

Targeted Case Management for Children with Chronic Medical Care Needs

DHHS has contracted with APS Healthcare to conduct prior authorization and utilization review for Targeted Case Management for Children with Chronic Medical Care needs effective 11-30-09. In order to receive a prior authorization, providers must follow all APS Healthcare, as well as DHHS requirements for this service.

Important information about provider requirements are posted on the APS Healthcare-Maine website: www.QualityCareforME.com

The Provider Manual is posted on the website at this link:

http://www.qualitycareforme.com/documents/provider_providermanual.pdf

APS CareConnection®

APS CareConnection® is the HIPAA-compliant, electronic, internet-based, review system. Providers are required to use APS CareConnection® to submit all clinical information, authorization requests, and to download authorization information.

Provider setup instructions and confidentiality and registration forms are located at this link: http://www.qualitycareforme.com/MaineProvider_APSCC_Mand_Enroll.htm

APS Healthcare Provider Relations staff are available by phone (866-521-0027, Option 1) or email (mainecare-prov@apshealthcare.com) to assist providers with the registration and setup process for APS CareConnection®.

Overview of the TCM Chronic Medical Care Needs Utilization Management Process

1. Providers submit a Prior Authorization (PA) request.
 - a. Approved requests will be authorized with an authorization start date, an authorization end date and an authorized number of units of service
 - b. The typical PA authorization will be for 30 days and 60 units.
 - c. Units that are authorized but not provided in a given authorization period do not “roll over” into the next authorization period. Authorized units are specific to each authorization date range and authorization number.
2. Providers submit a Continued Stay Review at the end of the initial authorization period or when the authorized units are exhausted, whichever comes first. To ensure there are no unauthorized days of service, a provider must submit a Continued Stay Review (CSR) request to APS Healthcare no later than the last covered day of the existing authorization. Backdating CSR requests is not recommended. Even when backdating is absolutely necessary, a parameter of up to ten (10) calendar days only from the date of submission applies. It is strongly recommended that providers do not backdate CSR requests, as this will increase the provider’s risk of additional uncompensated days of service should the late request be clinically denied.

- a. The typical CSR authorization will be for 90 days. Providers are expected to request the number of units that are appropriate to the need of the member.
- b. Units that are authorized but not provided in a given authorization period do not “roll over” into the next authorization period. Authorized units are specific to each authorization date range and authorization number.
3. Within 5 days of a consumer being terminated from the TCM Chronic Medical Care Needs service, providers must submit a Discharge in APS CareConnection®. For more information on Discharges, please see Appendix A of our Provider Manual:
http://www.qualitycareforme.com/documents/provider_providermanual.pdf

Procedure Codes and Billing Units for Prior Authorization and Continued Stay Requests

1. Review Type: Children’s Services
2. Auth Types: Prior Authorization (PA); Continued Stay Review (CSR)
3. Service Category: Targeted Case Management
4. Procedure Code: Targeted Case Management - Chronic Medical Care Needs (T1017UB)
5. Billing Unit = 15 minutes
6. PA Auth: 30 days, 60 units CSR Auth: 90 Days

Reconsideration and Appeal Processes

A provider may request a reconsideration of an authorization decision made by APS Healthcare. A consumer of TCM Chronic Medical Care Needs Services may request a reconsideration and/or an appeal of an authorization decision. See the APS Healthcare Provider Manual at the link posted above for detailed information about the reconsideration and appeal processes.

Purpose of Download Notifications

APS Healthcare provides a listing of all authorizations submitted, authorized, denied, or assigned authorization numbers. This listing is provided in the form of an Excel spreadsheet, called the Download Notification. Download notifications are designed to assist providers with receiving authorization numbers and updates regarding reviews submitted into the APS CareConnection® system. Providers are given this option as a way to utilize APS CareConnection® with a batching mechanism which provides authorization numbers and relating provider notes. For more information on Download Notifications, skip to the last page of this instruction document.

