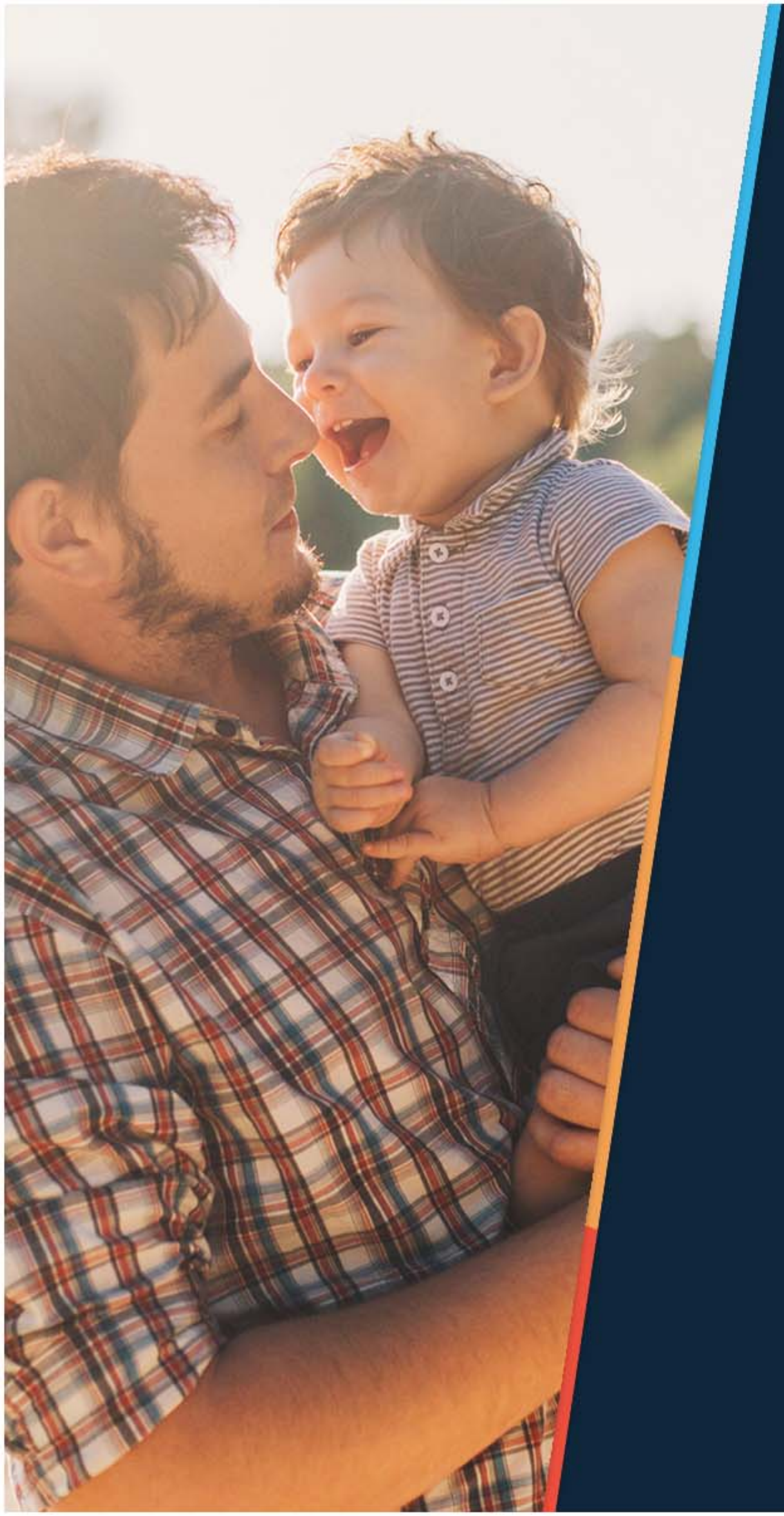
Welcome to the Georgia Collaborative ASO Provider Information Session

Please take a moment to review the following:

- We will get started closer to the top of the hour
- You MUST dial into the conference line to hear the presentation:
  - Call 1-877-993-0135 and enter passcode 9046331 when prompted
- Please DO NOT place your line on HOLD
  - If you place this call on hold we will be able to hear any hold music or hold recordings
  - If you get another call, please hang up from this call and dial back in when you have completed your other call.

Thank you for joining us. We will begin shortly!



The Georgia Collaborative ASO

DBHDD

Provider Information Session

beacon
health options

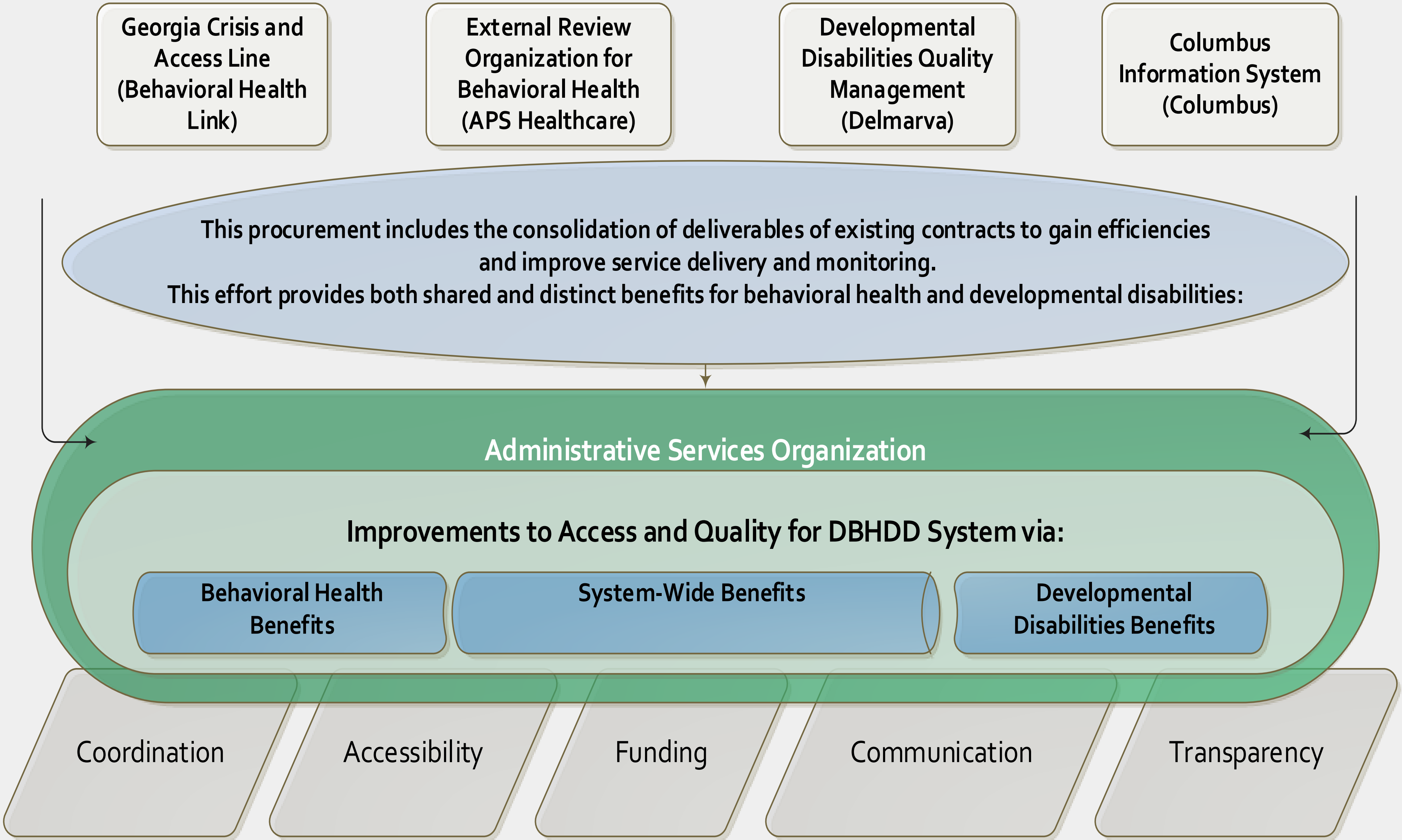
Introductions

- Department of Behavioral Health and Developmental Disabilities
  - Melissa Sperbeck, Deputy Chief of Staff
  - John Quesenberry, Director of Decision Support and Information Management
- Georgia Collaborative ASO
  - Jason Bearden, CEO, GA Collaborative ASO
  - Sheri A. Smidhum, Director, Provider Relations
  - Andrew Leece, Provider Relations Communications Specialist

Agenda

- Welcome and Introductions
- Current State vs. Future State
- ProviderConnect Overview
- Additional Training Options
- Questions

ASO Procurement / Future State



Georgia Crisis and Access Line (Behavioral Health Link)

External Review Organization for Behavioral Health (APS Healthcare)

Developmental Disabilities Quality Management (Delmarva)

Columbus Information System (Columbus)

This procurement includes the consolidation of deliverables of existing contracts to gain efficiencies and improve service delivery and monitoring.
This effort provides both shared and distinct benefits for behavioral health and developmental disabilities:

Administrative Services Organization

Improvements to Access and Quality for DBHDD System via:

Behavioral Health Benefits

System-Wide Benefits

Developmental Disabilities Benefits

Coordination

Accessibility

Funding

Communication

Transparency

The Georgia Collaborative ASO

beacon
health options

Delmarva Foundation
Georgia Quality Management System
Promoting Excellence and Quality

BHL

- The right service
- In the right amount
- For the right individuals
- At the right time

Goals of the Collaborative

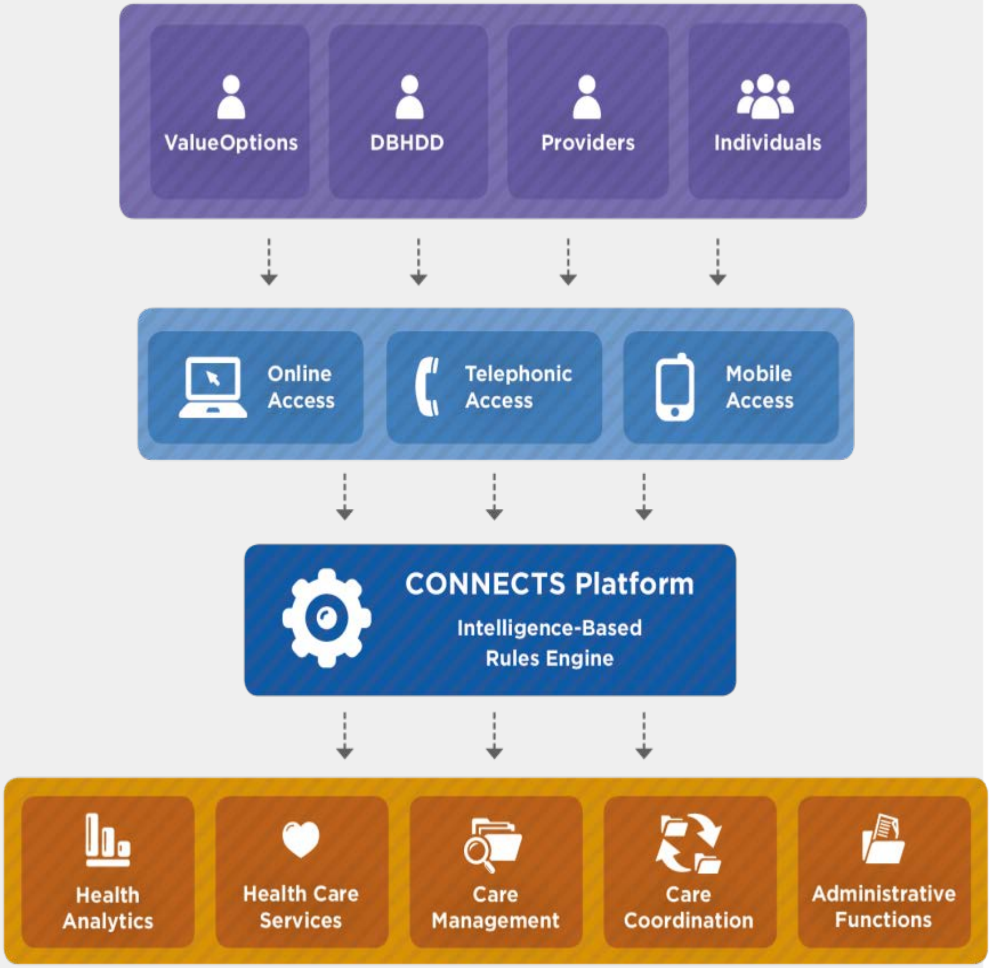
“Providing Easy Access to High Quality Care”

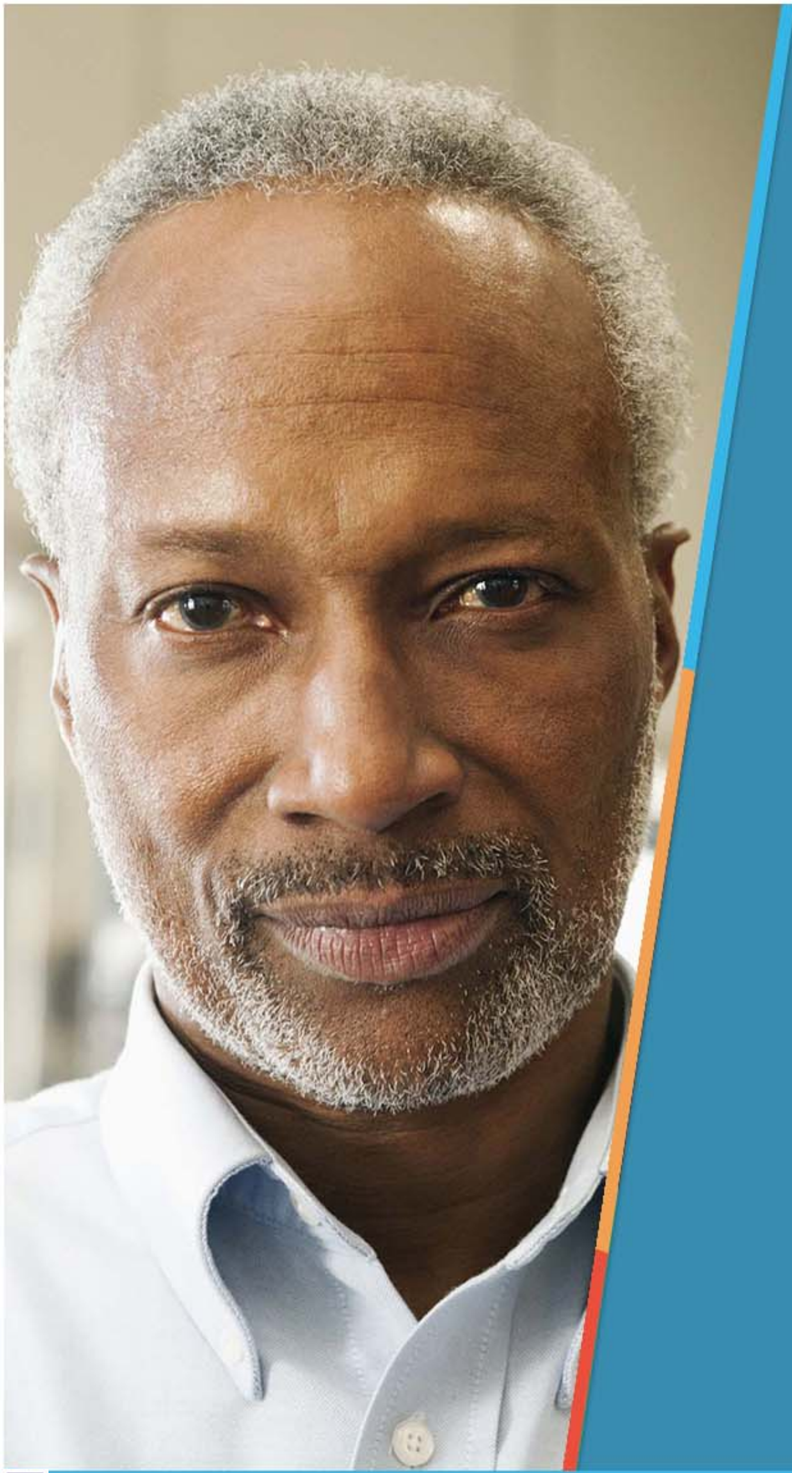
- Support recovery, resiliency and independence in community based service system
- Leverage technology through an integrated, customizable platform allowing all core functions to “communicate” (The CONNECTS platform)
- Coordination of previously disparate systems
- Improve outcomes and provider performance

Data Driven Outcomes and Processes

Integrated, customizable platform allowing all core functions to "communicate"

- Eligibility
- Provider demographics & credentialing
- Authorization
- Care coordination
- Health analytics
- Data transfer
- Claims payment
- Reporting


ValueOptions
DBHDD
Providers
Individuals
Online Access
Telephonic Access
Mobile Access
CONNECTS Platform
Intelligence-Based Rules Engine
Health Analytics
Health Care Services
Care Management
Care Coordination
Administrative Functions



An Introduction to ProviderConnect^{SM}

ProviderConnect - Services

An online tool where providers can:	
• Verify individual eligibility	• Register an Individual for funds
• Access and Print forms	• Request and View Authorizations
• Download and Print Authorization Letters	• Submit Claims and View Status
• Access Provider Summary Vouchers (PSVs)	• Submit Customer Service Inquiries
• Submit Updates to Provider Demographic Information	• Access ProviderConnect Message Center

INCREASED CONVENIENCE, DECREASED ADMINSTRATIVE PROCESSES

Disclaimer: Please note that screens used in this presentation are for demonstration purposes only and actual content may vary.

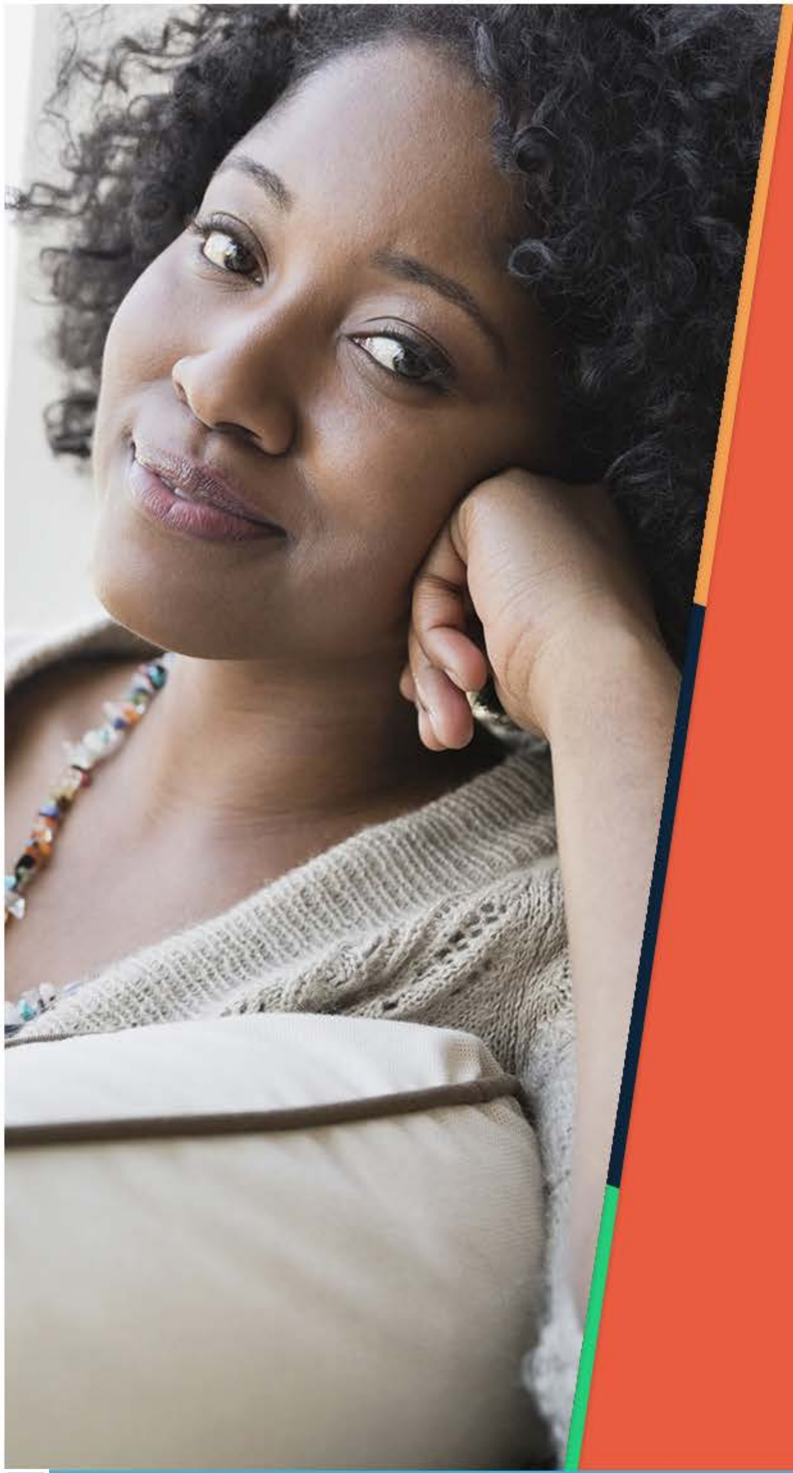
ProviderConnect Benefits

What are the benefits of ProviderConnect?

- Free and secure online application, available 24 / 7
- Reduce the need to call for routine information
- Mobile Device friendly

You can:

- Access the ProviderConnect message center
- Link to Educational Resources on our website
- View and print forms
- Submit or inquire about claims and view status
- Access Provider Summary Vouchers
- Submit updates to provider demographic information



Registering an Individual

Why Register an Individual?

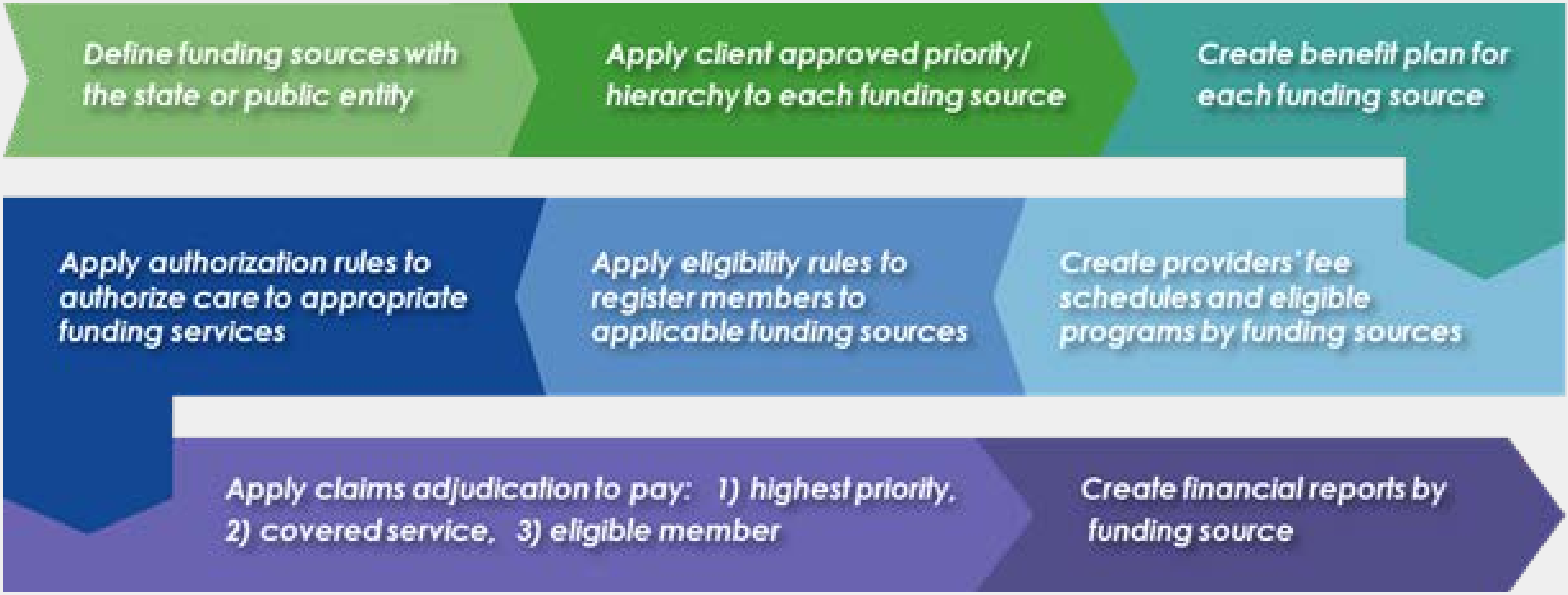
- Request for eligibility - Established individual in CONNECTS system
  - For new individuals creates a Consumer ID # (CID)
  - Robust “best match” logic so duplicate CIDs are not created for one individual
- Assigns funds and benefits to an individual
  - Must have funds and benefits on file in order to submit an authorization and claim
- Collects demographic data for reporting
- Allows provider to update individuals demographic information
- Assists with validation edits allowing for better quality data

Braided Funding Model Benefits

- Establishes the individual as the nexus for accessing multiple public funding sources.
- More efficient use of limited or constrained funds
- Ensure providers are accessing all available to fund sources to serve the individual holistically
- Leverages all funding sources for which an individual may be eligible (Coordination of benefits future FY 2016)
- Provides a comprehensive service package maximizing the resources available for an individual to lead a life of recovery
- Service utilization and expenditures can be broken out and tacked by funding source

Registration – Fund Source Assignment

- Registration Fund Source assignment initiates the Beacon Health Options Braided Funding model



Define funding sources with the state or public entity

Apply client approved priority/ hierarchy to each funding source

Create benefit plan for each funding source

Create providers' fee schedules and eligible programs by funding sources

Apply eligibility rules to register members to applicable funding sources

Apply authorization rules to authorize care to appropriate funding services

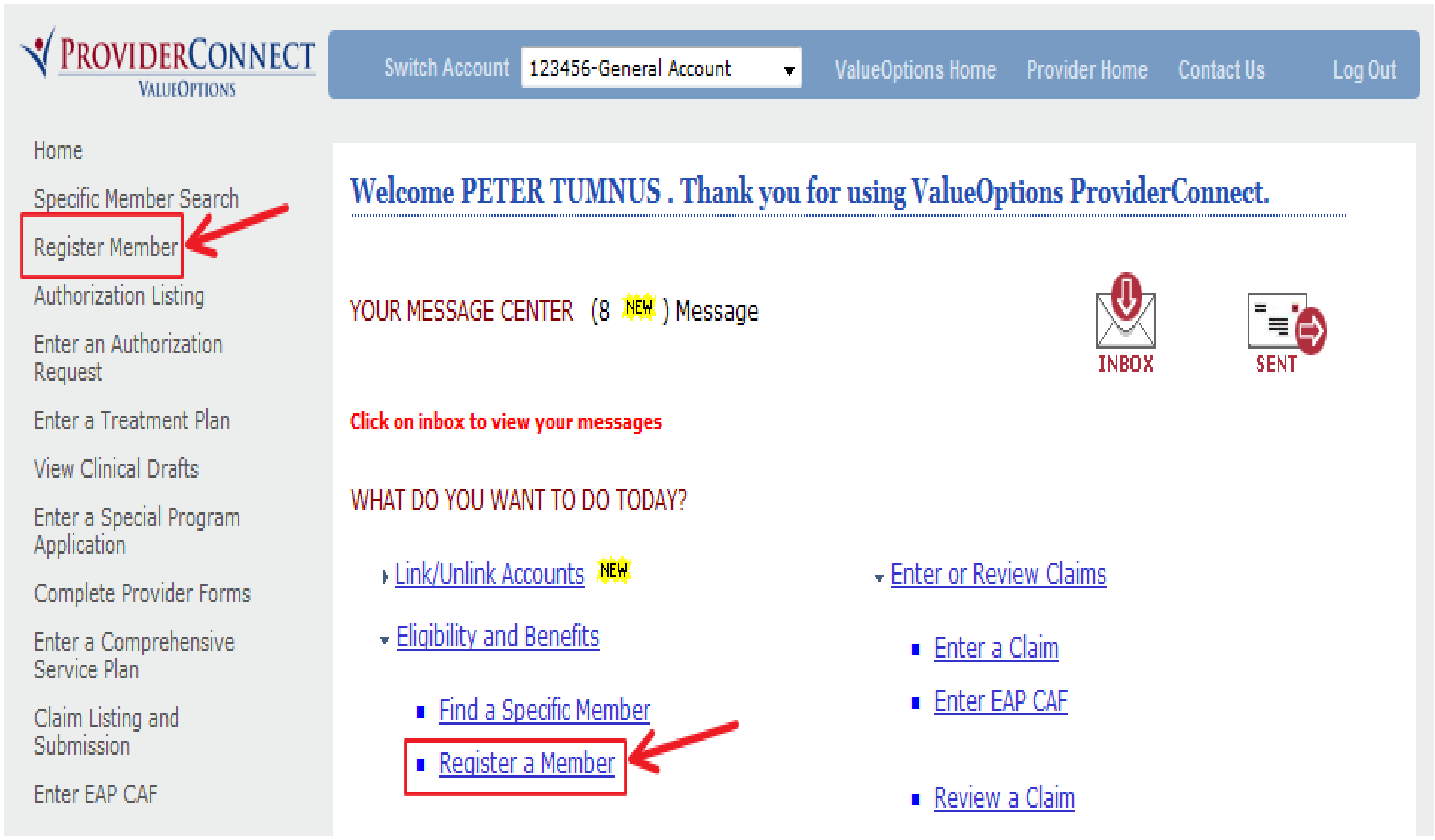
Apply claims adjudication to pay: 1) highest priority, 2) covered service, 3) eligible member

Create financial reports by funding source

Registration Changes

- Can be submitted two ways
  - One individual at a time through ProviderConnect
  - Multiple individuals at a time via Batch Registration process
- Collects basic demographic information about an individual and generates a Client Identification number (CID) if necessary
- Needs to be submitted separate from the authorization
- Is needed before an authorization can be requested
- Assigns fund sources to an individual based on individual's status and provides availability to access specific fund types

Register an Individual


ProviderConnect
ValueOptions
Switch Account
123456-General Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
INBOX
SENT
Link/Unlink Accounts
NEW
Eligibility and Benefits
Find a Specific Member
Register a Member
Enter or Review Claims
Enter a Claim
Enter EAP CAF
Review a Claim

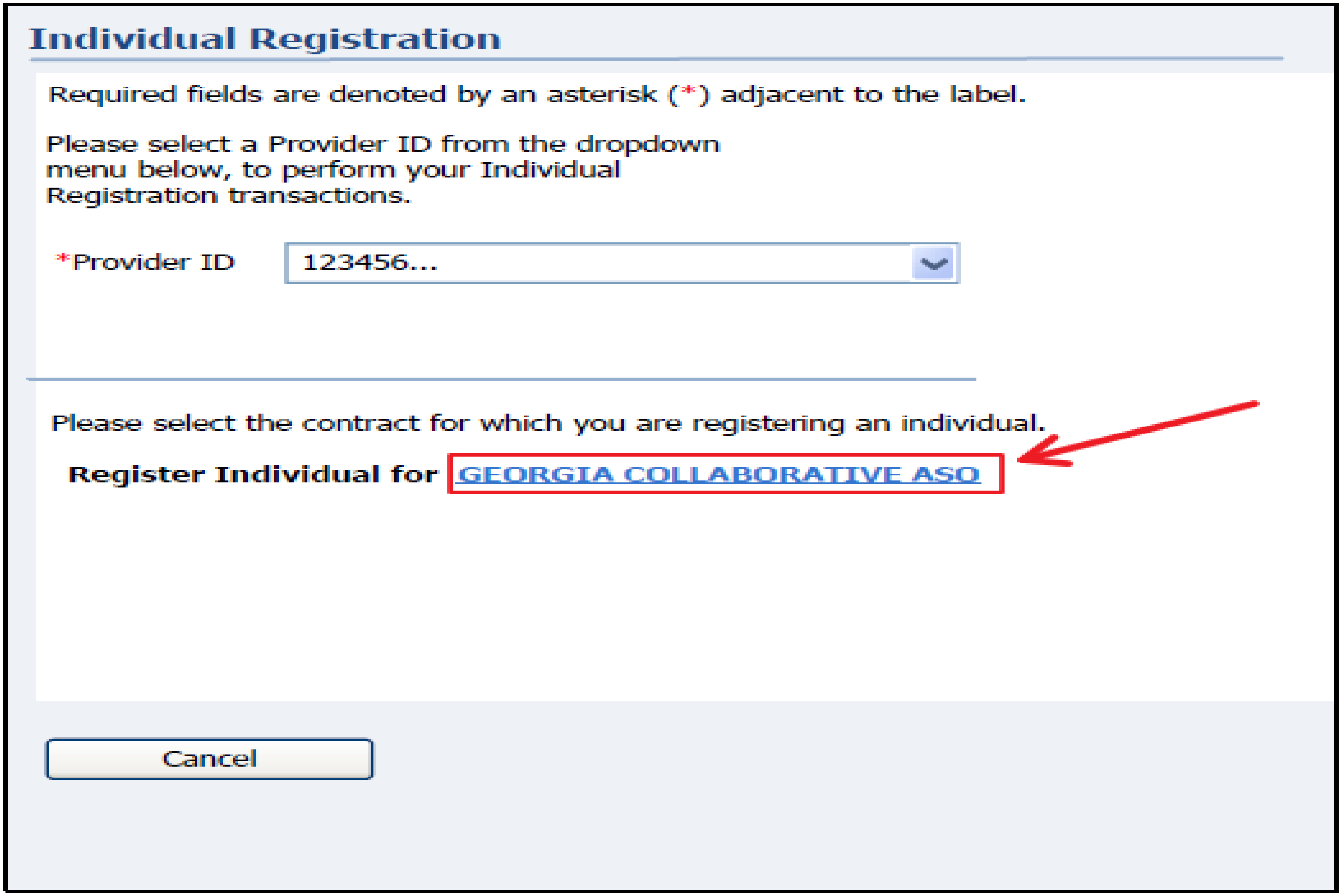
Welcome PETER TUMNUS . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER (8 NEW) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

Register an Individual



Individual Registration

Required fields are denoted by an asterisk (*) adjacent to the label.

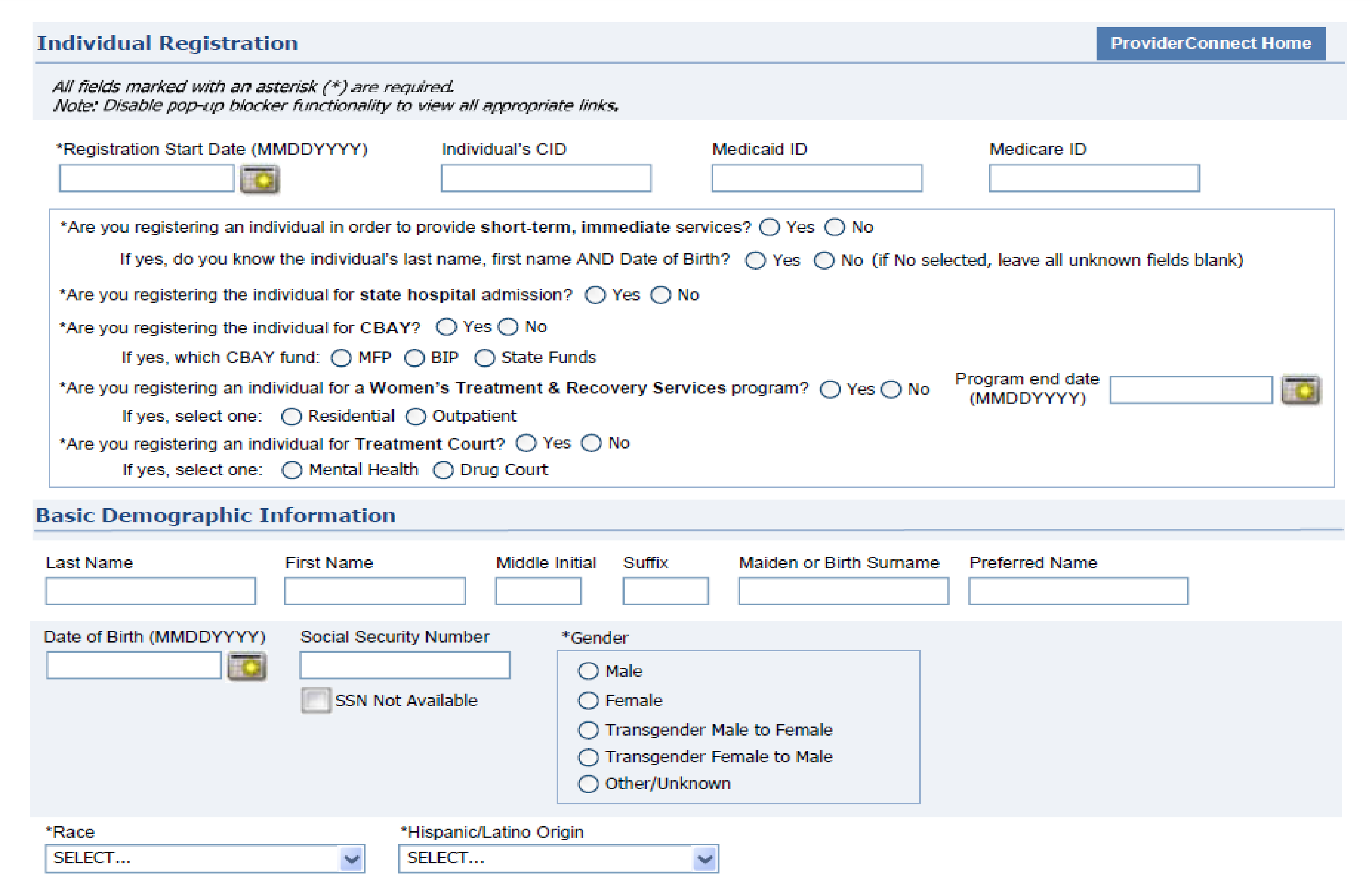
Please select a Provider ID from the dropdown menu below, to perform your Individual Registration transactions.

*Provider ID 123456...

Please select the contract for which you are registering an individual.

Register Individual for GEORGIA COLLABORATIVE ASO

Registration Page



Individual Registration

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

*Registration Start Date (MMDDYYYY)

Individual's CID

Medicaid ID

Medicare ID

*Are you registering an individual in order to provide **short-term, immediate** services? ○ Yes ○ No

If yes, do you know the individual's last name, first name AND Date of Birth? ○ Yes ○ No (if No selected, leave all unknown fields blank)

*Are you registering the individual for **state hospital** admission? ○ Yes ○ No

*Are you registering the individual for **CBAY**? ○ Yes ○ No

If yes, which CBAY fund: ○ MFP ○ BIP ○ State Funds

*Are you registering an individual for a **Women's Treatment & Recovery Services** program? ○ Yes ○ No

Program end date (MMDDYYYY)

If yes, select one: ○ Residential ○ Outpatient

*Are you registering an individual for **Treatment Court**? ○ Yes ○ No

If yes, select one: ○ Mental Health ○ Drug Court

Basic Demographic Information

Last Name

First Name

Middle Initial

Suffix

Maiden or Birth Surname

Preferred Name

Date of Birth (MMDDYYYY)

Social Security Number

☐ SSN Not Available

*Gender

○ Male
○ Female
○ Transgender Male to Female
○ Transgender Female to Male
○ Other/Unknown

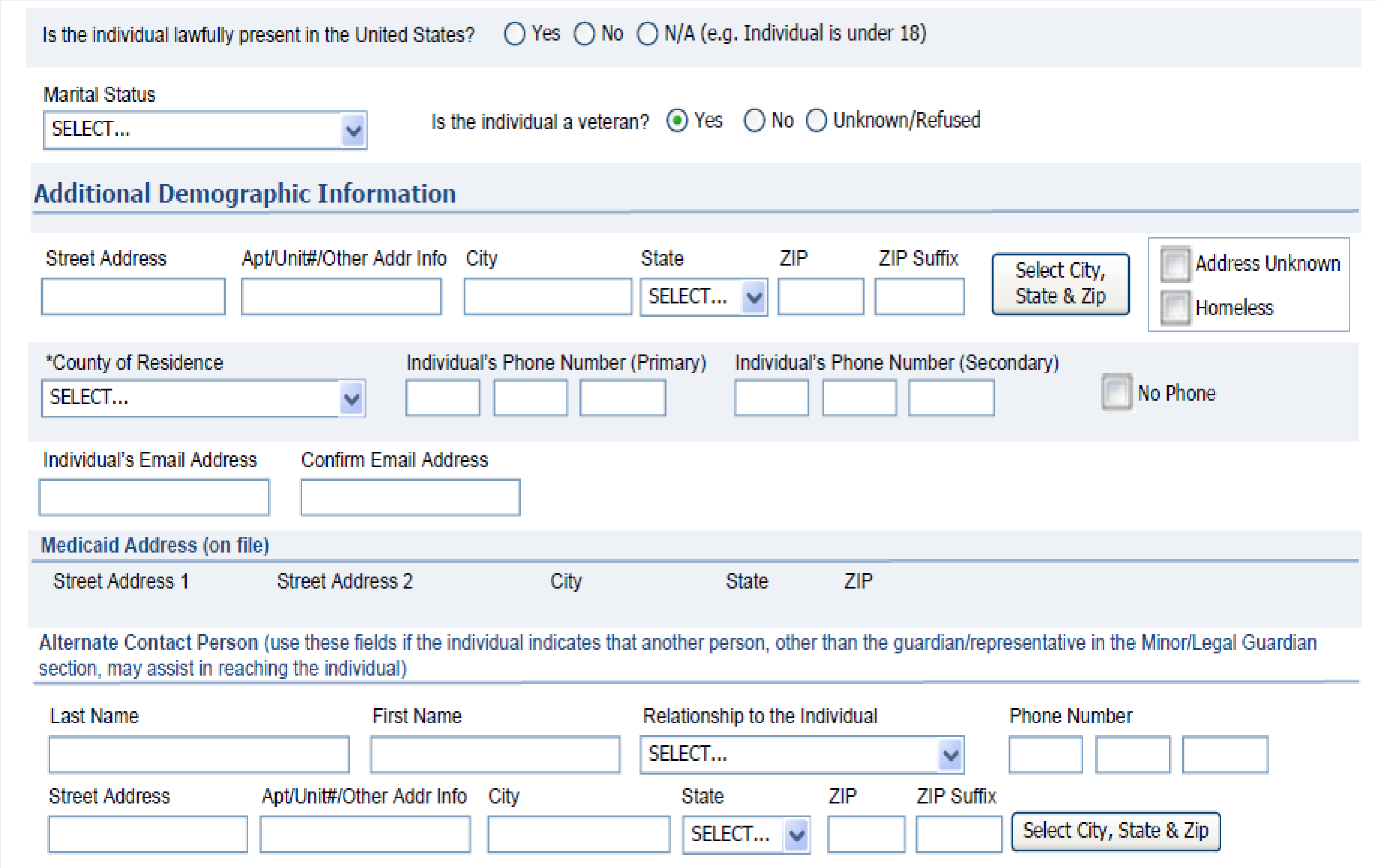
*Race

SELECT...

*Hispanic/Latino Origin

SELECT...

Registration Page



Is the individual lawfully present in the United States? ○ Yes ○ No ○ N/A (e.g. Individual is under 18)

Marital Status
SELECT...

