Acentra HEALTH

Peer Support Prior Authorization Implementation

Provider Education 2024

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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

Rehabilitative Behavioral Health Services (RBHS)

- Per SCDHHS policy, Rehabilitative Behavioral Health Services are available to all Medicaid beneficiaries diagnosed with mental health disorders and/or Substance Use Disorders
- Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. Information used to determine medical necessity should be:
  - Based on information provided by the beneficiary, the beneficiary's family, and/or collaterals who are familiar with the beneficiary.
  - Based on current clinical information (If diagnosis has not been reviewed in 12 or more months, the diagnosis should be confirmed immediately.
  - Made by a Licensed Practitioner of the Healing Arts (LPHA) enrolled in SC Medicaid.

Please refer to the SCDHHS Rehabilitative Behavioral Health Provider Manual for in depth details

Peer Support Services (PSS)

The purpose of this face-to-face service is to assist a beneficiary's recovery from mental health and/or substance abuse disorders by sharing similar experiences and recoveries.

Peer Support:

- Is Person-centered, empowering the beneficiary to make healthy decisions
- Allows members the opportunity to direct their own recovery process
- Promotes skills for coping and managing symptoms
- Utilizes the preservation and enhancement of community living skills

Peer Support Services (PSS) H0038

****effective 7/1/2024****

Peer support services (H0038) will require prior authorization for private providers of RBHS for continued treatment AFTER the allowed 216 units are exhausted. Units are provided on a Fiscal Year and start over every July 1. Maximum of 12 units per day.

Prior Authorization Requests

Authorization requests should always be submitted prior to services being rendered, when the member is near the end of the 216-unit allotment.

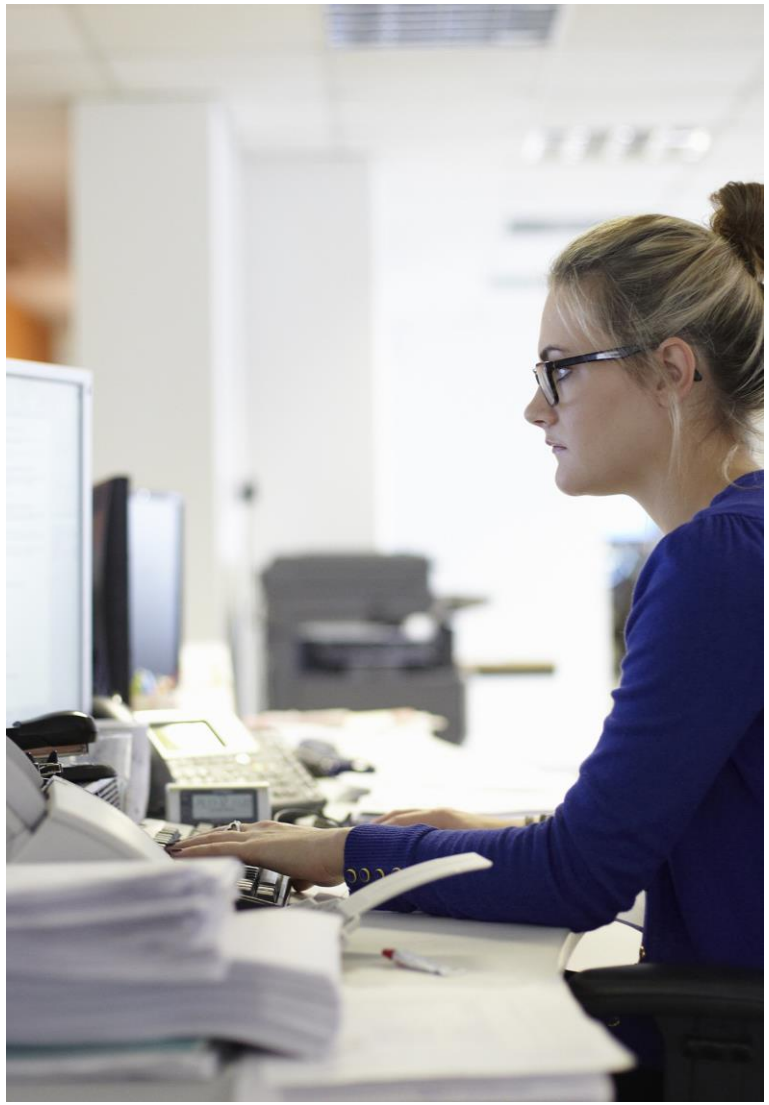
Providers are responsible for maintaining record of unit usage.

