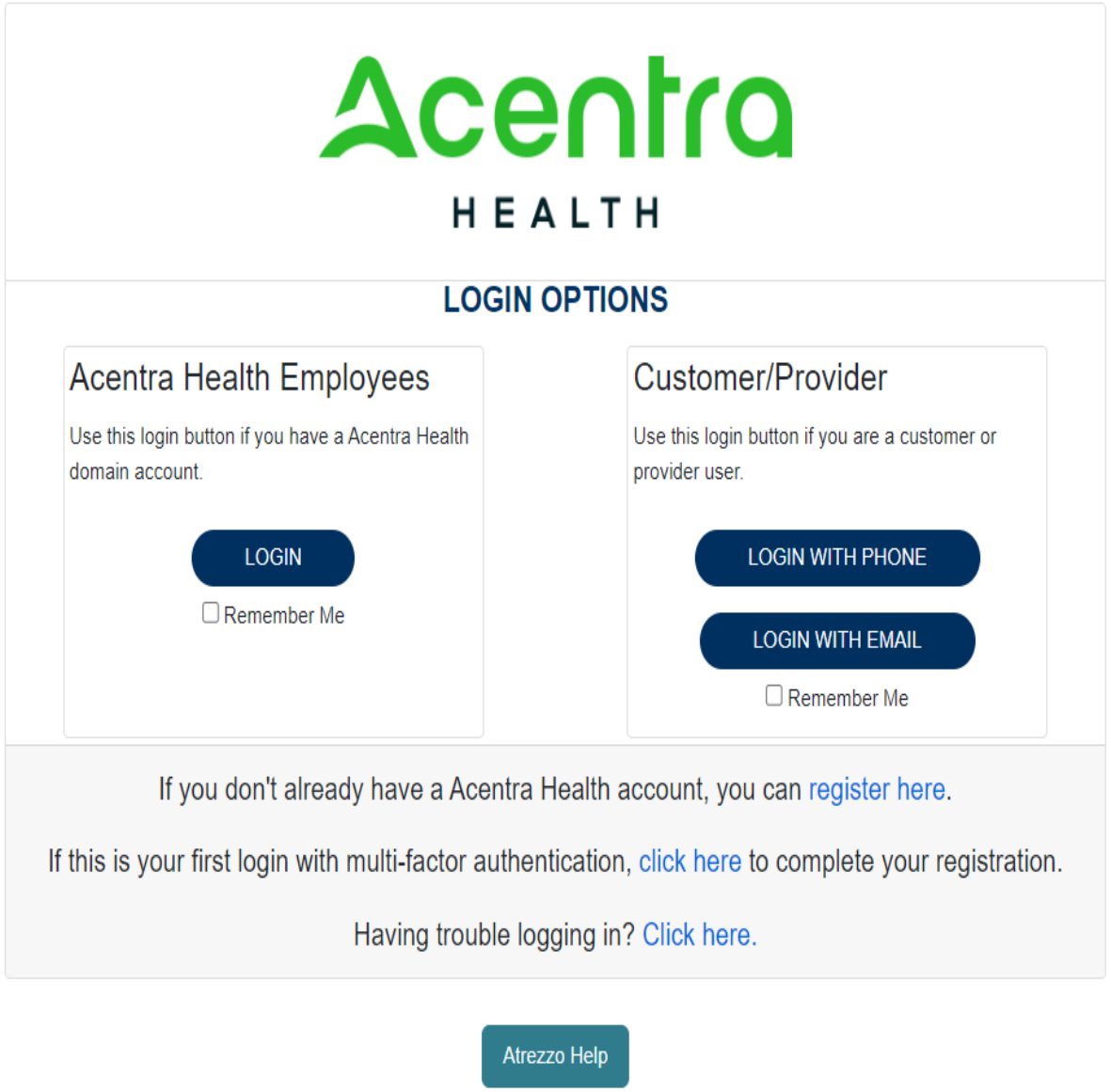
1. online at https://portal.kepro.com **or**
2. by faxing the MTCM Authorization form and all documentation to 1-855-300-0082