Is the individual a veteran? ● Yes ○ No ○ Unknown/Refused

Additional Demographic Information

Street Address
Apt/Unit#/Other Addr Info
City
State: SELECT...
ZIP
ZIP Suffix
Select City, State & Zip
☐ Address Unknown
☐ Homeless

*County of Residence: SELECT...
Individual's Phone Number (Primary)
Individual's Phone Number (Secondary)
☐ No Phone

Individual's Email Address
Confirm Email Address

Medicaid Address (on file)

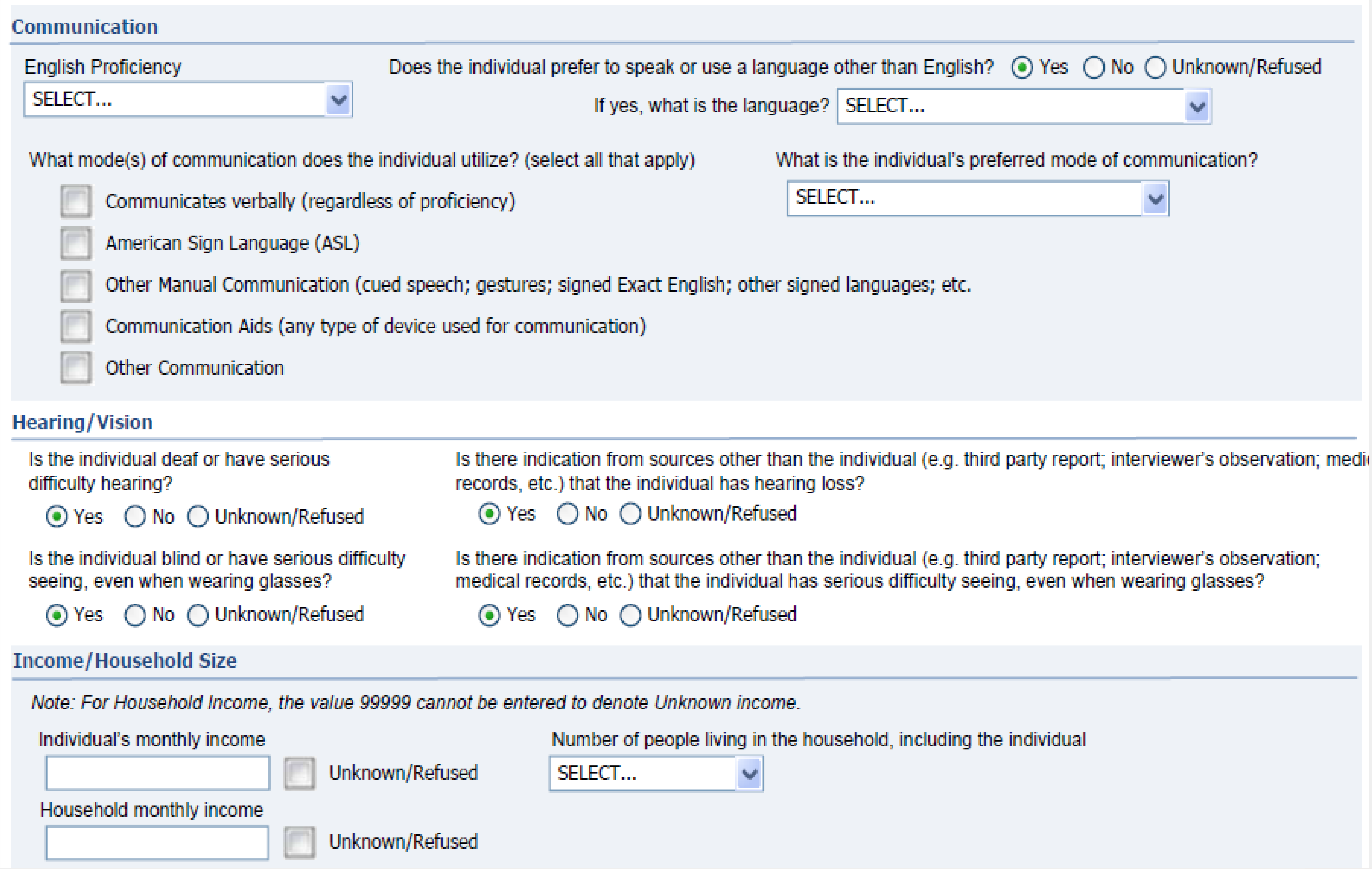
Street Address 1	Street Address 2	City	State	ZIP

Alternate Contact Person (use these fields if the individual indicates that another person, other than the guardian/representative in the Minor/Legal Guardian section, may assist in reaching the individual)

Last Name
First Name
Relationship to the Individual: SELECT...
Phone Number

Street Address
Apt/Unit#/Other Addr Info
City
State: SELECT...
ZIP
ZIP Suffix
Select City, State & Zip

Registration Page



Communication

English Proficiency
SELECT...

Does the individual prefer to speak or use a language other than English? ● Yes ○ No ○ Unknown/Refused

If yes, what is the language? SELECT...

What mode(s) of communication does the individual utilize? (select all that apply)

- ☐ Communicates verbally (regardless of proficiency)
- ☐ American Sign Language (ASL)
- ☐ Other Manual Communication (cued speech; gestures; signed Exact English; other signed languages; etc.
- ☐ Communication Aids (any type of device used for communication)
- ☐ Other Communication

What is the individual's preferred mode of communication?
SELECT...

Hearing/Vision

Is the individual deaf or have serious difficulty hearing?
● Yes ○ No ○ Unknown/Refused

Is there indication from sources other than the individual (e.g. third party report; interviewer's observation; medi records, etc.) that the individual has hearing loss?
● Yes ○ No ○ Unknown/Refused

Is the individual blind or have serious difficulty seeing, even when wearing glasses?
● Yes ○ No ○ Unknown/Refused

Is there indication from sources other than the individual (e.g. third party report; interviewer's observation; medical records, etc.) that the individual has serious difficulty seeing, even when wearing glasses?
● Yes ○ No ○ Unknown/Refused

Income/Household Size

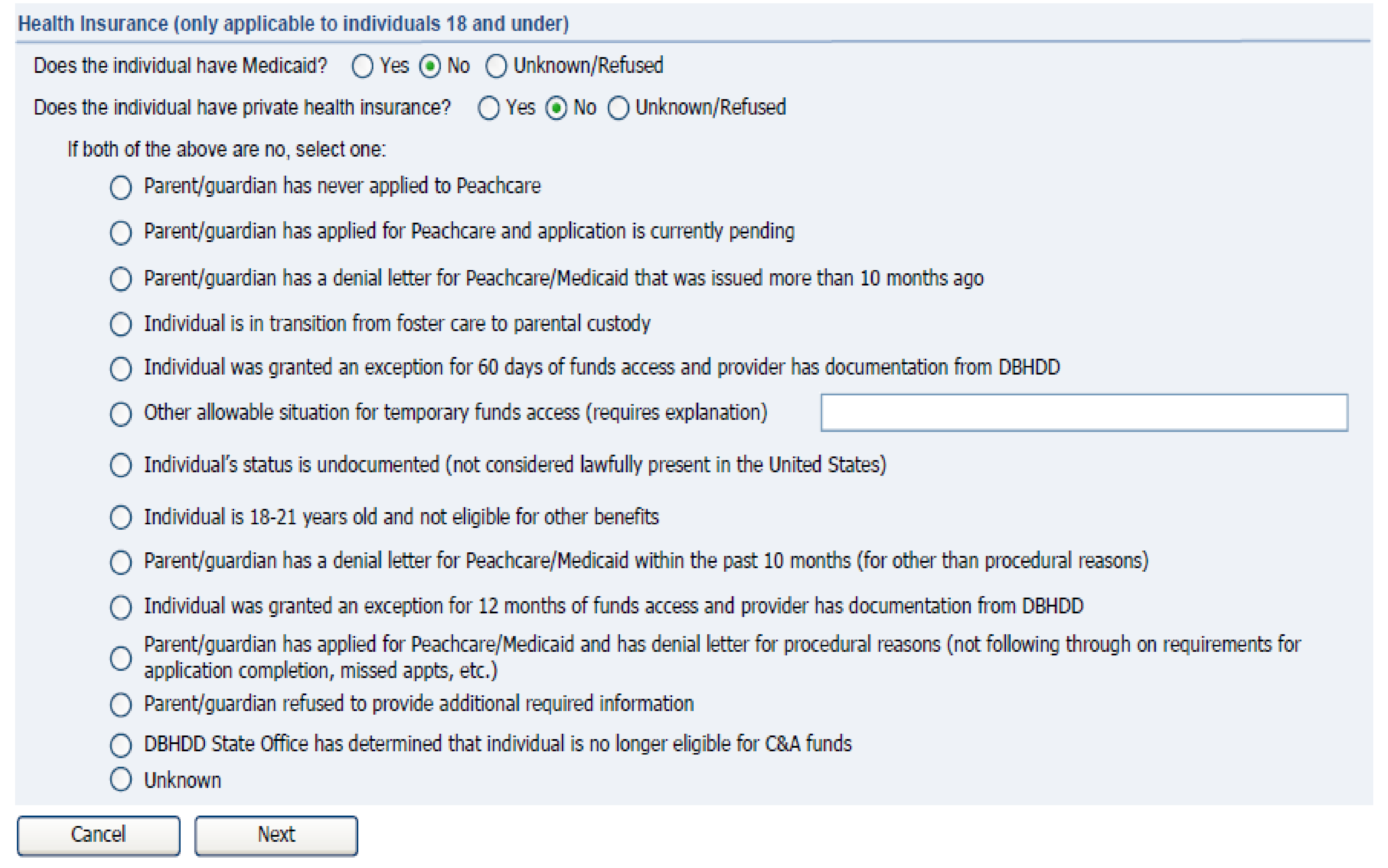
Note: For Household Income, the value 99999 cannot be entered to denote Unknown income.

Individual's monthly income
☐ Unknown/Refused

Household monthly income
☐ Unknown/Refused

Number of people living in the household, including the individual
SELECT...

Registration Page



Health Insurance (only applicable to individuals 18 and under)

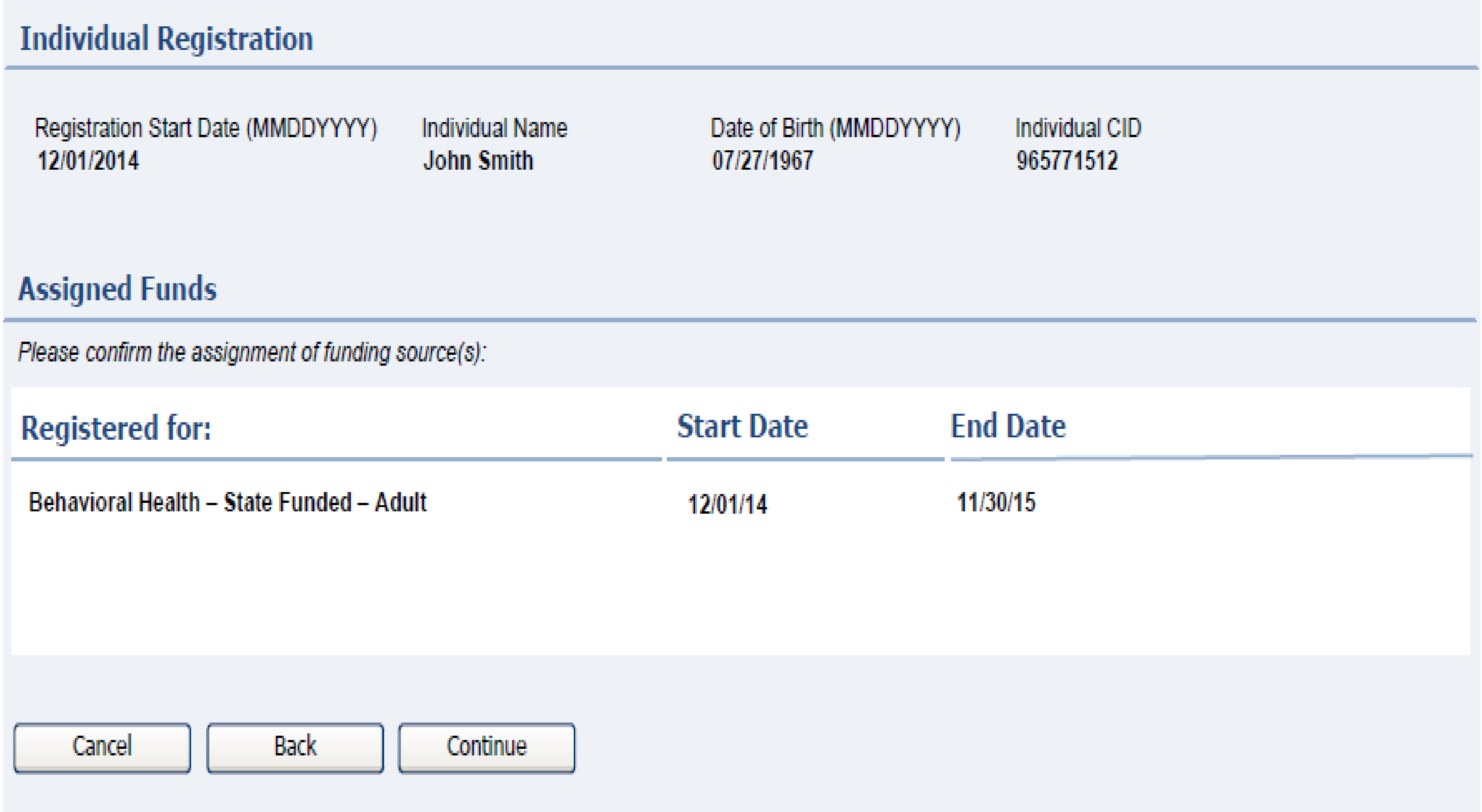
Does the individual have Medicaid? ○ Yes ● No ○ Unknown/Refused

Does the individual have private health insurance? ○ Yes ● No ○ Unknown/Refused

If both of the above are no, select one:

- ○ Parent/guardian has never applied to Peachcare
- ○ Parent/guardian has applied for Peachcare and application is currently pending
- ○ Parent/guardian has a denial letter for Peachcare/Medicaid that was issued more than 10 months ago
- ○ Individual is in transition from foster care to parental custody
- ○ Individual was granted an exception for 60 days of funds access and provider has documentation from DBHDD
- ○ Other allowable situation for temporary funds access (requires explanation)
- ○ Individual's status is undocumented (not considered lawfully present in the United States)
- ○ Individual is 18-21 years old and not eligible for other benefits
- ○ Parent/guardian has a denial letter for Peachcare/Medicaid within the past 10 months (for other than procedural reasons)
- ○ Individual was granted an exception for 12 months of funds access and provider has documentation from DBHDD
- ○ Parent/guardian has applied for Peachcare/Medicaid and has denial letter for procedural reasons (not following through on requirements for application completion, missed appts, etc.)
- ○ Parent/guardian refused to provide additional required information
- ○ DBHDD State Office has determined that individual is no longer eligible for C&A funds
- ○ Unknown

Registration Page



Individual Registration

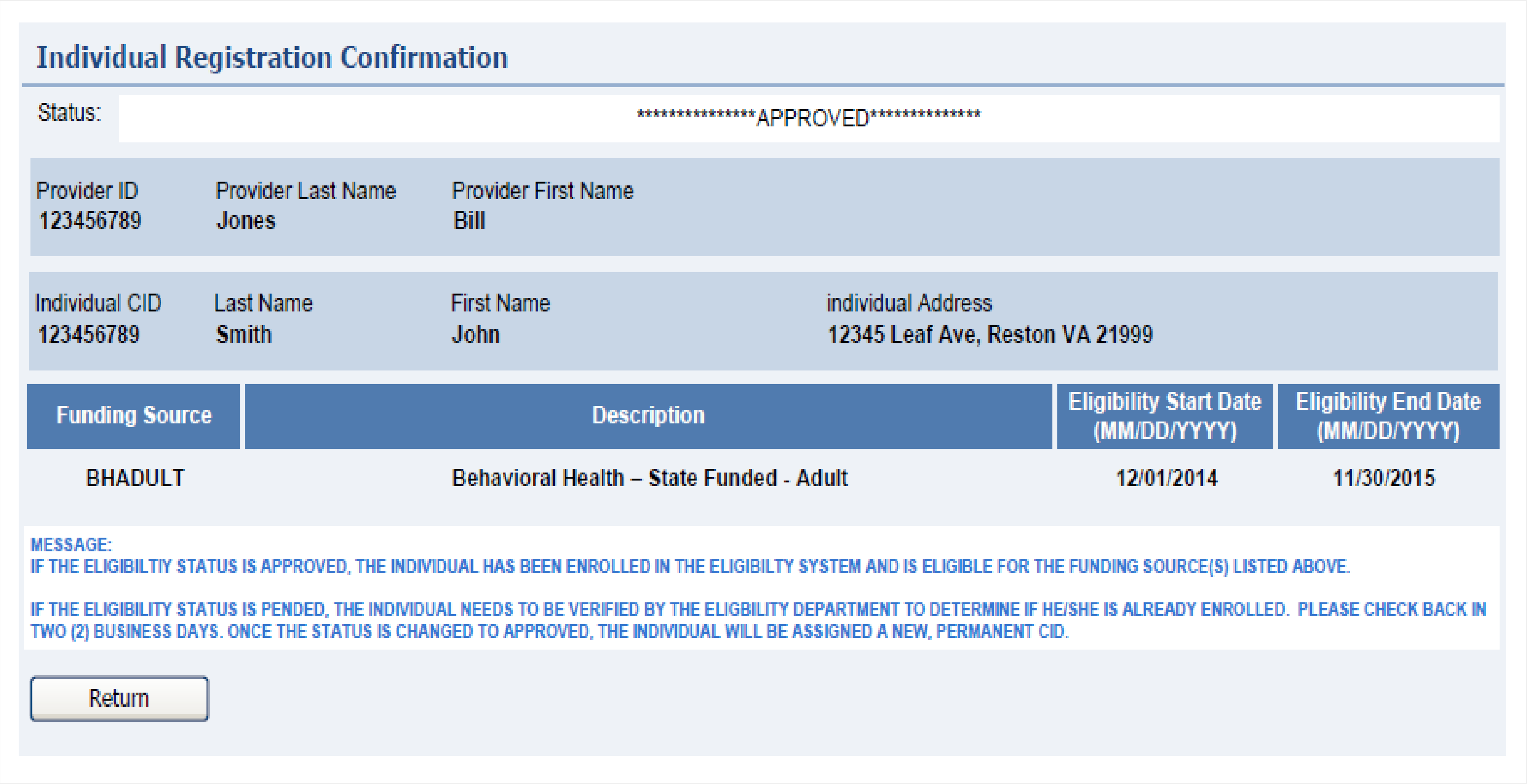
Registration Start Date (MMDDYYYY)	Individual Name	Date of Birth (MMDDYYYY)	Individual CID
12/01/2014	John Smith	07/27/1967	965771512

Assigned Funds

Please confirm the assignment of funding source(s):

Registered for:	Start Date	End Date
Behavioral Health – State Funded – Adult	12/01/14	11/30/15

Registration Confirmation



Individual Registration Confirmation

Status: ***************APPROVED**************

Provider ID	Provider Last Name	Provider First Name
123456789	Jones	Bill

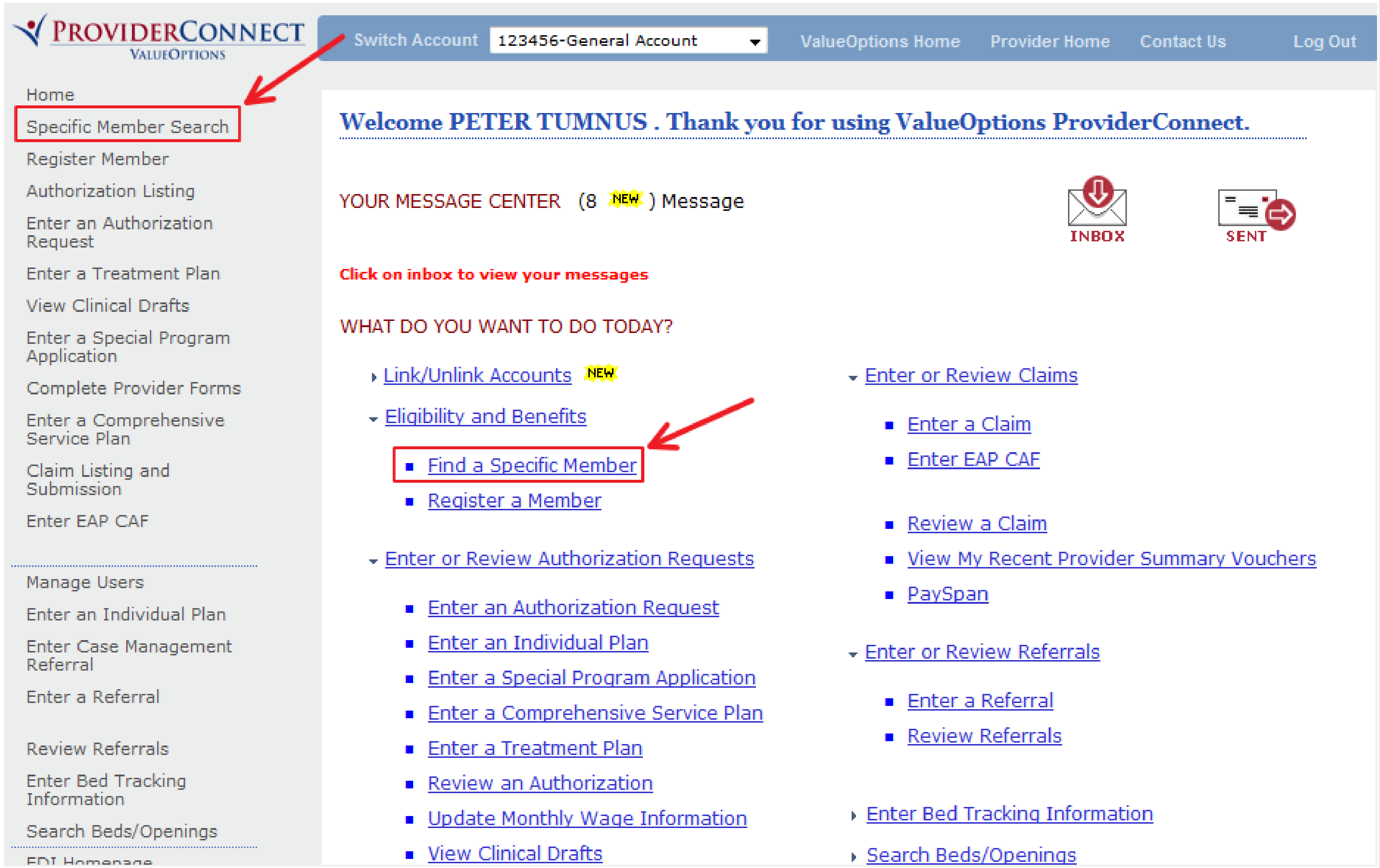
Individual CID	Last Name	First Name	individual Address
123456789	Smith	John	12345 Leaf Ave, Reston VA 21999

Funding Source	Description	Eligibility Start Date (MM/DD/YYYY)	Eligibility End Date (MM/DD/YYYY)
BHADULT	Behavioral Health – State Funded - Adult	12/01/2014	11/30/2015

MESSAGE:
IF THE ELIGIBILTIY STATUS IS APPROVED, THE INDIVIDUAL HAS BEEN ENROLLED IN THE ELIGIBILTY SYSTEM AND IS ELIGIBLE FOR THE FUNDING SOURCE(S) LISTED ABOVE.

IF THE ELIGIBILITY STATUS IS PENDED, THE INDIVIDUAL NEEDS TO BE VERIFIED BY THE ELIGBILITY DEPARTMENT TO DETERMINE IF HE/SHE IS ALREADY ENROLLED. PLEASE CHECK BACK IN TWO (2) BUSINESS DAYS. ONCE THE STATUS IS CHANGED TO APPROVED, THE INDIVIDUAL WILL BE ASSIGNED A NEW, PERMANENT CID.

Checking if an Individual is Registered


PROVIDERCONNECT
VALUEOPTIONS
Switch Account
123456-General Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
INBOX
SENT

Welcome PETER TUMNUS . Thank you for using ValueOptions ProviderConnect.

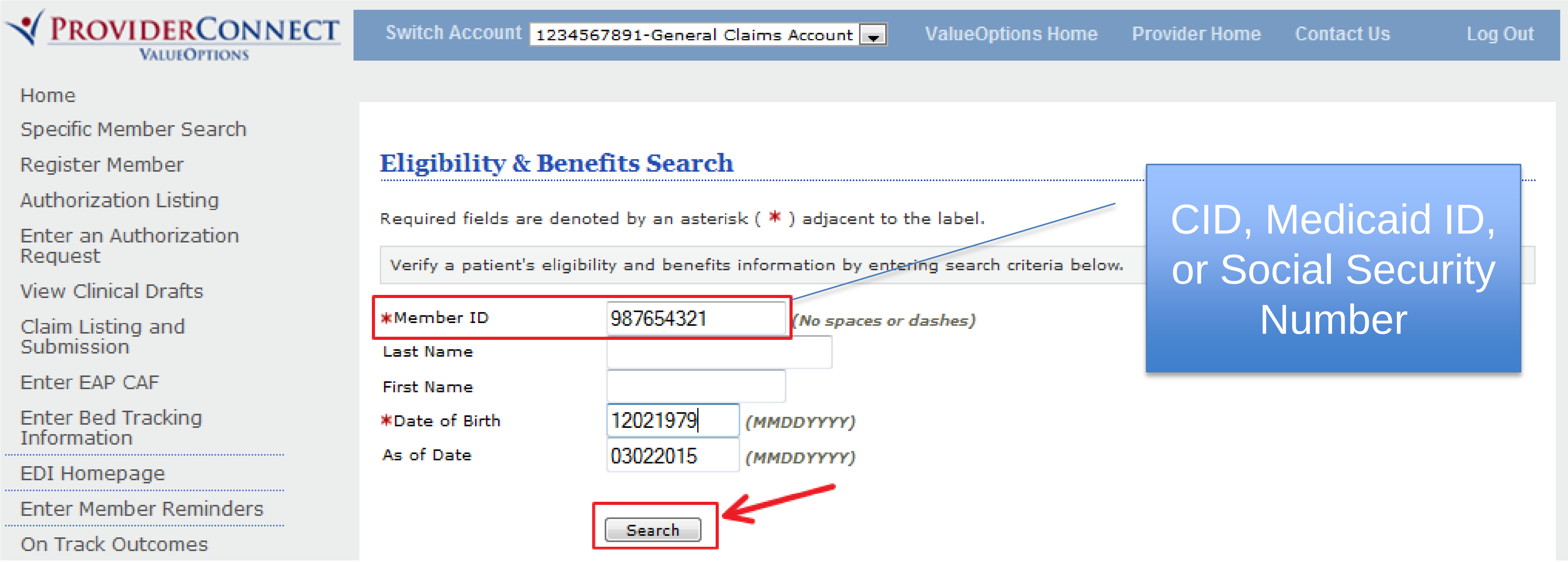
YOUR MESSAGE CENTER (8 NEW) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

Link/Unlink Accounts NEW
Eligibility and Benefits
Find a Specific Member
Register a Member
Enter or Review Authorization Requests
Enter an Authorization Request
Enter an Individual Plan
Enter a Special Program Application
Enter a Comprehensive Service Plan
Enter a Treatment Plan
Review an Authorization
Update Monthly Wage Information
View Clinical Drafts
Enter or Review Claims
Enter a Claim
Enter EAP CAF
Review a Claim
View My Recent Provider Summary Vouchers
PaySpan
Enter or Review Referrals
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings

Search for an Individual


PROVIDERCONNECT
VALUEOPTIONS
Switch Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
Enter EAP CAF
Enter Bed Tracking Information
EDI Homepage
Enter Member Reminders
On Track Outcomes
Search

Switch Account: 1234567891-General Claims Account

Eligibility & Benefits Search

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID: 987654321 (No spaces or dashes)

Last Name:

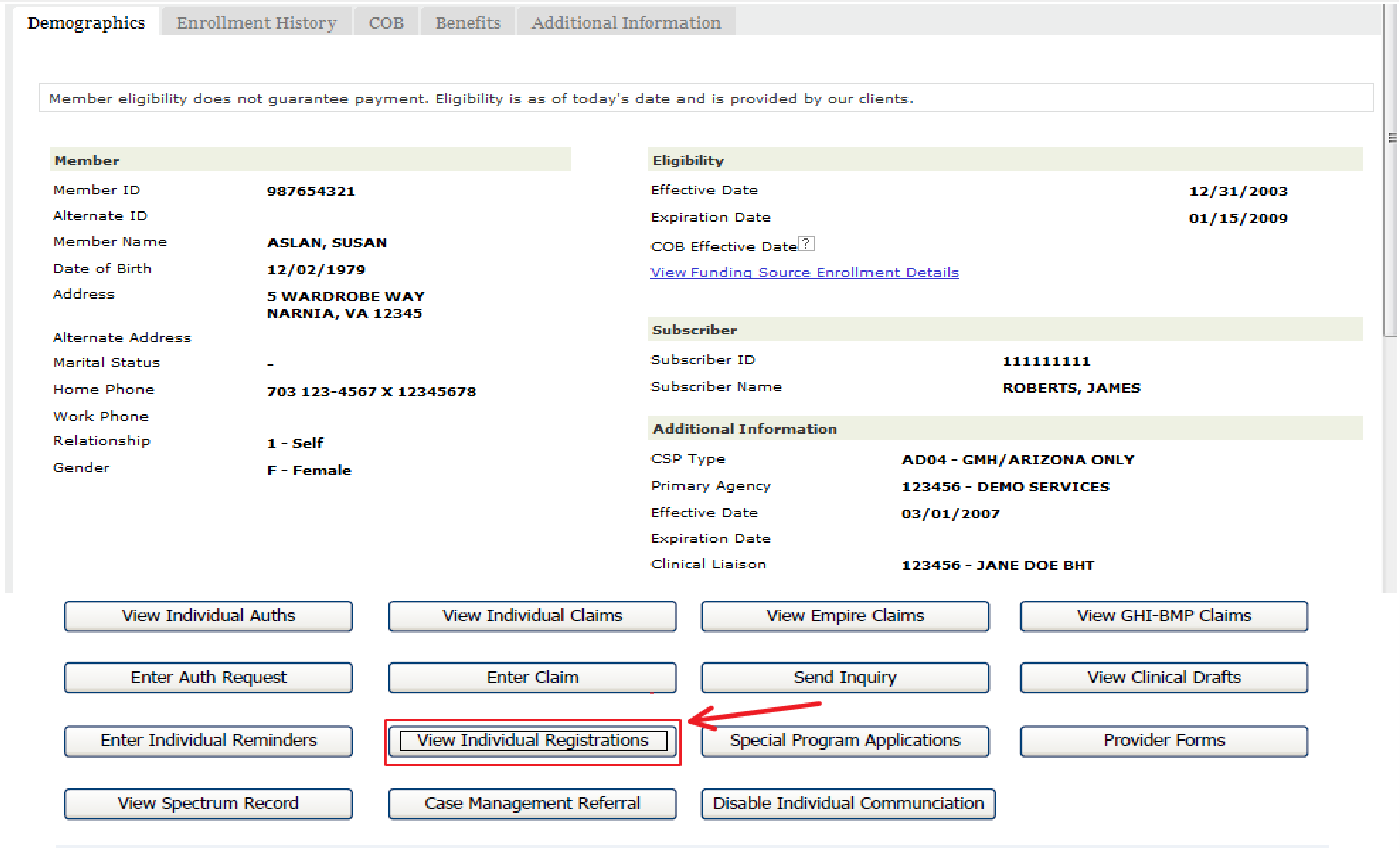
First Name:

*Date of Birth: 12021979 (MMDDYYYY)

As of Date: 03022015 (MMDDYYYY)

CID, Medicaid ID, or Social Security Number

View Individual Registrations


Demographics
Enrollment History
COB
Benefits
Additional Information
View Individual Auths
View Individual Claims
View Empire Claims
View GHI-BMP Claims
Enter Auth Request
Enter Claim
Send Inquiry
View Clinical Drafts
Enter Individual Reminders
View Individual Registrations
Special Program Applications
Provider Forms
View Spectrum Record
Case Management Referral
Disable Individual Communciation

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member

Member ID	987654321
Alternate ID	
Member Name	ASLAN, SUSAN
Date of Birth	12/02/1979
Address	5 WARDROBE WAY NARNIA, VA 12345
Alternate Address	
Marital Status	-
Home Phone	703 123-4567 X 12345678
Work Phone	
Relationship	1 - Self
Gender	F - Female

Eligibility

Effective Date	12/31/2003
Expiration Date	01/15/2009
COB Effective Date ?	

View Funding Source Enrollment Details

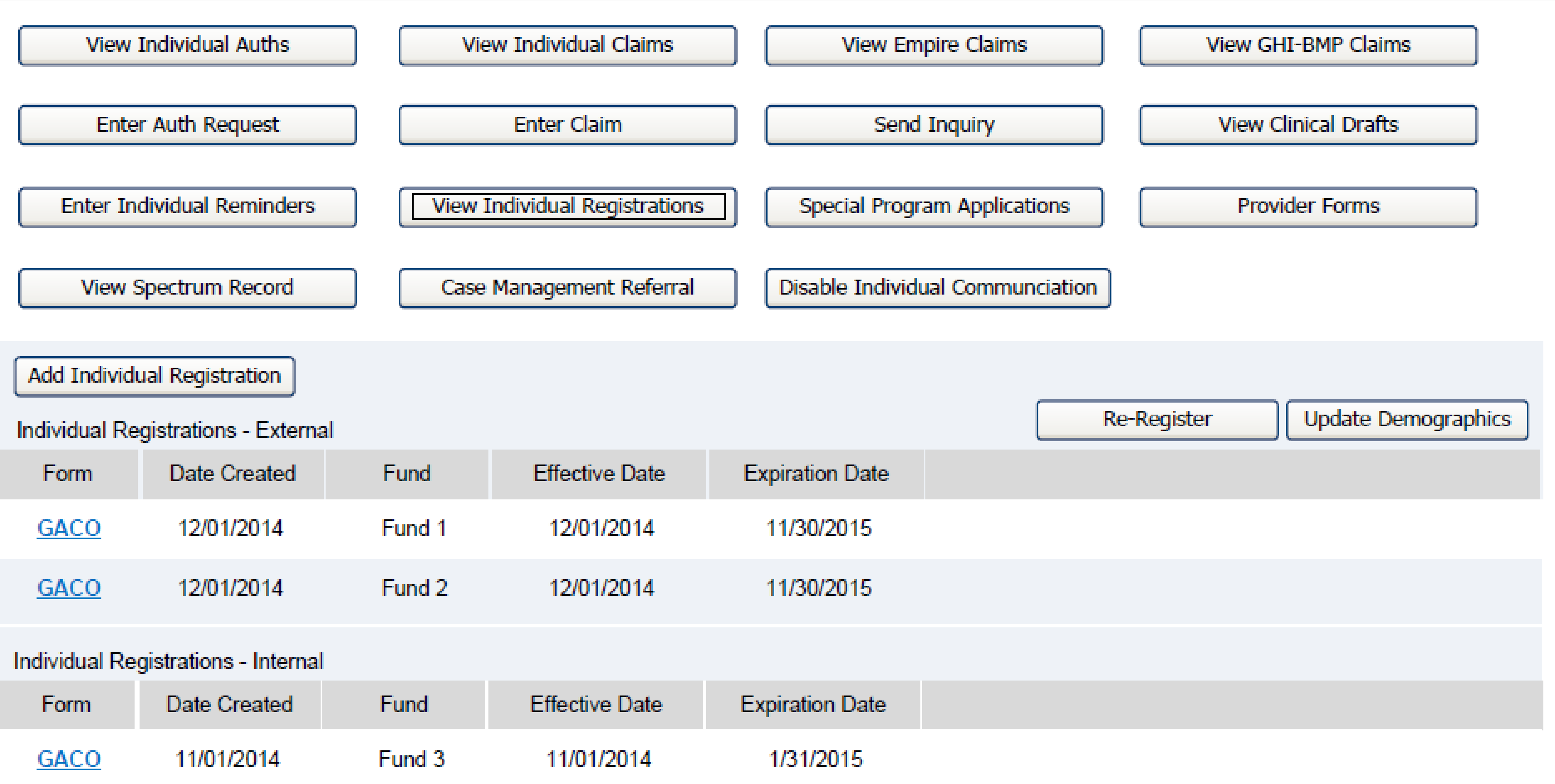
Subscriber

Subscriber ID	111111111
Subscriber Name	ROBERTS, JAMES

Additional Information

CSP Type	AD04 - GMH/ARIZONA ONLY
Primary Agency	123456 - DEMO SERVICES
Effective Date	03/01/2007
Expiration Date	
Clinical Liaison	123456 - JANE DOE BHT

Individual Registrations

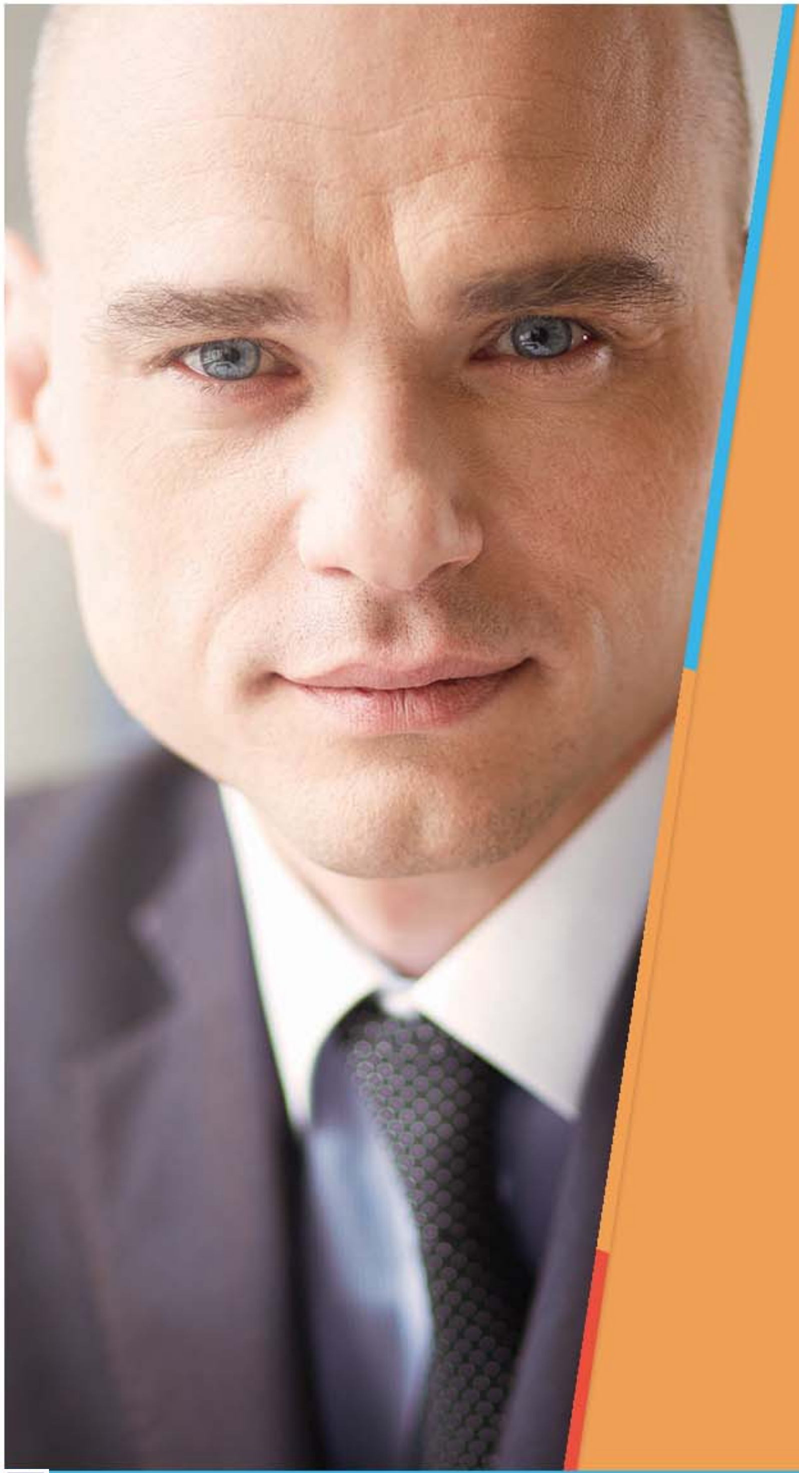

View Individual Auths
View Individual Claims
View Empire Claims
View GHI-BMP Claims
Enter Auth Request
Enter Claim
Send Inquiry
View Clinical Drafts
Enter Individual Reminders
View Individual Registrations
Special Program Applications
Provider Forms
View Spectrum Record
Case Management Referral
Disable Individual Communciation
Add Individual Registration
Re-Register
Update Demographics

Individual Registrations - External

Form	Date Created	Fund	Effective Date	Expiration Date
GACO	12/01/2014	Fund 1	12/01/2014	11/30/2015
GACO	12/01/2014	Fund 2	12/01/2014	11/30/2015

Individual Registrations - Internal

Form	Date Created	Fund	Effective Date	Expiration Date
GACO	11/01/2014	Fund 3	11/01/2014	1/31/2015

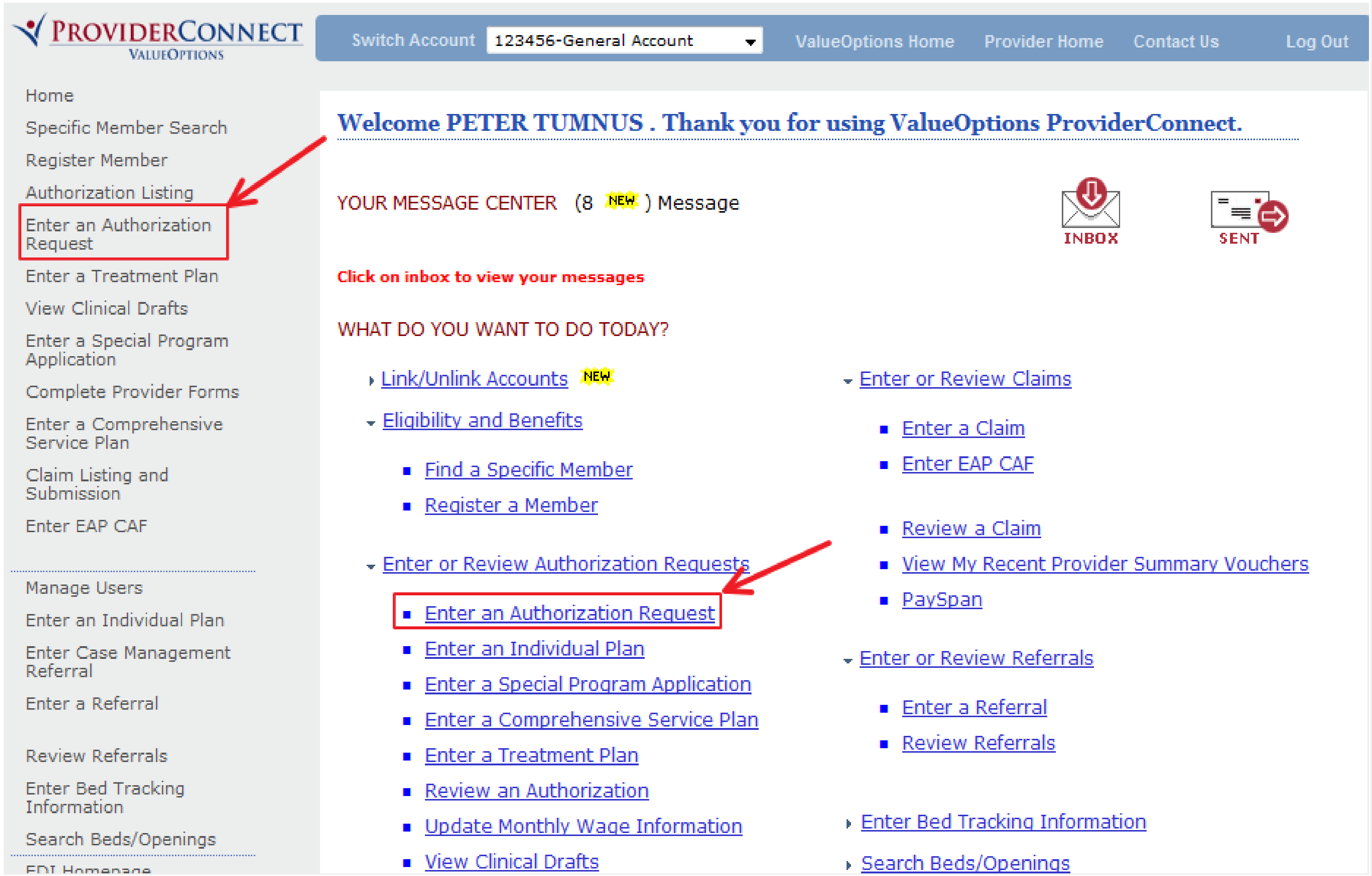


Authorizations

Authorization Changes

- Will be submitted through ProviderConnect or by Batch
- Outpatient Essential Services will need to be requested as needed and are no longer bundled
- CANS and ANSA is required instead of LOCUS and CAFAS

Enter an Authorization Request


ProviderConnect
ValueOptions
Switch Account
123456-General Account
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Log Out
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Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
EDI Homepage
INBOX
SENT

Welcome PETER TUMNUS . Thank you for using ValueOptions ProviderConnect.

