North Carolina Medicaid and North Carolina Health Choice

Quick Reference Guide

The purpose of this *Quick Reference Guide* is to highlight the ProviderConnect functionalities that will be used most often by providers. This document supplements information in the *North Carolina Medicaid and Health Choice User Guide* but specifically addresses:

Entering authorization requests
Checking authorization status and printing/downloading authorization letters
Submitting a discharge
Contacting Customer Service

LOGGING IN:

Go to: www.valueoptions.com | Providers | ProviderConnect Log In click 'Log In'

ENTERING AN AUTHORIZATION REQUEST:

- Capture the correct recipient; use the recipient's Medicaid ID number for Medicaid requests and the recipient's Health Choice ID number for Health Choice requests.
- Select provider ID matching the service being requested
  - If submitting a TFC request, use any MPN available to the submitting provider. The NPI associated with the MPN included on the submission will be replaced by ValueOptions with the appropriate LME NPI corresponding to the recipient's county of eligibility at the time of review
  - If clinical home provider submits initial Residential or PRTF request on behalf of the residential facility, use any MPN available to the submitting provider and state the name and NPI of the residential facility in the first sentence of the precipitating event
- Select correct Level of Service/Level of Care combination at the beginning of the review; see the table below:

If Requested Service is:	Select Level of Service as:	Select Level of Care as:
Community Support Team	INPATIENT/HLOC/SPECIALTY	COMMUNITY SUPPORT TEAM
Assertive Community Treatment Team	INPATIENT/HLOC/SPECIALTY	ASSERTIVE COMMUNITY TREATMENT
Psychosocial Rehabilitation	INPATIENT/HLOC/SPECIALTY	PSYCHOSOCIAL REHAB
Intensive In-Home	INPATIENT/HLOC/SPECIALTY	INTENSIVE IN-HOME
Child/Adolescent Day Treatment	INPATIENT/HLOC/SPECIALTY	DAY TREATMENT
Multisystemic Therapy	INPATIENT/HLOC/SPECIALTY	MST
Residential (group home level II-IV)	INPATIENT/HLOC/SPECIALTY	RESIDENTIAL CHILD CARE
Therapeutic Foster Care	INPATIENT/HLOC/SPECIALTY	FOSTER CARE
Facility Based Crisis	INPATIENT/HLOC/SPECIALTY	FACILITY BASED CRISIS
Substance Abuse Intensive Outpatient Therapy	INPATIENT/HLOC/SPECIALTY	IOP/SOP
Substance Abuse Comprehensive Outpatient Therapy	INPATIENT/HLOC/SPECIALTY	SACOT
Opioid Treatment	INPATIENT/HLOC/SPECIALTY	OPIOID TREATMENT
Substance Abuse Non-Medical Community Residential Treatment	INPATIENT/HLOC/SPECIALTY	NCMC ONLY SA NON MED RESI OVER 21
Substance Abuse Medically Monitored Community Residential Treatment	INPATIENT/HLOC/SPECIALTY	NCMC ONLY SA MED MONITORED RESI
Ambulatory Detoxification	INPATIENT/HLOC/SPECIALTY	NCMC ONLY AMBULATORY DETOX
Non-Hospital Medical Detoxification	INPATIENT/HLOC/SPECIALTY	NCMC ONLY NON-HOSPITAL MED DETOX
ADATC	INPATIENT/HLOC/SPECIALTY	NCMC ONLY MEDICALLY SPVSD/ADATC
MH/SA Targeted Case Management	INPATIENT/HLOC/SPECIALTY	TARGETED CASE MANAGEMENT
PRTF	INPATIENT/HLOC/SPECIALTY	PRTF
Inpatient	INPATIENT/HLOC/SPECIALTY	INPATIENT

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If Requested Service is:	Select Level of Service as:	Select Level of Care as:
Outpatient	OUTPATIENT	OUTPATIENT
Mobile Crisis	OUTPATIENT	OUTPATIENT
IDD Targeted Case Management *select Type of Service = Developmental Disability	OUTPATIENT	TARGETED CASE MANAGEMENT

Providers do not indicate a request as Initial or Concurrent when submitting via ProviderConnect. The system will identify a request as Initial or Concurrent based on built-in logic. There are **6** key data elements that determine whether the system identifies the request as Concurrent:

1. **Requested start date**—must be the day after the authorization on file expires. If an authorization expires 7/27/11, then the requested start date on the next request should be 7/28/11; if provider enters 7/29/11 or later in the Requested Start Date field, this causes a gap in authorization and the system labels the request as Initial. **ALSO**, if the concurrent request is submitted more than one day after the expiration date on file, the system labels it as Initial. If the expiration date on file is 7/27/11 and the request is submitted 7/29/11 or later, then it will be identified as an Initial due to the gap caused by late submission.
2. **Level of Service**—must be the same as the previous request.
3. **Type of Service**—must be the same as the previous request.
4. **Level of Care**—must be the same as the previous request.
5. **Type of Care** –must be the same as the previous request.
6. **Admit date**—must be the same as the last request. If 4/28/11 was entered as the admit date on the previous request, then 4/28/11 should be entered as the admit date on all subsequent requests. The admit date field is applicable to the ITR only.

If these data elements are entered correctly, then the provider will receive a prompt asking if this is a request for continuing care or a discharge. Make the appropriate selection. If a concurrent request, some clinical information included on the previous request will pre-populate on the concurrent request; review as necessary to ensure the information is accurate and up-to-date.

NOTE: Providers should not be deterred whether the system identifies the request Initial or Concurrent.

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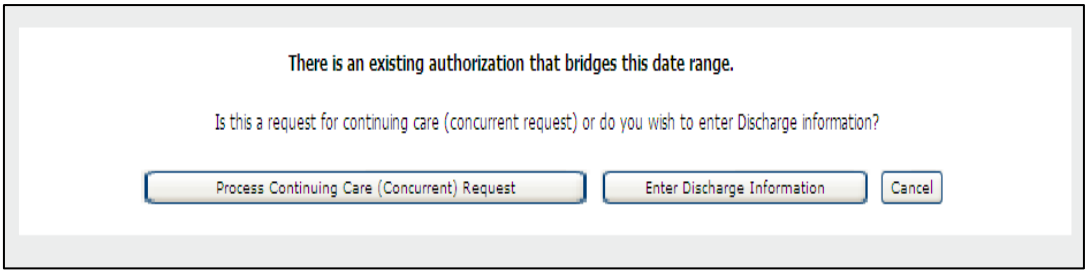


Attaching Documents:

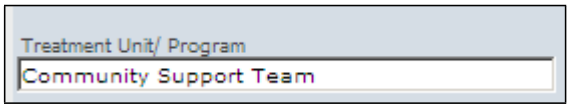
Attach all required documentation (e.g., PCP, service order, discharge plan form)

- Does this Document contain clinical information about the member: Select **'Yes'**
- Document description: select based on the document being attached
- Click **'Upload File'** button
- Click **'Browse'** button
- Find and select the document to attach, click **'Open'** button
- Click **'Upload'** button

NOTE: Acceptable file formats for attachments include Word, Excel, Adobe (PDF) and text files. Documents requiring signatures must be scanned and attached as PDFs.

Level of Care tab (for ITR only):

- Treatment Unit/Program field – Please type out the Level of Care in this field in detail (e.g. Community Support Team, Psychosocial Rehab, Foster care).



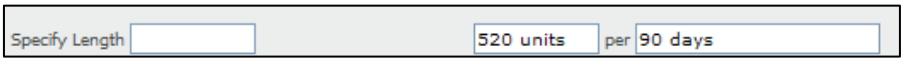
- At least one contact name and phone number is required - Please enter the Utilization Reviewer's contact information (name and phone number). This is the person Valueoptions will contact regarding any clinical questions.

Current Risks tab (for ITR only):

- Precipitant brief explanation – What specific **current** behaviors has the consumer exhibited causing you to request this service? Include root cause or particular history. Include progress or lack of progress during the reporting period. Diagnosis should not be entered here. ProviderConnect will prompt if you have exceeded 2000 characters.

Treatment Request tab (for ITR only):

- Specify Length – Enter the specific hours, units, etc 'per' week, month, etc in the additional fields provided.



Additional ProviderConnect Authorization Request Tips:

- System Time Out - ProviderConnect will time out after 30 minutes of no activity. Click on the screen to start the timer over.