**authorizations submitted online still require all required documentation to be uploaded

Prior Authorization Request using Web Portal

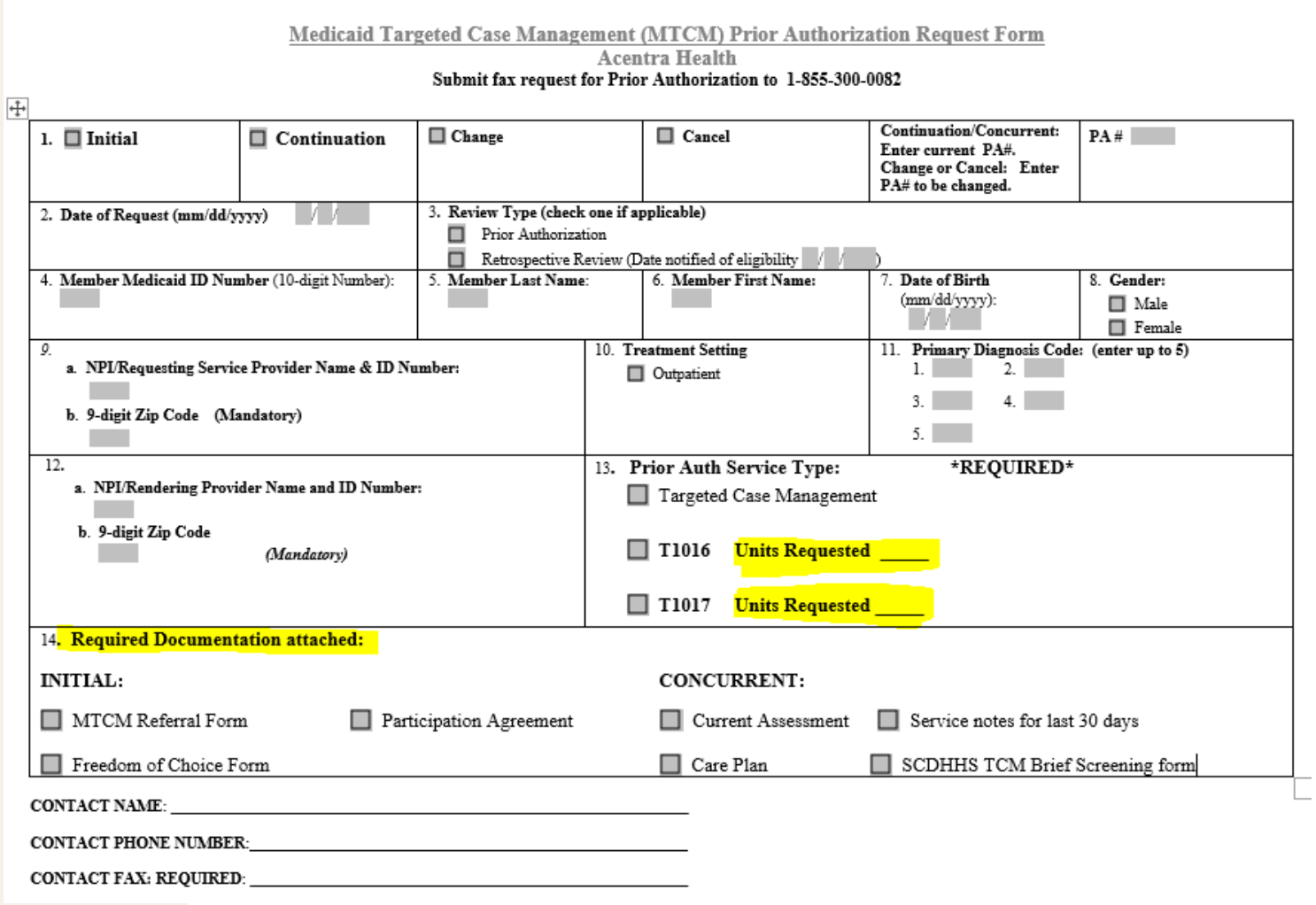
- Atrezzo Next Generation (ANG) is the Acentra Health Web portal
- Providers must complete a one-time registration for access to the portal to submit authorization requests
- SCDHHS.Acentra.Com houses several short, informative videos on how to use ANG
  - Provider Portal Registration Overview
  - Provider Portal UM Create A Case Wizard
  - Provider Portal Utilization Management

*Providers may call 855 326 5219 at any time for assistance with the web portal registration, log in or general questions.