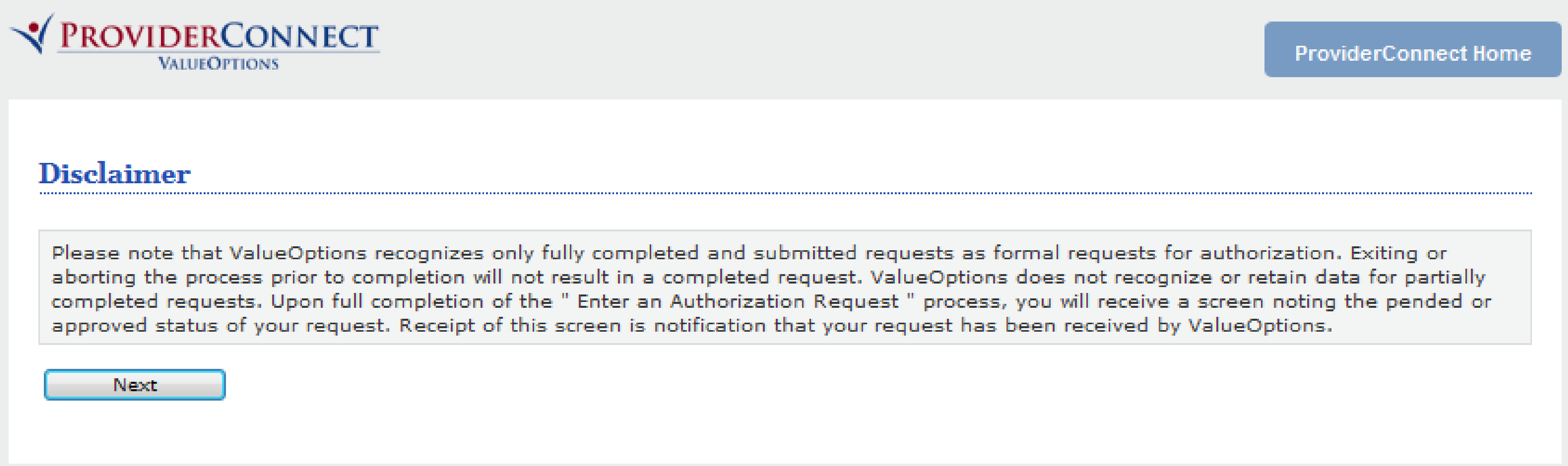
YOUR MESSAGE CENTER (8 NEW) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- Link/Unlink Accounts NEW
- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter an Individual Plan
  - Enter a Special Program Application
  - Enter a Comprehensive Service Plan
  - Enter a Treatment Plan
  - Review an Authorization
  - Update Monthly Wage Information
  - View Clinical Drafts
- Enter or Review Claims
  - Enter a Claim
  - Enter EAP CAF
  - Review a Claim
  - View My Recent Provider Summary Vouchers
  - PaySpan
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals
- Enter Bed Tracking Information
- Search Beds/Openings

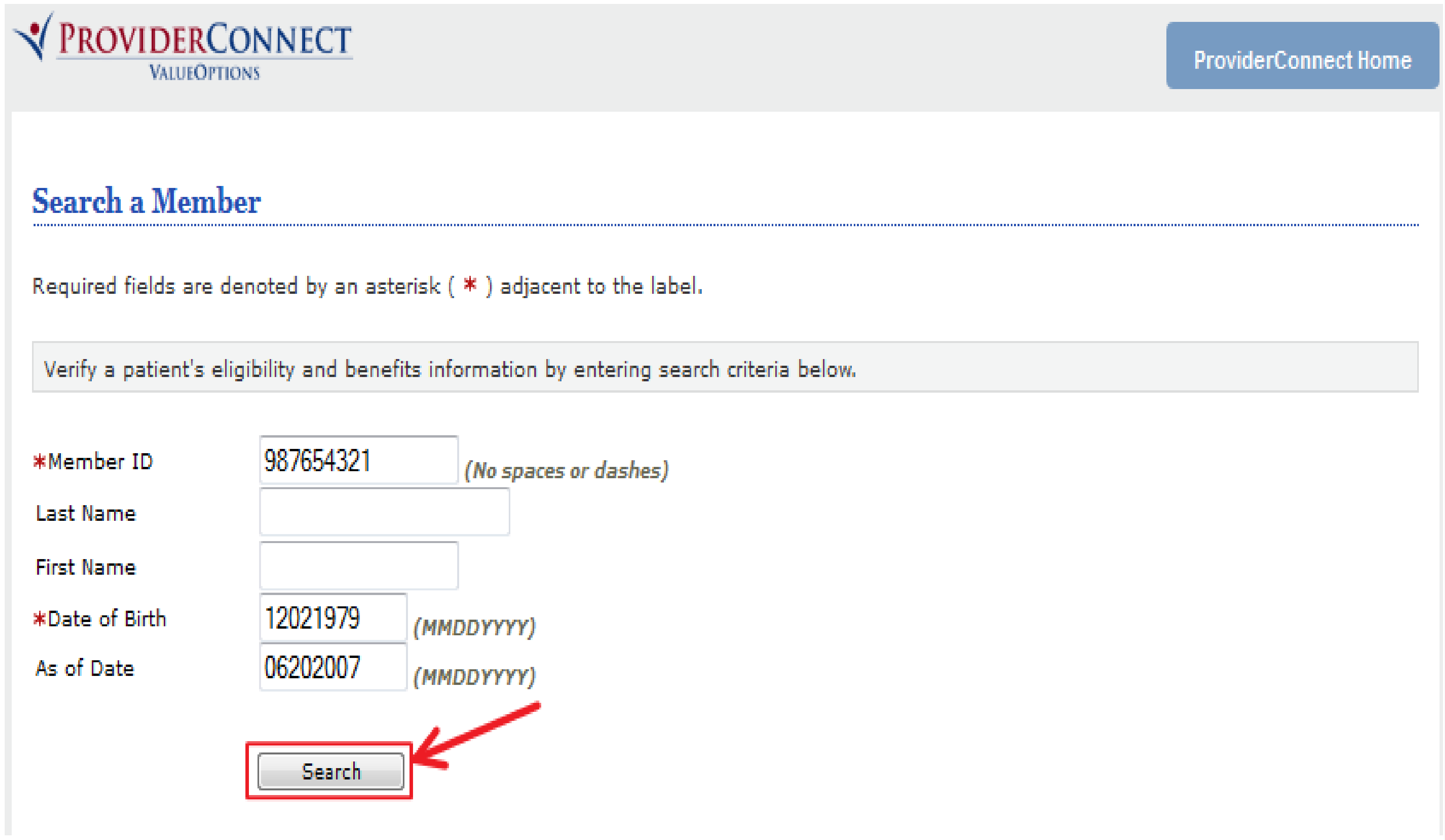
Disclaimer



Disclaimer

Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for authorization. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the " Enter an Authorization Request " process, you will receive a screen noting the pended or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions.

How to Search for an Individual


PROVIDERCONNECT
VALUEOPTIONS
ProviderConnect Home

Search a Member

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID 987654321 *(No spaces or dashes)*

Last Name

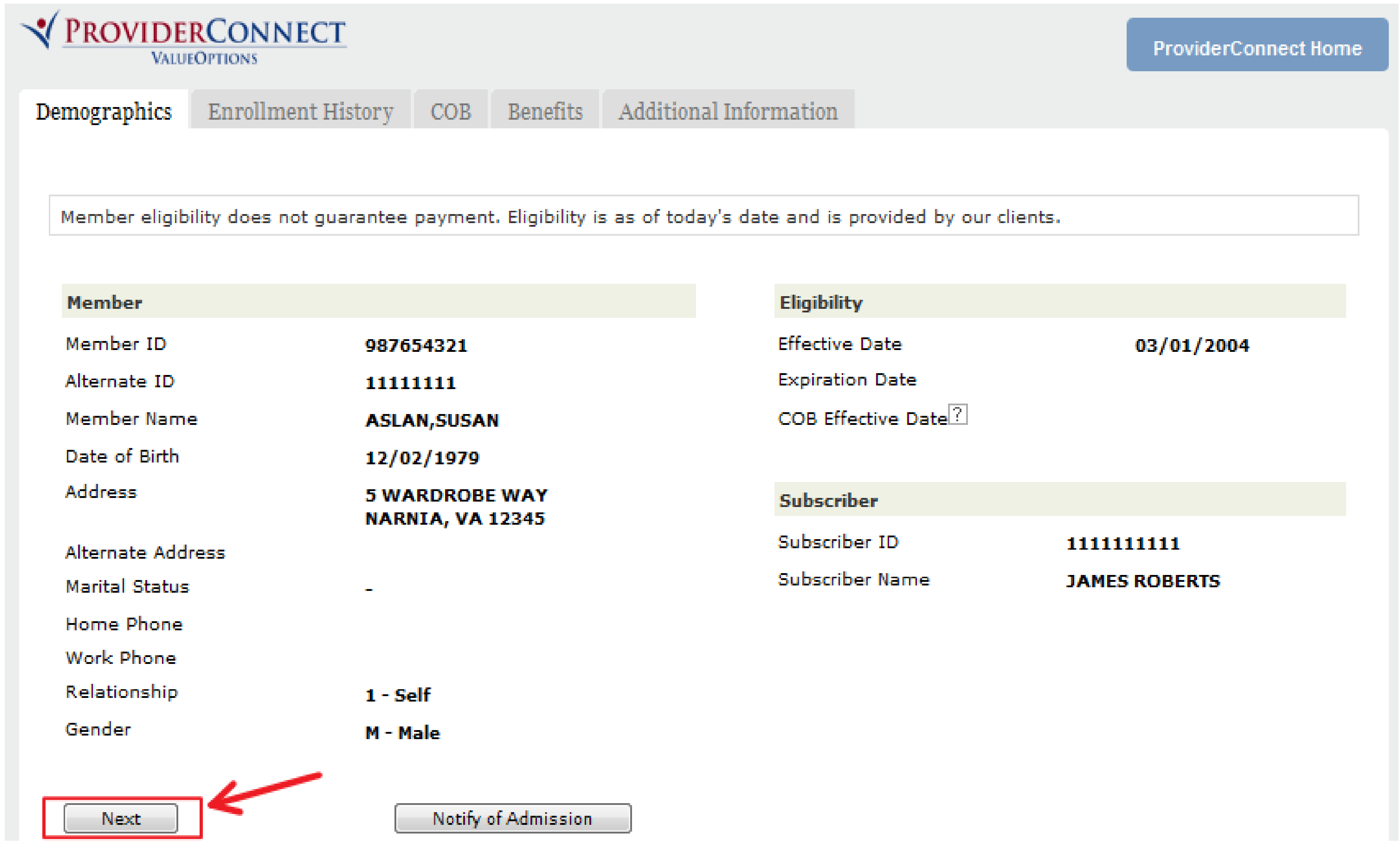
First Name

*Date of Birth 12021979 *(MMDDYYYY)*

As of Date 06202007 *(MMDDYYYY)*

Search

Individual Information


PROVIDERCONNECT
VALUEOPTIONS
ProviderConnect Home
Demographics
Enrollment History
COB
Benefits
Additional Information
Next
Notify of Admission

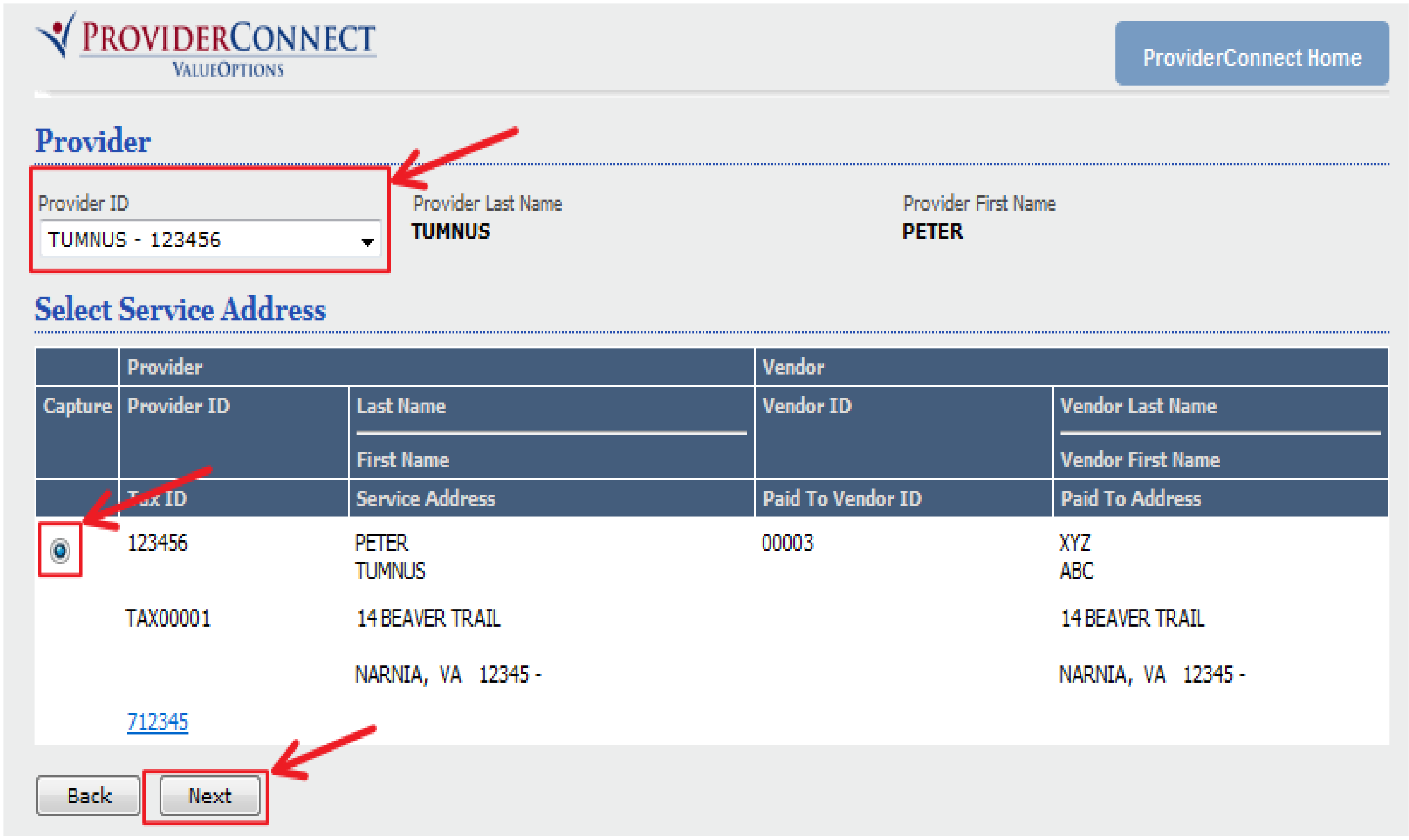
Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member	
Member ID	**987654321**
Alternate ID	**11111111**
Member Name	**ASLAN,SUSAN**
Date of Birth	**12/02/1979**
Address	**5 WARDROBE WAY** **NARNIA, VA 12345**
Alternate Address	
Marital Status	**-**
Home Phone	
Work Phone	
Relationship	**1 - Self**
Gender	**M - Male**

Eligibility	
Effective Date	**03/01/2004**
Expiration Date	
COB Effective Date ?	

Subscriber	
Subscriber ID	**1111111111**
Subscriber Name	**JAMES ROBERTS**

Service Address



ProviderConnect
ValueOptions
ProviderConnect Home

Provider

Provider ID: TUMNUS - 123456

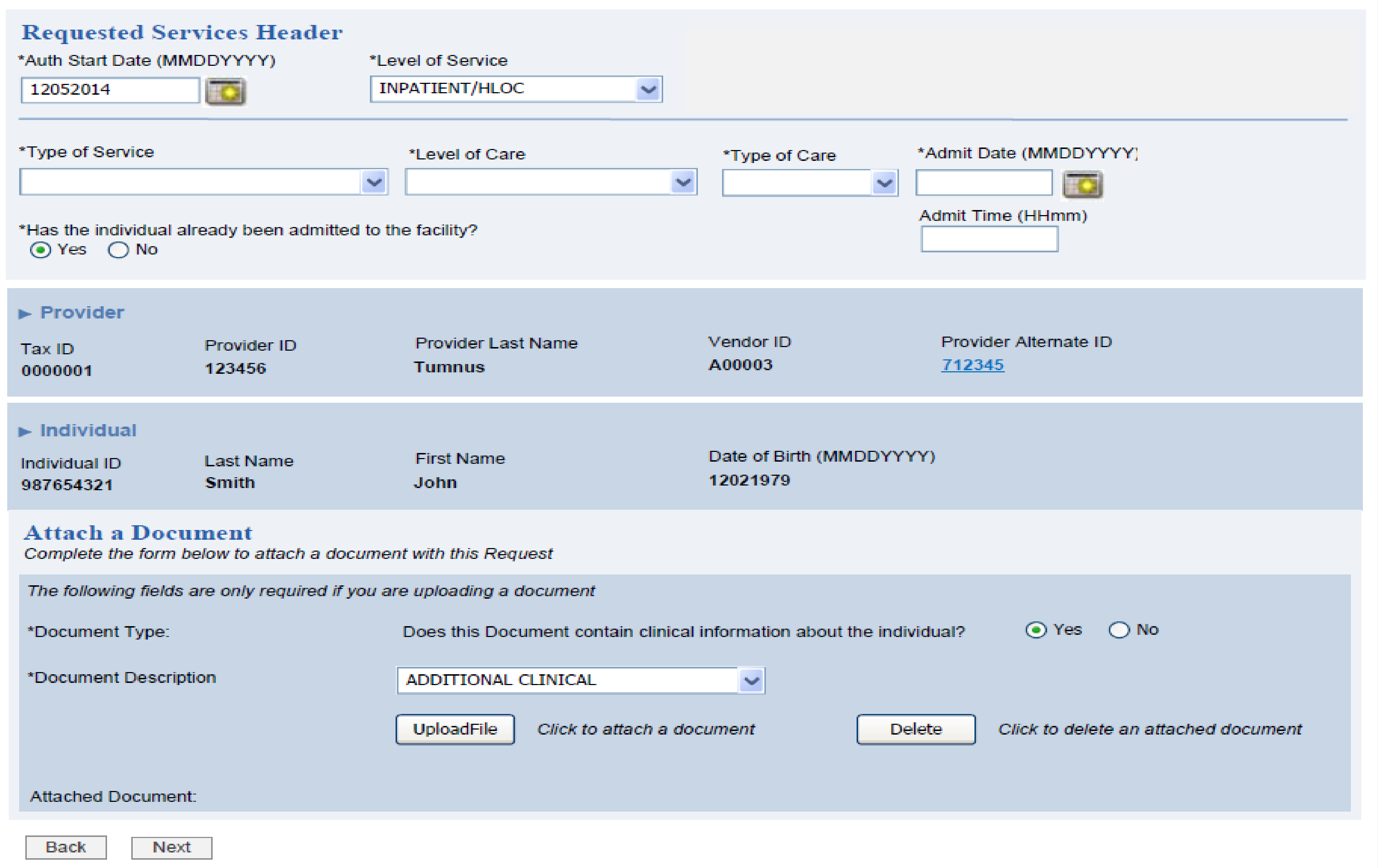
Provider Last Name: **TUMNUS**

Provider First Name: **PETER**

Select Service Address

Capture	Provider		Vendor	
	Provider ID	Last Name First Name	Vendor ID	Vendor Last Name Vendor First Name
	Tax ID	Service Address	Paid To Vendor ID	Paid To Address
●	123456	PETER TUMNUS	00003	XYZ ABC
	TAX00001	14 BEAVER TRAIL NARNIA, VA 12345 -		14 BEAVER TRAIL NARNIA, VA 12345 -
	712345			

Requested Services Header



Requested Services Header

*Auth Start Date (MMDDYYYY): 12052014

*Level of Service: INPATIENT/HLOC

*Type of Service:

*Level of Care:

*Type of Care:

*Admit Date (MMDDYYYY)

Admit Time (HHmm)

*Has the individual already been admitted to the facility?
● Yes ○ No

▶ Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID	Provider Alternate ID
0000001	**123456**	**Tumnus**	**A00003**	712345

▶ Individual

Individual ID	Last Name	First Name	Date of Birth (MMDDYYYY)
987654321	**Smith**	**John**	**12021979**

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the individual? ● Yes ○ No

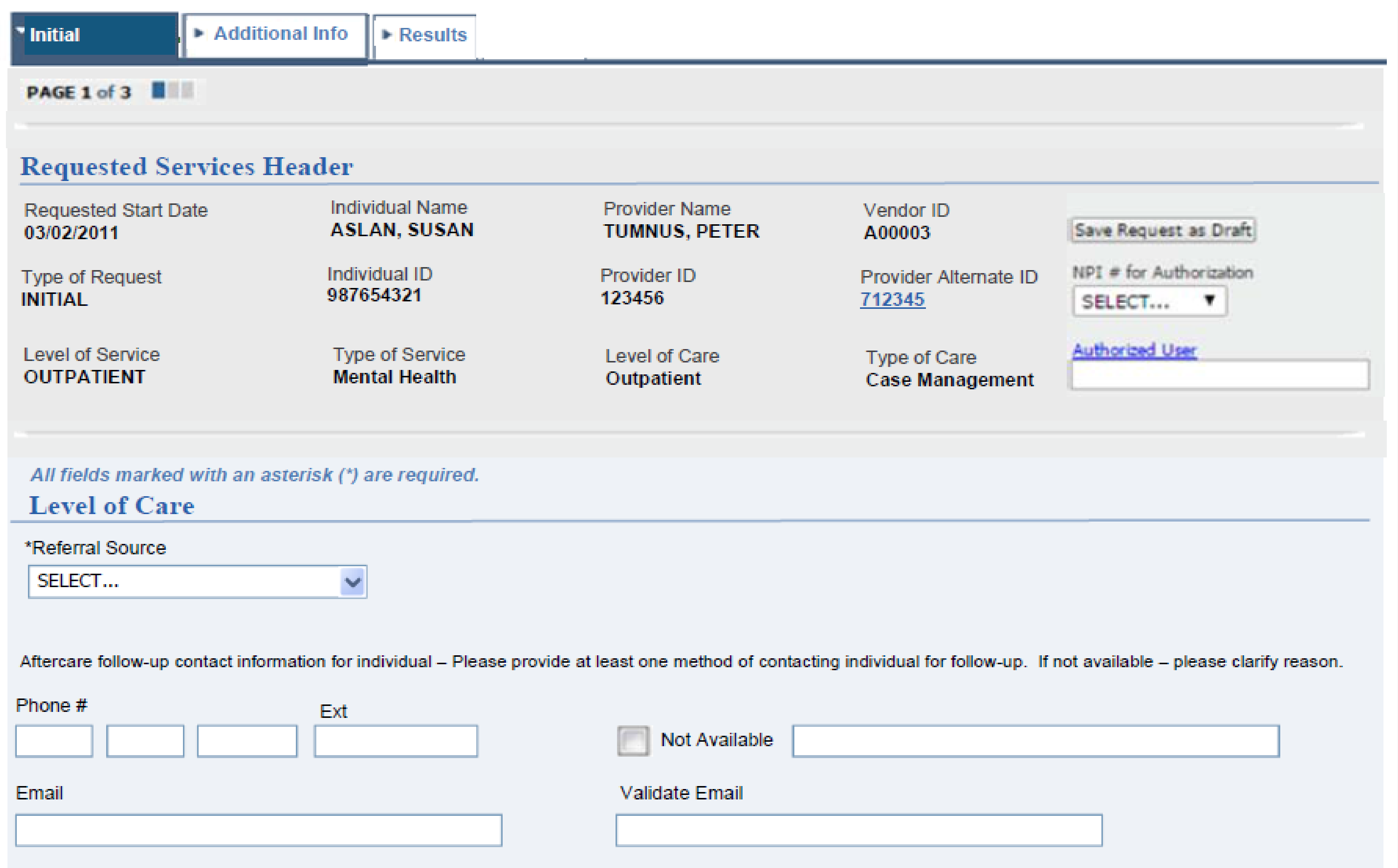
*Document Description: ADDITIONAL CLINICAL

Click to attach a document

Click to delete an attached document

Attached Document:

Requested Services / Level of Care



Requested Services Header

Requested Start Date
03/02/2011

Individual Name
ASLAN, SUSAN

Provider Name
TUMNUS, PETER

Vendor ID
A00003

Type of Request
INITIAL

Individual ID
987654321

Provider ID
123456

Provider Alternate ID
712345

NPI # for Authorization
SELECT...

Level of Service
OUTPATIENT

Type of Service
Mental Health

Level of Care
Outpatient

Type of Care
Case Management

Authorized User

All fields marked with an asterisk (*) are required.

Level of Care

*Referral Source
SELECT...

Aftercare follow-up contact information for individual – Please provide at least one method of contacting individual for follow-up. If not available – please clarify reason.

Phone #

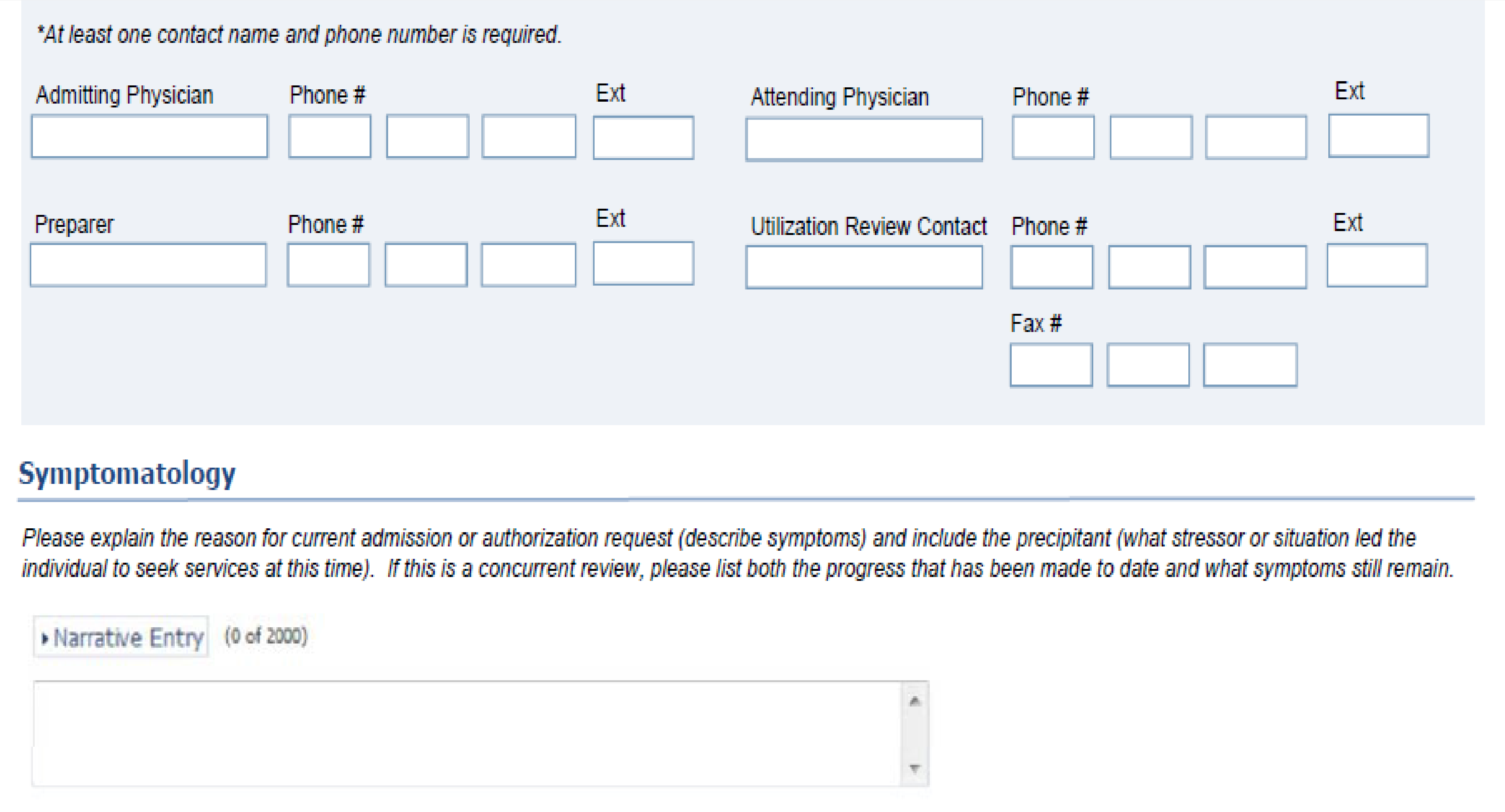
Ext

☐ Not Available

Email

Validate Email

Level of Care



At least one contact name and phone number is required.

Admitting Physician
Phone #
Ext

Attending Physician
Phone #
Ext

Preparer
Phone #
Ext

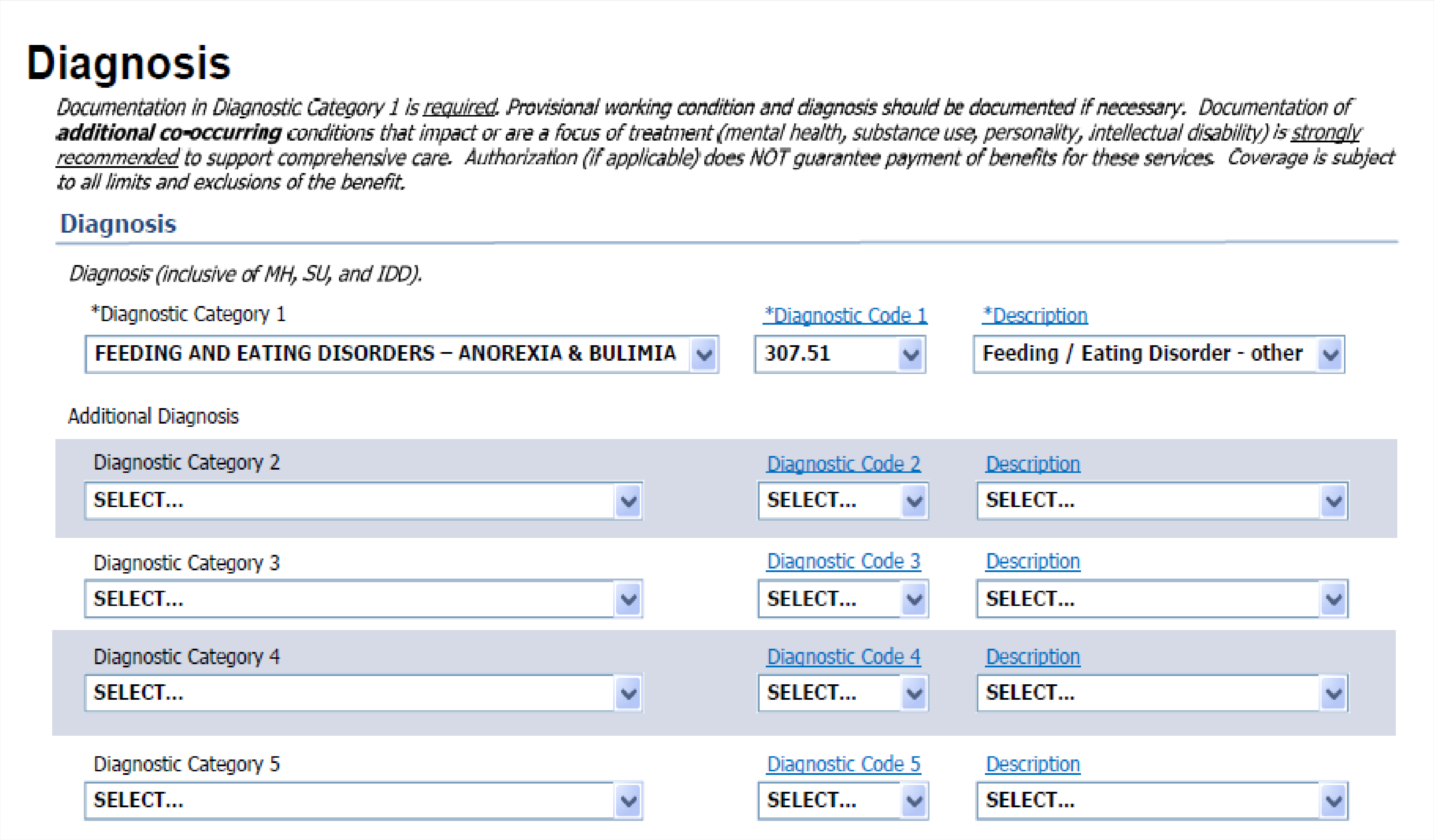
Utilization Review Contact
Phone #
Ext

Fax #

Symptomatology

Please explain the reason for current admission or authorization request (describe symptoms) and include the precipitant (what stressor or situation led the individual to seek services at this time). If this is a concurrent review, please list both the progress that has been made to date and what symptoms still remain.

Diagnosis



Diagnosis

*Documentation in Diagnostic Category 1 is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **additional co-occurring** conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions of the benefit.*

Diagnosis

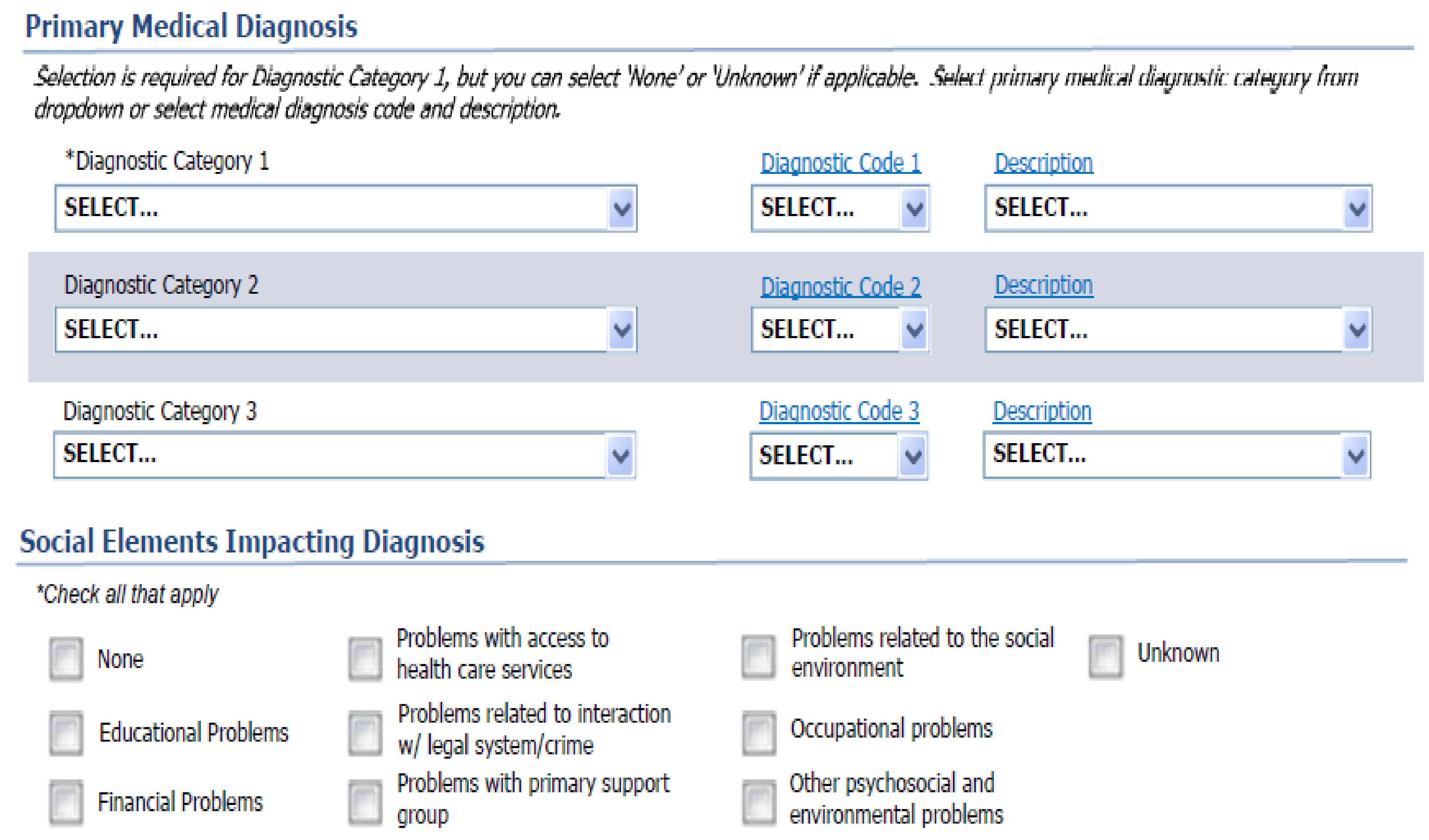
Diagnosis (inclusive of MH, SU, and IDD).

*Diagnostic Category 1	*Diagnostic Code 1	*Description
FEEDING AND EATING DISORDERS – ANOREXIA & BULIMIA	307.51	Feeding / Eating Disorder - other

Additional Diagnosis

Diagnostic Category 2	Diagnostic Code 2	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 3	Diagnostic Code 3	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 4	Diagnostic Code 4	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 5	Diagnostic Code 5	Description
SELECT...	SELECT...	SELECT...

Medical Diagnosis and Social Elements



Primary Medical Diagnosis

Selection is required for Diagnostic Category 1, but you can select 'None' or 'Unknown' if applicable. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

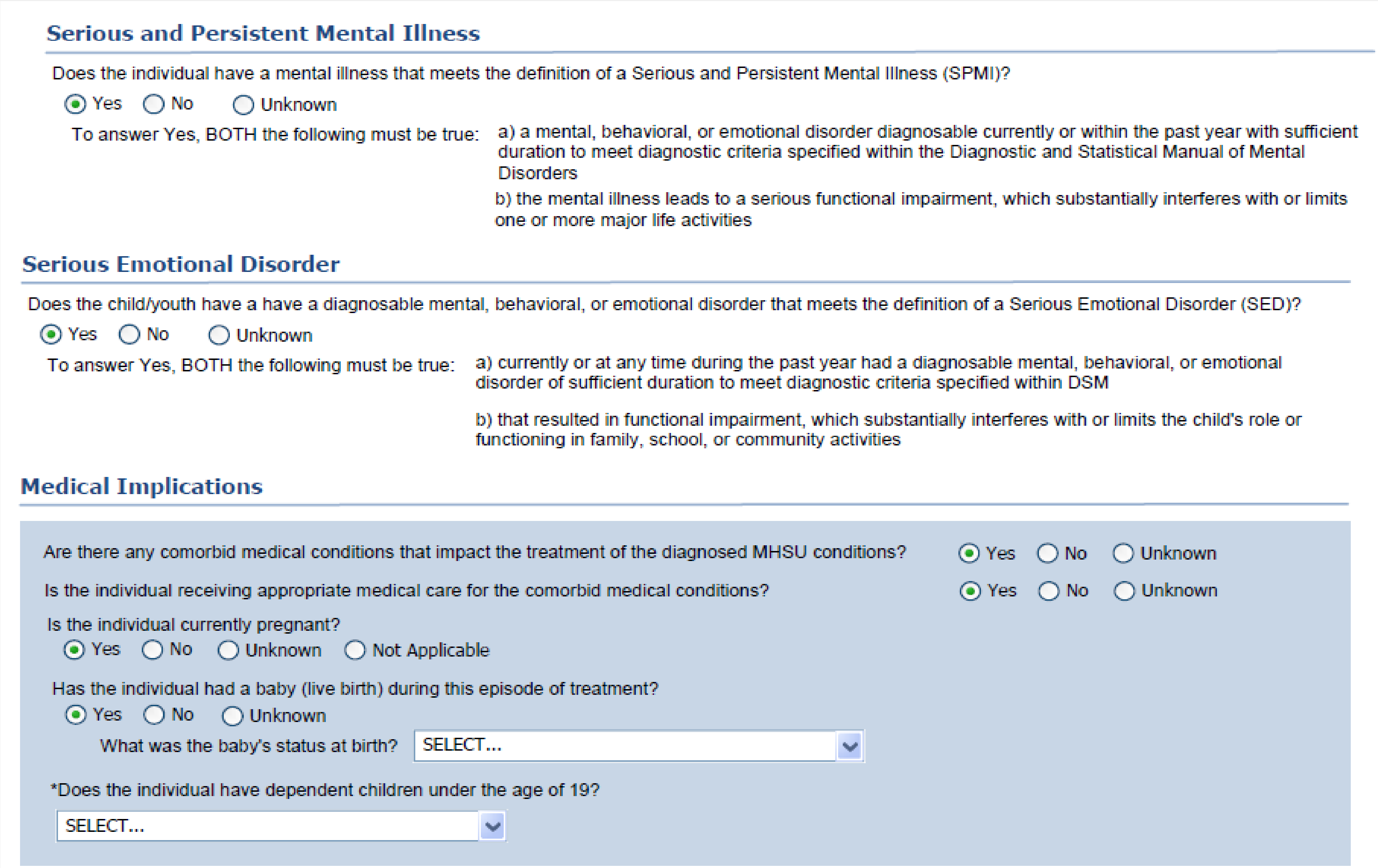
*Diagnostic Category 1	Diagnostic Code 1	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 2	Diagnostic Code 2	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 3	Diagnostic Code 3	Description
SELECT...	SELECT...	SELECT...

Social Elements Impacting Diagnosis

**Check all that apply*

☐ None
☐ Educational Problems
☐ Financial Problems
☐ Problems with access to health care services
☐ Problems related to interaction w/ legal system/crime
☐ Problems with primary support group
☐ Problems related to the social environment
☐ Occupational problems
☐ Other psychosocial and environmental problems
☐ Unknown

Additional Diagnosis



Serious and Persistent Mental Illness

Does the individual have a mental illness that meets the definition of a Serious and Persistent Mental Illness (SPMI)?

● Yes ○ No ○ Unknown

To answer Yes, BOTH the following must be true:

a) a mental, behavioral, or emotional disorder diagnosable currently or within the past year with sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders

b) the mental illness leads to a serious functional impairment, which substantially interferes with or limits one or more major life activities

Serious Emotional Disorder

Does the child/youth have a have a diagnosable mental, behavioral, or emotional disorder that meets the definition of a Serious Emotional Disorder (SED)?

● Yes ○ No ○ Unknown

To answer Yes, BOTH the following must be true:

a) currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM

b) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities

Medical Implications

Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions? ● Yes ○ No ○ Unknown

Is the individual receiving appropriate medical care for the comorbid medical conditions? ● Yes ○ No ○ Unknown

Is the individual currently pregnant?

● Yes ○ No ○ Unknown ○ Not Applicable

Has the individual had a baby (live birth) during this episode of treatment?

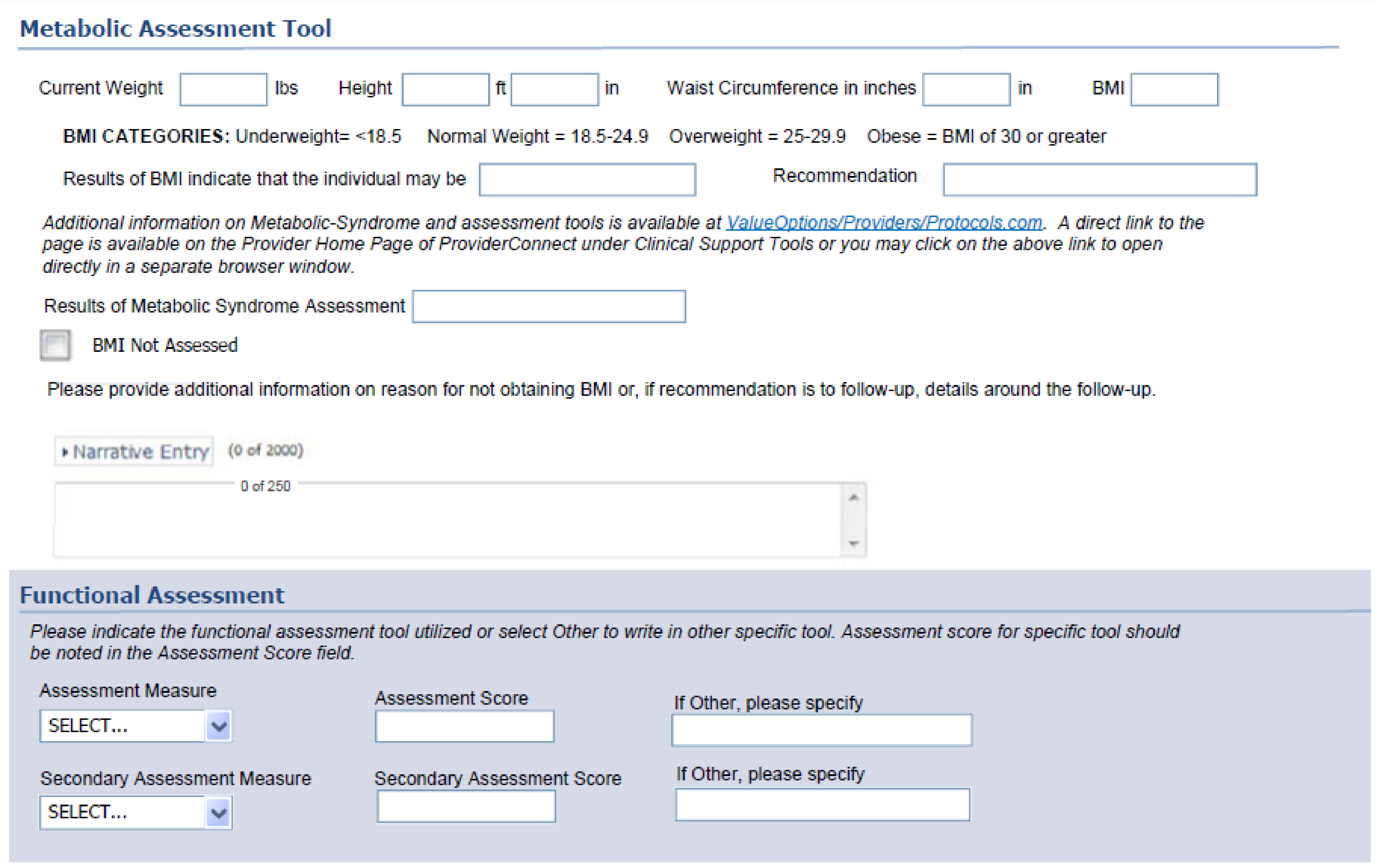
● Yes ○ No ○ Unknown

What was the baby's status at birth? SELECT...