To Submit a Prior Authorization Review for Targeted Case Management - Chronic Medical Care Needs

1. On the Home screen, choose the “UM” or “DSP” tab. On the blue bar, choose “New Request”.
2. Under “Member ID”, enter the member’s MaineCare ID number. Enter one other piece of identifying information, and select “Verify”.



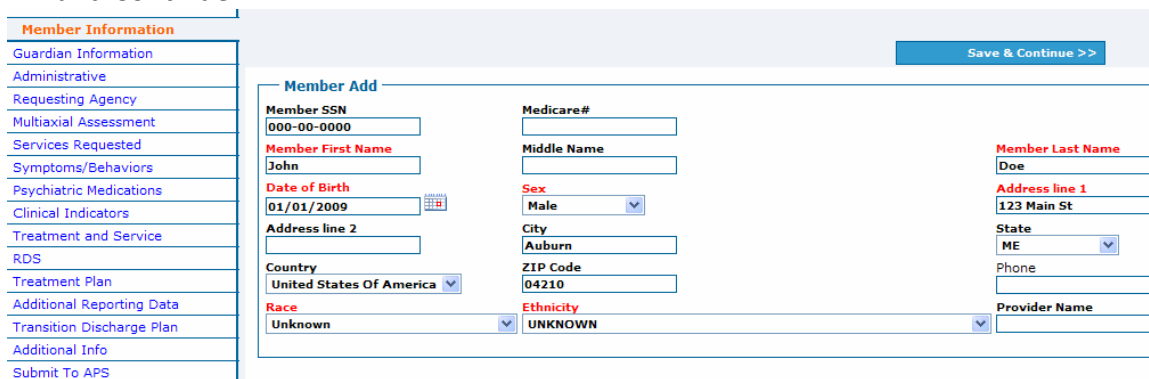
Eligibility **Note: Please enter at least one of the following Last Name, Member SSN or Date of Birth in order to verify eligibility.**

Member ID : Member Last Name :

Member SSN: Date of Birth :

[Verify](#)

3. On the resulting search screen under the eligibility information, select “Add New Request”.
4. You will be moved the first page of a new request, the Member Information section. This is a direct feed from MaineCare and cannot be edited. Press “Save and Continue”.



Member Information

- Guardian Information
- Administrative
- Requesting Agency
- Multiaxial Assessment
- Services Requested
- Symptoms/Behaviors
- Psychiatric Medications
- Clinical Indicators
- Treatment and Service
- RDS
- Treatment Plan
- Additional Reporting Data
- Transition Discharge Plan
- Additional Info
- Submit To APS

[Save & Continue >>](#)

Member Add

Member SSN: 000-00-0000 Medicare#:

Member First Name: John Middle Name: Member Last Name: Doe

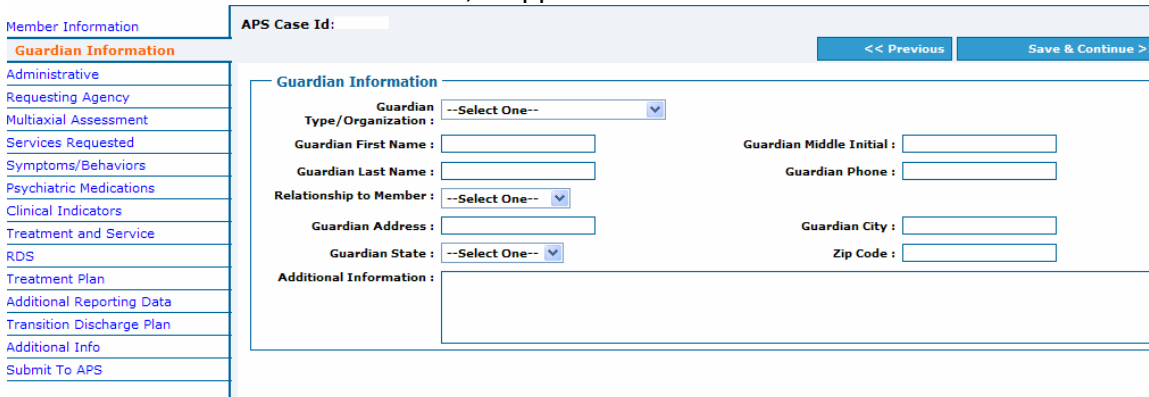
Date of Birth: 01/01/2009 Sex: Male Address line 1: 123 Main St