Prior Authorization Request using FAX

- Providers must complete the Acentra Health MTCM Prior Authorization request form
- Required documentation must accompany the request form
- Providers are responsible for determining and requesting the appropriate number of units for the requested period
  - MTCM is billed in 15 -minute unit increments; 1 unit = 15 minutes
  - Request the number of units you feel is medically necessary to service your member for 160 days



Medicaid Targeted Case Management (MTCM) Prior Authorization Request Form
Acentra Health
Submit fax request for Prior Authorization to 1-855-300-0082

1. ☐ Initial	☐ Continuation	☐ Change	☐ Cancel	Continuation/Concurrent: Enter current PA#. Change or Cancel: Enter PA# to be changed.	PA #
2. Date of Request (mm/dd/yyyy)		3. Review Type (check one if applicable) ☐ Prior Authorization ☐ Retrospective Review (Date notified of eligibility)			
4. Member Medicaid ID Number (10-digit Number):		5. Member Last Name:	6. Member First Name:	7. Date of Birth (mm/dd/yyyy):	8. Gender: ☐ Male ☐ Female
9. a. NPI/Requesting Service Provider Name & ID Number: b. 9-digit Zip Code (Mandatory)		10. Treatment Setting ☐ Outpatient		11. Primary Diagnosis Code: (enter up to 5) 1. 2. 3. 4. 5.	
12. a. NPI/Rendering Provider Name and ID Number: b. 9-digit Zip Code (Mandatory)		13. Prior Auth Service Type: *REQUIRED* ☐ Targeted Case Management ☐ T1016 Units Requested ____ ☐ T1017 Units Requested ____			

14. **Required Documentation attached:**

INITIAL:		CONCURRENT:	
☐ MTCM Referral Form	☐ Participation Agreement	☐ Current Assessment	☐ Service notes for last 30 days
☐ Freedom of Choice Form		☐ Care Plan	☐ SCDHHS TCM Brief Screening form

CONTACT NAME: _____

CONTACT PHONE NUMBER: _____

CONTACT FAX: REQUIRED: _____

Prior Authorization Requests – new members

- **Initial** authorization requests for <u>newly-referred</u> members must include the following:
  - **Acentra Health MTCM Prior Authorization form (**if requesting via fax)
  - **SCDHHS MTCM Referral Form**
  - **SCDHHS TCM Brief Screening Form**
  - **Freedom of Choice form**, signed
  - **Agreement to Participate form** OR, if the member is under the age of 16, **Parent/Caregiver/Guardian Agreement to Participate form**

****Members may not be engaged in Multisystemic Therapy (MST), Homebuilders, or Assertive Community Treatment and MCTM at the same time**

**Failure to submit required forms will result in administrative denial.

Prior Authorization Requests – new members

- Upon approval, Acentra Health will authorize the number of MTCM units necessary to complete the assessment and care plan within the 45-day period as defined by policy.
  - 24-40 Units for 45 days from date requested
- After completing the Case Management Assessment and Care Plan, the provider may then request prior authorization for additional services/units
  - A copy of the **Case Management Assessment and Care Plan** are required when requesting this continuation of services

**Failure to submit required forms will result in administrative denial.

Prior Authorization Requests – existing members

For members receiving MTCM services prior to 7/1/24 who continue to require case management

- 5 to 10 days before reaching the 180-day mark for the required updates to the assessment and care plan, provider must submit a Prior Authorization Request to Acentra Health
  - Must include the current **Case Management Assessment**
  - Most recent **Care Plan**
  - Most recent **progress summary** for the Care Plan
  - All **service notes** from the previous 30 days
  - Any additional information substantiating medical necessity (recent hospital discharges or psychological reports)
- A complete reassessment and new care plan are required annually by day 365 if services are still necessary.

**Failure to submit required forms may result in administrative denial.

Recap- Required Documentation

Initial New Member

Required Documents

- SCDHHS MTCM Referral Form
- SCDHHS TCM Brief Screening form
- Freedom of Choice Form
- Agreement to Participate

New Member 1st continued

Required Documents

- Completed Case Management Assessment
- Care Plan

Ongoing treatment every 160 days

Required Documents

- Case management assessment – less than 180 days old
- Care plan with any updates
- Progress Summary
- All MTCM service notes for previous 30 days

Reassessments and new Care Plans are required every 365 days from initial service.