*Does the individual have dependent children under the age of 19?

SELECT...

Metabolic and Functional Assessments



Metabolic Assessment Tool

Current Weight ____ lbs Height ____ ft ____ in Waist Circumference in inches ____ in BMI ____

BMI CATEGORIES: Underweight= <18.5 Normal Weight = 18.5-24.9 Overweight = 25-29.9 Obese = BMI of 30 or greater

Results of BMI indicate that the individual may be ____ Recommendation ____

Additional information on Metabolic-Syndrome and assessment tools is available at ValueOptions/Providers/Protocols.com. A direct link to the page is available on the Provider Home Page of ProviderConnect under Clinical Support Tools or you may click on the above link to open directly in a separate browser window.

Results of Metabolic Syndrome Assessment ____

☐ BMI Not Assessed

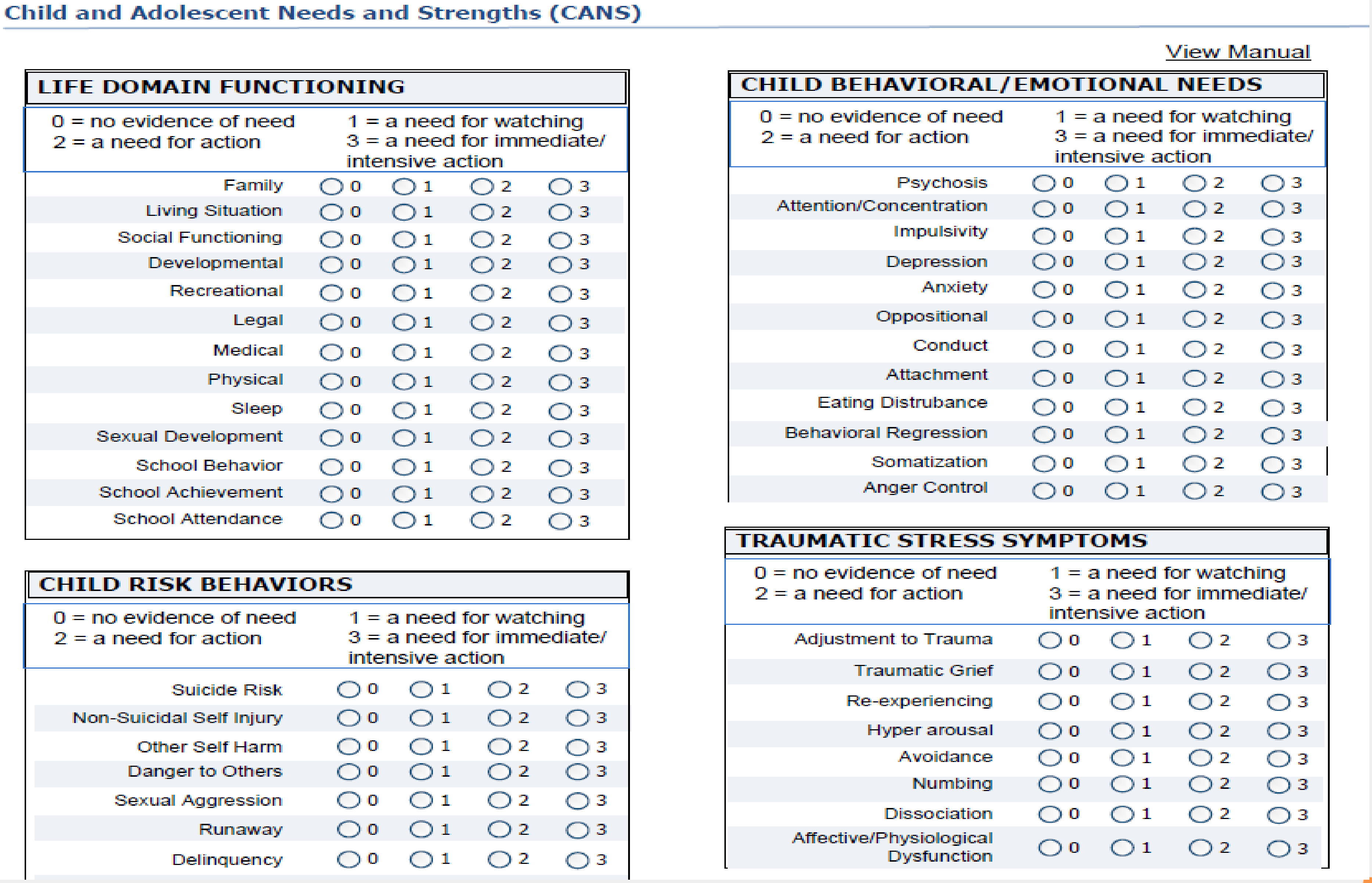
Please provide additional information on reason for not obtaining BMI or, if recommendation is to follow-up, details around the follow-up.

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

Assessment Measure	Assessment Score	If Other, please specify
SELECT...		
Secondary Assessment Measure	Secondary Assessment Score	If Other, please specify
SELECT...		

CANS Example



Child and Adolescent Needs and Strengths (CANS)

View Manual

LIFE DOMAIN FUNCTIONING

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Family	○ 0	○ 1	○ 2	○ 3
Living Situation	○ 0	○ 1	○ 2	○ 3
Social Functioning	○ 0	○ 1	○ 2	○ 3
Developmental	○ 0	○ 1	○ 2	○ 3
Recreational	○ 0	○ 1	○ 2	○ 3
Legal	○ 0	○ 1	○ 2	○ 3
Medical	○ 0	○ 1	○ 2	○ 3
Physical	○ 0	○ 1	○ 2	○ 3
Sleep	○ 0	○ 1	○ 2	○ 3
Sexual Development	○ 0	○ 1	○ 2	○ 3
School Behavior	○ 0	○ 1	○ 2	○ 3
School Achievement	○ 0	○ 1	○ 2	○ 3
School Attendance	○ 0	○ 1	○ 2	○ 3

CHILD RISK BEHAVIORS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Suicide Risk	○ 0	○ 1	○ 2	○ 3
Non-Suicidal Self Injury	○ 0	○ 1	○ 2	○ 3
Other Self Harm	○ 0	○ 1	○ 2	○ 3
Danger to Others	○ 0	○ 1	○ 2	○ 3
Sexual Aggression	○ 0	○ 1	○ 2	○ 3
Runaway	○ 0	○ 1	○ 2	○ 3
Delinquency	○ 0	○ 1	○ 2	○ 3

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

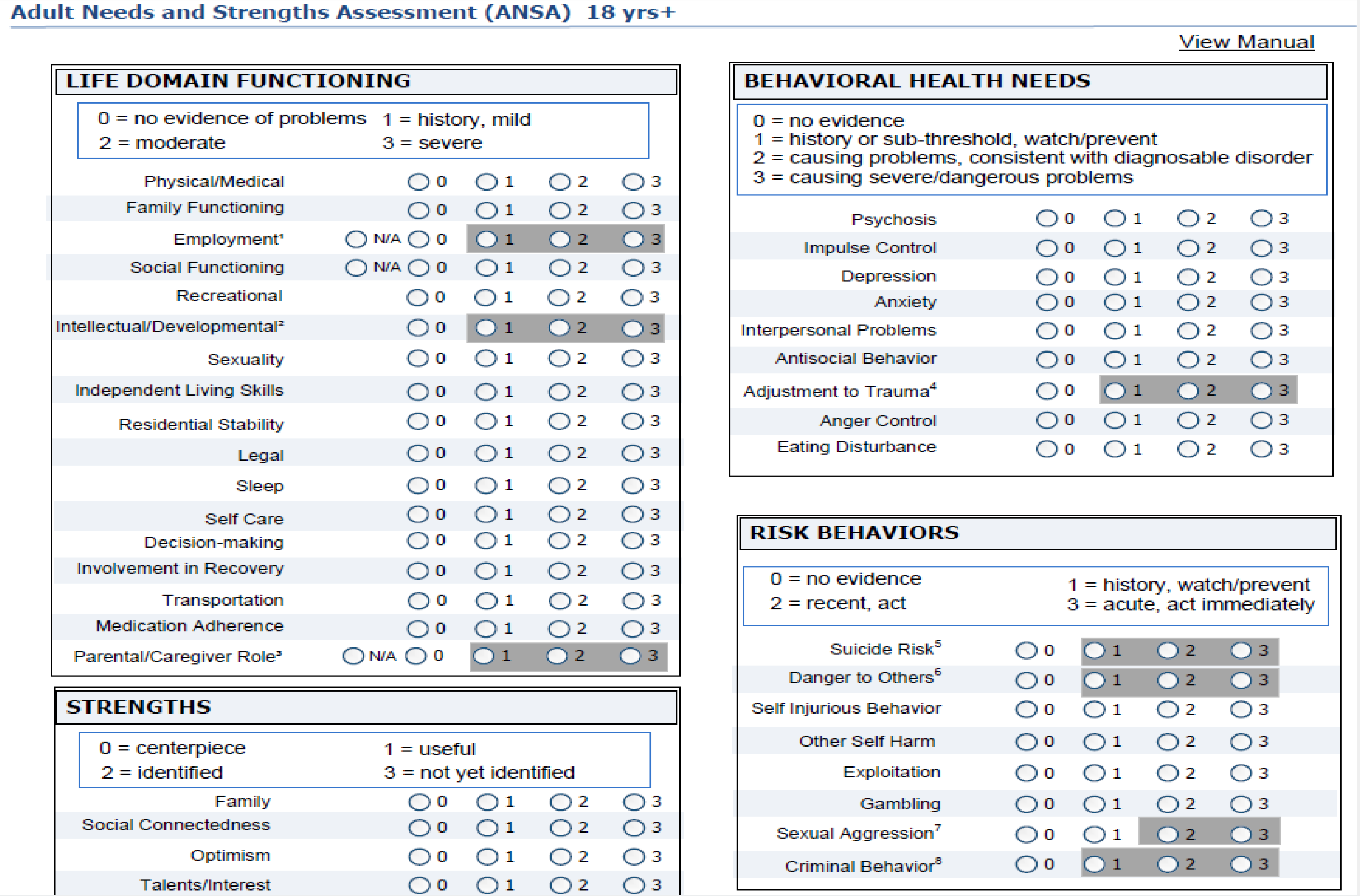
Psychosis	○ 0	○ 1	○ 2	○ 3
Attention/Concentration	○ 0	○ 1	○ 2	○ 3
Impulsivity	○ 0	○ 1	○ 2	○ 3
Depression	○ 0	○ 1	○ 2	○ 3
Anxiety	○ 0	○ 1	○ 2	○ 3
Oppositional	○ 0	○ 1	○ 2	○ 3
Conduct	○ 0	○ 1	○ 2	○ 3
Attachment	○ 0	○ 1	○ 2	○ 3
Eating Distrubance	○ 0	○ 1	○ 2	○ 3
Behavioral Regression	○ 0	○ 1	○ 2	○ 3
Somatization	○ 0	○ 1	○ 2	○ 3
Anger Control	○ 0	○ 1	○ 2	○ 3

TRAUMATIC STRESS SYMPTOMS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Adjustment to Trauma	○ 0	○ 1	○ 2	○ 3
Traumatic Grief	○ 0	○ 1	○ 2	○ 3
Re-experiencing	○ 0	○ 1	○ 2	○ 3
Hyper arousal	○ 0	○ 1	○ 2	○ 3
Avoidance	○ 0	○ 1	○ 2	○ 3
Numbing	○ 0	○ 1	○ 2	○ 3
Dissociation	○ 0	○ 1	○ 2	○ 3
Affective/Physiological Dysfunction	○ 0	○ 1	○ 2	○ 3

ANSA Example



Adult Needs and Strengths Assessment (ANSA) 18 yrs+

View Manual

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

Physical/Medical		○ 0	○ 1	○ 2	○ 3
Family Functioning		○ 0	○ 1	○ 2	○ 3
Employment[1]	○ N/A	○ 0	○ 1	○ 2	○ 3
Social Functioning	○ N/A	○ 0	○ 1	○ 2	○ 3
Recreational		○ 0	○ 1	○ 2	○ 3
Intellectual/Developmental[2]		○ 0	○ 1	○ 2	○ 3
Sexuality		○ 0	○ 1	○ 2	○ 3
Independent Living Skills		○ 0	○ 1	○ 2	○ 3
Residential Stability		○ 0	○ 1	○ 2	○ 3
Legal		○ 0	○ 1	○ 2	○ 3
Sleep		○ 0	○ 1	○ 2	○ 3
Self Care		○ 0	○ 1	○ 2	○ 3
Decision-making		○ 0	○ 1	○ 2	○ 3
Involvement in Recovery		○ 0	○ 1	○ 2	○ 3
Transportation		○ 0	○ 1	○ 2	○ 3
Medication Adherence		○ 0	○ 1	○ 2	○ 3
Parental/Caregiver Role[3]	○ N/A	○ 0	○ 1	○ 2	○ 3

STRENGTHS

0 = centerpiece 1 = useful
2 = identified 3 = not yet identified

Family	○ 0	○ 1	○ 2	○ 3
Social Connectedness	○ 0	○ 1	○ 2	○ 3
Optimism	○ 0	○ 1	○ 2	○ 3
Talents/Interest	○ 0	○ 1	○ 2	○ 3

BEHAVIORAL HEALTH NEEDS

0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

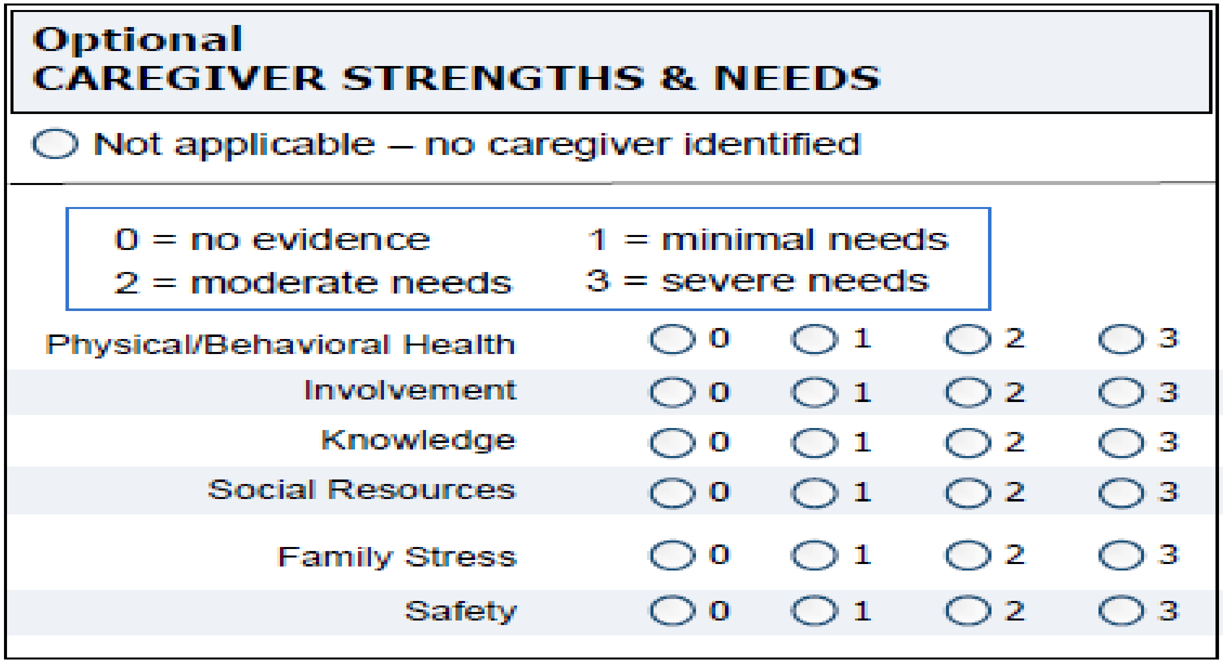
Psychosis	○ 0	○ 1	○ 2	○ 3
Impulse Control	○ 0	○ 1	○ 2	○ 3
Depression	○ 0	○ 1	○ 2	○ 3
Anxiety	○ 0	○ 1	○ 2	○ 3
Interpersonal Problems	○ 0	○ 1	○ 2	○ 3
Antisocial Behavior	○ 0	○ 1	○ 2	○ 3
Adjustment to Trauma[4]	○ 0	○ 1	○ 2	○ 3
Anger Control	○ 0	○ 1	○ 2	○ 3
Eating Disturbance	○ 0	○ 1	○ 2	○ 3

RISK BEHAVIORS

0 = no evidence 1 = history, watch/prevent
2 = recent, act 3 = acute, act immediately

Suicide Risk[5]	○ 0	○ 1	○ 2	○ 3
Danger to Others[6]	○ 0	○ 1	○ 2	○ 3
Self Injurious Behavior	○ 0	○ 1	○ 2	○ 3
Other Self Harm	○ 0	○ 1	○ 2	○ 3
Exploitation	○ 0	○ 1	○ 2	○ 3
Gambling	○ 0	○ 1	○ 2	○ 3
Sexual Aggression[7]	○ 0	○ 1	○ 2	○ 3
Criminal Behavior[8]	○ 0	○ 1	○ 2	○ 3

ANSA Example

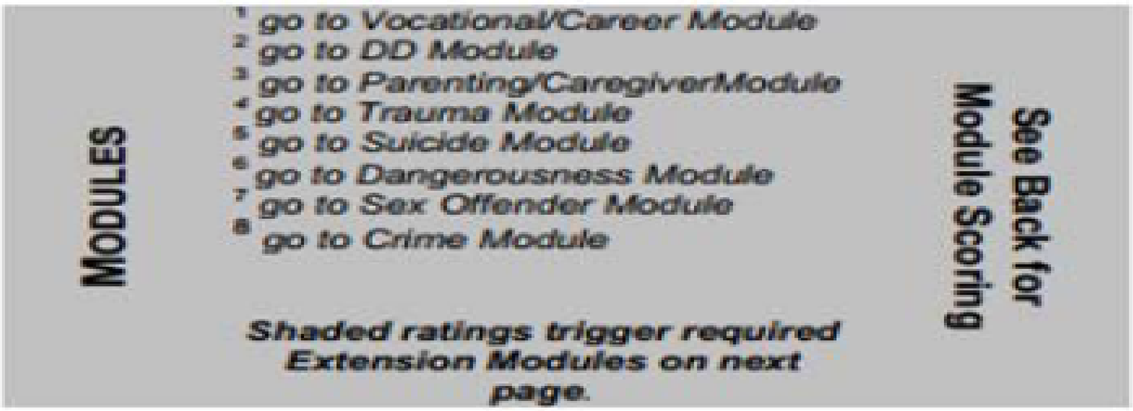


Optional
CAREGIVER STRENGTHS & NEEDS

○ Not applicable – no caregiver identified

0 = no evidence
1 = minimal needs
2 = moderate needs
3 = severe needs

Physical/Behavioral Health	○ 0	○ 1	○ 2	○ 3
Involvement	○ 0	○ 1	○ 2	○ 3
Knowledge	○ 0	○ 1	○ 2	○ 3
Social Resources	○ 0	○ 1	○ 2	○ 3
Family Stress	○ 0	○ 1	○ 2	○ 3
Safety	○ 0	○ 1	○ 2	○ 3



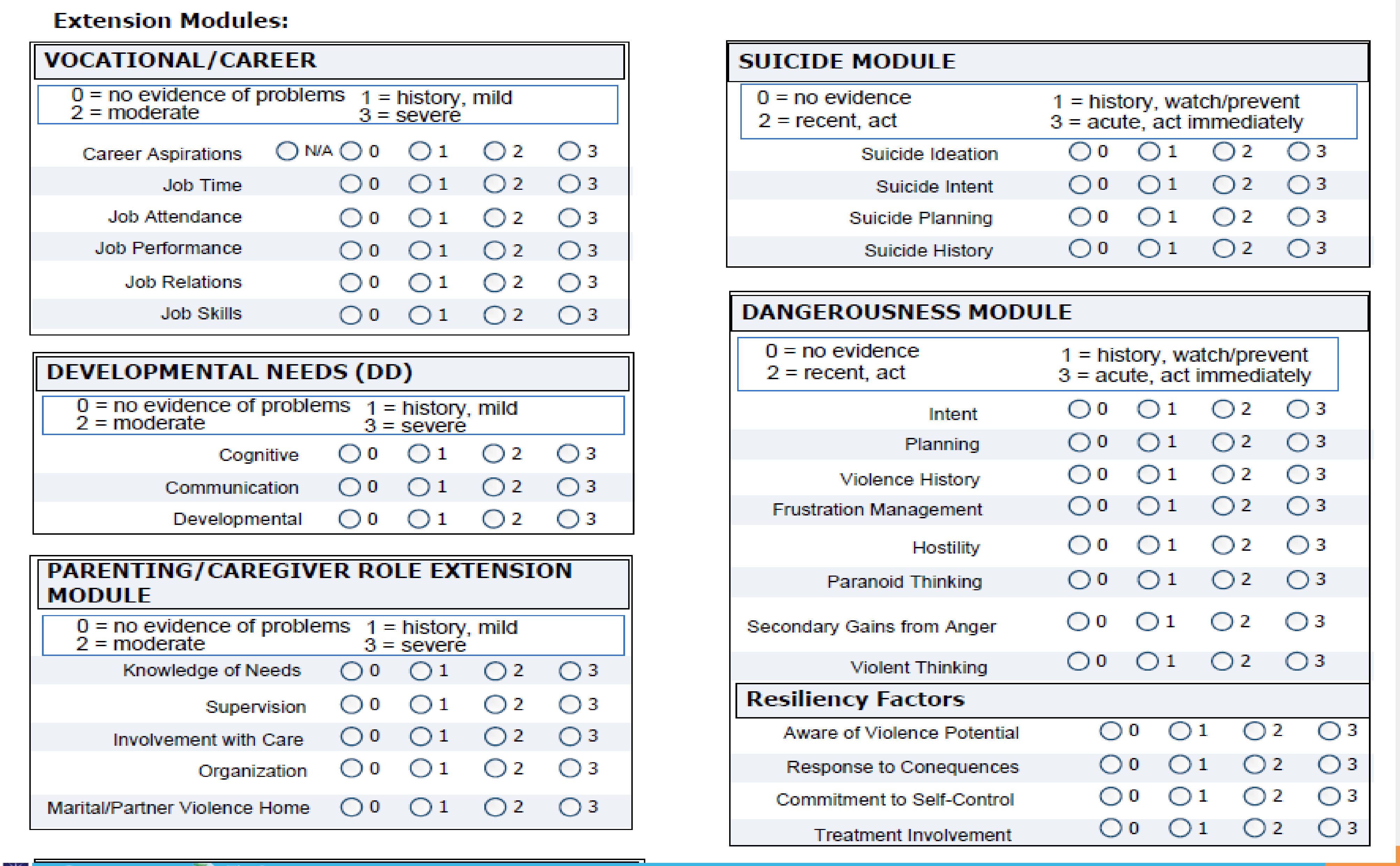
MODULES

[1] *go to Vocational/Career Module*
[2] *go to DD Module*
[3] *go to Parenting/CaregiverModule*
[4] *go to Trauma Module*
[5] *go to Suicide Module*
[6] *go to Dangerousness Module*
[7] *go to Sex Offender Module*
[8] *go to Crime Module*

See Back for Module Scoring

Shaded ratings trigger required Extension Modules on next page.

ANSA Extension Modules Example



Extension Modules:

VOCATIONAL/CAREER

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

Career Aspirations	○ N/A	○ 0	○ 1	○ 2	○ 3
Job Time		○ 0	○ 1	○ 2	○ 3
Job Attendance		○ 0	○ 1	○ 2	○ 3
Job Performance		○ 0	○ 1	○ 2	○ 3
Job Relations		○ 0	○ 1	○ 2	○ 3
Job Skills		○ 0	○ 1	○ 2	○ 3

DEVELOPMENTAL NEEDS (DD)

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

Cognitive	○ 0	○ 1	○ 2	○ 3
Communication	○ 0	○ 1	○ 2	○ 3
Developmental	○ 0	○ 1	○ 2	○ 3

PARENTING/CAREGIVER ROLE EXTENSION MODULE

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

Knowledge of Needs	○ 0	○ 1	○ 2	○ 3
Supervision	○ 0	○ 1	○ 2	○ 3
Involvement with Care	○ 0	○ 1	○ 2	○ 3
Organization	○ 0	○ 1	○ 2	○ 3
Marital/Partner Violence Home	○ 0	○ 1	○ 2	○ 3

SUICIDE MODULE

0 = no evidence 1 = history, watch/prevent
2 = recent, act 3 = acute, act immediately

Suicide Ideation	○ 0	○ 1	○ 2	○ 3
Suicide Intent	○ 0	○ 1	○ 2	○ 3
Suicide Planning	○ 0	○ 1	○ 2	○ 3
Suicide History	○ 0	○ 1	○ 2	○ 3

DANGEROUSNESS MODULE

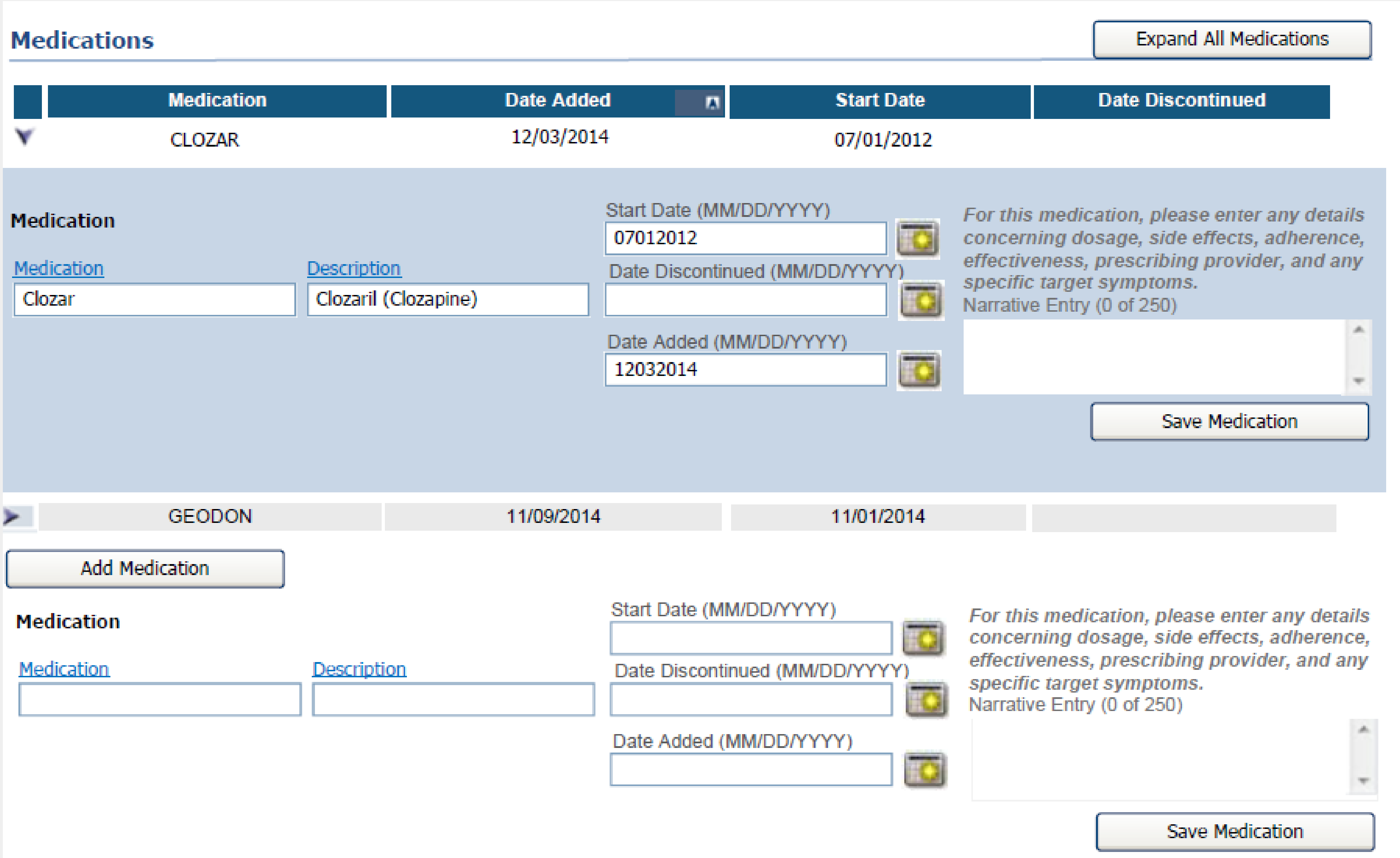
0 = no evidence 1 = history, watch/prevent
2 = recent, act 3 = acute, act immediately

Intent	○ 0	○ 1	○ 2	○ 3
Planning	○ 0	○ 1	○ 2	○ 3
Violence History	○ 0	○ 1	○ 2	○ 3
Frustration Management	○ 0	○ 1	○ 2	○ 3
Hostility	○ 0	○ 1	○ 2	○ 3
Paranoid Thinking	○ 0	○ 1	○ 2	○ 3
Secondary Gains from Anger	○ 0	○ 1	○ 2	○ 3
Violent Thinking	○ 0	○ 1	○ 2	○ 3

Resiliency Factors

Aware of Violence Potential	○ 0	○ 1	○ 2	○ 3
Response to Conequences	○ 0	○ 1	○ 2	○ 3
Commitment to Self-Control	○ 0	○ 1	○ 2	○ 3
Treatment Involvement	○ 0	○ 1	○ 2	○ 3

Medications



Medications

	Medication	Date Added	Start Date	Date Discontinued
▼	CLOZAR	12/03/2014	07/01/2012	
►	GEODON	11/09/2014	11/01/2014	

Medication

Medication: Clozar

Description: Clozaril (Clozapine)

Start Date (MM/DD/YYYY): 07012012

Date Discontinued (MM/DD/YYYY):

Date Added (MM/DD/YYYY): 12032014

For this medication, please enter any details concerning dosage, side effects, adherence, effectiveness, prescribing provider, and any specific target symptoms.

Narrative Entry (0 of 250)

Medication

Medication:

Description:

Start Date (MM/DD/YYYY):

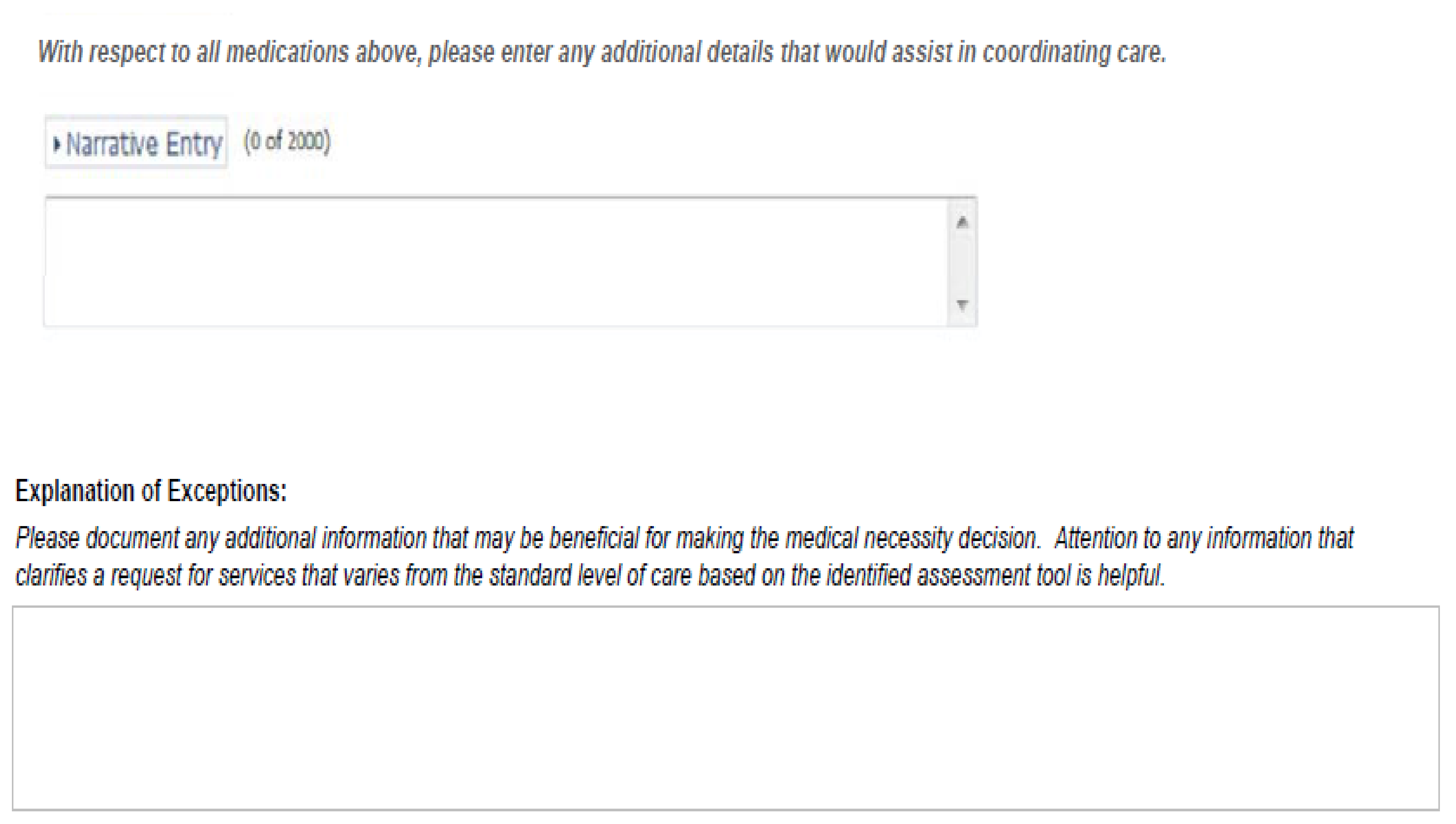
Date Discontinued (MM/DD/YYYY):

Date Added (MM/DD/YYYY):

For this medication, please enter any details concerning dosage, side effects, adherence, effectiveness, prescribing provider, and any specific target symptoms.

Narrative Entry (0 of 250)

Medications

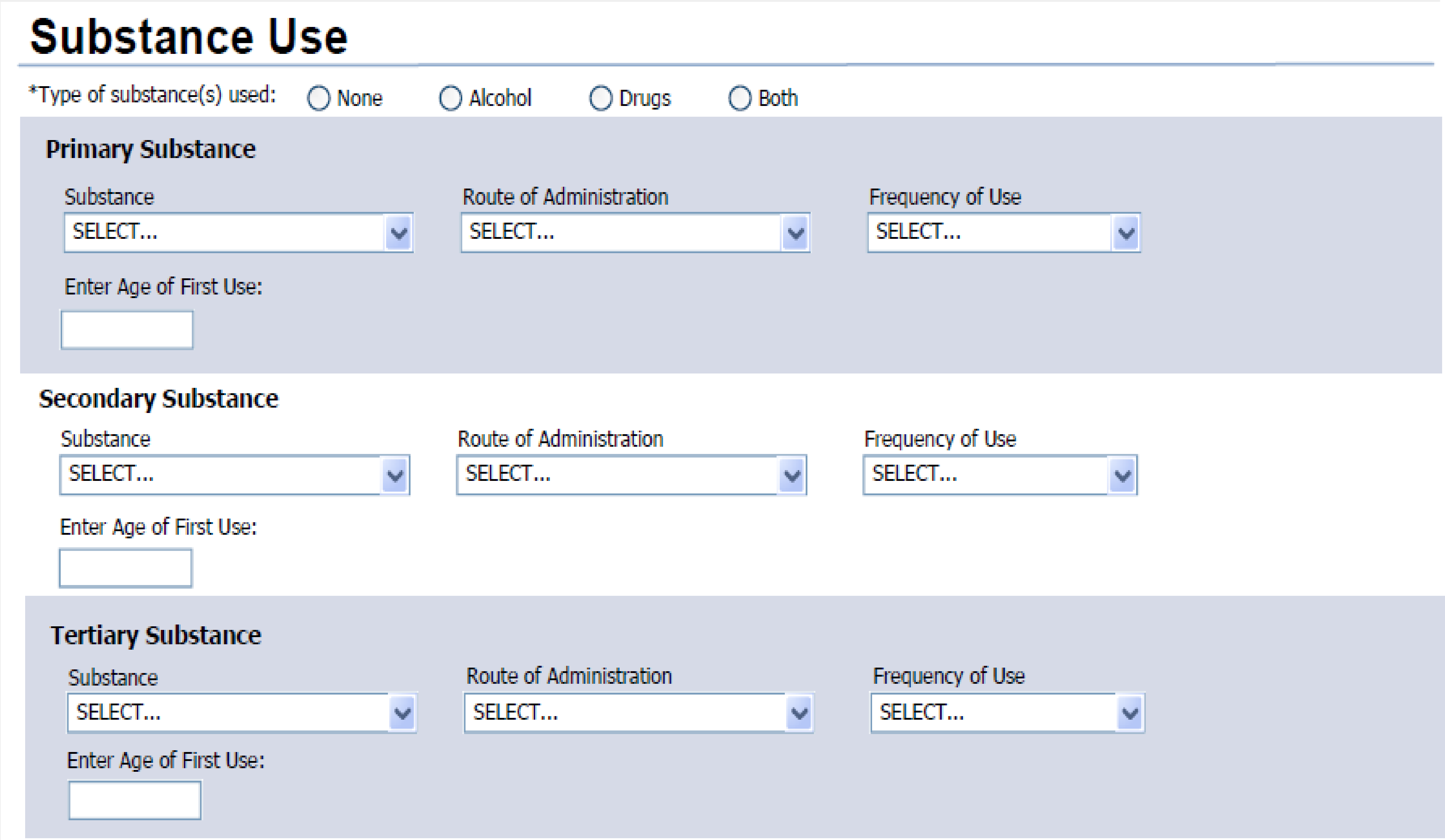


With respect to all medications above, please enter any additional details that would assist in coordinating care.

Explanation of Exceptions:

Please document any additional information that may be beneficial for making the medical necessity decision. Attention to any information that clarifies a request for services that varies from the standard level of care based on the identified assessment tool is helpful.

Substance Use



Substance Use

*Type of substance(s) used: ○ None ○ Alcohol ○ Drugs ○ Both

Primary Substance

Substance: SELECT...

Route of Administration: SELECT...

Frequency of Use: SELECT...

Enter Age of First Use:

Secondary Substance

Substance: SELECT...

Route of Administration: SELECT...

Frequency of Use: SELECT...

Enter Age of First Use:

Tertiary Substance

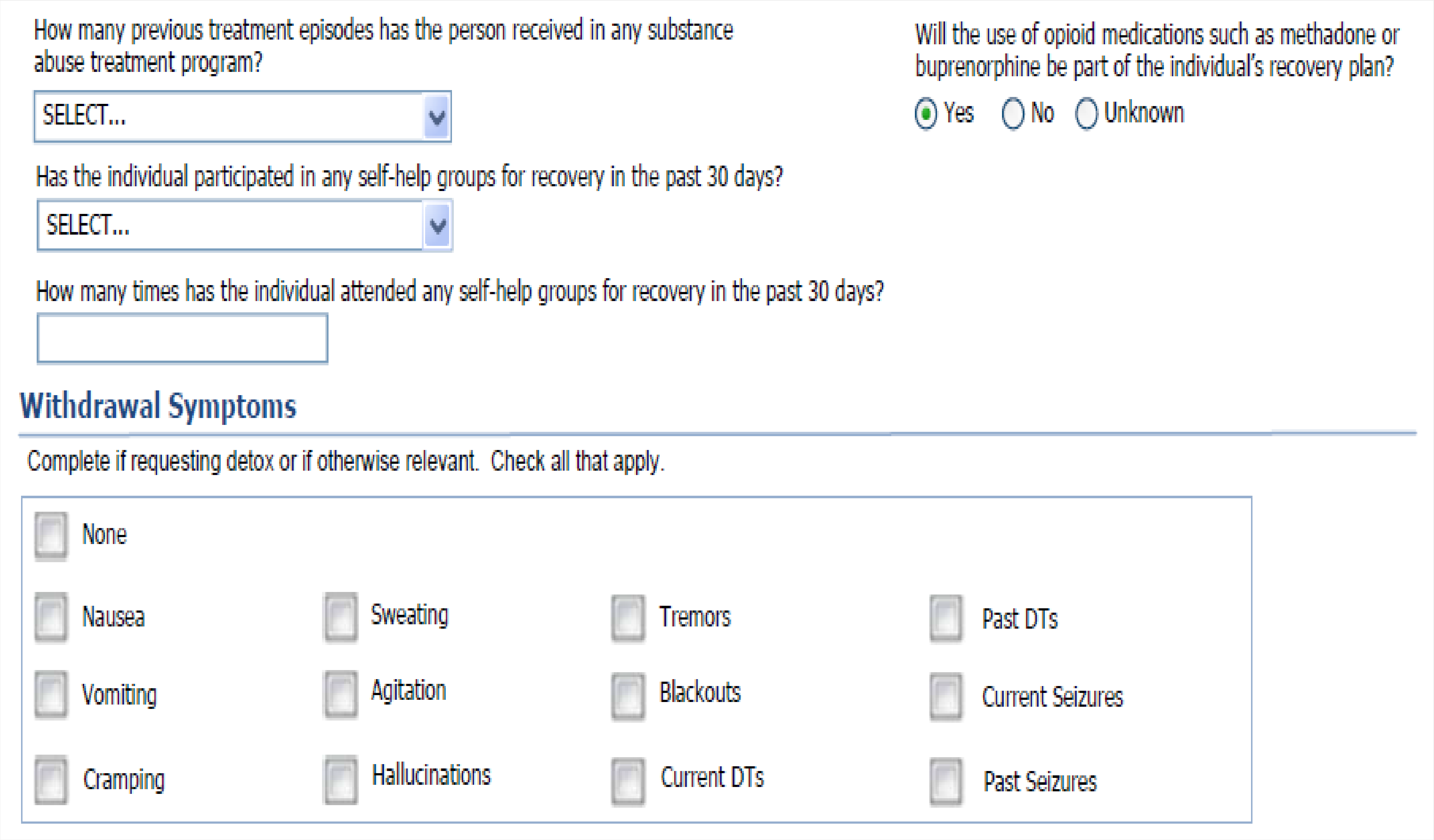
Substance: SELECT...

Route of Administration: SELECT...

Frequency of Use: SELECT...

Enter Age of First Use:

Substance Use



How many previous treatment episodes has the person received in any substance abuse treatment program?

SELECT...

Has the individual participated in any self-help groups for recovery in the past 30 days?

SELECT...

How many times has the individual attended any self-help groups for recovery in the past 30 days?

Will the use of opioid medications such as methadone or buprenorphine be part of the individual's recovery plan?