If a claim is denied for no PA, you may submit a request to Acentra Health with a copy of the Medicaid denial.

Authorization requests may be submitted online at https://portal.kepro.com or by fax using the SC Outpatient Prior Authorization Request form.

For assistance with the Atrezzo portal please call 1-855-326-5219

Submitting a Request for Authorization



- **Providers are highly encouraged to use Atrezzo, the provider web portal to submit requests. Available 24/7 365 days a year.**
- Efficient, easy access to enter and verify authorizations
- View and print letters with ease
- Reduces the “did you receive my fax” burden
- Portal.Kepro.com to register for access
- Guides on using Atrezzo found online at scdhhs.acentra.com
- Web portal training can be scheduled at provider’s request

Outpatient Prior Authorization Request Form
Acentra Health, SCDHHS QIO

Acentra Health, SCDHHS QIO now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for Prior Authorization to: 1-855-300-0082

1. ☐ **Initial**	☐ **Recertification**	☐ **Change**	☐ **Cancel**	**Recert: Enter previous PA#. Change or Cancel: Enter PA# to be changed or canceled.**	**PA #**
2. **Date of Request (mm/dd/yyyy)**		3. **Review Type (check one if applicable)** ☐ Prior Authorization ☐ Retrospective Prepayment 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 ☐ Provider's Office	11. **Primary Diagnosis Code/ Description: (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:** ☐ Mental Health Counseling ☐ Therapies (PT, OT, SP) ☐ DME ☐ Home Health ☐ Hospice ☐ Autism Spectrum Disorder			

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SC QIO OP Fax Form
Revised: 04/2024
Approved: 04/2024

Authorization Types

❑ Prior Authorization

Should always be submitted prior to the service being rendered.

- when 216 units have been exhausted.

❑ 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.

Providers must identify the Request Type when submitting a request to Acentra Health.

Documenting Medical Necessity – Admission Criteria

Admission Criteria

- Beneficiary has been diagnosed with a SPMI, and/or a SUD.
- Beneficiary meets two or more of the following criteria as a result of the mental illness:
  - Has had significant difficulty independently and consistently accessing behavioral health services (e.g., relies on emergency department services, has had two or more inpatient admissions over the last year),
  - Is being released from incarceration, or being discharged from a hospital or facility-based program,
  - Has had severe functional impairment that interferes with activities of daily living, including hygiene, nutrition, finances, home maintenance, child care, or difficulties with other community service needs, such as housing, transportation or legal issues,
  - Has experienced significant challenges meeting educational or employment goals,
  - Lives in unsafe or temporary housing,
  - Does not have sufficient family or other social support, or the supports that are in place are insufficient to help ameliorate or manage his or her condition.
- Beneficiary is assessed to be at low risk of serious harm to self or others.
- Beneficiary has demonstrated a need for assistance with community living and the service is recommended by a LPHA acting within the scope of his/her professional licensure.
- The service, including frequency of the service, is recommended as a result of the DA,
- Beneficiary has an IPOC that addresses mental health concerns and any co-occurring general medical condition,
- The person is expected to benefit from the intervention and needs would not be better clinically met by any other formal or informal system or support.

Documenting Medical Necessity – Continued Service

The beneficiary is eligible to continue service if the following circumstances are met:

- Beneficiary continues to meet admission guides for this level of care
- The IPOC, current or revised, can be reasonably expected to improve the presenting mental illness and objective behavioral indicator of improvement are documented in the progress notes
- Beneficiary is actively involved in the Peer Support Process, participating in interventions
- Beneficiary does not require a higher level of care and no other intervention level would be appropriate
- Beneficiary is making some progress, but the interventions need to be modified so that greater gains can be achieved.