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.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

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

- InterQual® or State defined 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

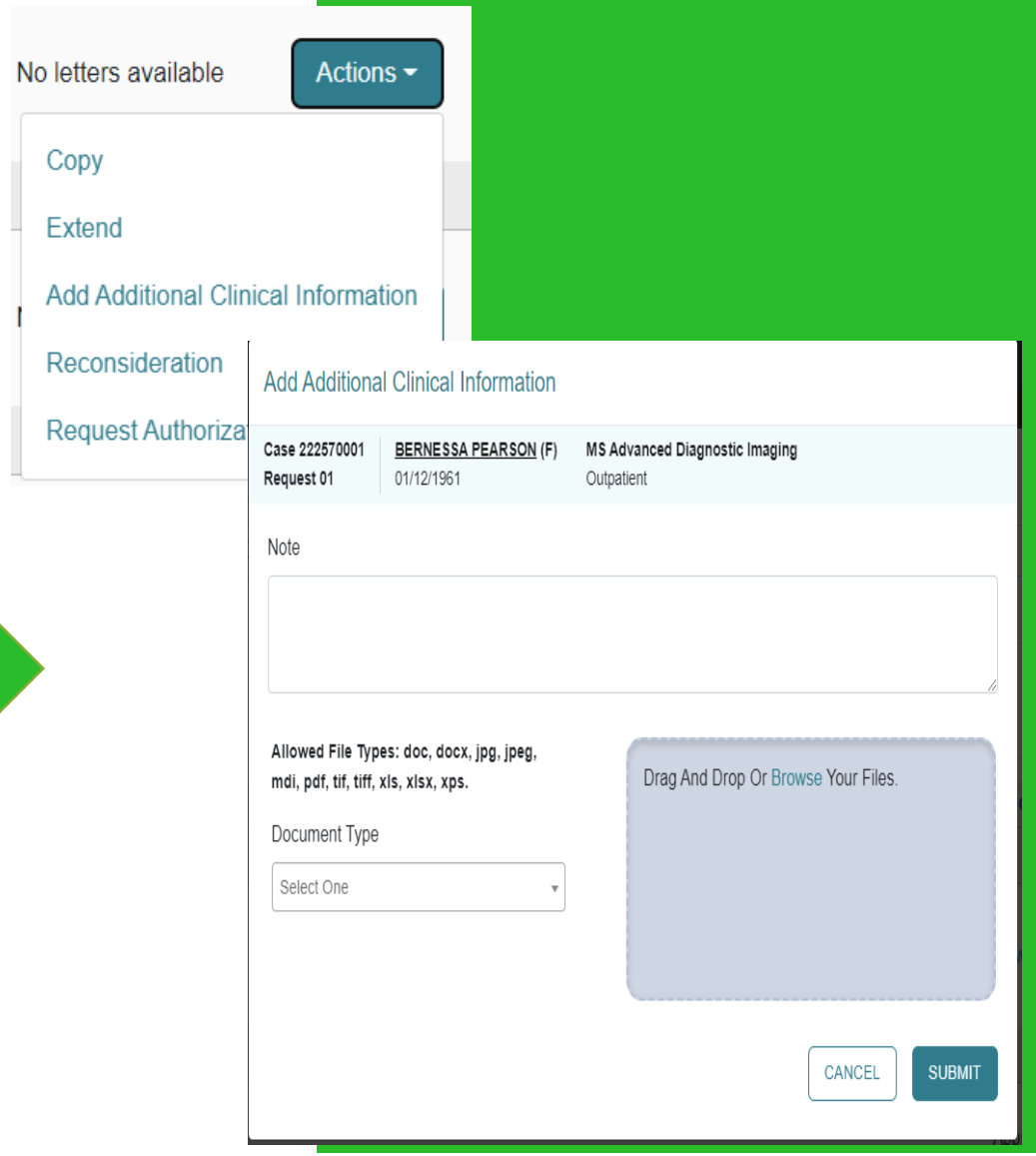
- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider NPI 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 is missing required documentation as outlined in policy, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pended, 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.