● Yes ○ No ○ Unknown

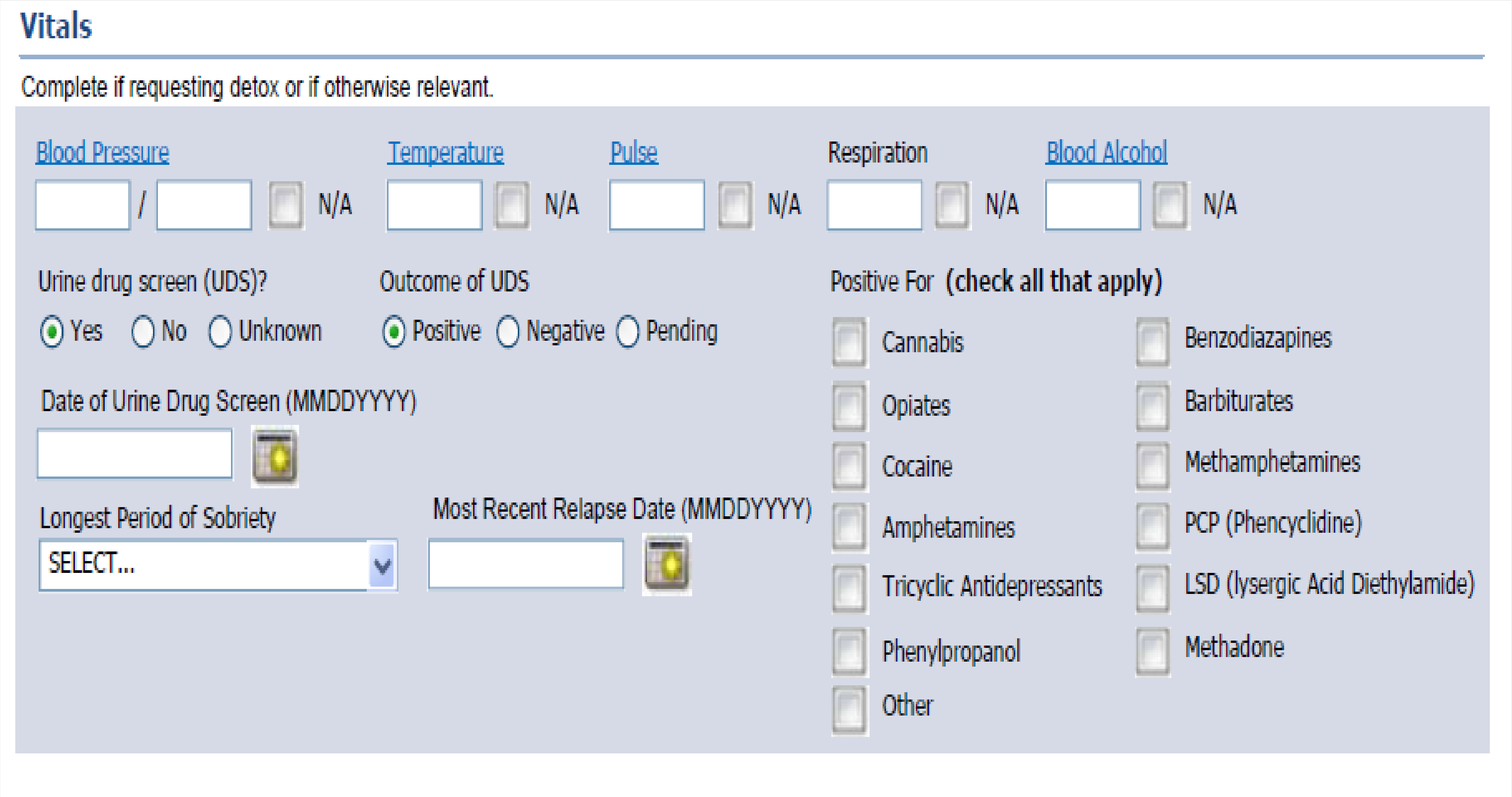
Withdrawal Symptoms

Complete if requesting detox or if otherwise relevant. Check all that apply.

☐ None

☐ Nausea	☐ Sweating	☐ Tremors	☐ Past DTs
☐ Vomiting	☐ Agitation	☐ Blackouts	☐ Current Seizures
☐ Cramping	☐ Hallucinations	☐ Current DTs	☐ Past Seizures

Vitals



Vitals

Complete if requesting detox or if otherwise relevant.

Blood Pressure ☐ / ☐ ☐ N/A

Temperature ☐ ☐ N/A

Pulse ☐ ☐ N/A

Respiration ☐ ☐ N/A

Blood Alcohol ☐ ☐ N/A

Urine drug screen (UDS)?
● Yes ○ No ○ Unknown

Outcome of UDS
● Positive ○ Negative ○ Pending

Date of Urine Drug Screen (MMDDYYYY)

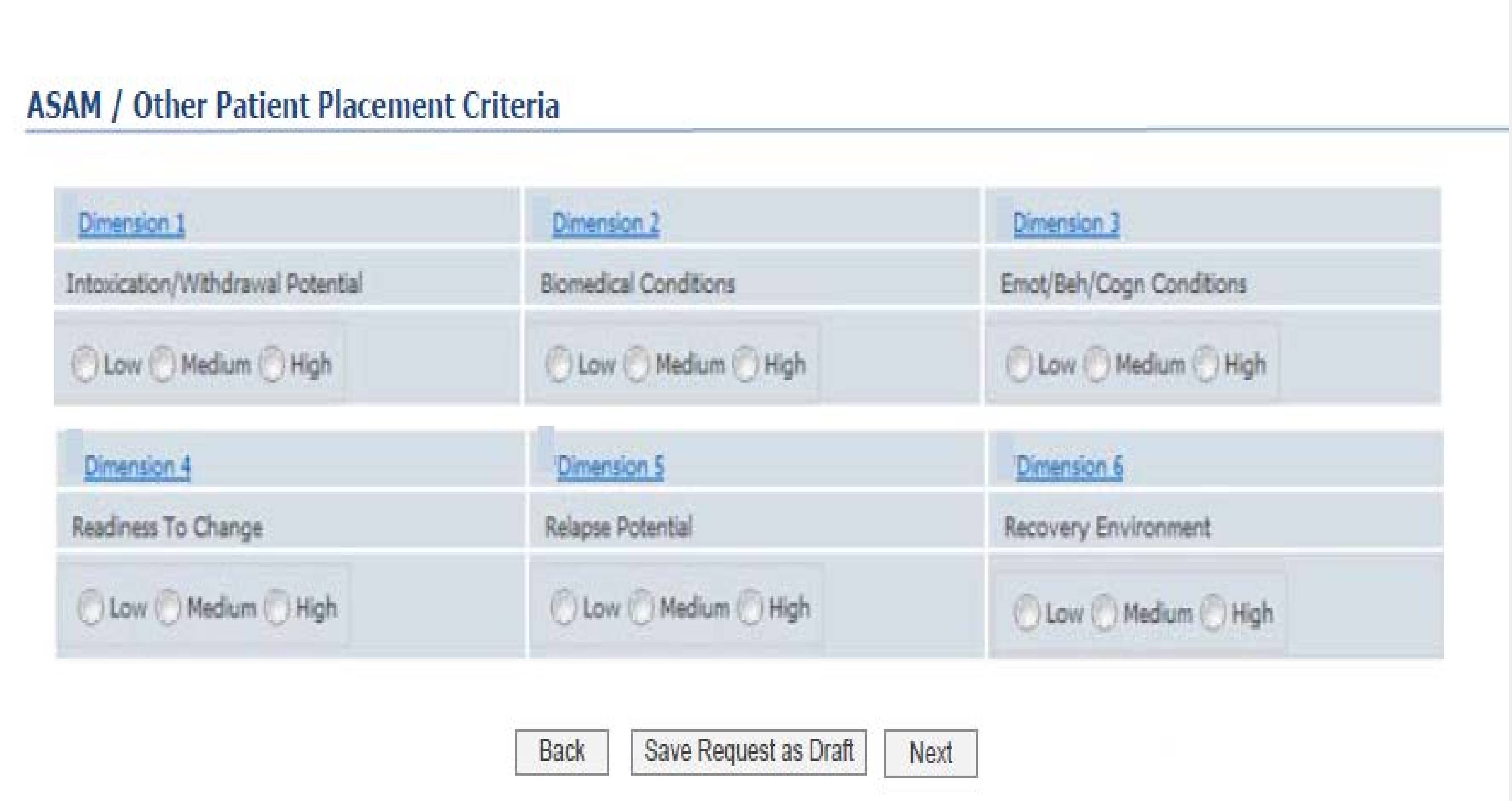
Longest Period of Sobriety
SELECT...

Most Recent Relapse Date (MMDDYYYY)

Positive For **(check all that apply)**

- ☐ Cannabis
- ☐ Opiates
- ☐ Cocaine
- ☐ Amphetamines
- ☐ Tricyclic Antidepressants
- ☐ Phenylpropanol
- ☐ Other
- ☐ Benzodiazapines
- ☐ Barbiturates
- ☐ Methamphetamines
- ☐ PCP (Phencyclidine)
- ☐ LSD (lysergic Acid Diethylamide)
- ☐ Methadone

ASAM

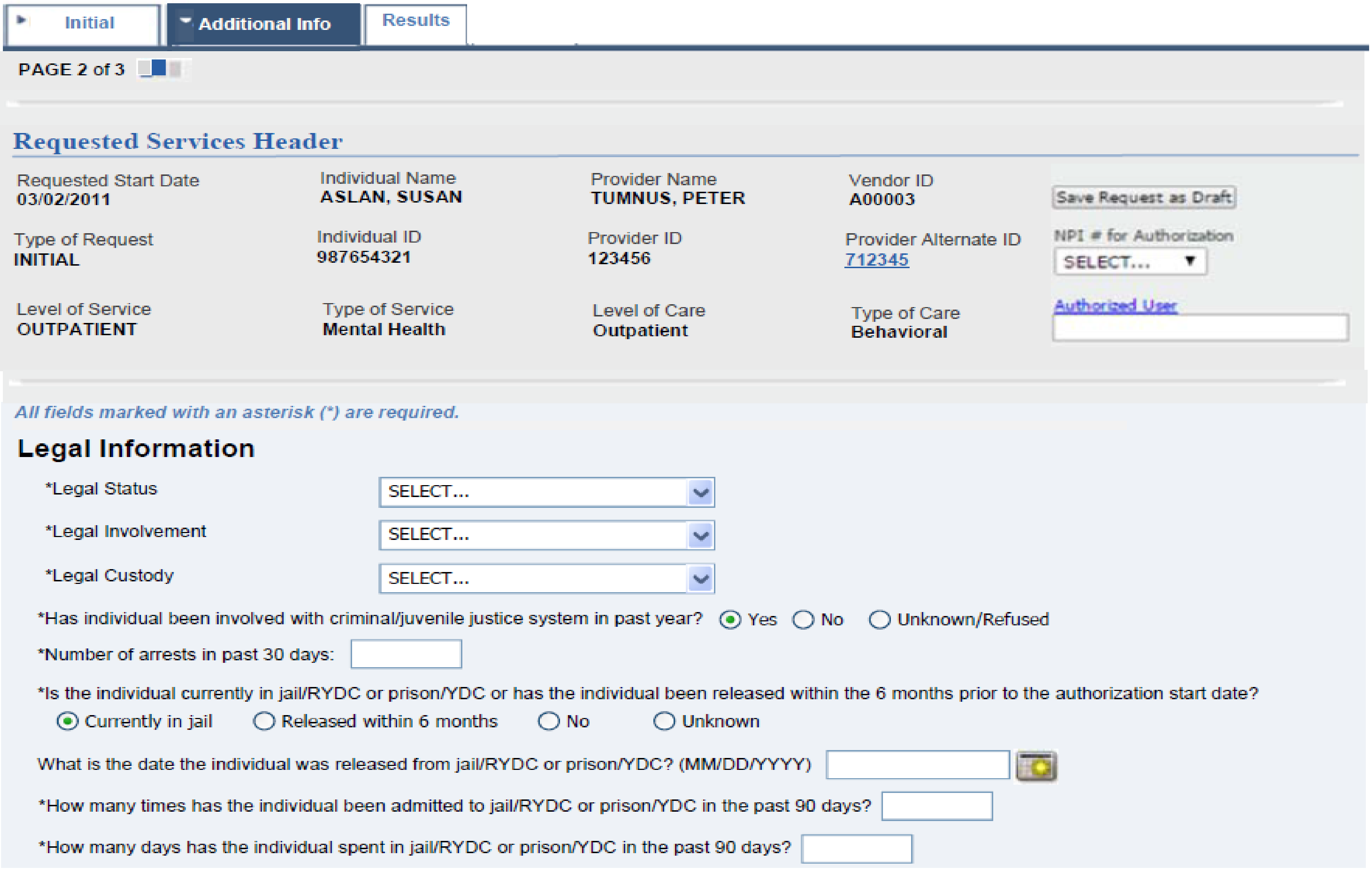


ASAM / Other Patient Placement Criteria

Dimension 1	Dimension 2	Dimension 3
Intoxication/Withdrawal Potential	Biomedical Conditions	Emot/Beh/Cogn Conditions
○ Low ○ Medium ○ High	○ Low ○ Medium ○ High	○ Low ○ Medium ○ High

Dimension 4	Dimension 5	Dimension 6
Readiness To Change	Relapse Potential	Recovery Environment
○ Low ○ Medium ○ High	○ Low ○ Medium ○ High	○ Low ○ Medium ○ High

Legal Information



PAGE 2 of 3

Requested Services Header

Requested Start Date **03/02/2011**	Individual Name **ASLAN, SUSAN**	Provider Name **TUMNUS, PETER**	Vendor ID **A00003**	
Type of Request **INITIAL**	Individual ID **987654321**	Provider ID **123456**	Provider Alternate ID 712345	NPI # for Authorization SELECT... ▼
Level of Service **OUTPATIENT**	Type of Service **Mental Health**	Level of Care **Outpatient**	Type of Care **Behavioral**	Authorized User

All fields marked with an asterisk (*) are required.

Legal Information

*Legal Status: SELECT...

*Legal Involvement: SELECT...

*Legal Custody: SELECT...

*Has individual been involved with criminal/juvenile justice system in past year? ● Yes ○ No ○ Unknown/Refused

*Number of arrests in past 30 days:

*Is the individual currently in jail/RYDC or prison/YDC or has the individual been released within the 6 months prior to the authorization start date?

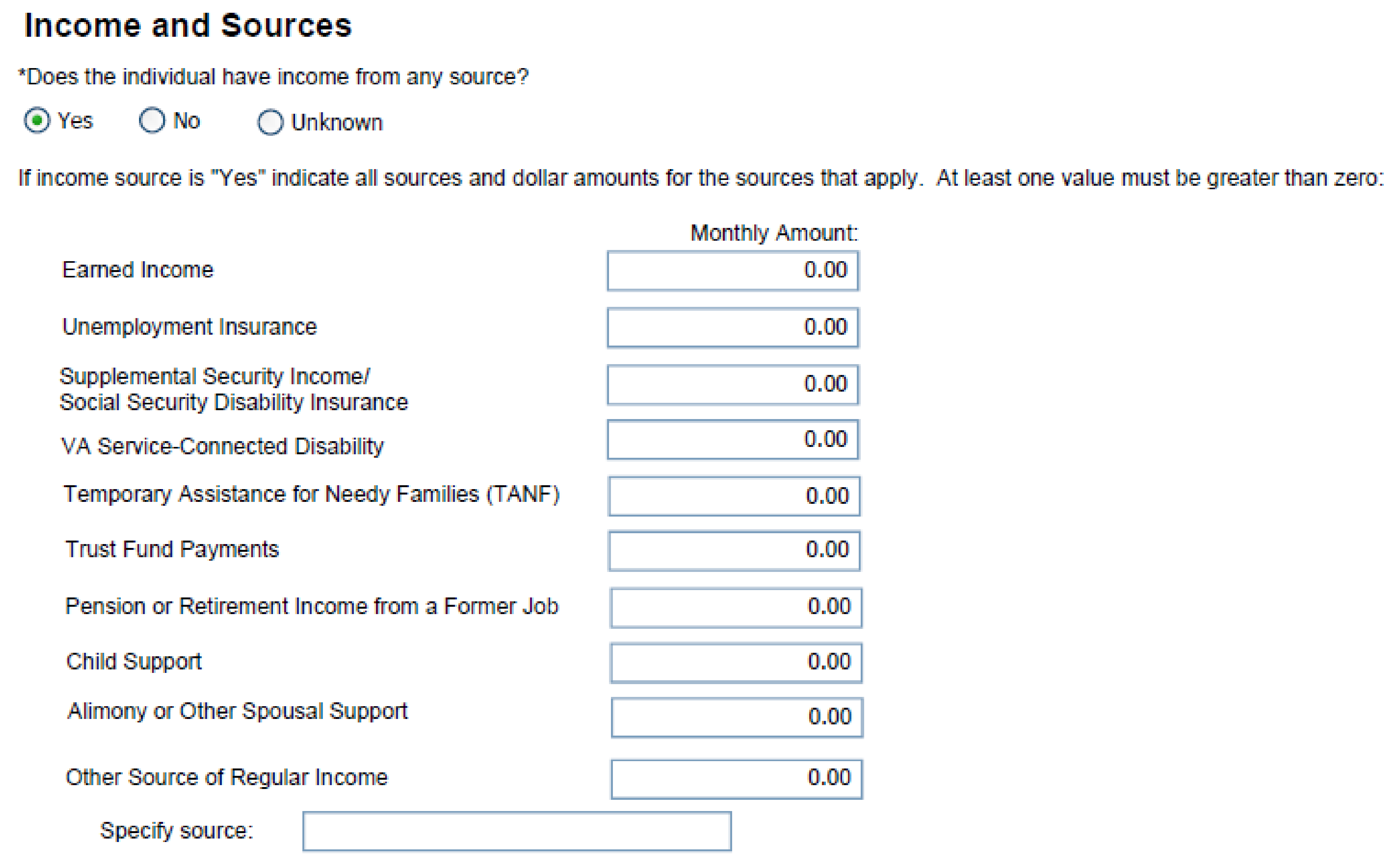
● Currently in jail ○ Released within 6 months ○ No ○ Unknown

What is the date the individual was released from jail/RYDC or prison/YDC? (MM/DD/YYYY)

*How many times has the individual been admitted to jail/RYDC or prison/YDC in the past 90 days?

*How many days has the individual spent in jail/RYDC or prison/YDC in the past 90 days?

Income and Sources



Income and Sources

*Does the individual have income from any source?

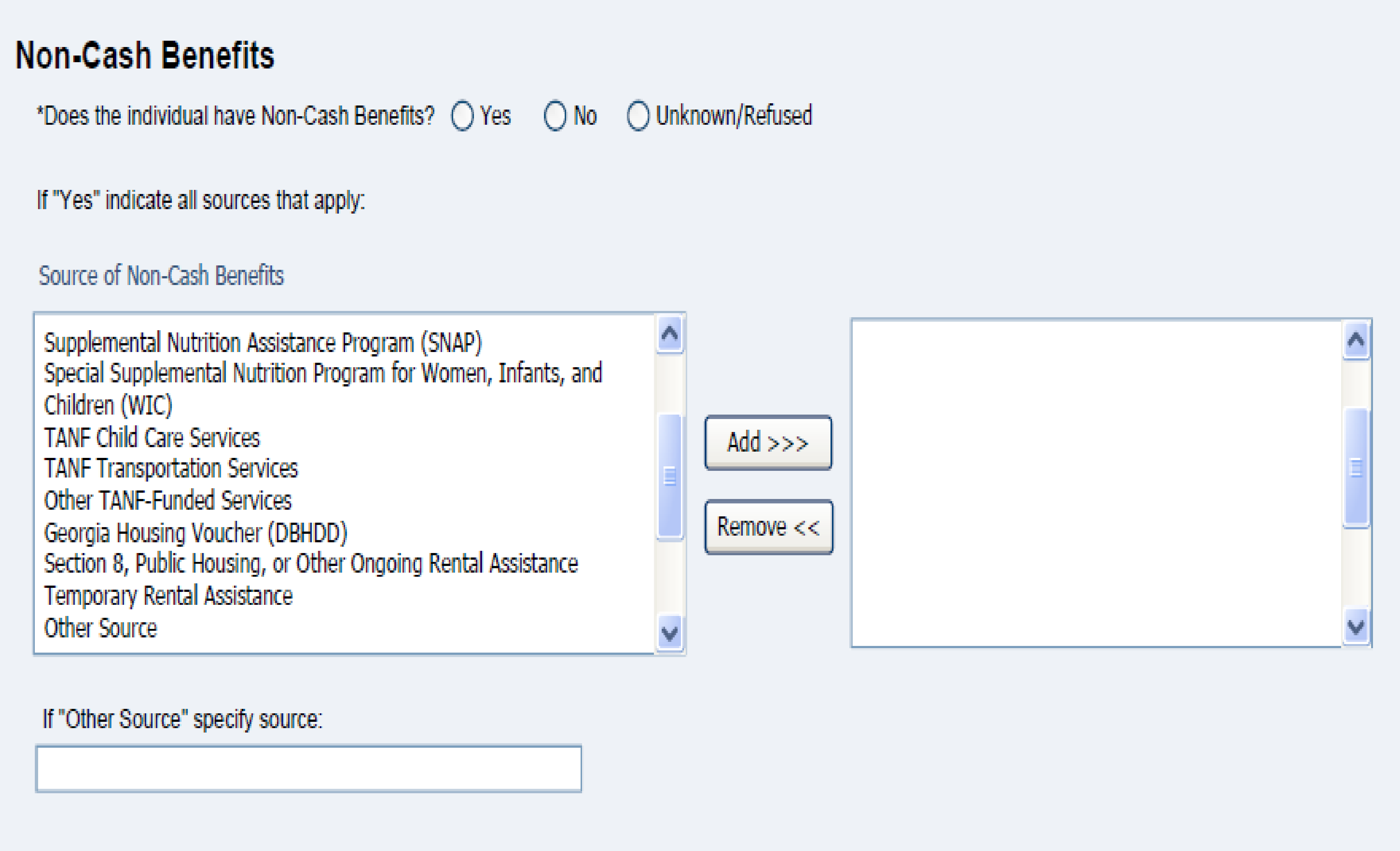
● Yes ○ No ○ Unknown

If income source is "Yes" indicate all sources and dollar amounts for the sources that apply. At least one value must be greater than zero:

	Monthly Amount:
Earned Income	0.00
Unemployment Insurance	0.00
Supplemental Security Income/ Social Security Disability Insurance	0.00
VA Service-Connected Disability	0.00
Temporary Assistance for Needy Families (TANF)	0.00
Trust Fund Payments	0.00
Pension or Retirement Income from a Former Job	0.00
Child Support	0.00
Alimony or Other Spousal Support	0.00
Other Source of Regular Income	0.00

Specify source:

Non-Cash Benefits



Non-Cash Benefits

*Does the individual have Non-Cash Benefits? ○ Yes ○ No ○ Unknown/Refused

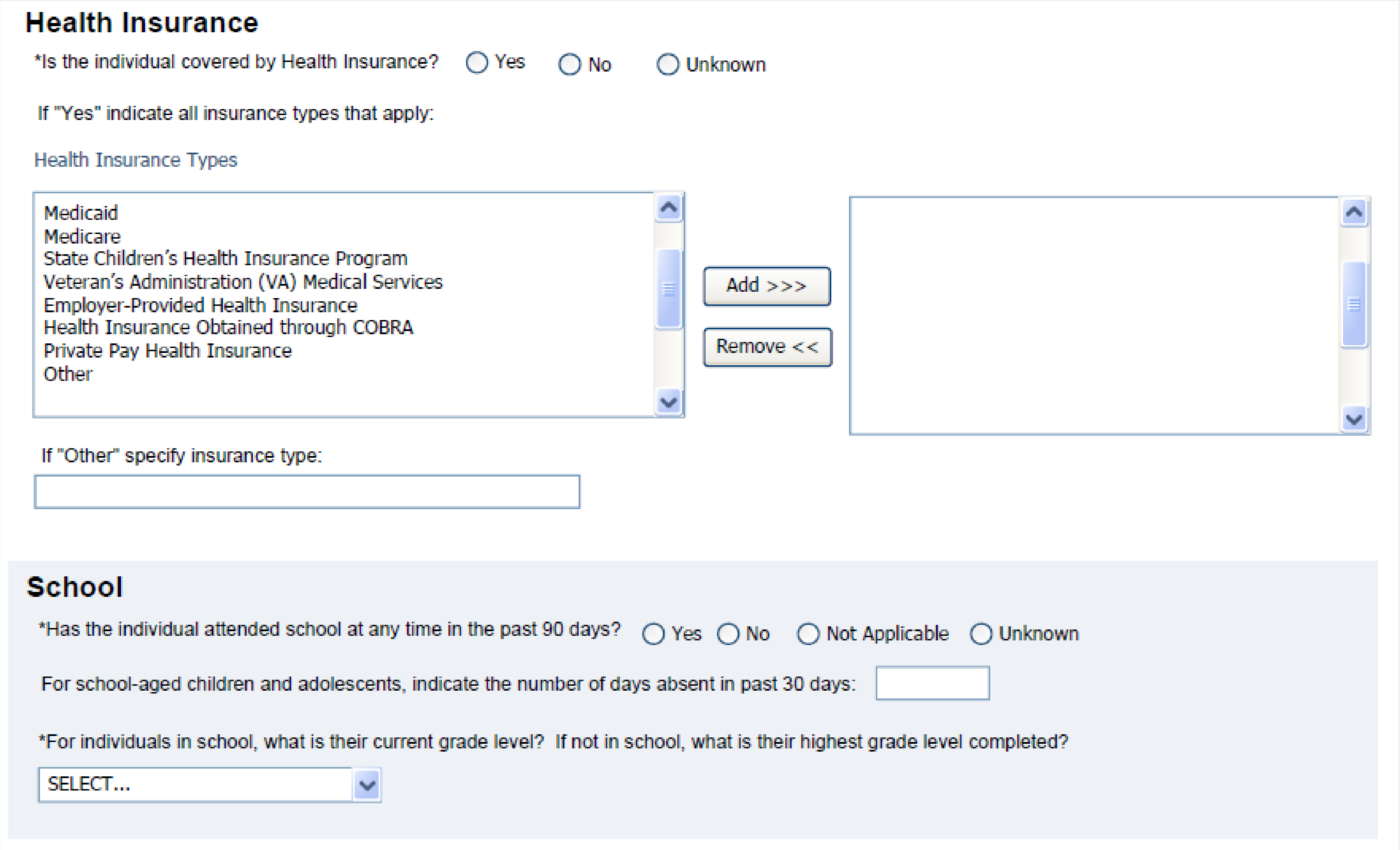
If "Yes" indicate all sources that apply:

Source of Non-Cash Benefits

- Supplemental Nutrition Assistance Program (SNAP)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- TANF Child Care Services
- TANF Transportation Services
- Other TANF-Funded Services
- Georgia Housing Voucher (DBHDD)
- Section 8, Public Housing, or Other Ongoing Rental Assistance
- Temporary Rental Assistance
- Other Source

If "Other Source" specify source:

Health Insurance



Health Insurance

*Is the individual covered by Health Insurance? ○ Yes ○ No ○ Unknown

If "Yes" indicate all insurance types that apply:

Health Insurance Types

Medicaid
Medicare
State Children's Health Insurance Program
Veteran's Administration (VA) Medical Services
Employer-Provided Health Insurance
Health Insurance Obtained through COBRA
Private Pay Health Insurance
Other

If "Other" specify insurance type:

School

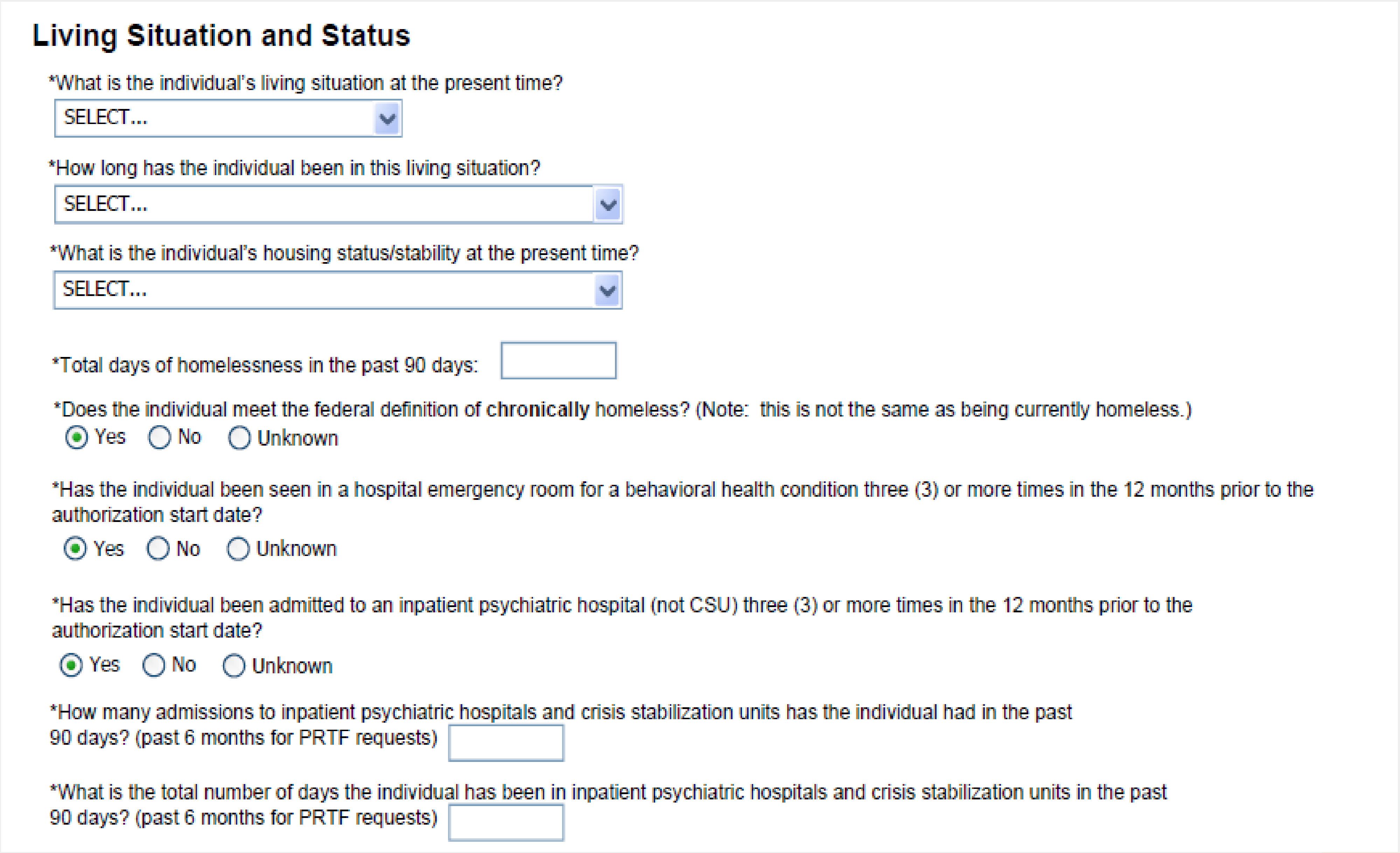
*Has the individual attended school at any time in the past 90 days? ○ Yes ○ No ○ Not Applicable ○ Unknown

For school-aged children and adolescents, indicate the number of days absent in past 30 days:

*For individuals in school, what is their current grade level? If not in school, what is their highest grade level completed?

SELECT...

Living Situation and Status



Living Situation and Status

*What is the individual's living situation at the present time?

SELECT...

*How long has the individual been in this living situation?

SELECT...

*What is the individual's housing status/stability at the present time?

SELECT...

*Total days of homelessness in the past 90 days:

*Does the individual meet the federal definition of chronically homeless? (Note: this is not the same as being currently homeless.)

● Yes ○ No ○ Unknown

*Has the individual been seen in a hospital emergency room for a behavioral health condition three (3) or more times in the 12 months prior to the authorization start date?

● Yes ○ No ○ Unknown

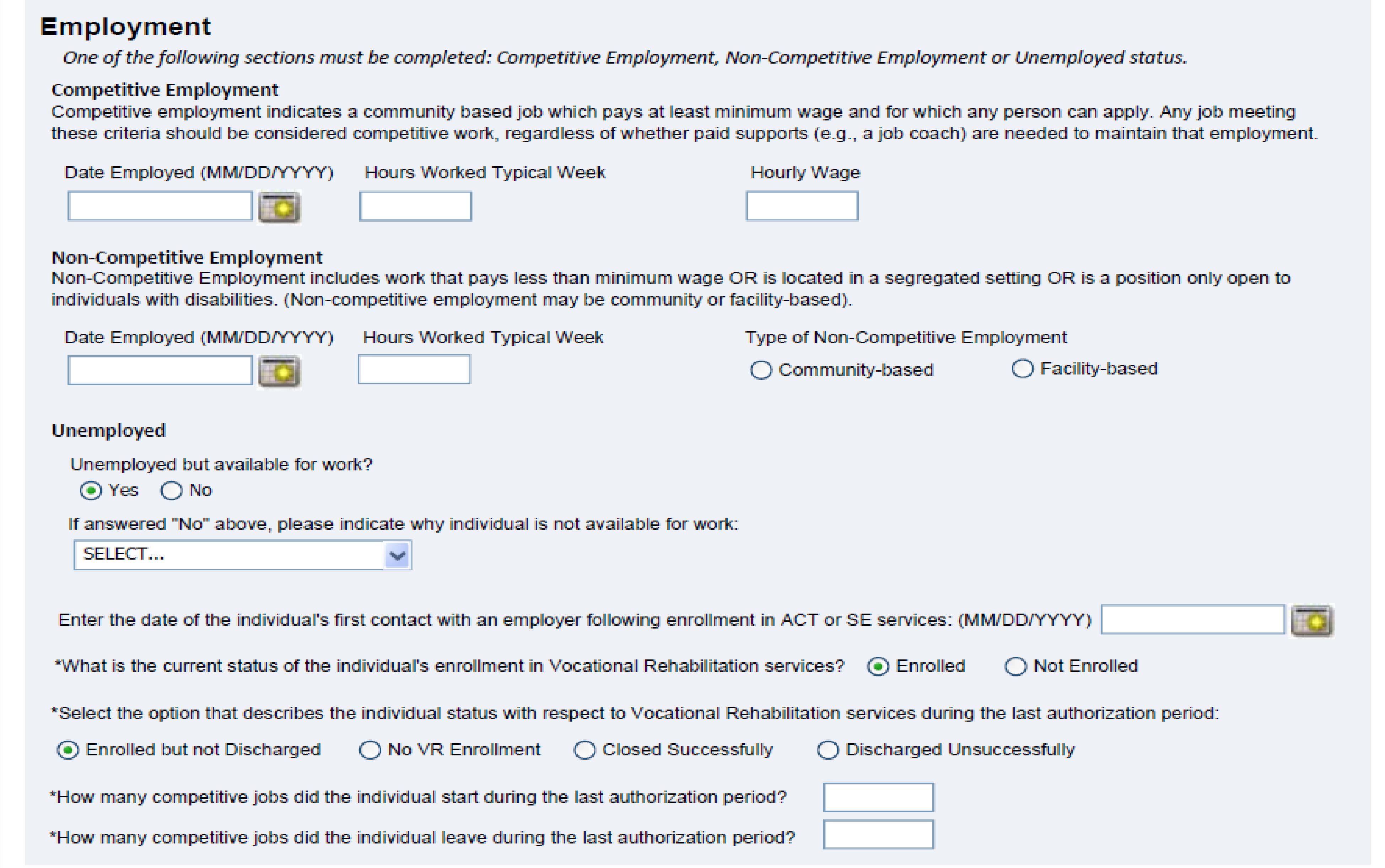
*Has the individual been admitted to an inpatient psychiatric hospital (not CSU) three (3) or more times in the 12 months prior to the authorization start date?

● Yes ○ No ○ Unknown

*How many admissions to inpatient psychiatric hospitals and crisis stabilization units has the individual had in the past 90 days? (past 6 months for PRTF requests)

*What is the total number of days the individual has been in inpatient psychiatric hospitals and crisis stabilization units in the past 90 days? (past 6 months for PRTF requests)

Employment



Employment

One of the following sections must be completed: Competitive Employment, Non-Competitive Employment or Unemployed status.

Competitive Employment

Competitive employment indicates a community based job which pays at least minimum wage and for which any person can apply. Any job meeting these criteria should be considered competitive work, regardless of whether paid supports (e.g., a job coach) are needed to maintain that employment.

Date Employed (MM/DD/YYYY)

Hours Worked Typical Week

Hourly Wage

Non-Competitive Employment

Non-Competitive Employment includes work that pays less than minimum wage OR is located in a segregated setting OR is a position only open to individuals with disabilities. (Non-competitive employment may be community or facility-based).

Date Employed (MM/DD/YYYY)

Hours Worked Typical Week

Type of Non-Competitive Employment

○ Community-based ○ Facility-based

Unemployed

Unemployed but available for work?

● Yes ○ No

If answered "No" above, please indicate why individual is not available for work:

SELECT...

Enter the date of the individual's first contact with an employer following enrollment in ACT or SE services: (MM/DD/YYYY)

*What is the current status of the individual's enrollment in Vocational Rehabilitation services? ● Enrolled ○ Not Enrolled

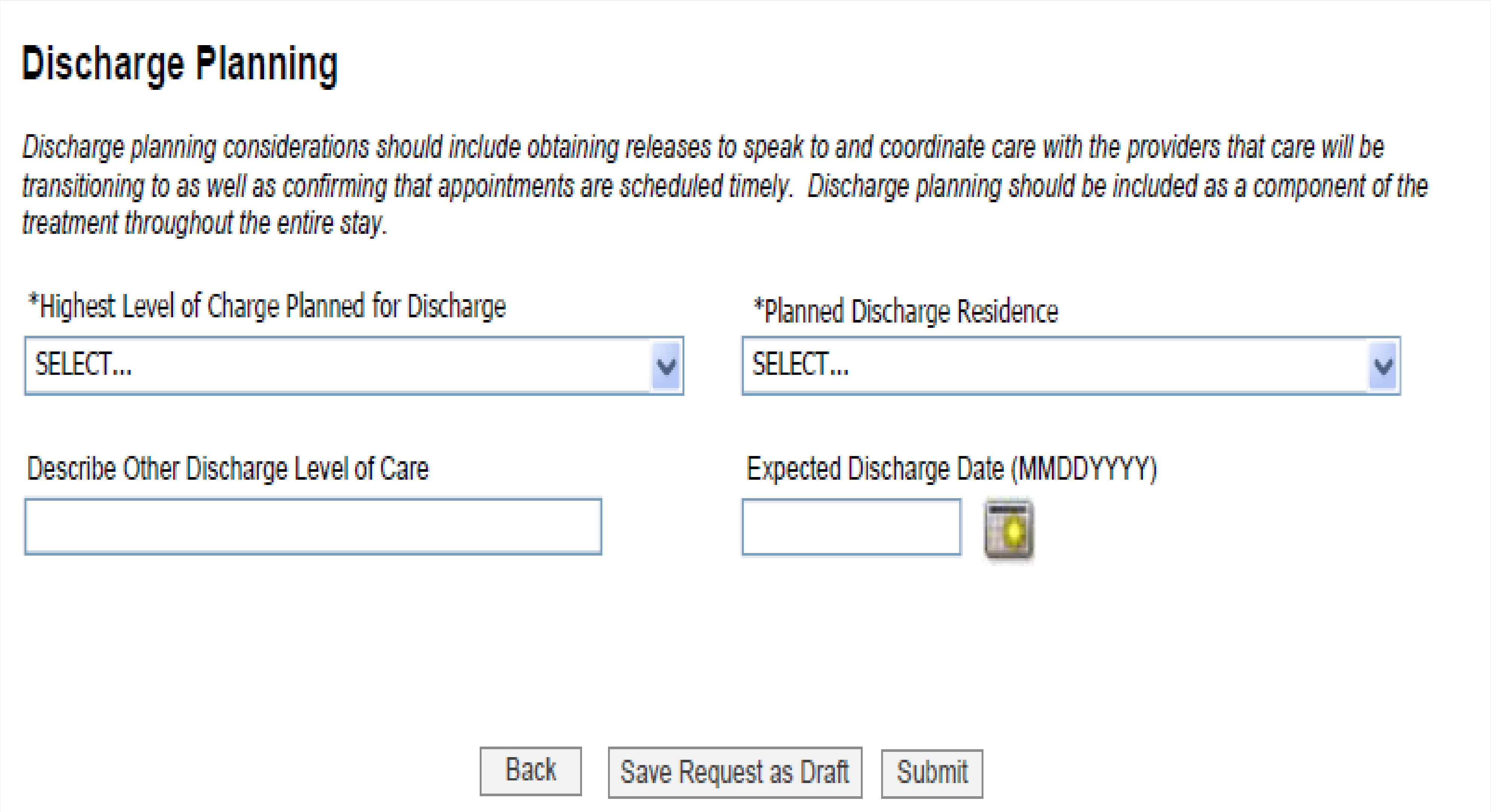
*Select the option that describes the individual status with respect to Vocational Rehabilitation services during the last authorization period:

● Enrolled but not Discharged ○ No VR Enrollment ○ Closed Successfully ○ Discharged Unsuccessfully

*How many competitive jobs did the individual start during the last authorization period?

*How many competitive jobs did the individual leave during the last authorization period?

Discharge Planning



Discharge Planning

Discharge planning considerations should include obtaining releases to speak to and coordinate care with the providers that care will be transitioning to as well as confirming that appointments are scheduled timely. Discharge planning should be included as a component of the treatment throughout the entire stay.

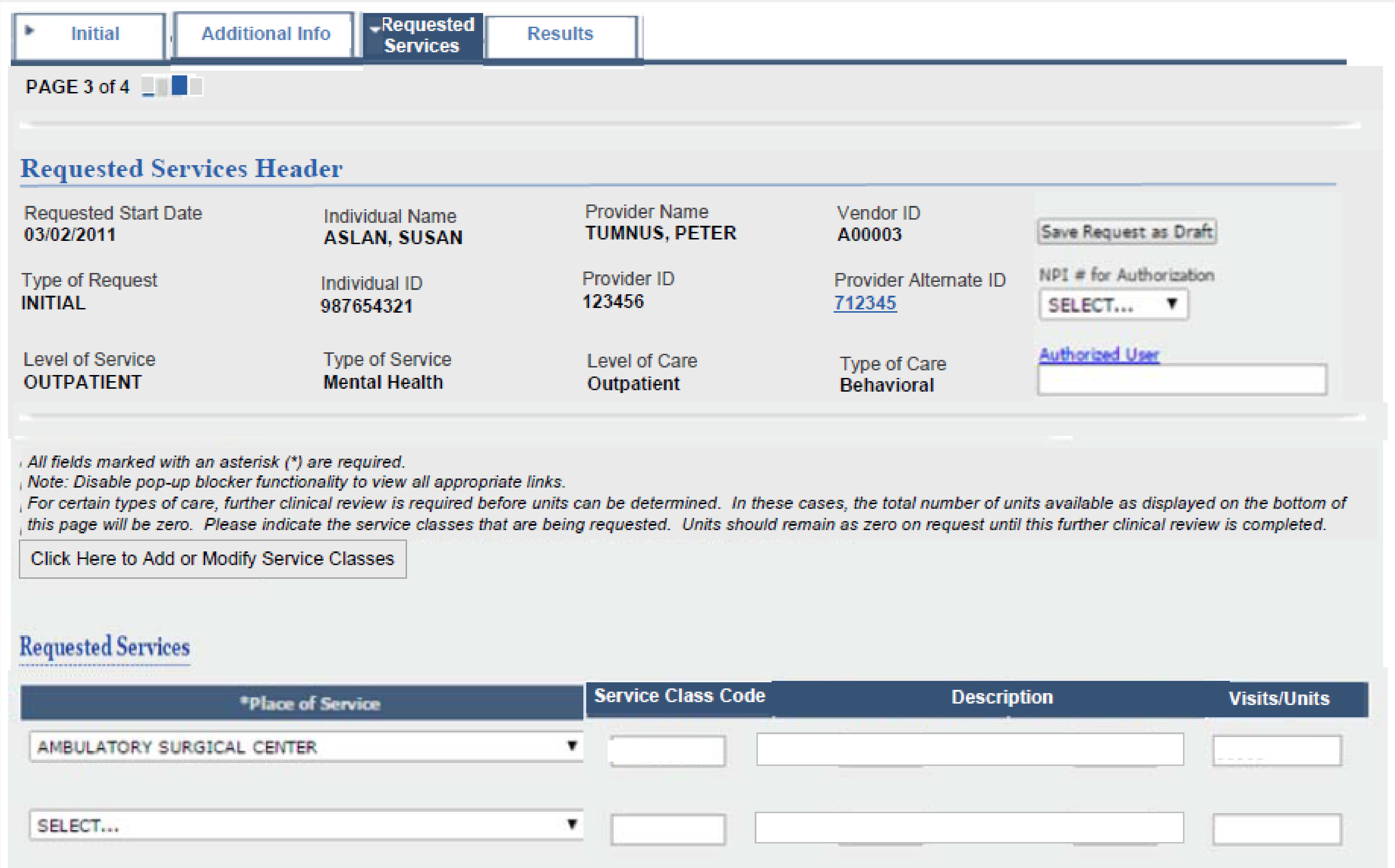
*Highest Level of Charge Planned for Discharge: SELECT...

*Planned Discharge Residence: SELECT...

Describe Other Discharge Level of Care

Expected Discharge Date (MMDDYYYY)

Requested Services


Initial
Additional Info
Requested Services
Results
Save Request as Draft
Authorized User
Click Here to Add or Modify Service Classes

PAGE 3 of 4

Requested Services Header

Requested Start Date
03/02/2011

Individual Name
ASLAN, SUSAN

Provider Name
TUMNUS, PETER

Vendor ID
A00003

Type of Request
INITIAL

Individual ID
987654321

Provider ID
123456

Provider Alternate ID
712345

NPI # for Authorization
SELECT...