Address line 2: City: Auburn State: ME

Country: United States Of America ZIP Code: 04210 Phone:

Race: Unknown Ethnicity: UNKNOWN Provider Name:

5. Enter the Guardian Information, if applicable. Click “Save and Continue”.



Member Information APS Case Id:

[<< Previous](#) [Save & Continue >>](#)

Guardian Information

Guardian Type/Organization: --Select One--

Guardian First Name: Guardian Middle Initial:

Guardian Last Name: Guardian Phone:

Relationship to Member: --Select One--

Guardian Address: Guardian City:

Guardian State: --Select One-- Zip Code:

Additional Information:

6. On the Administrative section:
 - a. Select “Prior Authorization” under the “Authorization Type”.
 - b. Fill out the start date you wish authorization to begin.
 - c. Under “The Request Is”, select “Routine”.
 - d. Under “Review Type”, choose “Children’s Services”.


- e. Under "Category of Service", choose "Targeted Case Management".
- f. Click "Save and Continue".

<ul style="list-style-type: none"> Guardian Information <li style="background-color: #e0e0e0;">Administrative Requesting Agency Multiaxial Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS 	<div style="text-align: right;"> << Previous Save & Continue >> </div> <h3 style="margin: 0;">Administrative</h3> <p>Organization : APS Healthcare Maine Testing</p> <p>Authorization Type : Prior Authorization</p> <p>Status : New</p> <p>Do you know the service start date? Yes</p> <p>Start Date for Current Authorization Request : 12/04/2009 01:00 AM</p> <p>This Request is : Routine</p> <p>Request Submitted : Electronically</p> <p>Request Submitted Date : 12/04/2009</p> <p>Review Type : Children's Services</p> <p>Category of Service :</p> <div style="border: 1px solid black; padding: 2px;"> <ul style="list-style-type: none"> Targeted Case Management Inpatient Services Private Psychiatric Facility Day Treatment Crisis Support Services Infant Mental Health Children's Outpatient Family PsychoEducational Child Community Assertive Treatment (ACT) Medication Services Child and Family Behavioral Health Treatment (Community Based) Community Based Treatment for Children without Permanency Private Non Medical Crisis Unit PNMI Intensive Residential Treatment PNMI Residential Treatment Treatment Foster Care Children's PNMI Services Multidimensional Treatment Foster Care </div> <p>Location Address : -----Select-----</p> <p>Date of Referral : 07:59 AM</p> <p>Location at time of Referral : -----Select-----</p> <p>Date Worker Assigned :</p>
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7. You will be automatically moved to the "Requesting Agency" section. Please fill out all fields in red with the contact information for the case manager. On the question "Is this agency/individual the treating provider" click "Yes". Then choose "Save and Continue".

<ul style="list-style-type: none"> Member Information Guardian Information Administrative <li style="background-color: #e0e0e0;">Requesting Agency Multiaxial Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS 	<div style="text-align: right;"> << Previous Save & Continue >> </div> <h3 style="margin: 0;">Requesting Facility/Agency/Clinician</h3> <p>Requesting Facility/ Agency Name : TRAINING</p> <p>Requesting Staff First Name : Jane</p> <p>Requesting Staff Last Name : Doe</p> <p>Requesting Staff Phone (With Area Code) : (866) 521-0027</p> <p>Requesting Staff E-mail :</p> <p>Utilization Manager/Supervisor Name :</p> <p>Utilization Manager/Supervisor Phone :</p> <p>Utilization Manager/Supervisor E-mail :</p> <p>Is this agency/individual the treating provider? <input checked="" type="radio"/> Yes <input type="radio"/> No</p>
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8. You will be automatically moved to the “Multiaxial Assessment” section.
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis” fields.
 - b. Fill out any additional Axis I-V information if applicable.
 - c. Choose “Save and Continue”.