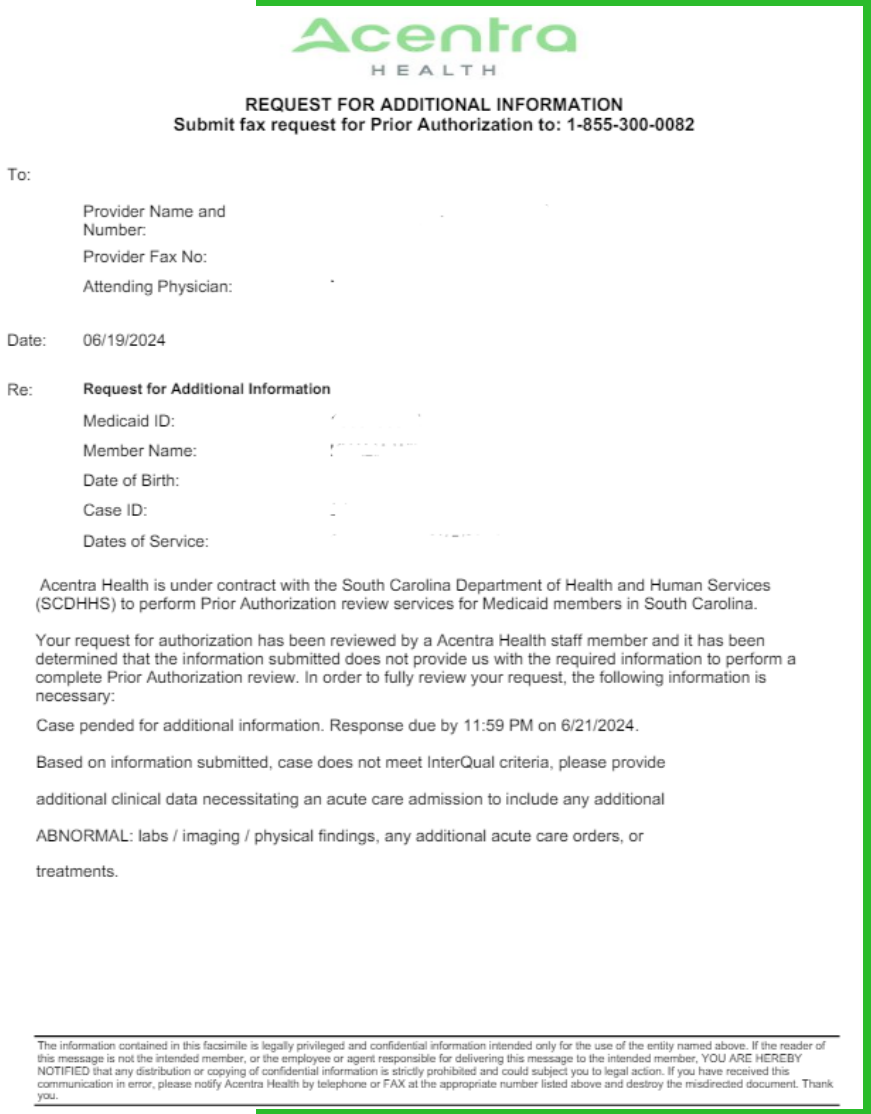
Responding to Pended Reviews

- 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.



Responding to Pended Reviews

- If you submitted the request via fax:
  - Attach requested documentation to the Pend Letter sent to you from Acentra Health
  - Fax letter and documentation to 1-855-300-0082 within 2 business days of the letter



Acentra HEALTH

REQUEST FOR ADDITIONAL INFORMATION
Submit fax request for Prior Authorization to: 1-855-300-0082

To:

Provider Name and Number:
Provider Fax No:
Attending Physician:

Date: 06/19/2024

Re: **Request for Additional Information**

Medicaid ID:
Member Name:
Date of Birth:
Case ID:
Dates of Service:

Acentra Health is under contract with the South Carolina Department of Health and Human Services (SCDHHS) to perform Prior Authorization review services for Medicaid members in South Carolina.

Your request for authorization has been reviewed by a Acentra Health staff member and it has been determined that the information submitted does not provide us with the required information to perform a complete Prior Authorization review. In order to fully review your request, the following information is necessary:

Case pended for additional information. Response due by 11:59 PM on 6/21/2024.

Based on information submitted, case does not meet InterQual criteria, please provide additional clinical data necessitating an acute care admission to include any additional ABNORMAL: labs / imaging / physical findings, any additional acute care orders, or treatments.

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. This does not apply to those cases that were denied for untimely submission.

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
  - Via phone (will still require additional information to be faxed)
  - Fax
  - Web portal *preferred
- A clinical reviewer will review any additional information submitted. If unable to meet State approved criteria or policy, 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 calendar days from the reconsideration determination notice:
  - 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

Resources and Education

- Medicaid Targeted Case Management Services Manual
- 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