Level of Service
OUTPATIENT

Type of Service
Mental Health

Level of Care
Outpatient

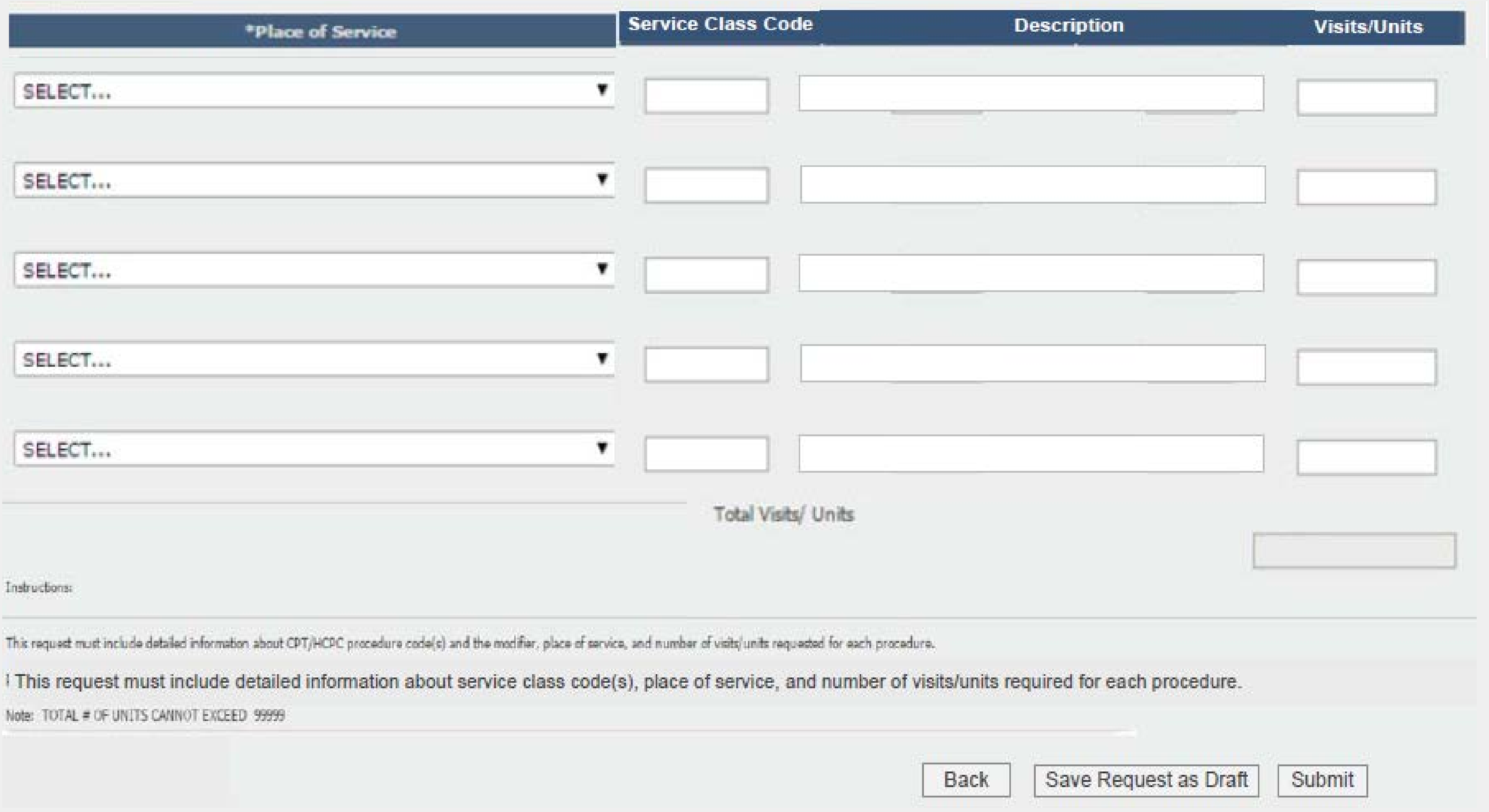
Type of Care
Behavioral

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.
For certain types of care, further clinical review is required before units can be determined. In these cases, the total number of units available as displayed on the bottom of this page will be zero. Please indicate the service classes that are being requested. Units should remain as zero on request until this further clinical review is completed.

Requested Services

*Place of Service	Service Class Code	Description	Visits/Units
AMBULATORY SURGICAL CENTER			
SELECT...			

Requested Services



*Place of Service	Service Class Code	Description	Visits/Units
SELECT... ▼			
SELECT... ▼			
SELECT... ▼			
SELECT... ▼			
SELECT... ▼			

Total Visits/ Units

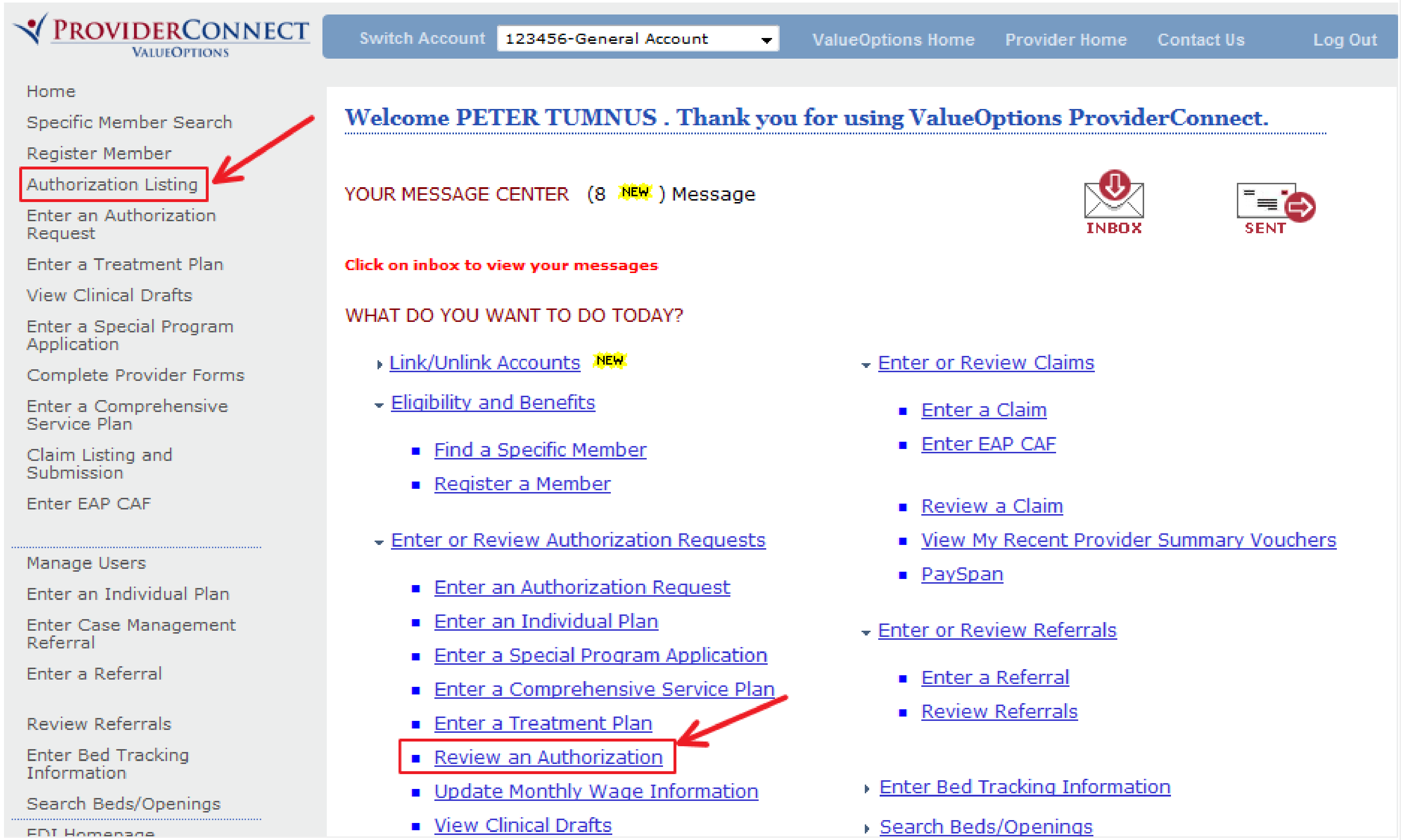
Instructions:

This request must include detailed information about CPT/HCPC procedure code(s) and the modifier, place of service, and number of visits/units requested for each procedure.

This request must include detailed information about service class code(s), place of service, and number of visits/units required for each procedure.

Note: TOTAL # OF UNITS CANNOT EXCEED 99999

Review an Authorization


ProviderConnect
ValueOptions
Switch Account
123456-General Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
EDI Homepage
INBOX
SENT

Welcome PETER TUMNUS . Thank you for using ValueOptions ProviderConnect.

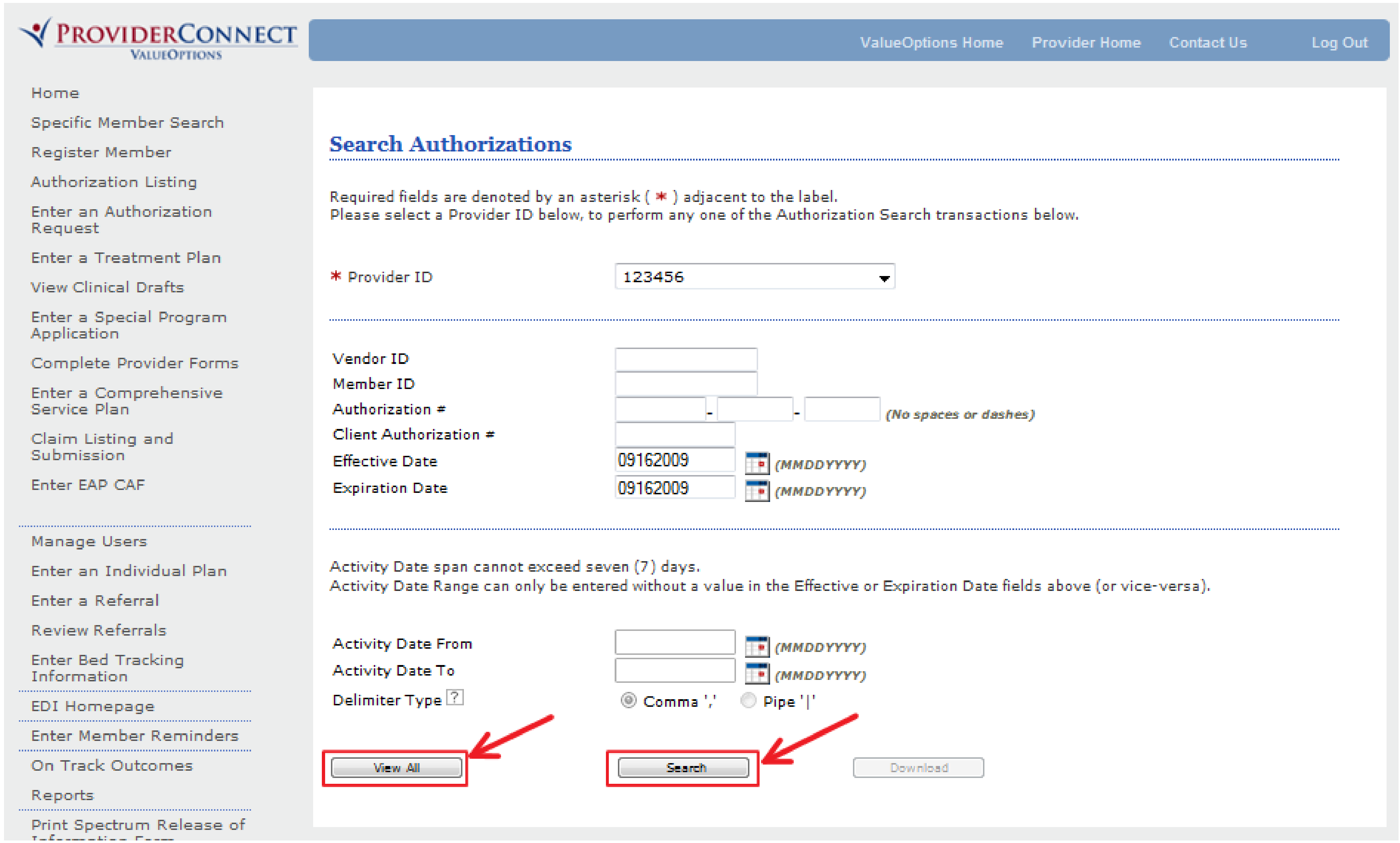
YOUR MESSAGE CENTER (8 NEW) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- Link/Unlink Accounts NEW
- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter an Individual Plan
  - Enter a Special Program Application
  - Enter a Comprehensive Service Plan
  - Enter a Treatment Plan
  - Review an Authorization
  - Update Monthly Wage Information
  - View Clinical Drafts
- Enter or Review Claims
  - Enter a Claim
  - Enter EAP CAF
  - Review a Claim
  - View My Recent Provider Summary Vouchers
  - PaySpan
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals
- Enter Bed Tracking Information
- Search Beds/Openings

Search Authorizations


PROVIDERCONNECT
VALUEOPTIONS
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter a Referral
Review Referrals
Enter Bed Tracking Information
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of Information Form
View All
Search
Download

Search Authorizations

Required fields are denoted by an asterisk (*) adjacent to the label.
Please select a Provider ID below, to perform any one of the Authorization Search transactions below.

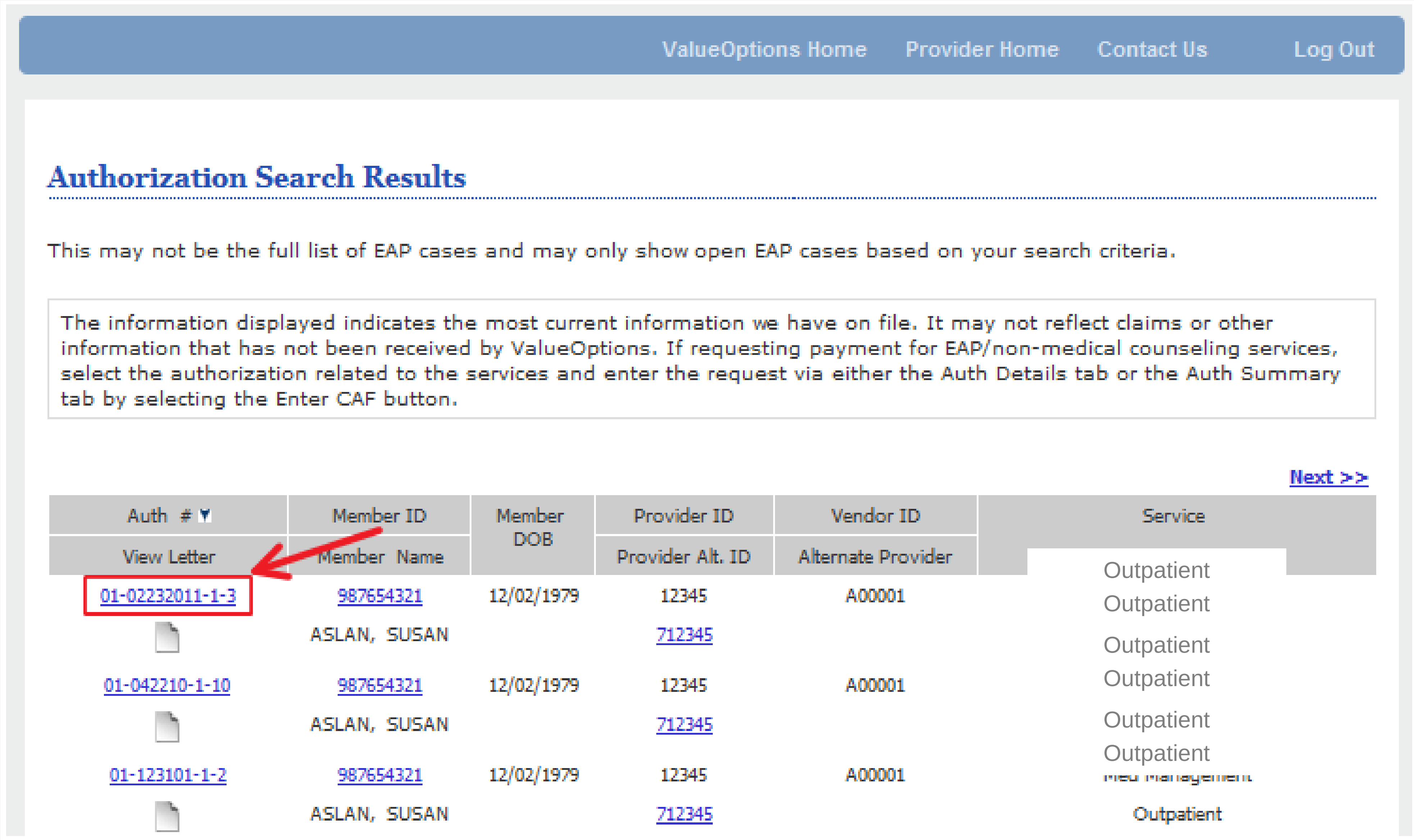
* Provider ID: 123456

Vendor ID:
Member ID:
Authorization #: - - (No spaces or dashes)
Client Authorization #:
Effective Date: 09162009 (MMDDYYYY)
Expiration Date: 09162009 (MMDDYYYY)

Activity Date span cannot exceed seven (7) days.
Activity Date Range can only be entered without a value in the Effective or Expiration Date fields above (or vice-versa).

Activity Date From: (MMDDYYYY)
Activity Date To: (MMDDYYYY)
Delimiter Type ?: ● Comma ',' ○ Pipe '|'

Authorization Search Results

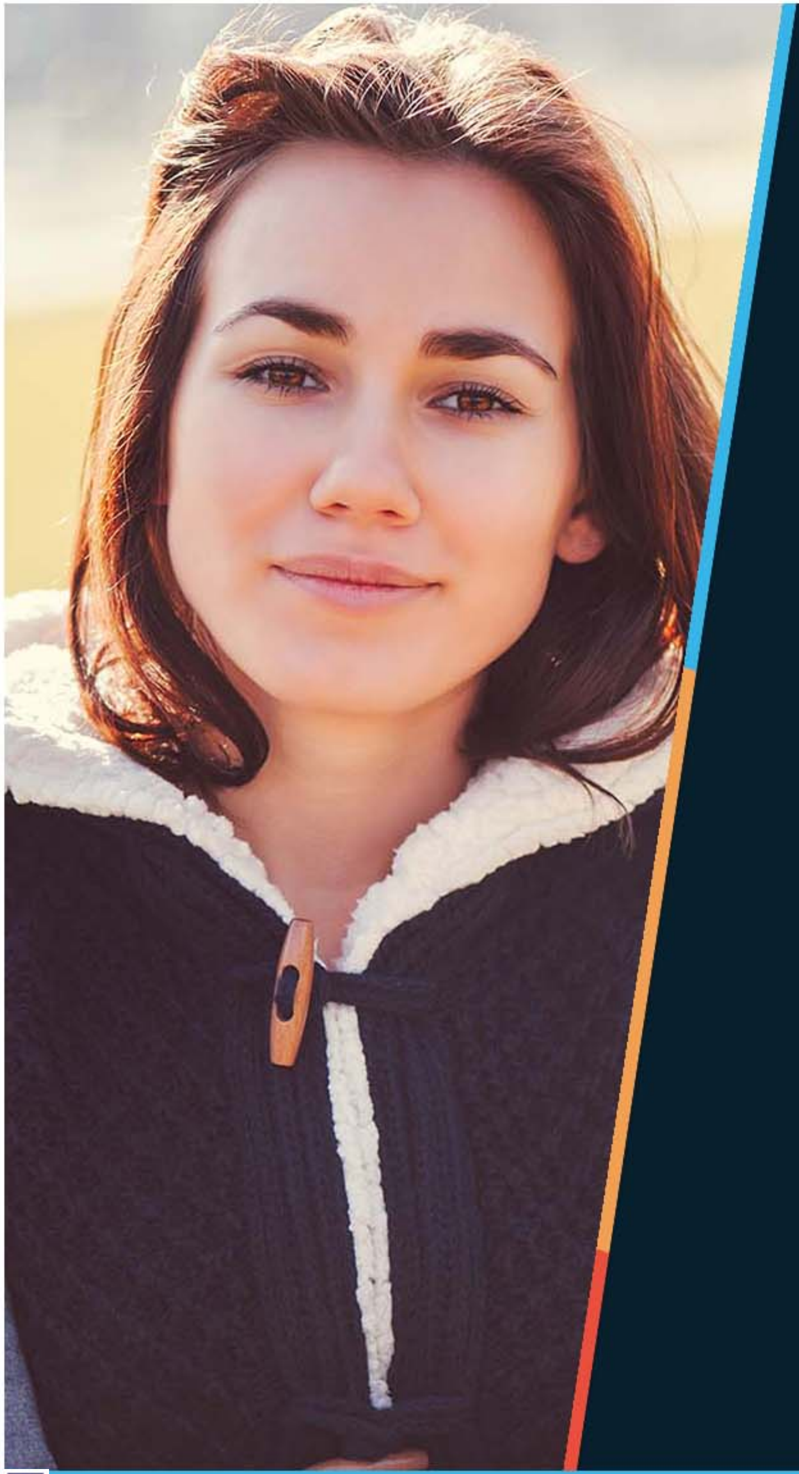


Authorization Search Results

This may not be the full list of EAP cases and may only show open EAP cases based on your search criteria.

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions. If requesting payment for EAP/non-medical counseling services, select the authorization related to the services and enter the request via either the Auth Details tab or the Auth Summary tab by selecting the Enter CAF button.

Auth #	Member ID	Member DOB	Provider ID	Vendor ID	Service
View Letter	Member Name		Provider Alt. ID	Alternate Provider	
01-02232011-1-3	987654321	12/02/1979	12345	A00001	Outpatient Outpatient
🗋	ASLAN, SUSAN		712345		
01-042210-1-10	987654321	12/02/1979	12345	A00001	Outpatient Outpatient
🗋	ASLAN, SUSAN		712345		
01-123101-1-2	987654321	12/02/1979	12345	A00001	Outpatient Outpatient Med Management
🗋	ASLAN, SUSAN		712345		Outpatient

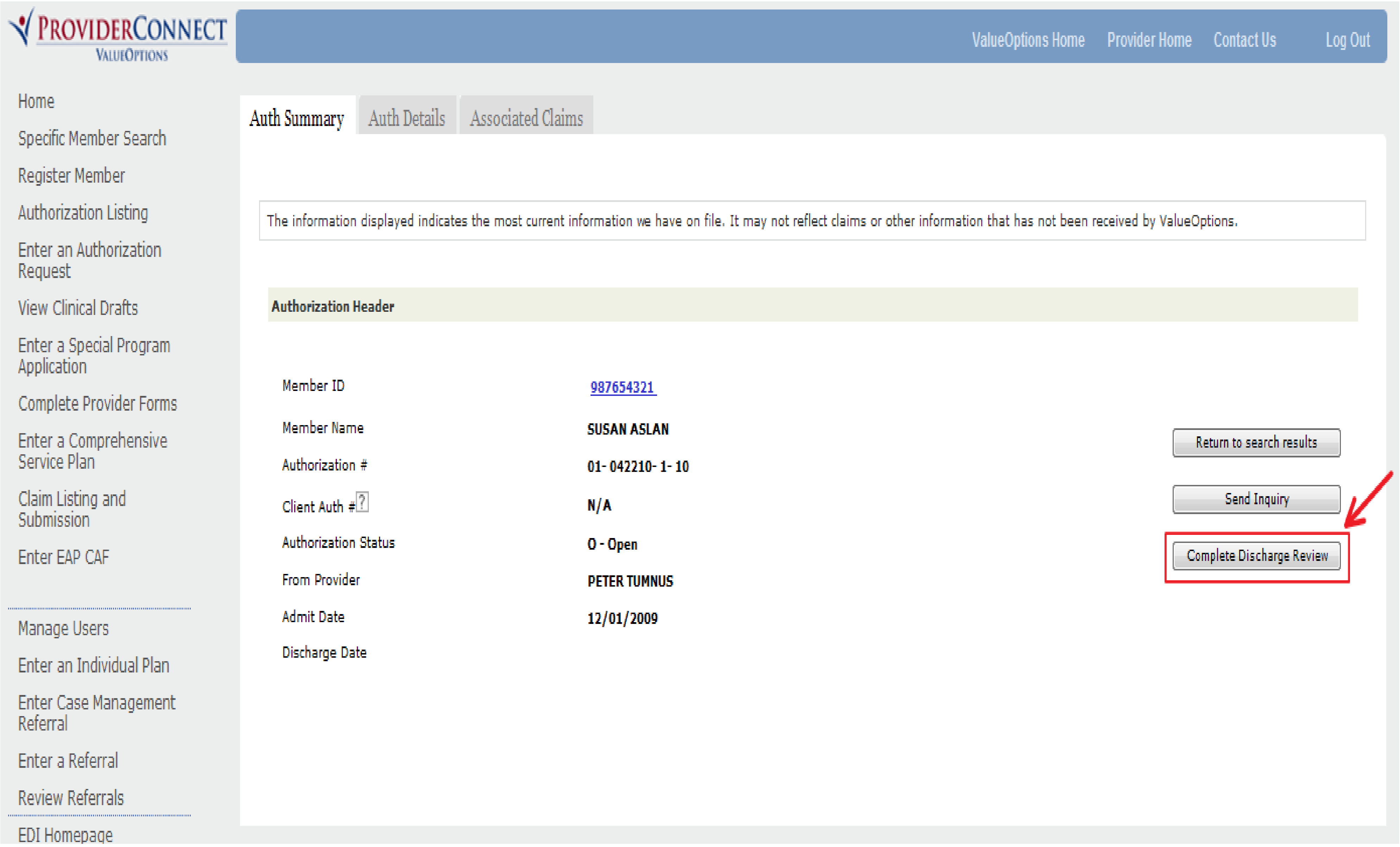


Discharges

Discharge Changes

- Entered through ProviderConnect or by batch
- CANS and ANSA is required instead of LOCUS and CAFAS

Complete Discharge Review

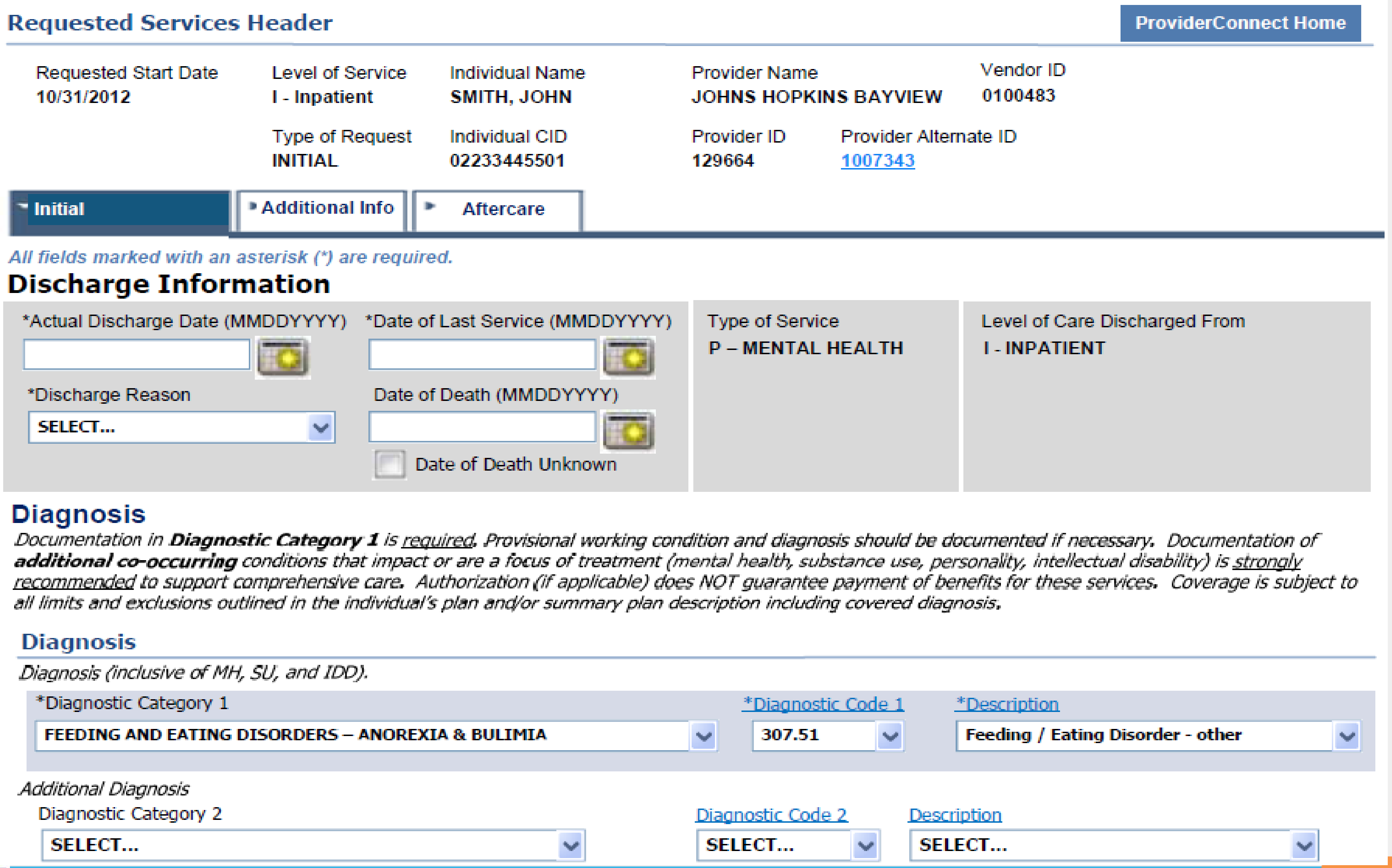

PROVIDERCONNECT
VALUEOPTIONS
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
EDI Homepage
Auth Summary
Auth Details
Associated Claims
Return to search results
Send Inquiry
Complete Discharge Review

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Authorization Header

Member ID	987654321
Member Name	SUSAN ASLAN
Authorization #	01- 042210- 1- 10
Client Auth # ?	N/A
Authorization Status	O - Open
From Provider	PETER TUMNUS
Admit Date	12/01/2009
Discharge Date	

Complete Information



Requested Services Header

Requested Start Date
10/31/2012

Level of Service
I - Inpatient

Individual Name
SMITH, JOHN

Provider Name
JOHNS HOPKINS BAYVIEW

Vendor ID
0100483

Type of Request
INITIAL

Individual CID
02233445501

Provider ID
129664

Provider Alternate ID
1007343

All fields marked with an asterisk (*) are required.

Discharge Information

*Actual Discharge Date (MMDDYYYY)

*Date of Last Service (MMDDYYYY)

*Discharge Reason
SELECT...

Date of Death (MMDDYYYY)

☐ Date of Death Unknown

Type of Service
P – MENTAL HEALTH

Level of Care Discharged From
I - INPATIENT

Diagnosis

*Documentation in **Diagnostic Category 1** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **additional co-occurring** conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the individual's plan and/or summary plan description including covered diagnosis.*

Diagnosis

Diagnosis (inclusive of MH, SU, and IDD).

*Diagnostic Category 1
FEEDING AND EATING DISORDERS – ANOREXIA & BULIMIA

*Diagnostic Code 1
307.51

*Description
Feeding / Eating Disorder - other

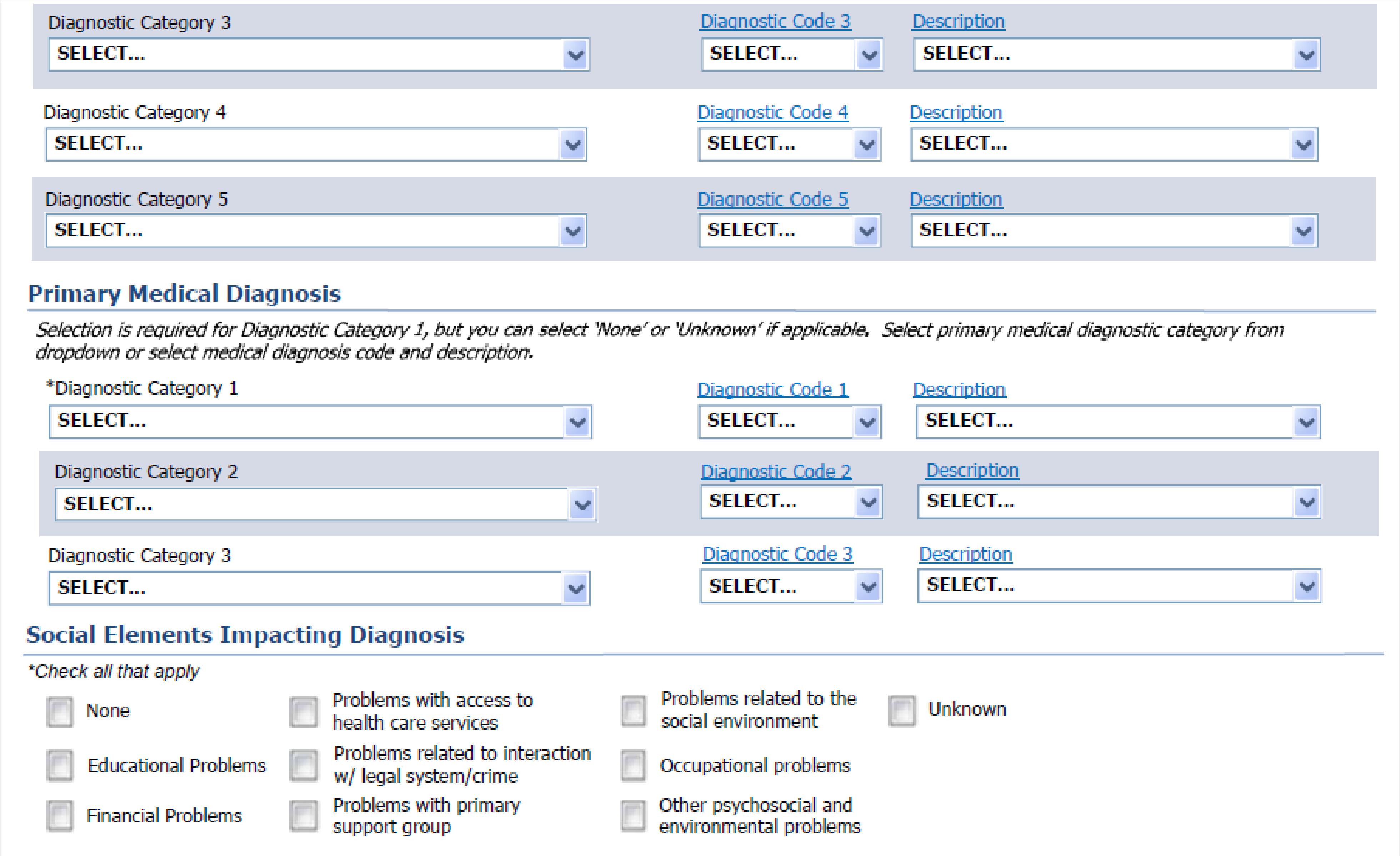
Additional Diagnosis

Diagnostic Category 2
SELECT...

Diagnostic Code 2
SELECT...

Description
SELECT...

Diagnosis and Social Elements



Diagnostic Category 3	Diagnostic Code 3	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 4	Diagnostic Code 4	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 5	Diagnostic Code 5	Description
SELECT...	SELECT...	SELECT...

Primary Medical Diagnosis

Selection is required for Diagnostic Category 1, but you can select 'None' or 'Unknown' if applicable. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

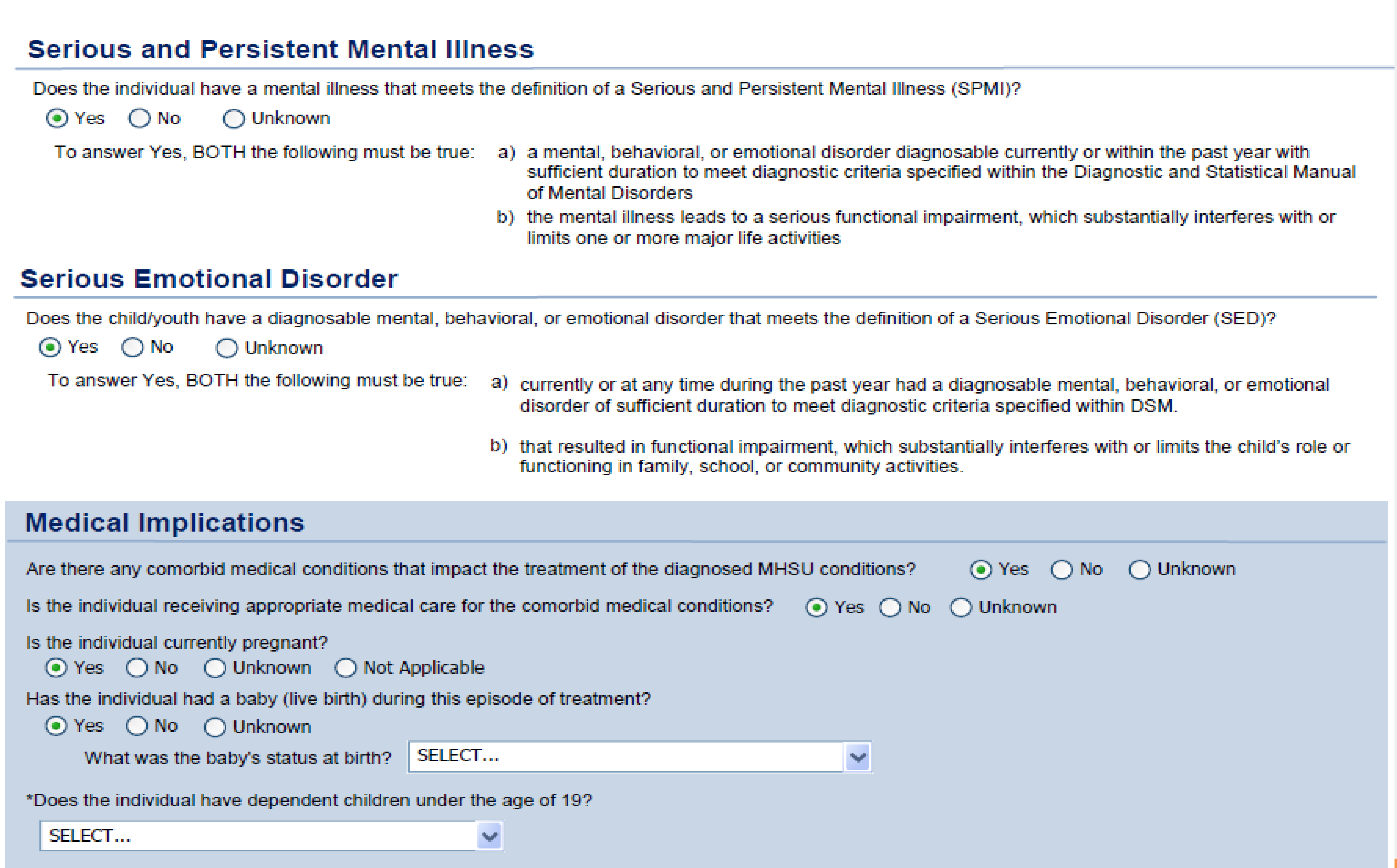
*Diagnostic Category 1	Diagnostic Code 1	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 2	Diagnostic Code 2	Description
SELECT...	SELECT...	SELECT...
Diagnostic Category 3	Diagnostic Code 3	Description
SELECT...	SELECT...	SELECT...

Social Elements Impacting Diagnosis

**Check all that apply*

☐ None
☐ Educational Problems
☐ Financial Problems
☐ Problems with access to health care services
☐ Problems related to interaction w/ legal system/crime
☐ Problems with primary support group
☐ Problems related to the social environment
☐ Occupational problems
☐ Other psychosocial and environmental problems
☐ Unknown

Complete Discharge Review



Serious and Persistent Mental Illness

Does the individual have a mental illness that meets the definition of a Serious and Persistent Mental Illness (SPMI)?

● Yes ○ No ○ Unknown

To answer Yes, BOTH the following must be true:

a) a mental, behavioral, or emotional disorder diagnosable currently or within the past year with sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders

b) the mental illness leads to a serious functional impairment, which substantially interferes with or limits one or more major life activities

Serious Emotional Disorder

Does the child/youth have a diagnosable mental, behavioral, or emotional disorder that meets the definition of a Serious Emotional Disorder (SED)?

● Yes ○ No ○ Unknown

To answer Yes, BOTH the following must be true:

a) currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM.

b) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Medical Implications

Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions? ● Yes ○ No ○ Unknown

Is the individual receiving appropriate medical care for the comorbid medical conditions? ● Yes ○ No ○ Unknown

Is the individual currently pregnant?

● Yes ○ No ○ Unknown ○ Not Applicable

Has the individual had a baby (live birth) during this episode of treatment?

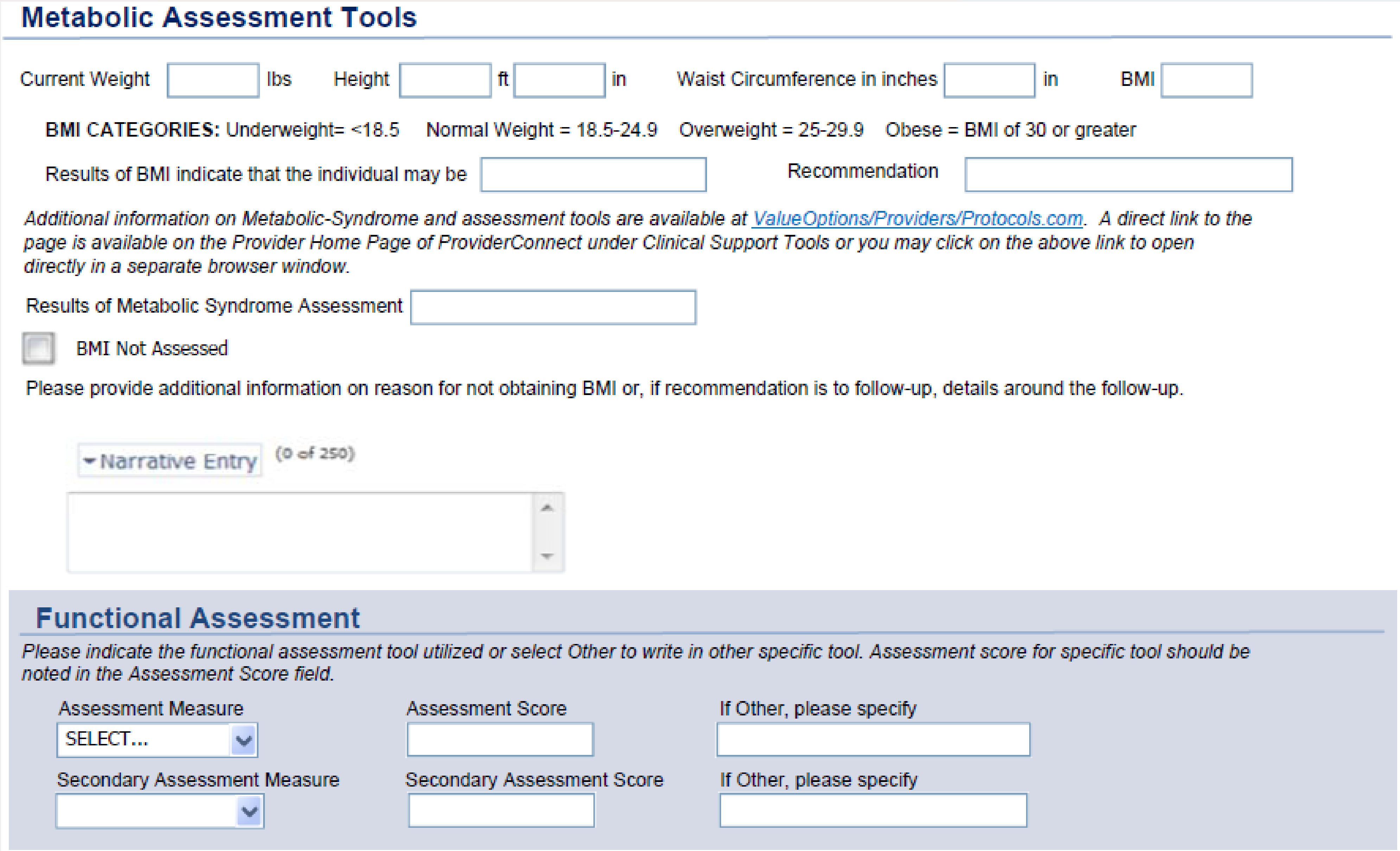
● Yes ○ No ○ Unknown

What was the baby's status at birth? SELECT...

*Does the individual have dependent children under the age of 19?

SELECT...

Metabolic Assessment and Functional Assessment



Metabolic Assessment Tools

Current Weight ☐ lbs Height ☐ ft ☐ in Waist Circumference in inches ☐ in BMI ☐

BMI CATEGORIES: Underweight= <18.5 Normal Weight = 18.5-24.9 Overweight = 25-29.9 Obese = BMI of 30 or greater

Results of BMI indicate that the individual may be ☐ Recommendation ☐

Additional information on Metabolic-Syndrome and assessment tools are available at ValueOptions/Providers/Protocols.com. A direct link to the page is available on the Provider Home Page of ProviderConnect under Clinical Support Tools or you may click on the above link to open directly in a separate browser window.