Date of Diagnostic Assessment : 

Axis I/II/III

Primary Diagnosis : CEREBRAL PALSY NOS

Co-occurring Primary Diagnosis :

Axis I Diagnosis 1 :

Axis I Diagnosis 2:

Axis II Diagnosis 1:

Axis II Diagnosis 2:

Axis III:

Axis IV

Problems in Family Relations :

Problems in Friendship/Social Relations:

Legal Issues:

School Problems:

Work Problems:

Custody/Placement Issues:

Financial Difficulties:

Problems in Living Situation:

Physical Health:

Problems With Access to HealthCare:

Other Psychosocial & Environmental Problems:

Axis V

Axis V Current:

Since last authorization request, GAF Score has:

9. You will be automatically moved to the “Services Requested” section.
 - a. Choose “Add New Procedure Request”.
 - b. Choose the “T1017 UB - Targeted Case Management - Chronic Medical Care Needs” code under the “Service” drop-down.
 - c. Choose the “Frequency”.
 - d. Choose the “Billing Provider ID” number.
 - e. The “Service Length” will automatically populate, as will the “Units”.
 - f. The last field is “Auth End Date”. Place your cursor in the field entitled “Service Length”, and press the TAB key on your keyboard. The “Auth End Date” will now automatically fill in for you.
 - g. Choose “Save”, and then “Save and Continue”.

Guardian Inform Add Procedure Request Save

Add/Modify Procedure Request

Service: **T10170B-Targeted Case Management - Chronic Medical Care Needs**

Frequency: **Weekly**

Start Date: **12/04/2009**

Billing Provider ID: **123456789**

Service Length: **30**

Units: **60**

Auth End Date: **01/02/2010**

Save

Administrative
 Requesting Agen
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Services Requ
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 Clinical Indicator
 Treatment and S
 RDS
 Treatment Plan
 Additional Report
 Transition Discha
 Additional Info
 Submit To APS

10. You will be moved to the “Symptoms and Behavior” section. Please complete the “Agency Involvement” and “Family/Social Involvement” sections as applicable. Choose “Save and Continue”.

Agency Involvement

Agency Involvement : **DHHS Elder Services Corrections (Court, JCCO, etc.) EAP DHHS Child Welfare Special Ed/504 Other None**

Other Agency Involvement : _____

Family/Social Involvement

Family/Social Involvement : **Family Spouse/Partner Friends Religious group**

Other Family/Social Involvement : _____

Rate Overall Level of Family Involvement in Treatment Goals : **None**

Rate Overall Level of Natural Supports Involvement with the Client/Family : **None**

11. Fill out the “Psychiatric Medications” section if applicable. Please include all relevant medications. Choose “Save and Continue” to move forward.

<< Previous Save & Continue >>

Psychiatric Medications

Is the member currently prescribed any psychiatric medications? Yes No

If yes, does member take medications as prescribed? Yes No

Did you notify the member's PCP of this medication? Yes No

Is the Member's PCP prescribing psychiatric medications to the member? Yes No N/A

List Medications

Medication Type	Medication Name	Action
Antidepressant	Zoloft	Remove

Add Medication

Additional Medication Info (Non-Prescribed, Vitamins, Supplements, Dosage, Frequency, Etc.)