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

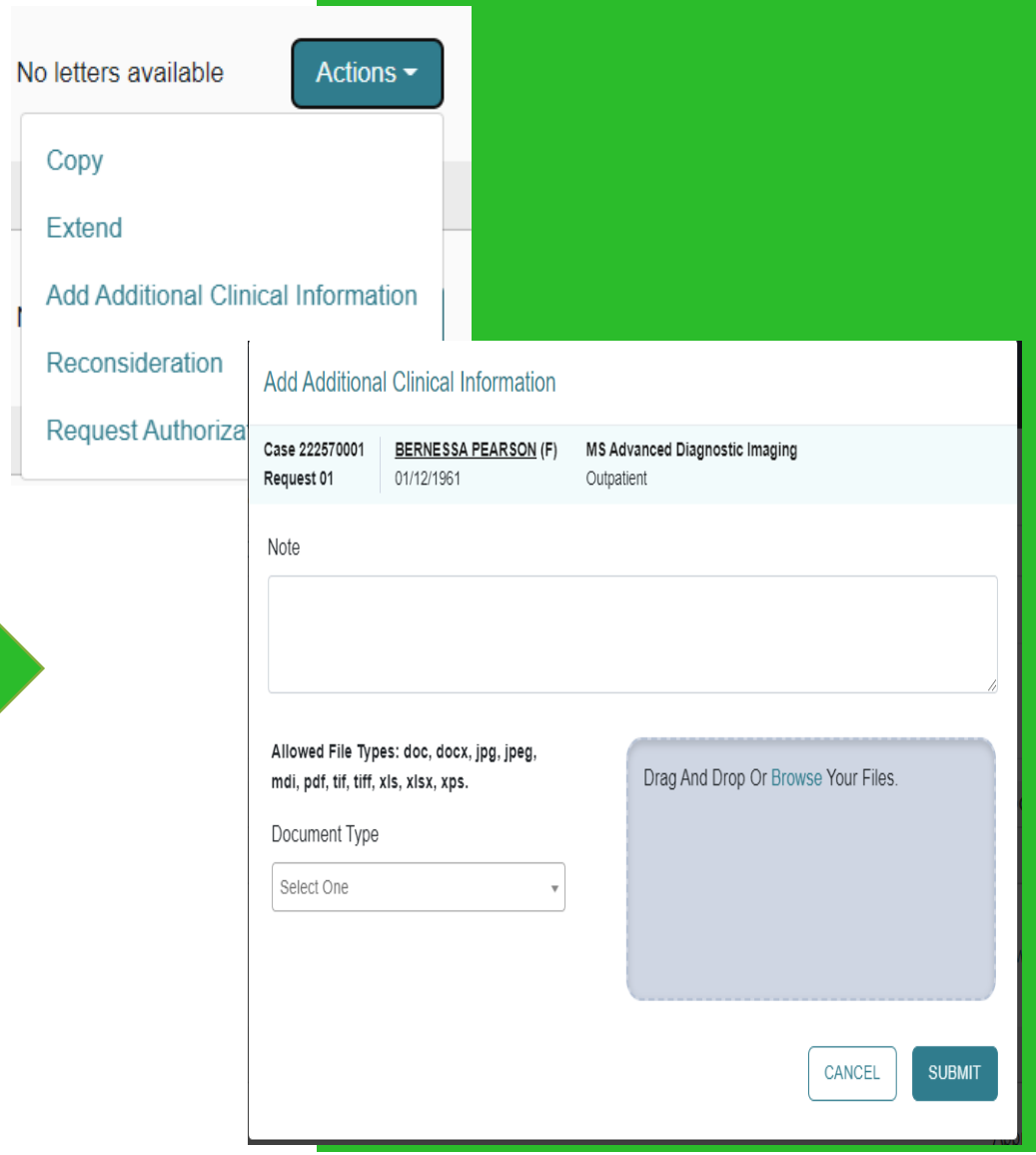
- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax and 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, required documentation not received
- 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 not meeting 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
  - Web portal *preferred
  - Fax
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet 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 an internal review or 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

- SCDHHS Rehabilitative Behavioral Health Services (RBHS) 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

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