Results of Metabolic Syndrome Assessment ☐

☐ BMI Not Assessed

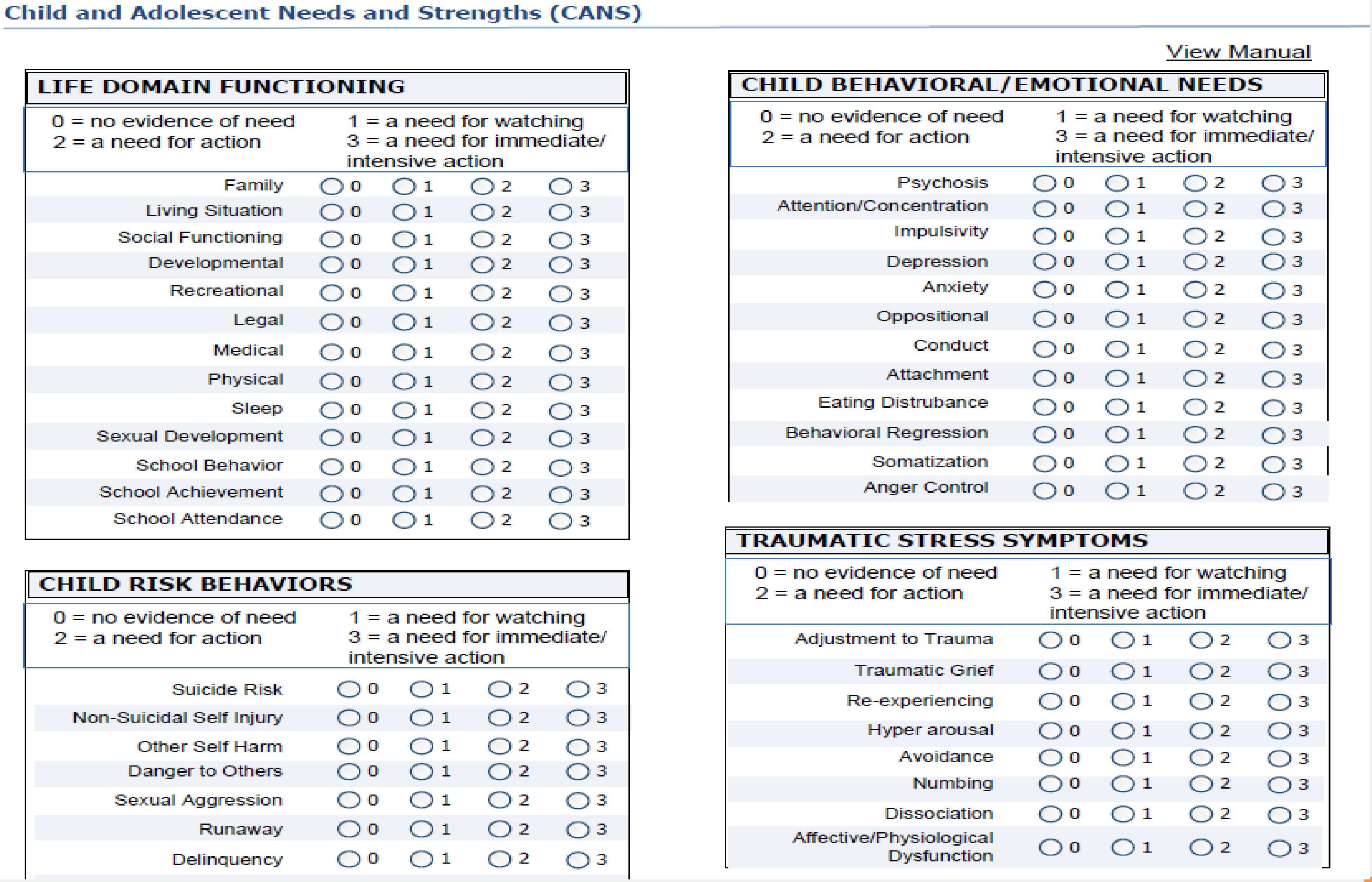
Please provide additional information on reason for not obtaining BMI or, if recommendation is to follow-up, details around the follow-up.

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

Assessment Measure	Assessment Score	If Other, please specify
SELECT...		
Secondary Assessment Measure	Secondary Assessment Score	If Other, please specify

CANS Example



Child and Adolescent Needs and Strengths (CANS)

View Manual

LIFE DOMAIN FUNCTIONING

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Family	○ 0	○ 1	○ 2	○ 3
Living Situation	○ 0	○ 1	○ 2	○ 3
Social Functioning	○ 0	○ 1	○ 2	○ 3
Developmental	○ 0	○ 1	○ 2	○ 3
Recreational	○ 0	○ 1	○ 2	○ 3
Legal	○ 0	○ 1	○ 2	○ 3
Medical	○ 0	○ 1	○ 2	○ 3
Physical	○ 0	○ 1	○ 2	○ 3
Sleep	○ 0	○ 1	○ 2	○ 3
Sexual Development	○ 0	○ 1	○ 2	○ 3
School Behavior	○ 0	○ 1	○ 2	○ 3
School Achievement	○ 0	○ 1	○ 2	○ 3
School Attendance	○ 0	○ 1	○ 2	○ 3

CHILD RISK BEHAVIORS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Suicide Risk	○ 0	○ 1	○ 2	○ 3
Non-Suicidal Self Injury	○ 0	○ 1	○ 2	○ 3
Other Self Harm	○ 0	○ 1	○ 2	○ 3
Danger to Others	○ 0	○ 1	○ 2	○ 3
Sexual Aggression	○ 0	○ 1	○ 2	○ 3
Runaway	○ 0	○ 1	○ 2	○ 3
Delinquency	○ 0	○ 1	○ 2	○ 3

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

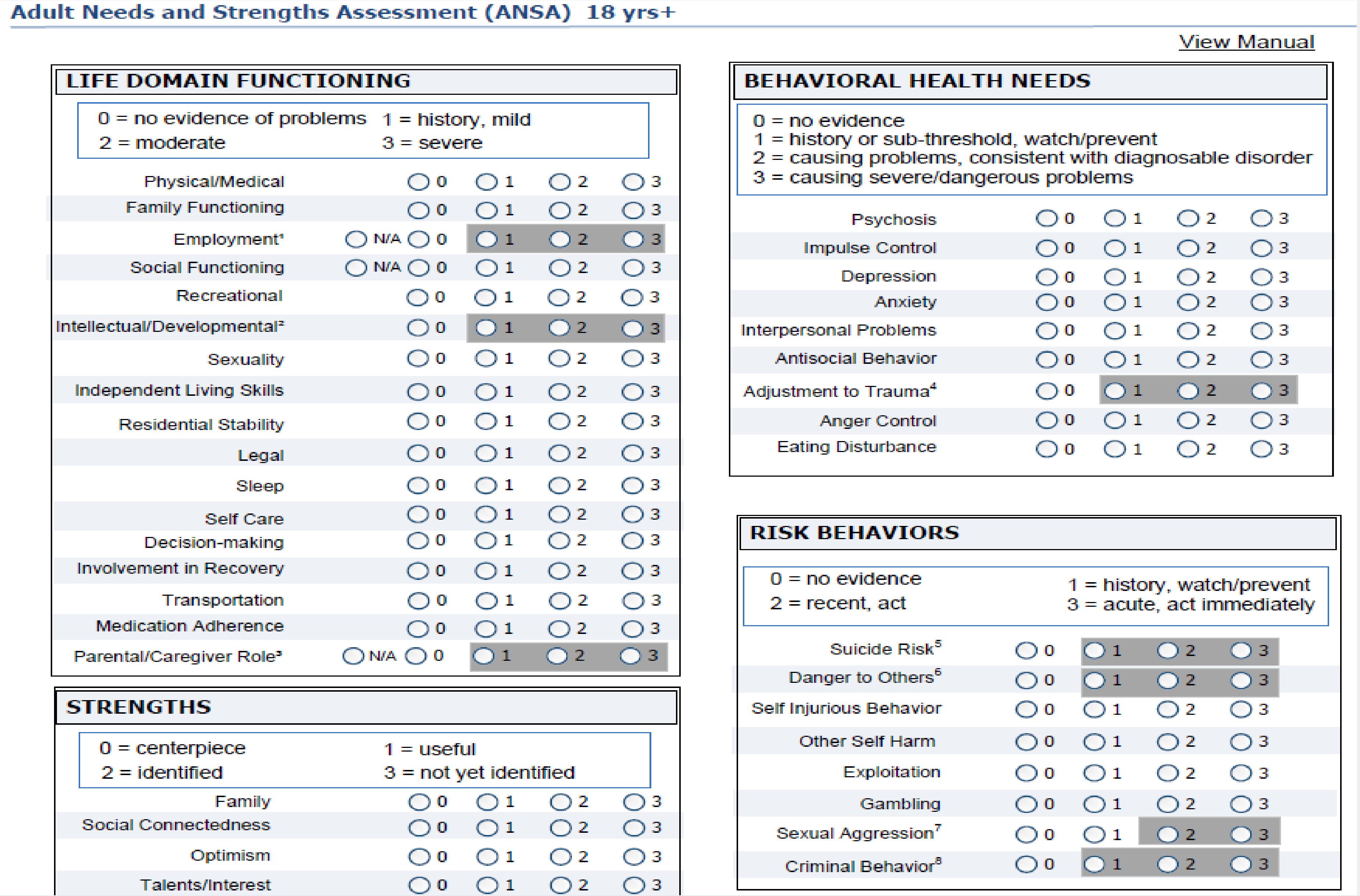
Psychosis	○ 0	○ 1	○ 2	○ 3
Attention/Concentration	○ 0	○ 1	○ 2	○ 3
Impulsivity	○ 0	○ 1	○ 2	○ 3
Depression	○ 0	○ 1	○ 2	○ 3
Anxiety	○ 0	○ 1	○ 2	○ 3
Oppositional	○ 0	○ 1	○ 2	○ 3
Conduct	○ 0	○ 1	○ 2	○ 3
Attachment	○ 0	○ 1	○ 2	○ 3
Eating Distrubance	○ 0	○ 1	○ 2	○ 3
Behavioral Regression	○ 0	○ 1	○ 2	○ 3
Somatization	○ 0	○ 1	○ 2	○ 3
Anger Control	○ 0	○ 1	○ 2	○ 3

TRAUMATIC STRESS SYMPTOMS

0 = no evidence of need
2 = a need for action
1 = a need for watching
3 = a need for immediate/ intensive action

Adjustment to Trauma	○ 0	○ 1	○ 2	○ 3
Traumatic Grief	○ 0	○ 1	○ 2	○ 3
Re-experiencing	○ 0	○ 1	○ 2	○ 3
Hyper arousal	○ 0	○ 1	○ 2	○ 3
Avoidance	○ 0	○ 1	○ 2	○ 3
Numbing	○ 0	○ 1	○ 2	○ 3
Dissociation	○ 0	○ 1	○ 2	○ 3
Affective/Physiological Dysfunction	○ 0	○ 1	○ 2	○ 3

ANSA Example



Adult Needs and Strengths Assessment (ANSA) 18 yrs+

View Manual

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems
1 = history, mild
2 = moderate
3 = severe

Physical/Medical		○ 0	○ 1	○ 2	○ 3
Family Functioning		○ 0	○ 1	○ 2	○ 3
Employment[1]	○ N/A	○ 0	○ 1	○ 2	○ 3
Social Functioning	○ N/A	○ 0	○ 1	○ 2	○ 3
Recreational		○ 0	○ 1	○ 2	○ 3
Intellectual/Developmental[2]		○ 0	○ 1	○ 2	○ 3
Sexuality		○ 0	○ 1	○ 2	○ 3
Independent Living Skills		○ 0	○ 1	○ 2	○ 3
Residential Stability		○ 0	○ 1	○ 2	○ 3
Legal		○ 0	○ 1	○ 2	○ 3
Sleep		○ 0	○ 1	○ 2	○ 3
Self Care		○ 0	○ 1	○ 2	○ 3
Decision-making		○ 0	○ 1	○ 2	○ 3
Involvement in Recovery		○ 0	○ 1	○ 2	○ 3
Transportation		○ 0	○ 1	○ 2	○ 3
Medication Adherence		○ 0	○ 1	○ 2	○ 3
Parental/Caregiver Role[3]	○ N/A	○ 0	○ 1	○ 2	○ 3

STRENGTHS

0 = centerpiece
1 = useful
2 = identified
3 = not yet identified

Family	○ 0	○ 1	○ 2	○ 3
Social Connectedness	○ 0	○ 1	○ 2	○ 3
Optimism	○ 0	○ 1	○ 2	○ 3
Talents/Interest	○ 0	○ 1	○ 2	○ 3

BEHAVIORAL HEALTH NEEDS

0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

Psychosis	○ 0	○ 1	○ 2	○ 3
Impulse Control	○ 0	○ 1	○ 2	○ 3
Depression	○ 0	○ 1	○ 2	○ 3
Anxiety	○ 0	○ 1	○ 2	○ 3
Interpersonal Problems	○ 0	○ 1	○ 2	○ 3
Antisocial Behavior	○ 0	○ 1	○ 2	○ 3
Adjustment to Trauma[4]	○ 0	○ 1	○ 2	○ 3
Anger Control	○ 0	○ 1	○ 2	○ 3
Eating Disturbance	○ 0	○ 1	○ 2	○ 3

RISK BEHAVIORS

0 = no evidence
1 = history, watch/prevent
2 = recent, act
3 = acute, act immediately

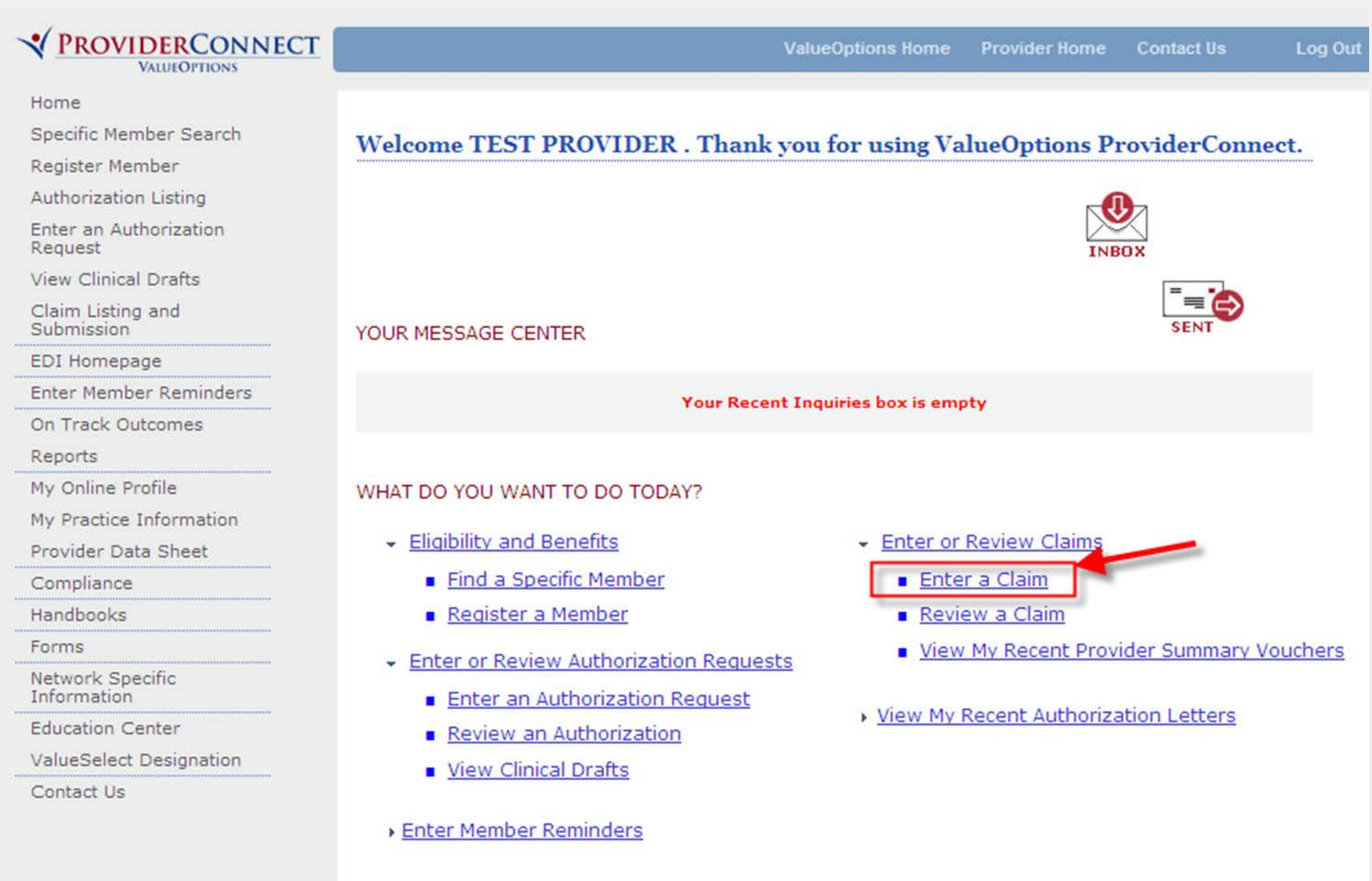
Suicide Risk[5]	○ 0	○ 1	○ 2	○ 3
Danger to Others[6]	○ 0	○ 1	○ 2	○ 3
Self Injurious Behavior	○ 0	○ 1	○ 2	○ 3
Other Self Harm	○ 0	○ 1	○ 2	○ 3
Exploitation	○ 0	○ 1	○ 2	○ 3
Gambling	○ 0	○ 1	○ 2	○ 3
Sexual Aggression[7]	○ 0	○ 1	○ 2	○ 3
Criminal Behavior[8]	○ 0	○ 1	○ 2	○ 3

Claim Submission

Claim Submission Changes

- Check runs for state funded claims will be issued weekly
- No changes are being made to Medicaid claims processes
- Can submit via Batch or Direct Claim Submission
  - Direct Claim Submission
    - Ability to enter a claim directly into ProviderConnect portal without using special software
    - Recommended for providers submitting a lower claim volume
  - Batch Claim Submission
    - Allows for upload of HIPAA 5010 compliant 837i and 837p files
    - Recommended for facilities and providers submitting a higher volume of claims
    - Offers acknowledgment via 999 and 277CA files as well as email
    - 835 file offered through PaySpan

Enter a Claim


PROVIDERCONNECT
VALUEOPTIONS
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us
INBOX
SENT

Welcome TEST PROVIDER . Thank you for using ValueOptions ProviderConnect.

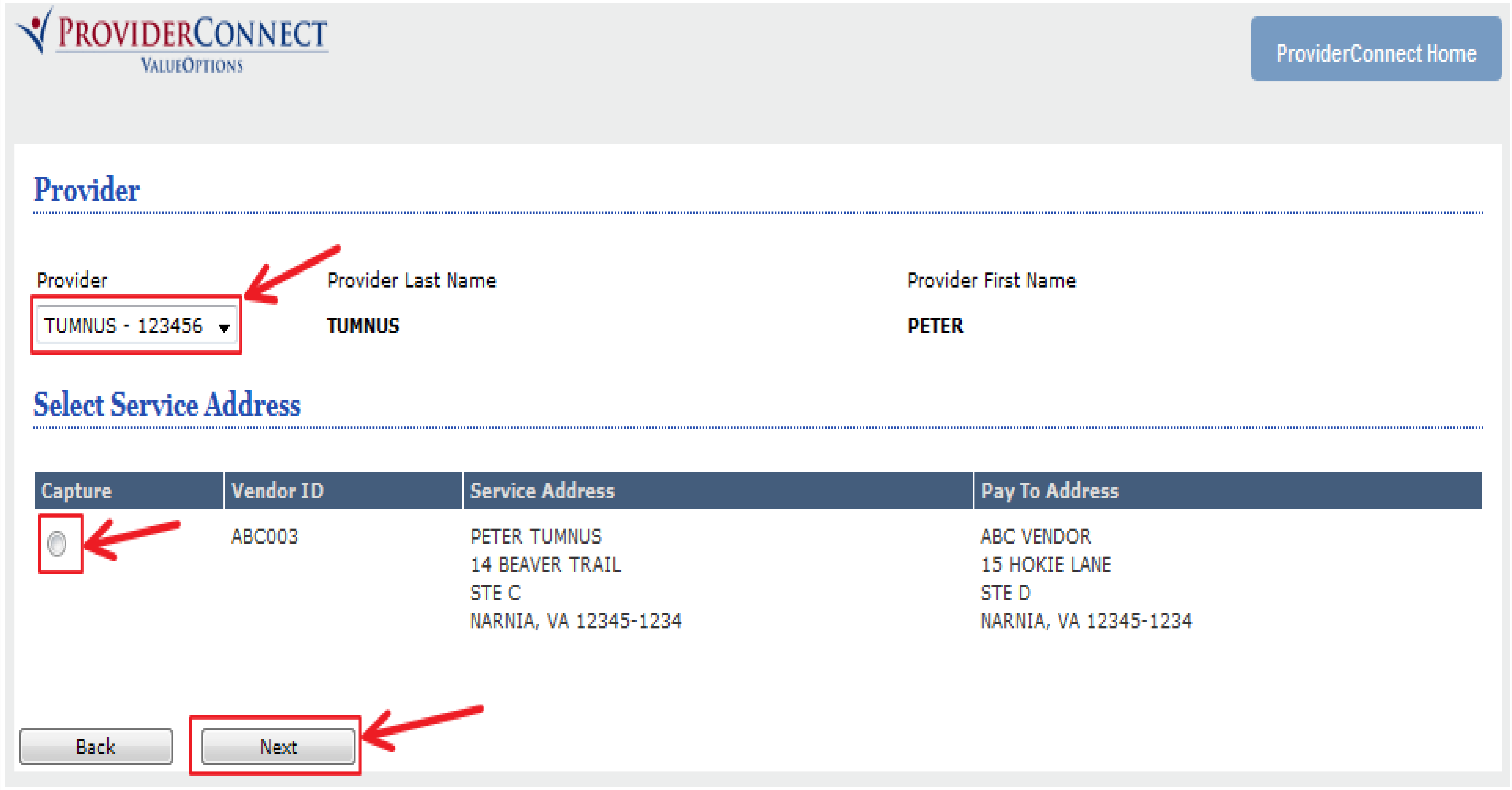
YOUR MESSAGE CENTER

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Review an Authorization
  - View Clinical Drafts
- Enter Member Reminders
- Enter or Review Claims
  - Enter a Claim
  - Review a Claim
  - View My Recent Provider Summary Vouchers
- View My Recent Authorization Letters

Select Service Address



ProviderConnect
ValueOptions
ProviderConnect Home

Provider

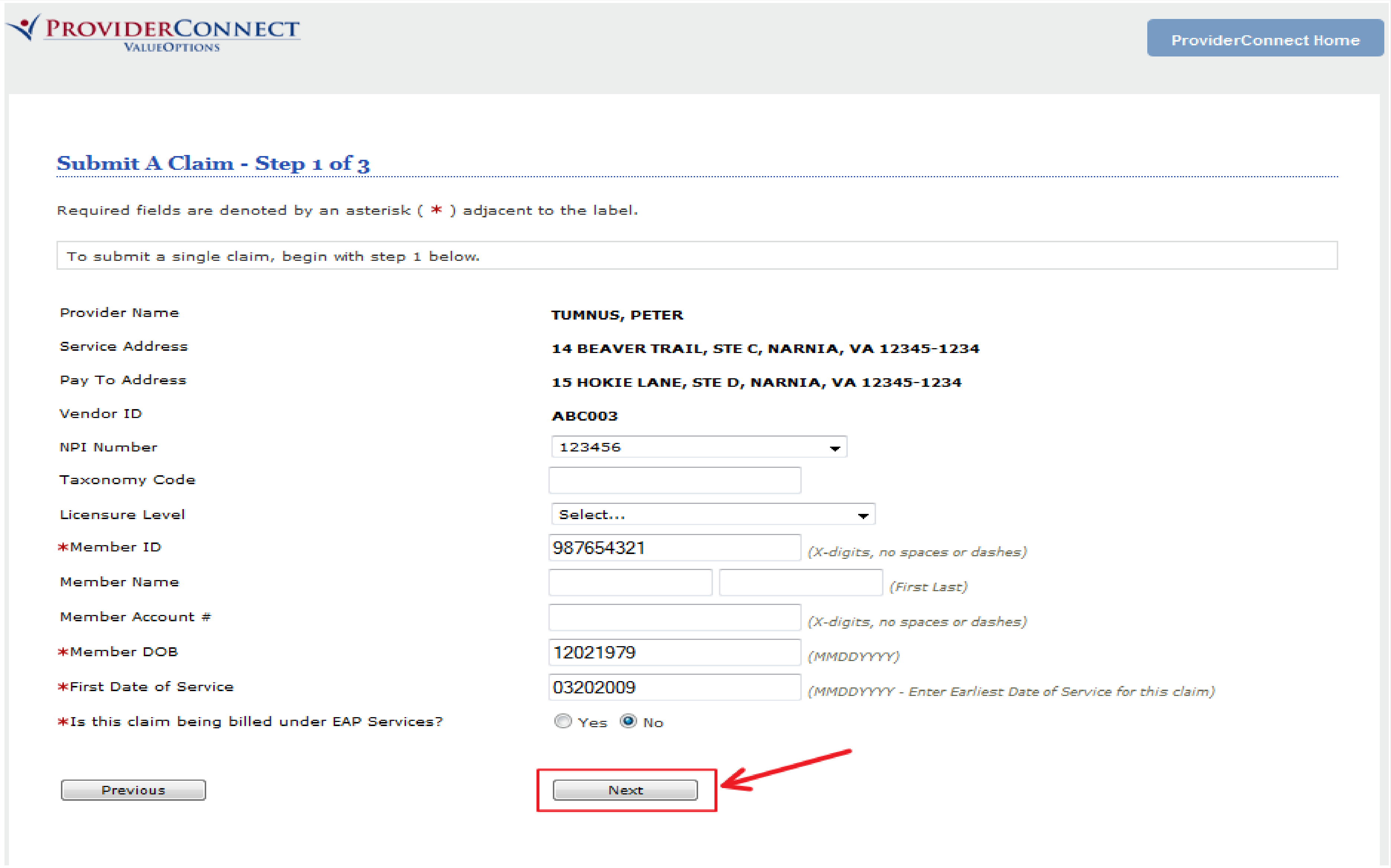
Provider	Provider Last Name	Provider First Name
TUMNUS - 123456	**TUMNUS**	**PETER**

Select Service Address

Capture	Vendor ID	Service Address	Pay To Address
○	ABC003	PETER TUMNUS 14 BEAVER TRAIL STE C NARNIA, VA 12345-1234	ABC VENDOR 15 HOKIE LANE STE D NARNIA, VA 12345-1234

Back
Next

Step 1: Search for the Individual



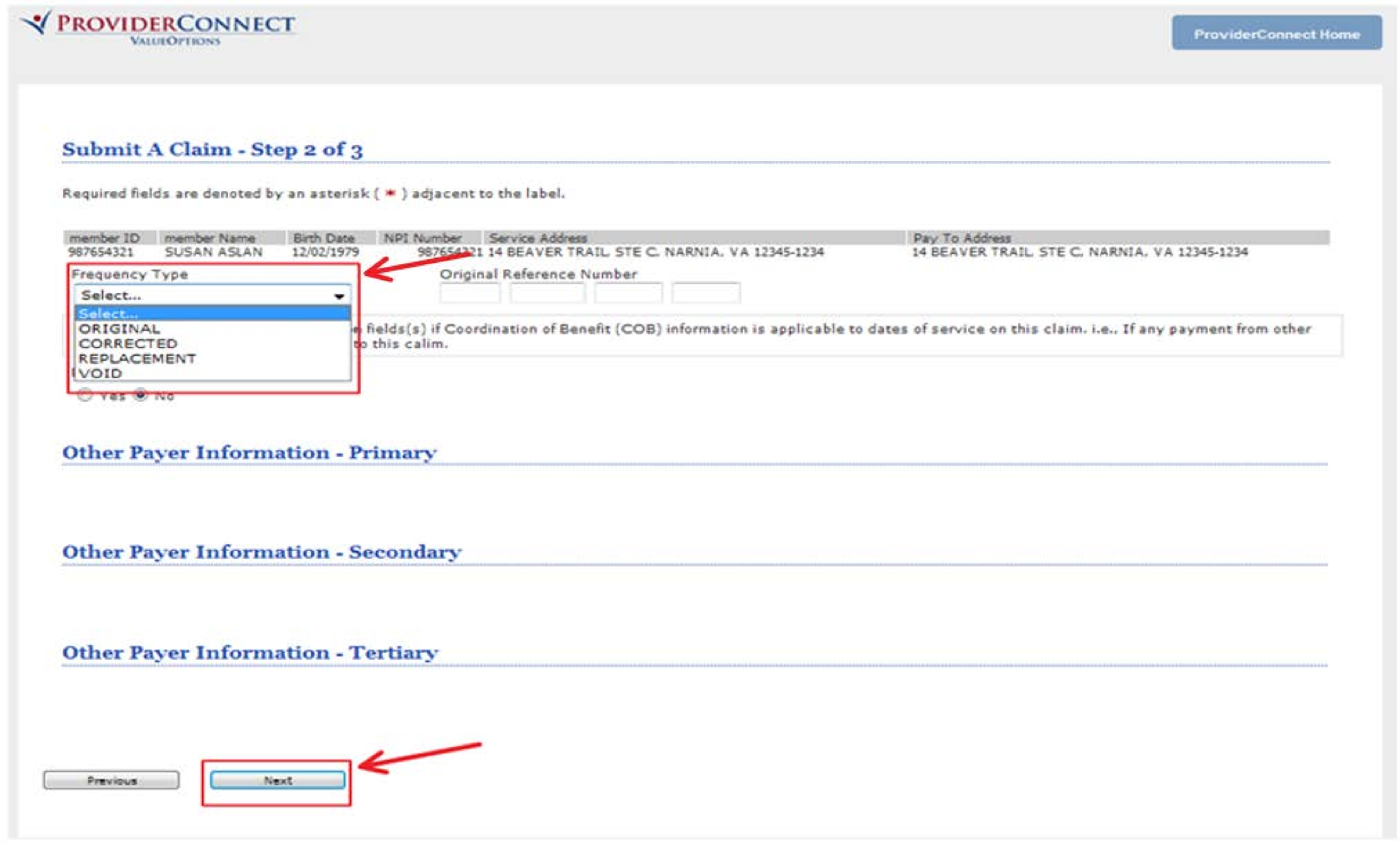
Submit A Claim - Step 1 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.

To submit a single claim, begin with step 1 below.

Provider Name	**TUMNUS, PETER**
Service Address	**14 BEAVER TRAIL, STE C, NARNIA, VA 12345-1234**
Pay To Address	**15 HOKIE LANE, STE D, NARNIA, VA 12345-1234**
Vendor ID	**ABC003**
NPI Number	123456
Taxonomy Code	
Licensure Level	Select...
*Member ID	987654321 *(X-digits, no spaces or dashes)*
Member Name	*(First Last)*
Member Account #	*(X-digits, no spaces or dashes)*
*Member DOB	12021979 *(MMDDYYYY)*
*First Date of Service	03202009 *(MMDDYYYY - Enter Earliest Date of Service for this claim)*
*Is this claim being billed under EAP Services?	○ Yes ● No

Step 2: Frequency Type


PROVIDERCONNECT
VALUEOPTIONS
ProviderConnect Home

Submit A Claim - Step 2 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.

member ID	member Name	Birth Date	NPI Number	Service Address	Pay To Address
987654321	SUSAN ASLAN	12/02/1979	987654321	14 BEAVER TRAIL STE C. NARNIA. VA 12345-1234	14 BEAVER TRAIL STE C. NARNIA. VA 12345-1234

Frequency Type

Select...
Select...
ORIGINAL
CORRECTED
REPLACEMENT
VOID

Original Reference Number

e fields(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. i.e., If any payment from other to this calim.

○ Yes ● No

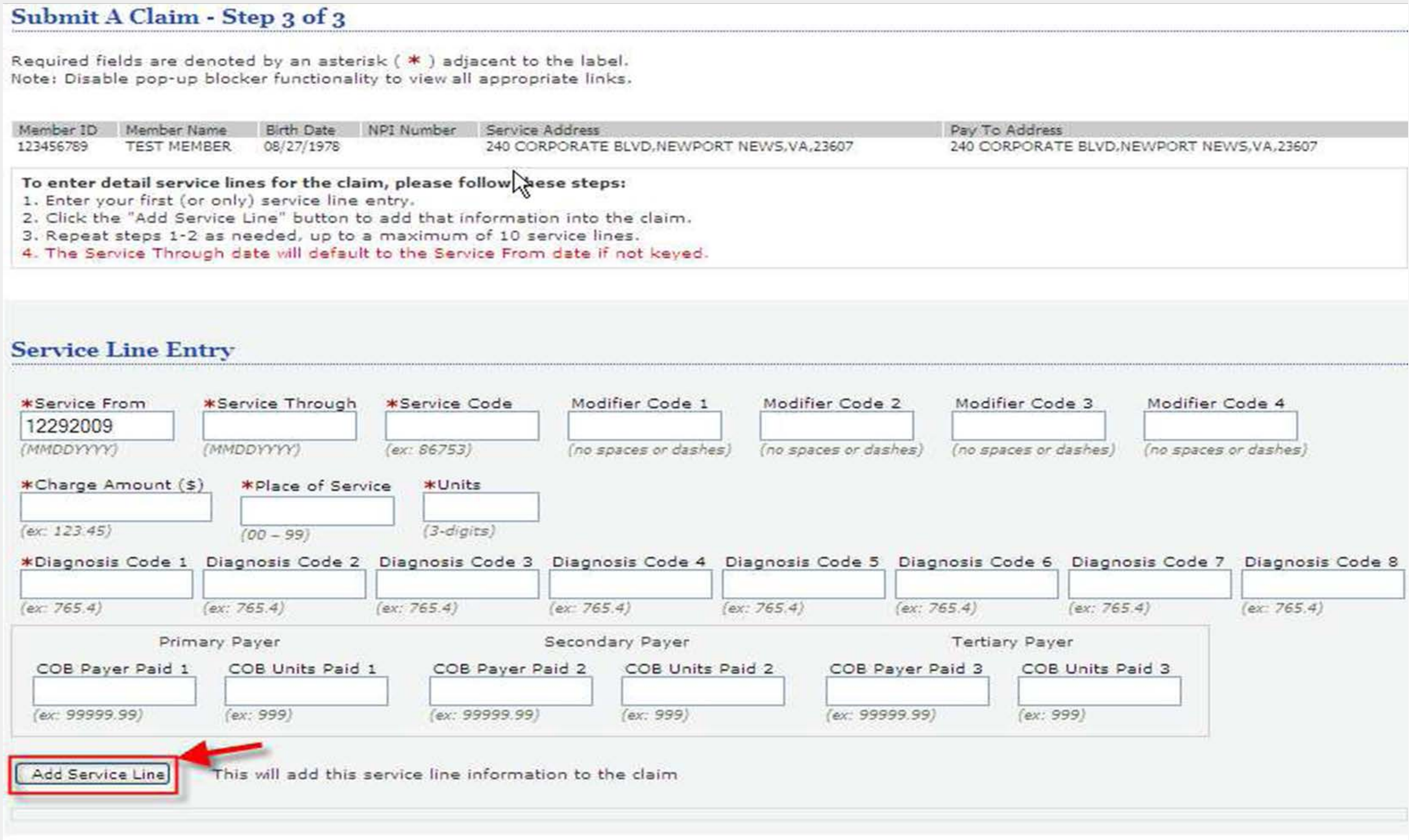
Other Payer Information - Primary

Other Payer Information - Secondary

Other Payer Information - Tertiary

Previous
Next

Step 3: Claim Line Entry



Submit A Claim - Step 3 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.
Note: Disable pop-up blocker functionality to view all appropriate links.

Member ID	Member Name	Birth Date	NPI Number	Service Address	Pay To Address
123456789	TEST MEMBER	08/27/1978		240 CORPORATE BLVD,NEWPORT NEWS,VA,23607	240 CORPORATE BLVD,NEWPORT NEWS,VA,23607

To enter detail service lines for the claim, please follow these steps:

1. Enter your first (or only) service line entry.
2. Click the "Add Service Line" button to add that information into the claim.
3. Repeat steps 1-2 as needed, up to a maximum of 10 service lines.
4. The Service Through date will default to the Service From date if not keyed.

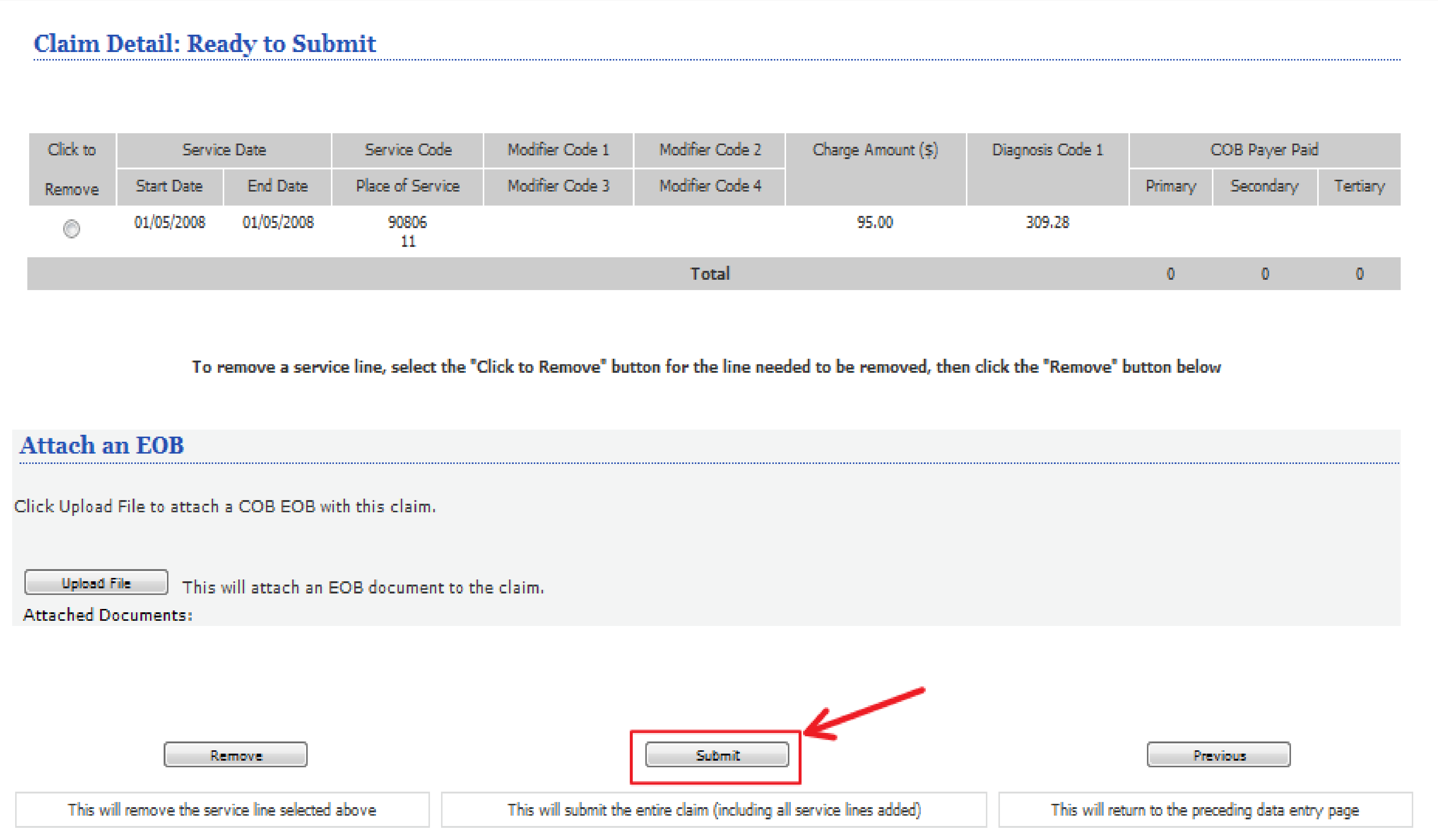
Service Line Entry

*Service From: 12292009 (MMDDYYYY)

*Service Through
(MMDDYYYY)
*Service Code
(ex: 86753)
Modifier Code 1
(no spaces or dashes)
Modifier Code 2
(no spaces or dashes)
Modifier Code 3
(no spaces or dashes)
Modifier Code 4
(no spaces or dashes)
*Charge Amount ($)
(ex: 123.45)
*Place of Service
(00 – 99)
*Units
(3-digits)
*Diagnosis Code 1
(ex: 765.4)
Diagnosis Code 2
(ex: 765.4)
Diagnosis Code 3
(ex: 765.4)
Diagnosis Code 4
(ex: 765.4)
Diagnosis Code 5
(ex: 765.4)
Diagnosis Code 6
(ex: 765.4)
Diagnosis Code 7
(ex: 765.4)
Diagnosis Code 8
(ex: 765.4)
Primary Payer
COB Payer Paid 1
(ex: 99999.99)
COB Units Paid 1
(ex: 999)
Secondary Payer
COB Payer Paid 2
(ex: 99999.99)
COB Units Paid 2
(ex: 999)
Tertiary Payer
COB Payer Paid 3
(ex: 99999.99)
COB Units Paid 3
(ex: 999)
Add Service Line

This will add this service line information to the claim

Step 3: Submitting



Claim Detail: Ready to Submit

Click to	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount ($)	Diagnosis Code 1	COB Payer Paid		
Remove	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary	Tertiary
○	01/05/2008	01/05/2008	90806 11			95.00	309.28			
				Total				0	0	0

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

Attach an EOB

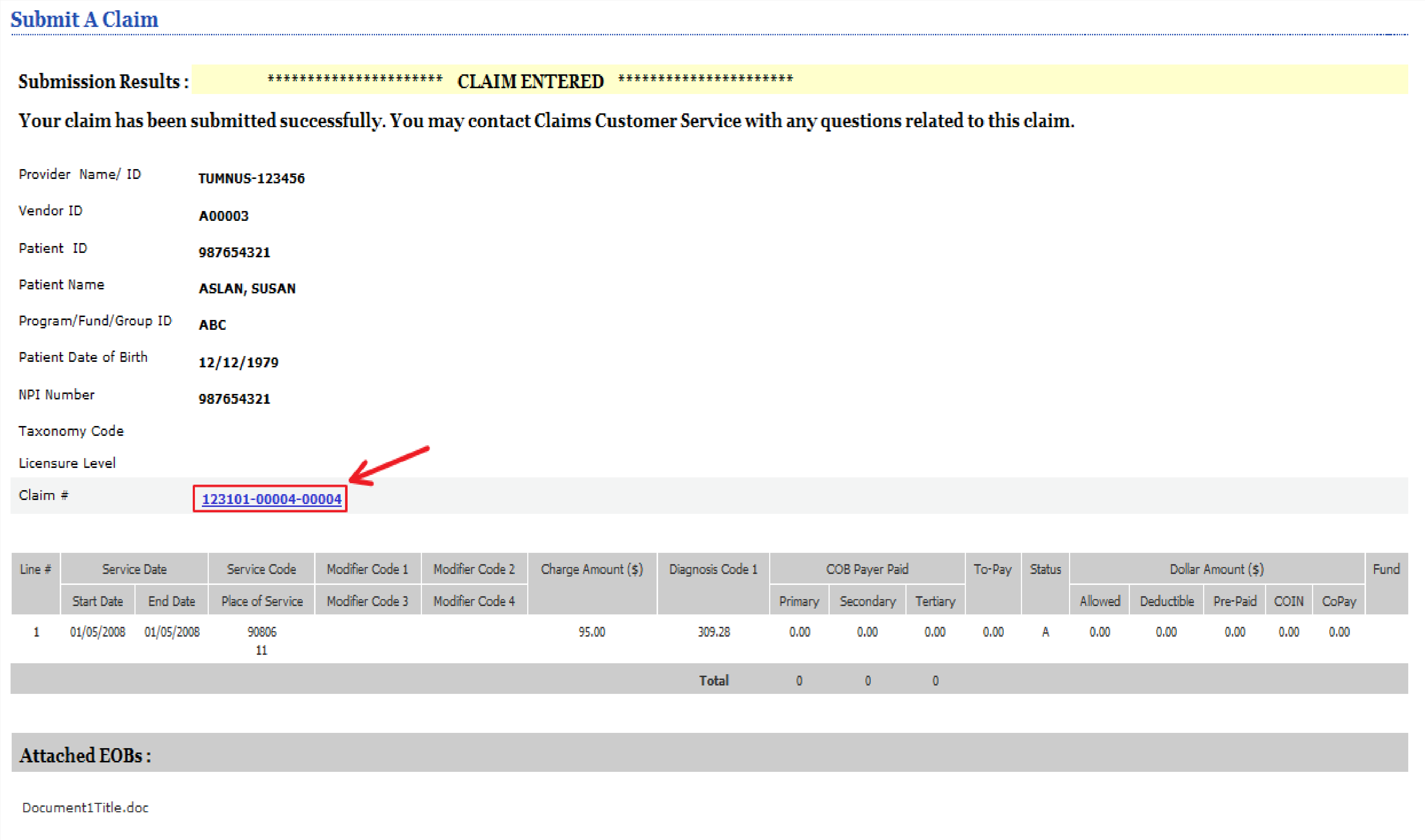
Click Upload File to attach a COB EOB with this claim.