Notes: _____

12. Fill out the “Clinical Indicators Justifying Service Request” section as applicable. Choose “Save and Continue”.

<< Previous
Save & Continue >>

Clinical Indicators Justifying Service Request

Risk/Danger To Self/Others

	Current Severity <small>(None, Mild, Moderate, Severe)</small>	History of Severity <small>(Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years)</small>
Aggressiveness :	Mild ▾	Within 7 days ▾
Fire Setting :	None ▾	---Select--- ▾
Assaultive :	None ▾	---Select--- ▾
Homicidal Attempt :	None ▾	---Select--- ▾
Homicidal Ideation :	None ▾	---Select--- ▾
Self Care Deficit :	Mild ▾	Within 8-90 days ▾
Self-injurious Behavior :	None ▾	---Select--- ▾
Sexually Inappropriate Behavior :	None ▾	---Select--- ▾
Suicide Attempt :	None ▾	---Select--- ▾
Suicidal Ideation :	None ▾	---Select--- ▾
Use of Weapons :	None ▾	---Select--- ▾
Harm to Animals :	None ▾	---Select--- ▾

Symptoms And Behavior

	Current Severity <small>(None, Mild, Moderate, Severe)</small>	History of Severity <small>(Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years)</small>
Anxiety/Panic :	None ▾	---Select--- ▾
Attachment Problems :	None ▾	---Select--- ▾
Depressed Mood :	None ▾	---Select--- ▾

13. Choose “Save and Continue” to move past the “Treatment and Service History” page and the “RDS” page.

14. “Treatment Plan” page:

a. Fill out the “Individual Treatment Plan” as applicable.

Individual Treatment Plan

Describe Member's Strengths and Skills :

Positive family network
 Positive peer support
 Interest in work/volunteer activity
 Realistic, positive expectations and goals for future
 Good problem-solving skills/ able to seek help when needed
 Spiritual/Cultural involvement
 Natural Supports
 Good physical health/self-care
 Stable home setting
 Involvement in positive activities/interests
 Good self-awareness/self-understanding
 Other
 Consumer's strengths are incorporated into the treatment plan

Is the Member/Caregiver Involved in Forming the Treatment Plan? Yes No

List those involved with the development of the plan :

Member's Expectation of Treatment and Perception of Needs :

Family/Caregiver's Expectation of Treatment and Perception of Member's Needs :

Disabilities and Accomodations Required For the Delivery of the Service :

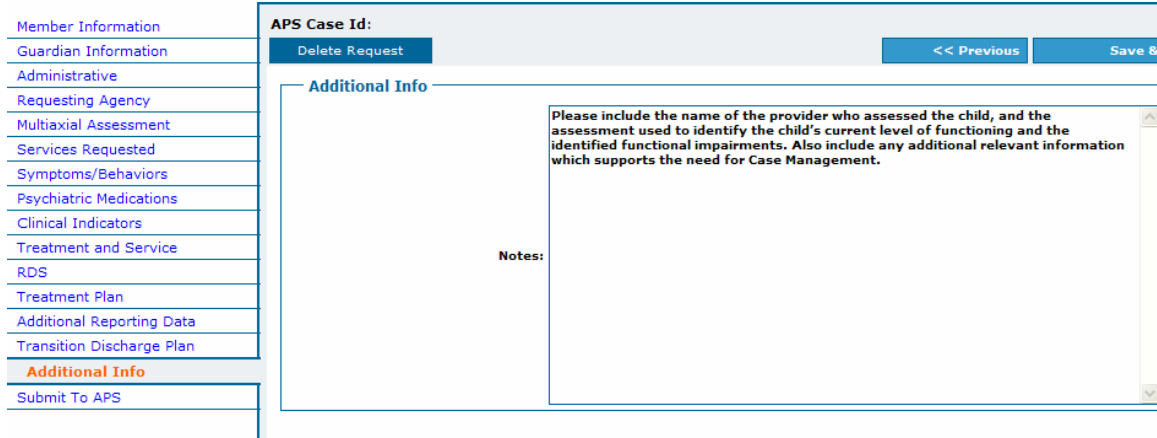
- b. Fill in the “Treatment Plan Goals” using the “Add New Goal” link, located at the very bottom of the page. Please identify the overarching problem and needs in the Problem Statement box.