- Save Request as Draft – ProviderConnect allows the ability to save a request as a draft for 30 days. Once saved, the provider can access the draft by clicking **View Clinical Drafts** from the Main Menu of the ProviderConnect Home page.

CHECK AUTHORIZATION STATUS

1. Click the **Authorization Listing** link in the navigation bar or **Review an Authorization** link in the Main Menu screen of the ProviderConnect Home page.
2. Click **View All** to see all authorizations for your provider ID number. The **Authorization Search Results** screen will display all of the authorizations, 150 max per page. Results can be sorted by Auth#, Member ID, or Member Name.

-or-

3. Enter an authorization date range in the **Effective Date** and **Expiration Date** fields.
4. Click **Search**. The **Search Results Screen** will display the specified authorization.
5. Click **Auth#** hyperlink
6. Click **Auth Details** tab

Print/Download Authorization Letters**

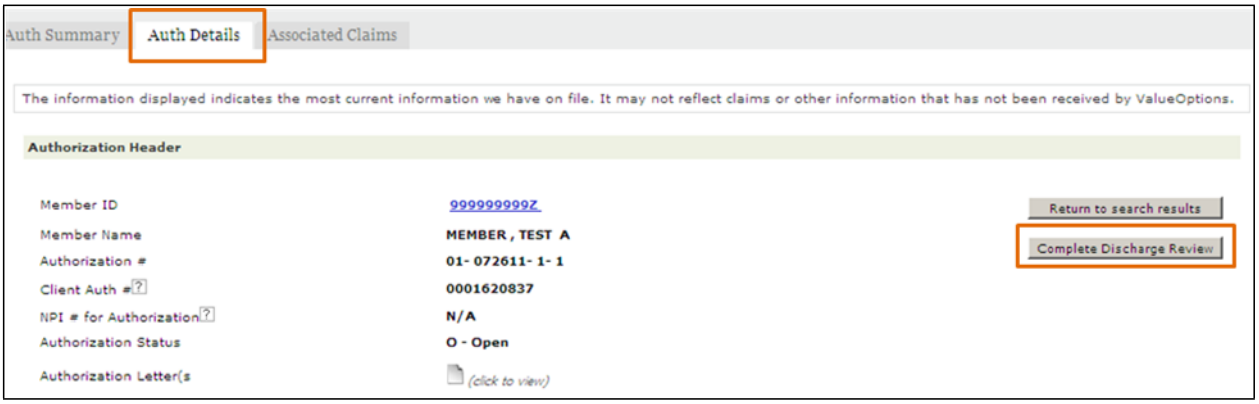
1. Click **View My Recent Authorization Letters** from the Main Menu of the ProviderConnect Home page to access authorization letters created in the last 7 days…OR
2. Click on a **View Letter** icon on the Authorization Search Results screen.
3. Click the **View** hyperlink (under the Select column) to display the authorization letter.

**Adverse determination letters created on/after September 25, 2011 are viewable on ProviderConnect.

SUBMITTING A DISCHARGE:

Providers are able to submit discharges via ProviderConnect. The most efficient path to submit a discharge is to click on the appropriate authorization number for the chosen member from the **Authorization Search Results** screen.

To verify if this is the correct authorization, click the **Auth Details** tab to display the dates of service authorized and then click the "**Complete Discharge Review**" button. Enter the information requested and click "**Save Discharge Information**" at the bottom of the screen. Clicking "**Save Discharge Information**" transmits the discharge information just entered to ValueOptions and provides a confirmation that can be printed.



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CONTACTING CUSTOMER SERVICE via PROVIDERCONNECT:

In addition to contacting Customer Service by telephone at (888) 510-1150, providers can submit consumer specific customer service inquiries via ProviderConnect. Providers receive written responses from Customer Service that will appear in the **Inbox** of the Message Center in ProviderConnect within five business days. Navigate to the ***Auth Summary*** **tab** after selecting a specific authorization for a consumer and click "**Send Inquiry**."

The following screen appears after clicking the "**Send Inquiry**" button. Complete the requested information and click "**Submit**" at the bottom of the page.

For ProviderConnect technical assistance contact:
EDI Help Desk at (888) 247-9311 Monday through Friday from 8 am – 6 pm Eastern Standard Time.