- c. Select “Save and Continue”.

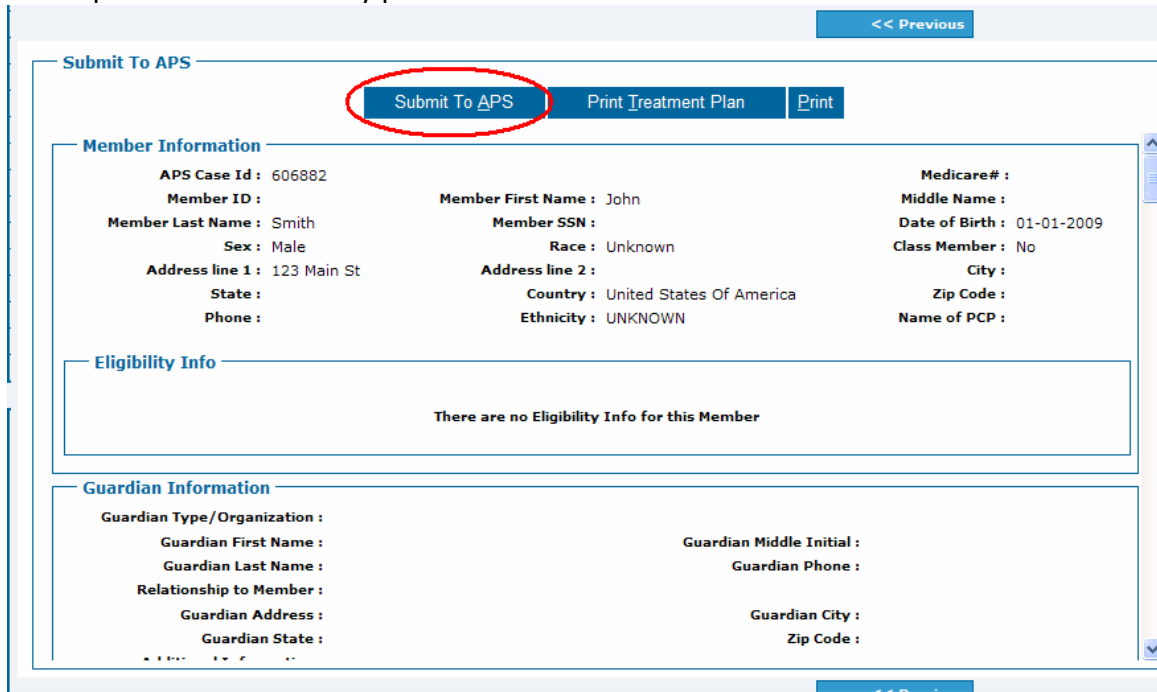
15. Choose “Save and Continue” to move past the “Additional Required Reporting Data” page.
16. Fill out the “Transition Discharge Plan” as appropriate. Please note - if you answer “No” to the first question, please select “Other” on the “Anticipated Step Down Service” section in order to move forward. Choose “Save and Continue”.

	First Appt. Post Discharge	Day/Mo	First Appt. Post Discharge	Day/Mo
<input type="checkbox"/> Natural Supports			<input type="checkbox"/> 6S&N	
<input type="checkbox"/> Respite			<input type="checkbox"/> Adult HomeBased Services	
<input type="checkbox"/> AA/NA			<input type="checkbox"/> DLSS	
<input type="checkbox"/> Peer Support			<input type="checkbox"/> Substance Abuse Tx	
<input type="checkbox"/> Outpatient			<input type="checkbox"/> Crisis Services	
<input type="checkbox"/> Groups			<input type="checkbox"/> Crisis Unit	
<input type="checkbox"/> Psychiatric/Med. Mgt.			<input type="checkbox"/> Post/Child Welfare	
<input type="checkbox"/> Case Management/C.I.			<input type="checkbox"/> Adult Protective	
<input type="checkbox"/> Section 24			<input type="checkbox"/> Supported Nursing Facility	
<input type="checkbox"/> Day Treatment			<input type="checkbox"/> Medical Hospitalization	
<input type="checkbox"/> ACT/I.C.I.			<input type="checkbox"/> Residential Treatment	
<input type="checkbox"/> Corrections			<input checked="" type="checkbox"/> Other	

17. You will be moved to the “Additional Information” page. Please include the name of the provider who assessed the child, and the assessment used to identify the child’s current level of functioning and the identified functional impairments. Also include any additional relevant information which supports the need for Case Management. Press “Save and Continue”.



18. You are now finished entering all required information for this review. **You must choose the “Submit to APS” option near the center of the page to complete the request and submit to APS for review.** You will receive a pop-up that states your request was successfully processed.



Please contact APS Provider Relations at 866-521-0027, Option 1 with questions.

To Submit a Continued Stay Review for Targeted Case Management -
Chronic Medical Care Needs

***Please note - in this section, screen shots have only been included for those sections where one was not included in the Prior Authorization instruction section.**

Please have on hand your most recently authorized APS Case ID. (If you are unsure of this information, you may search for it under the “Search Responses” option.)

1. On the Home screen, choose the “UM” or “DSP” tab.
2. Under the “Search Request” option, enter the most recently authorized APS Case ID and click “Search”.
 - a. Click the “EXT” link.
 - b. Record the new APS Case ID number for future reference.
3. Verify the member information. Click “Save and Continue”.
4. Enter the Guardian Information, if applicable. Click “Save and Continue”.
5. On the Administrative section:
 - a. Fill out the start date for this request.
 - b. Click “Save and Continue”.
6. You will be automatically moved to the “Requesting Agency” section. Please fill out all fields with the contact information for the clinician, and then choose “Save and Continue”.
7. You will be automatically moved to the “Multiaxial Assessment” section.
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis” fields, if not already completed.
 - b. Fill out any additional Axis I-V information if applicable.
 - c. Choose “Save and Continue”.
8. You will be automatically moved to the “Services Requested” section.
 - a. Choose “Modify” next to the procedure code.
 - b. The “Service Length” will automatically populate, as will the “Units”. You may adjust the units as needed, to cover expected number of sessions during this authorization period.
 - c. The last field is “Auth End Date”. Please place your cursor in the “Service Length” box, and click the “Tab” key on your keyboard. The “Auth End Date” will then automatically populate for you.
 - d. Choose “Save”, and then “Save and Continue”.
9. You will be moved to the “Symptoms and Behavior” section. Please complete the “Agency Involvement” and “Family/Social Involvement” sections as applicable. Choose “Save and Continue”.
10. Update the “Psychiatric Medications” section if applicable. Choose “Save and Continue” to move forward.

11. Fill out the “Clinical Indicators Justifying Service Request” section as applicable. Choose “Save and Continue”.
12. Complete the “Treatment and Service History” page as applicable. Choose “Save and Continue”.

Treatment And Service History

Select the tool or tools used to screen for co-occurring mental health and substance use disorders. Next to each selected tool, indicate if there were one or more YES responses. If the AC-OK is used, answer for all 3 domains. If the MHSF III is used, CRAFFT or UNCOPE must also be used

This Tool Used: AC-OK MH Issues Domain **Select** ▼


This Tool Used: AC-OK Trauma Issues Domain **Select** ▼

This Tool Used: AC-OK Sub Abuse Issues Domain **Select** ▼

This Tool Used: UNCOPE **Select** ▼

This Tool Used: CRAFFT **Select** ▼

This Tool Used: MHSF III **Select** ▼

Date of assessment for co-occurring disorders : 

Have you communicated with the Member's PCP to coordinate mental health and physical health care? No Yes N/A

Is member receiving integrated MH/SA services? No Yes

How long has member been receiving this service:

How many times has member been seen by your service within this authorization period?

Number of Inpatient Admissions in Last 12 Months : ▼

Number of ER or other crisis episodes last 12 months : ▼

Number of years of active mental health treatment : ▼

Number of lifetime homeless episodes? ▼

Number of lifetime jail/prison terms? ▼

Currently on probation/parole/conditional release? No Yes

For youth in school, number of suspensions last 12 months? ▼

For youth under age 18, number of times run away for over a 24 hour period : ▼

13. Choose “Save and Continue” to move past the “RDS” page.
14. “Treatment Plan” page:
 - a. Please complete all relevant fields, especially “Potential Barriers to Treatment” and “Criteria for Discharge”.
 - b. In the “Treatment Plan Goals” section, use the “Modify” link to update existing long-term and short-term goals and identify progress towards goals. Use the “Add New Goal” link to add any new long-term goals.
15. Complete only the top section of the “Additional Required Reporting Data” page as applicable. Choose “Save and Continue”.

Additional Required Reporting Data

Current Living Situation : ----- Select ----- ▼

Other Living Situation :

Does the Member Receive a Rent Subsidy? : **No** ▼

Current Vocational/Employment Status : ----- Select ----- ▼

Other Employment Status :

Does the Member Receive Vocational Rehab Services? : **No** ▼

Was the Member involved with the legal system/ police within the last 6 months? : **Unknown** ▼

Since the last authorization period has the Member missed a significant number of days of school? : **Unknown** ▼

16. Fill out the “Transition Discharge Plan” as appropriate - an update to this page is required at each Continued Stay Review. Please note - if you answer “No” to the first question, please select “Other” on the “Anticipated Step Down Service” section in order to move forward. Choose “Save and Continue”.
17. You will be moved to the “Additional Information” page.
 - a. Please include updated information regarding the continued need for the service. If you feel it would be helpful you can provide a narrative regarding the work that has been completed and the activities that are remaining.
 - b. Select the appropriate option from the “Treatment Progress” drop-down.
 - c. Choose “Save and Continue”.
18. You are now finished entering all required information for this review. **You must choose the “Submit to APS” option near the center of the page to complete the request and submit to APS for review.** You will receive a pop-up that states your request was successfully processed.

It is strongly suggested that providers return to CareConnection® 24 hours after submitting Prior Authorizations and Continued Stay Reviews, to verify if the request has been authorized or held for more information. Using the “Search Responses” button, search for the most recent APS Case ID and use the “VIEW” link to verify authorization request status and to see any notes from APS staff.

Download Notification Process:

1. Log into CareConnection®
2. Click the UM tab (the UM tab is needed to access the Download Notifications).
3. Click the “Download Notifications” tab within the blue bar.
4. Choose the requesting organization from the drop down menu.
5. Click “Get Archived Notifications”.
 - a. Notification search results will appear below. These are called batches. All reviews that are submitted into the system will run through a batch process that evening and become available there-after.
 - b. Batches are shown newest to oldest – top to bottom.
6. Click “Download” for the corresponding batch to be pulled.
7. Click “OK” when the dialog box opens. All information will now appear in right to left format in an excel document. This information must be formatted before printing.
8. Open a new excel sheet.
9. Copy and paste downloaded information into this new excel sheet.
10. Repeat steps 6, 7 and 9 for each batch that needs to be downloaded.
11. Sorting downloads: If there is more than one client or several download batches captured please follow the steps below.
 - a. Highlight all cells corresponding to captured data.
 - b. Click “Data”
 - c. Click “Sort”
 - d. Click “Sort by: Column A”
 - e. Click “My Data Range has: No header row”.
 - f. Click “OK” – this will sort all of the information by case ID number.
 - g. Check for duplicate cases, match the code and delete all duplicates.
12. Printing Downloads:
 - a. Click “File”
 - b. Click “Print Preview”
 - c. Click “Setup”
 - d. Click “Orientation: Landscape”
 - e. Adjust “Scaling: to 80% normal size”
 - f. Click “Sheet”
 - g. Click “Print: Gridlines”