This will attach an EOB document to the claim.

Attached Documents:

This will remove the service line selected above	This will submit the entire claim (including all service lines added)	This will return to the preceding data entry page

Summary Page



Submit A Claim

Submission Results : ********************** CLAIM ENTERED **********************

Your claim has been submitted successfully. You may contact Claims Customer Service with any questions related to this claim.

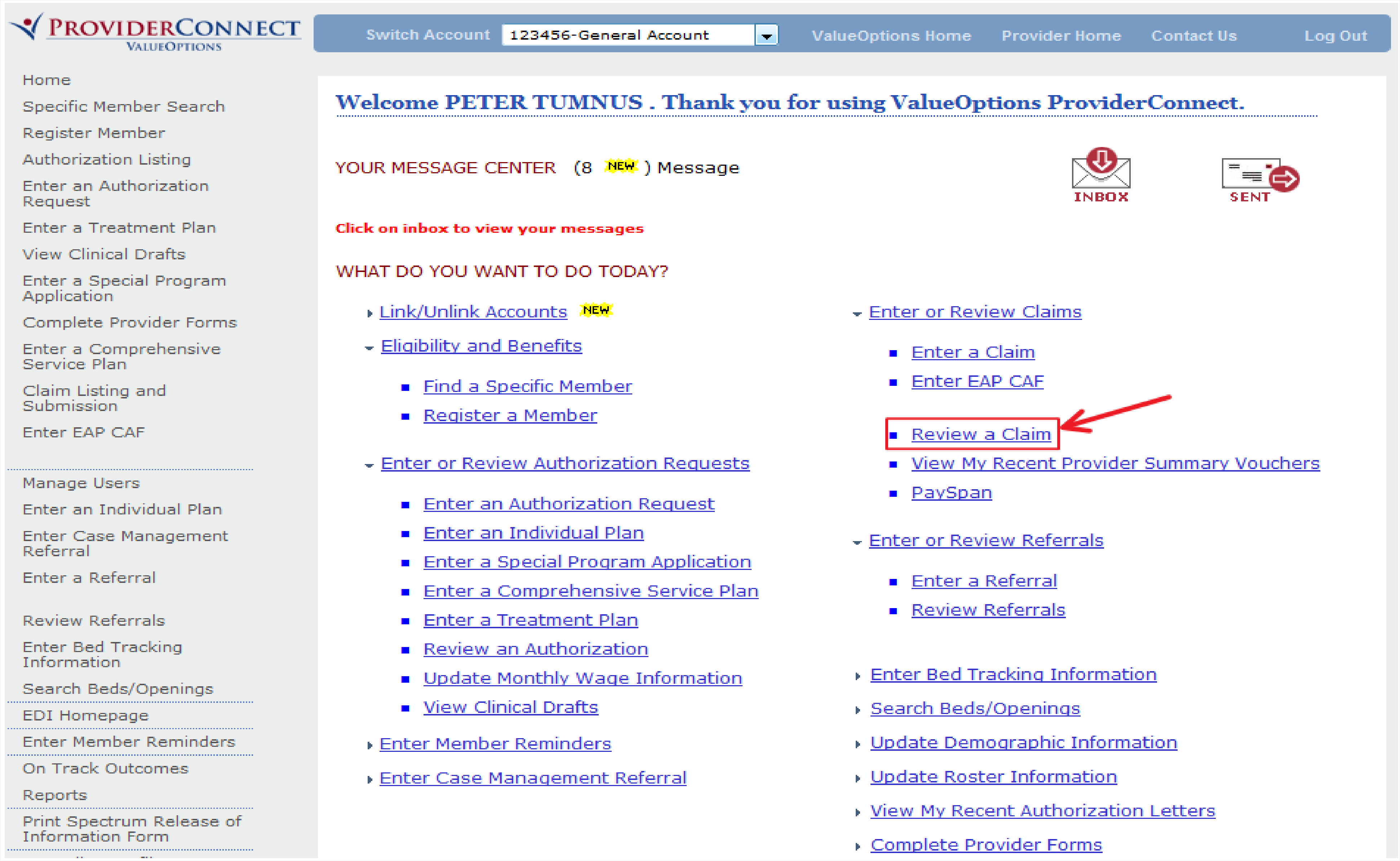
Provider Name/ ID	**TUMNUS-123456**
Vendor ID	**A00003**
Patient ID	**987654321**
Patient Name	**ASLAN, SUSAN**
Program/Fund/Group ID	**ABC**
Patient Date of Birth	**12/12/1979**
NPI Number	**987654321**
Taxonomy Code	
Licensure Level	
Claim #	**123101-00004-00004**

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount ($)	Diagnosis Code 1	COB Payer Paid			To-Pay	Status	Dollar Amount ($)					Fund
	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary	Tertiary			Allowed	Deductible	Pre-Paid	COIN	CoPay	
1	01/05/2008	01/05/2008	90806 11			95.00	309.28	0.00	0.00	0.00	0.00	A	0.00	0.00	0.00	0.00	0.00	
							Total	0	0	0								

Attached EOBs :

Document1Title.doc

Review a Claim


PROVIDERCONNECT
VALUEOPTIONS
Switch Account
123456-General Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of Information Form
INBOX
SENT

Welcome PETER TUMNUS . Thank you for using ValueOptions ProviderConnect.

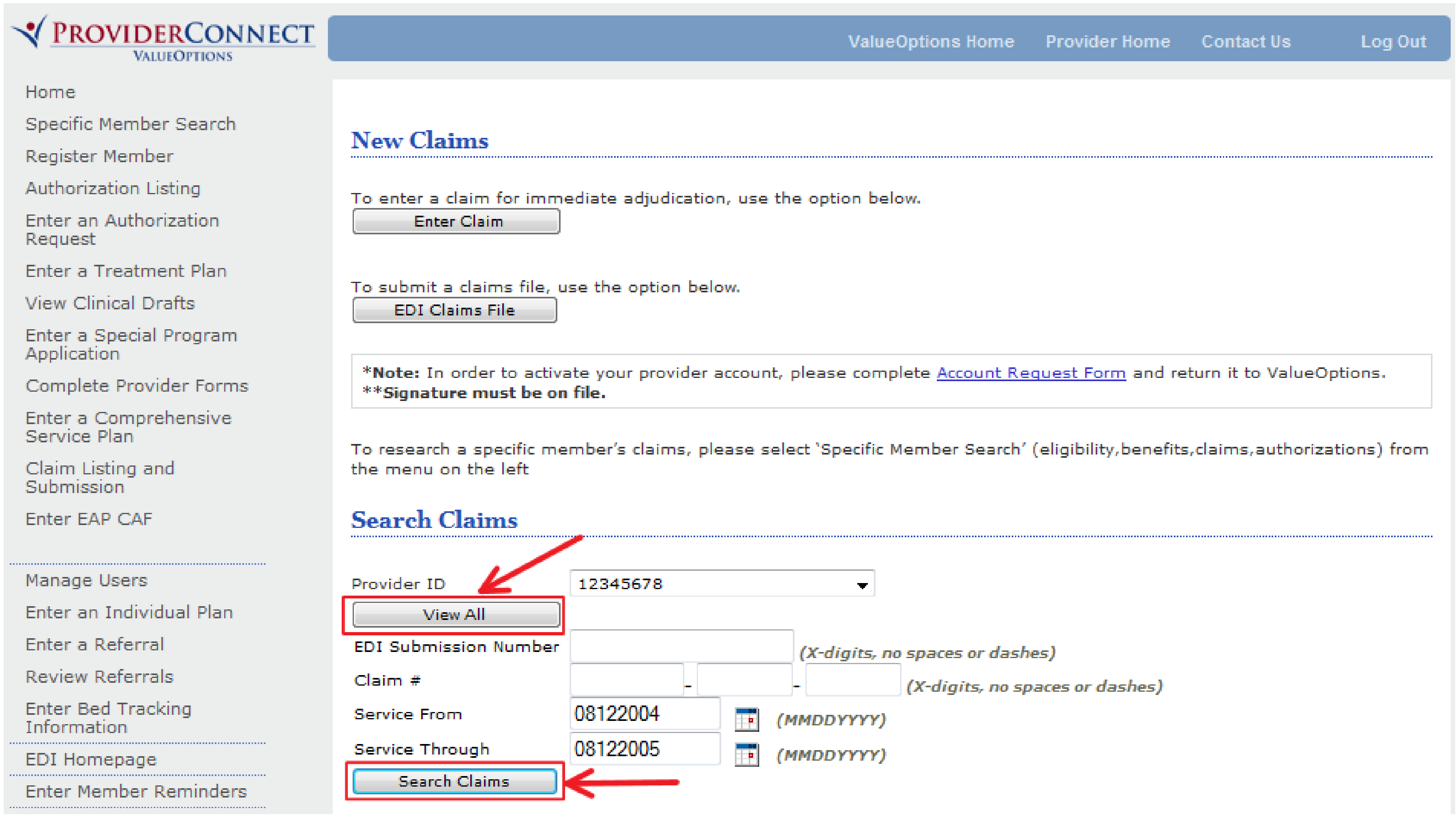
YOUR MESSAGE CENTER (8 NEW) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- Link/Unlink Accounts NEW
- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter an Individual Plan
  - Enter a Special Program Application
  - Enter a Comprehensive Service Plan
  - Enter a Treatment Plan
  - Review an Authorization
  - Update Monthly Wage Information
  - View Clinical Drafts
- Enter Member Reminders
- Enter Case Management Referral
- Enter or Review Claims
  - Enter a Claim
  - Enter EAP CAF
  - Review a Claim
  - View My Recent Provider Summary Vouchers
  - PaySpan
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals
- Enter Bed Tracking Information
- Search Beds/Openings
- Update Demographic Information
- Update Roster Information
- View My Recent Authorization Letters
- Complete Provider Forms

Search Claims


PROVIDERCONNECT
VALUEOPTIONS
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter a Referral
Review Referrals
Enter Bed Tracking Information
EDI Homepage
Enter Member Reminders

New Claims

To enter a claim for immediate adjudication, use the option below.

Enter Claim

To submit a claims file, use the option below.

EDI Claims File

***Note:** In order to activate your provider account, please complete Account Request Form and return it to ValueOptions.
****Signature must be on file.**

To research a specific member's claims, please select 'Specific Member Search' (eligibility,benefits,claims,authorizations) from the menu on the left

Search Claims

Provider ID 12345678

EDI Submission Number (X-digits, no spaces or dashes)

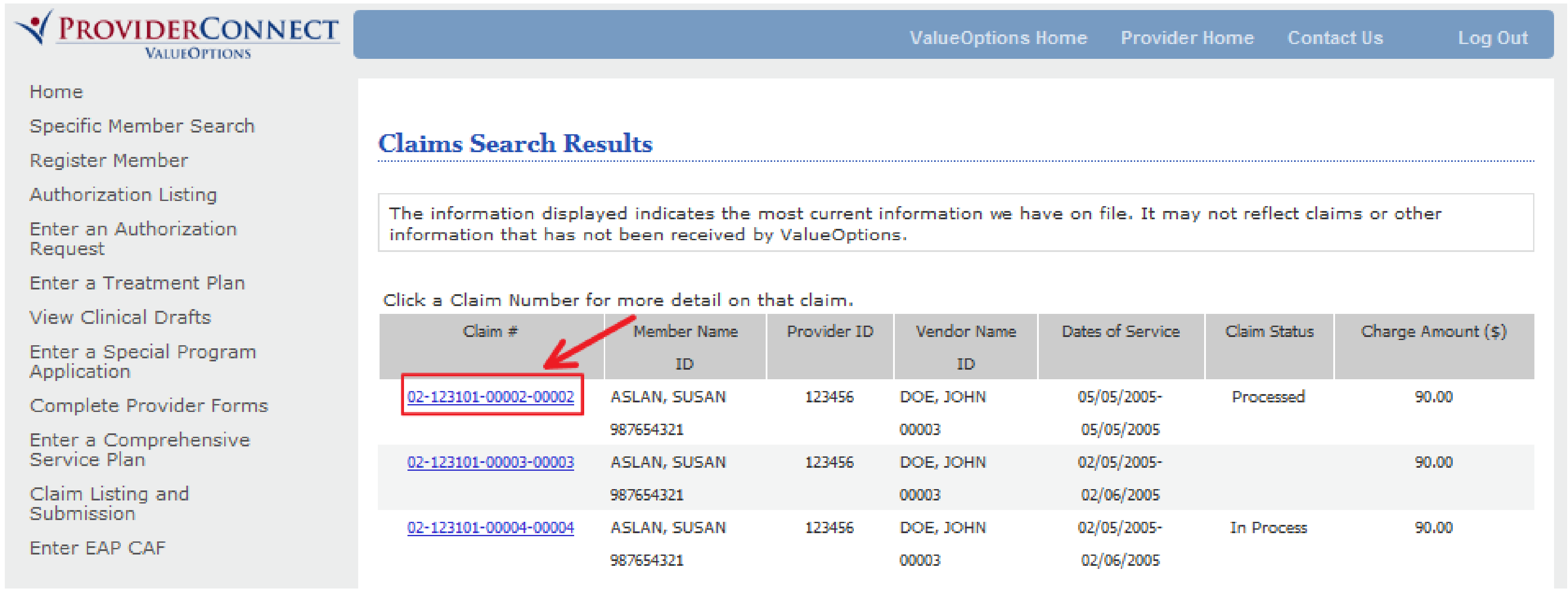
Claim # - - (X-digits, no spaces or dashes)

Service From 08122004 (MMDDYYYY)

Service Through 08122005 (MMDDYYYY)

Search Claims

Claim Search Results


PROVIDERCONNECT
VALUEOPTIONS
ValueOptions Home
Provider Home
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Log Out
Home
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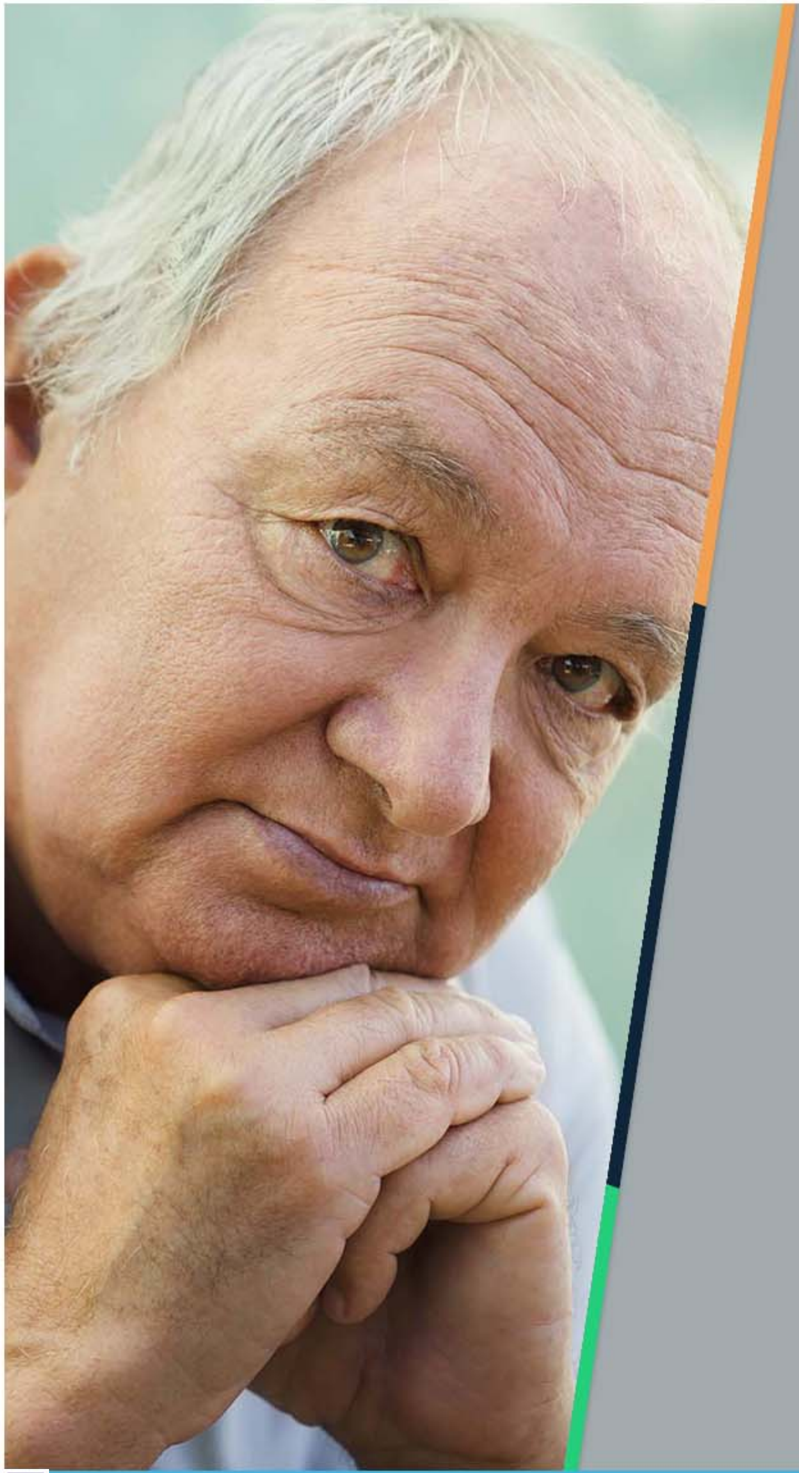
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF

Claims Search Results

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

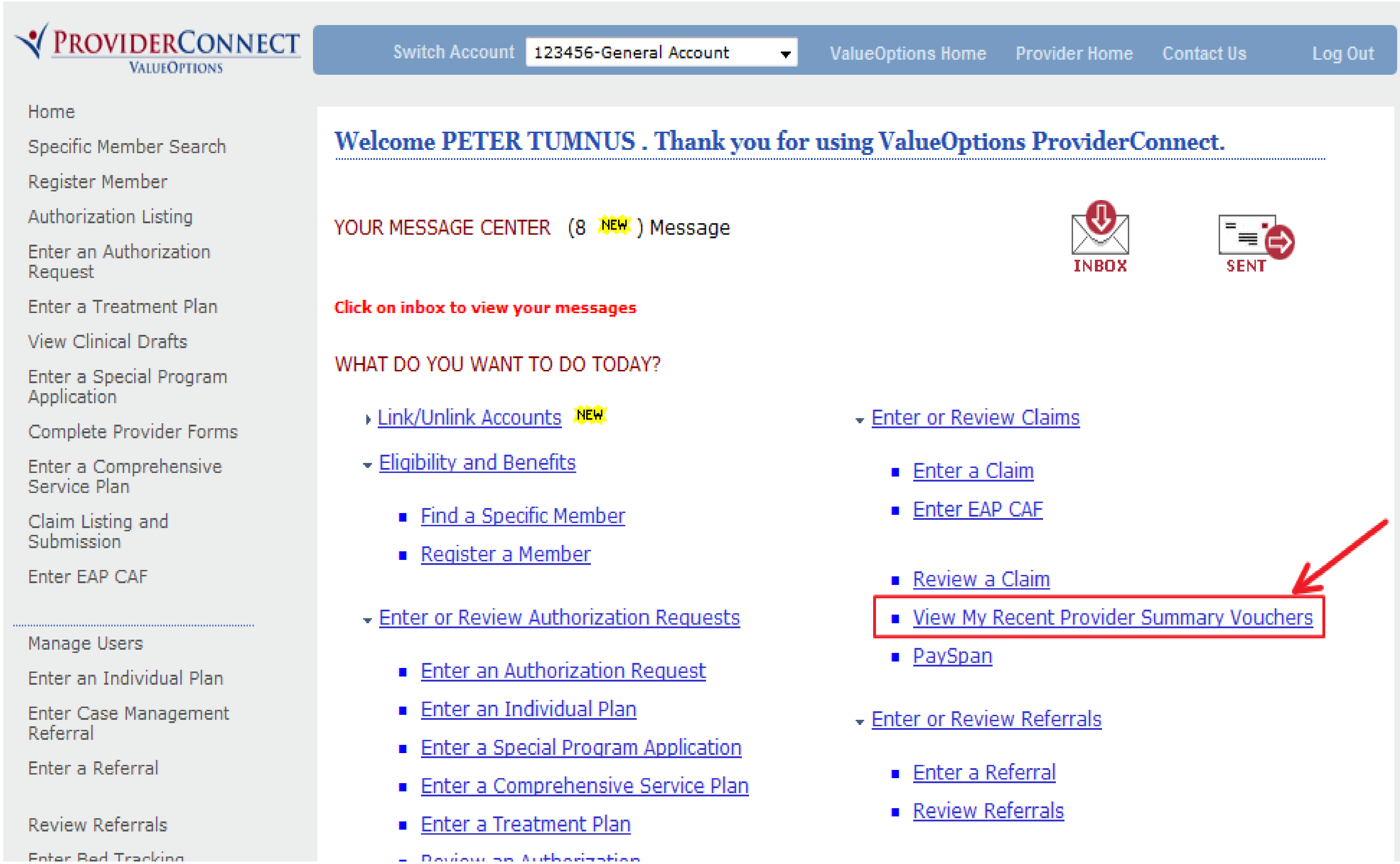
Click a Claim Number for more detail on that claim.

Claim #	Member Name ID	Provider ID	Vendor Name ID	Dates of Service	Claim Status	Charge Amount ($)
02-123101-00002-00002	ASLAN, SUSAN 987654321	123456	DOE, JOHN 00003	05/05/2005- 05/05/2005	Processed	90.00
02-123101-00003-00003	ASLAN, SUSAN 987654321	123456	DOE, JOHN 00003	02/05/2005- 02/06/2005		90.00
02-123101-00004-00004	ASLAN, SUSAN 987654321	123456	DOE, JOHN 00003	02/05/2005- 02/06/2005	In Process	90.00



Provider Summary Vouchers

Viewing Provider Summary Vouchers


ProviderConnect
ValueOptions
Switch Account
123456-General Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
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Claim Listing and Submission
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Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking
INBOX
SENT

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  - Enter an Authorization Request
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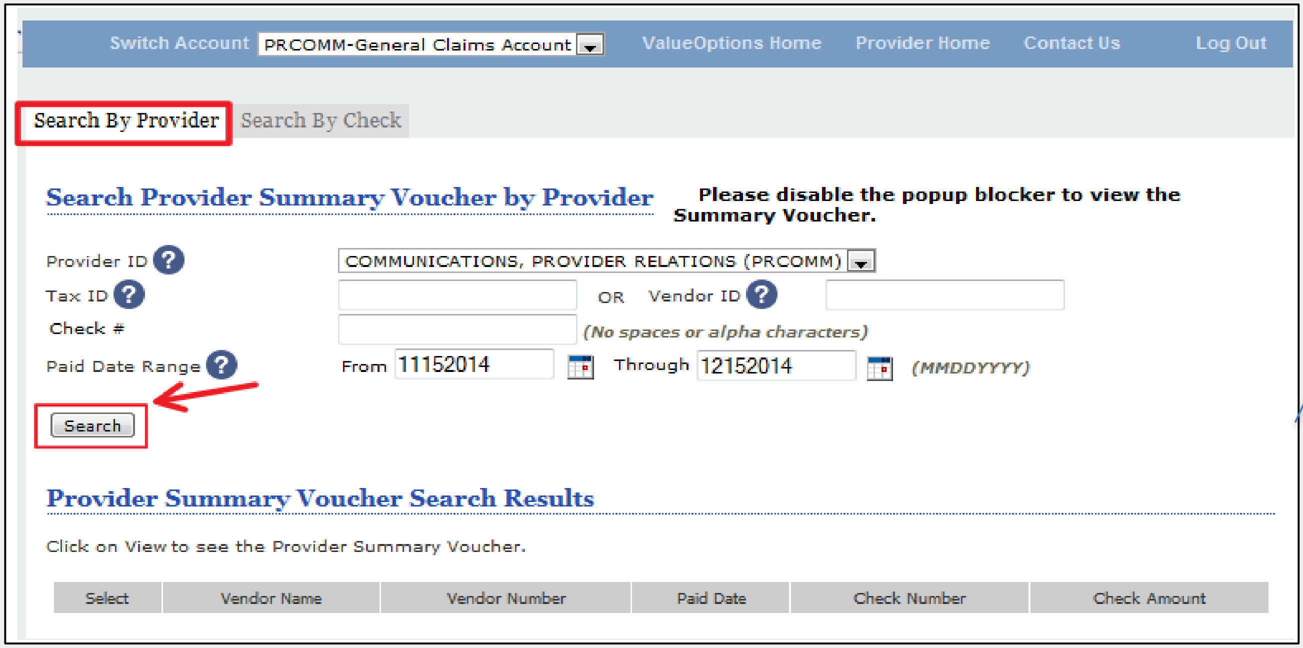
  - Enter a Special Program Application
  - Enter a Comprehensive Service Plan
  - Enter a Treatment Plan
  - Review an Authorization
- Enter or Review Claims
  - Enter a Claim
  - Enter EAP CAF
  - Review a Claim
  - View My Recent Provider Summary Vouchers
  - PaySpan
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals

Search By Provider or Check


Switch Account
PRCOMM-General Claims Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Search By Provider
Search By Check
Search

Search Provider Summary Voucher by Provider

Please disable the popup blocker to view the Summary Voucher.

Provider ID: COMMUNICATIONS, PROVIDER RELATIONS (PRCOMM)

Tax ID OR Vendor ID

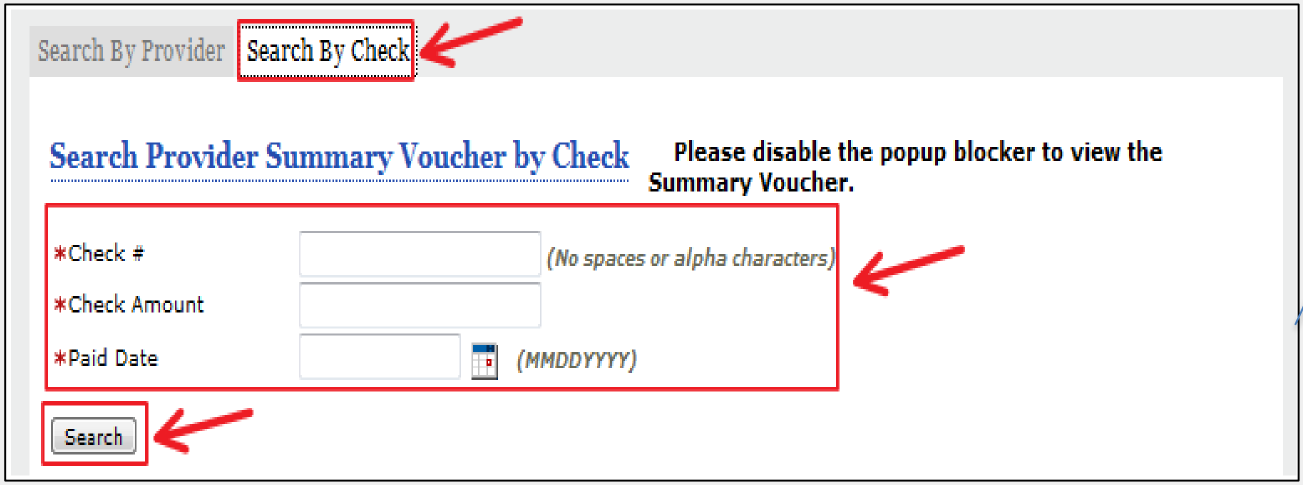
Check # *(No spaces or alpha characters)*

Paid Date Range From 11152014 Through 12152014 *(MMDDYYYY)*

Provider Summary Voucher Search Results

Click on View to see the Provider Summary Voucher.

Select	Vendor Name	Vendor Number	Paid Date	Check Number	Check Amount


Search By Provider
Search By Check
Search

Search Provider Summary Voucher by Check

Please disable the popup blocker to view the Summary Voucher.

*Check # *(No spaces or alpha characters)*

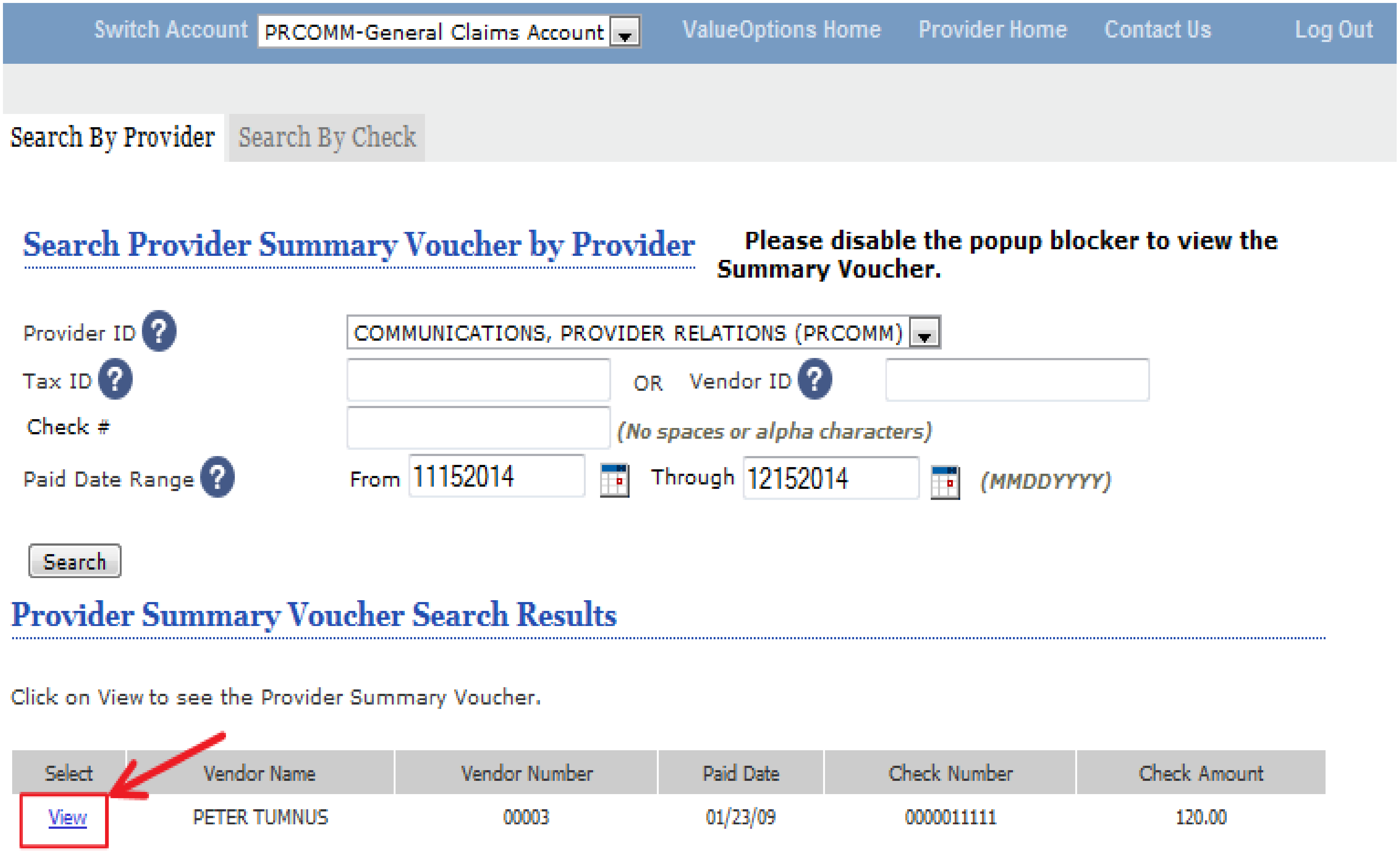
*Check Amount

*Paid Date *(MMDDYYYY)*

Search by Provider

Search by Check

Search Results



Switch Account
PRCOMM-General Claims Account
ValueOptions Home
Provider Home
Contact Us
Log Out
Search By Provider
Search By Check

Search Provider Summary Voucher by Provider

Please disable the popup blocker to view the Summary Voucher.

Provider ID: COMMUNICATIONS, PROVIDER RELATIONS (PRCOMM)

Tax ID OR Vendor ID

Check # *(No spaces or alpha characters)*

Paid Date Range From 11152014 Through 12152014 *(MMDDYYYY)*

Search

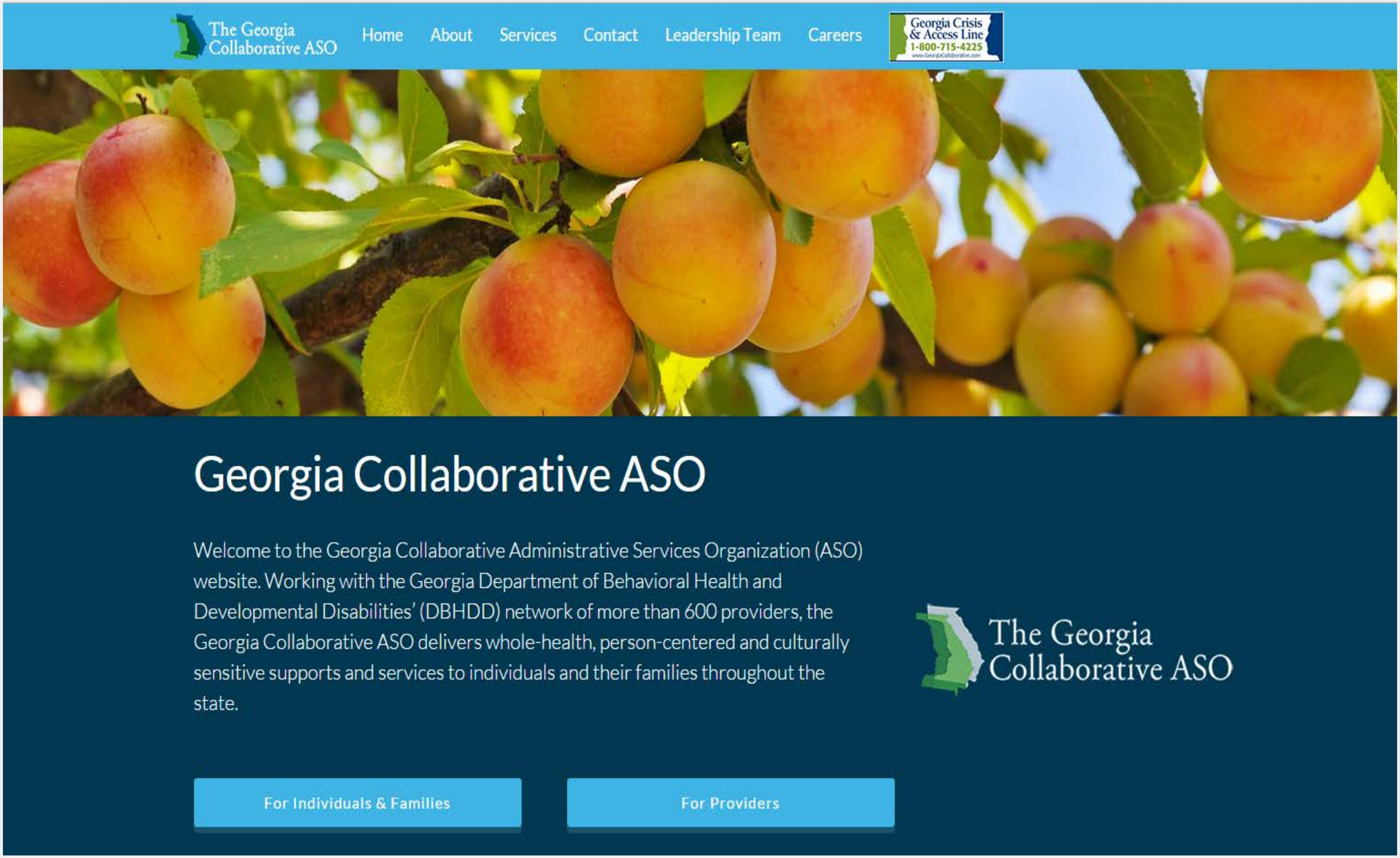
Provider Summary Voucher Search Results

Click on View to see the Provider Summary Voucher.

Select	Vendor Name	Vendor Number	Paid Date	Check Number	Check Amount
View	PETER TUMNUS	00003	01/23/09	0000011111	120.00

Provider Resources

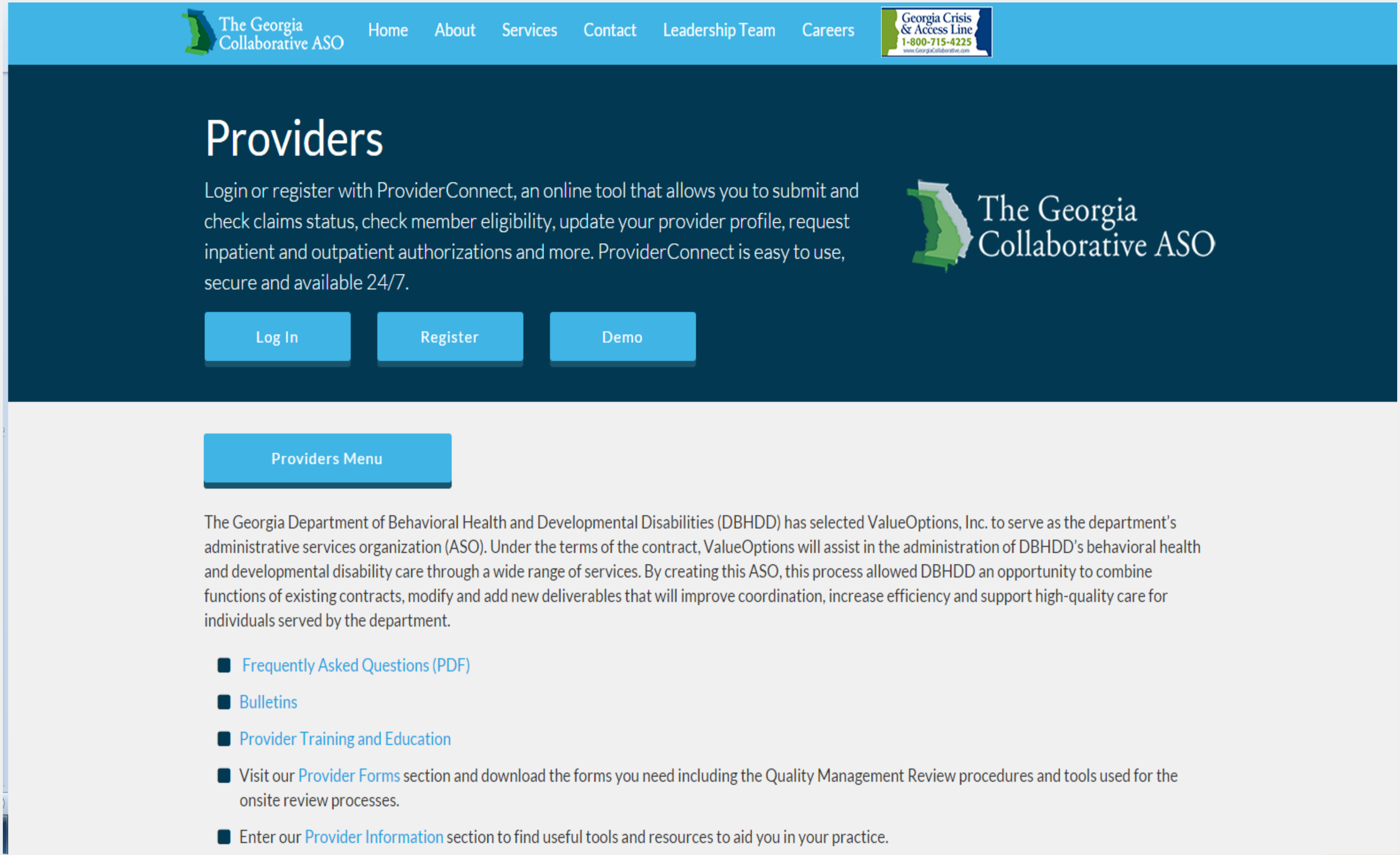
Provider Resources


The Georgia Collaborative ASO
Home
About
Services
Contact
Leadership Team
Careers
Georgia Crisis & Access Line
1-800-715-4225
The Georgia Collaborative ASO
For Individuals & Families
For Providers

Georgia Collaborative ASO

Welcome to the Georgia Collaborative Administrative Services Organization (ASO) website. Working with the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) network of more than 600 providers, the Georgia Collaborative ASO delivers whole-health, person-centered and culturally sensitive supports and services to individuals and their families throughout the state.

Provider Resources


The Georgia Collaborative ASO
Home
About
Services
Contact
Leadership Team
Careers
Georgia Crisis & Access Line 1-800-715-4225
The Georgia Collaborative ASO
Log In
Register
Demo
Providers Menu

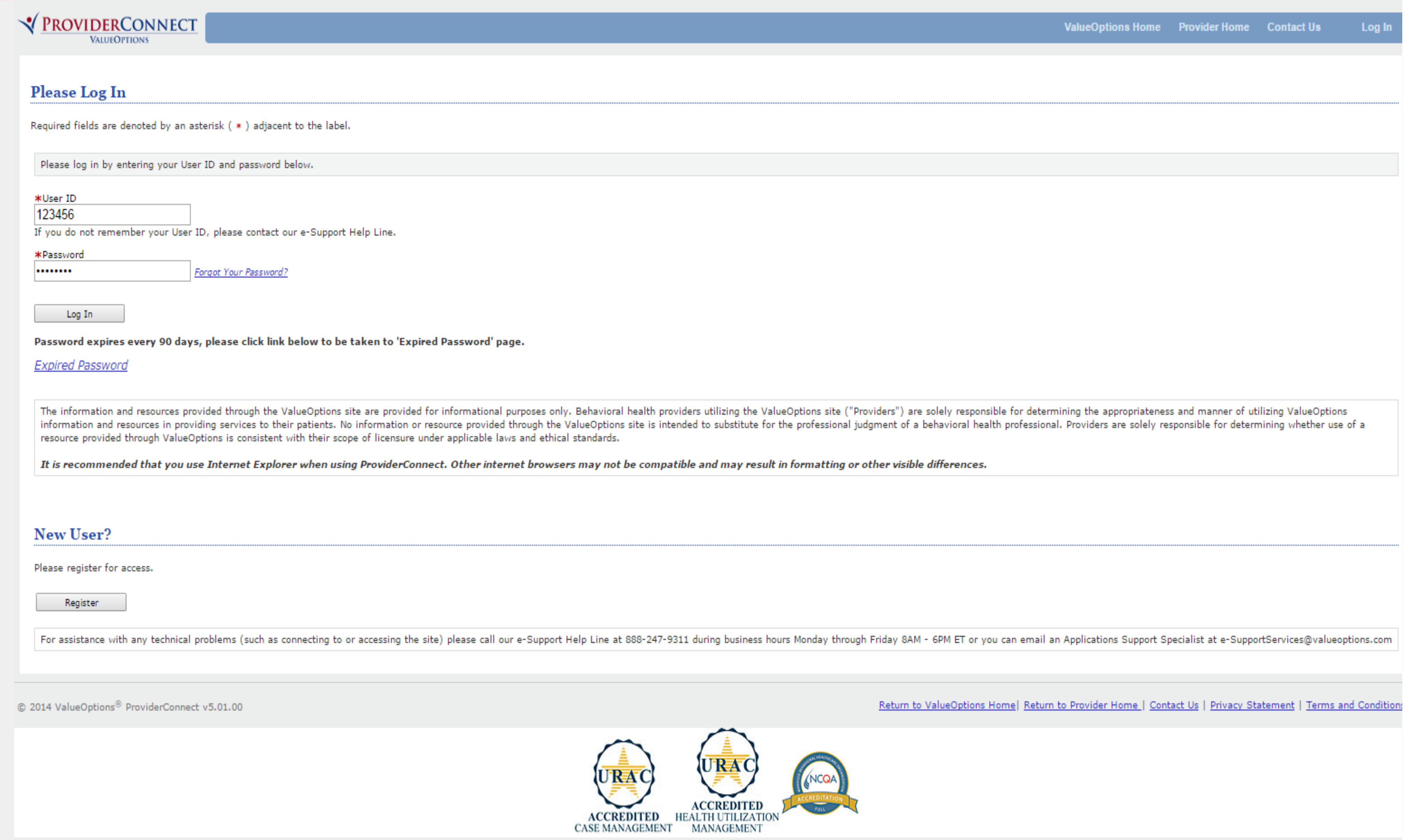
Providers

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) has selected ValueOptions, Inc. to serve as the department's administrative services organization (ASO). Under the terms of the contract, ValueOptions will assist in the administration of DBHDD's behavioral health and developmental disability care through a wide range of services. By creating this ASO, this process allowed DBHDD an opportunity to combine functions of existing contracts, modify and add new deliverables that will improve coordination, increase efficiency and support high-quality care for individuals served by the department.

- Frequently Asked Questions (PDF)
- Bulletins
- Provider Training and Education
- Visit our Provider Forms section and download the forms you need including the Quality Management Review procedures and tools used for the onsite review processes.
- Enter our Provider Information section to find useful tools and resources to aid you in your practice.

Provider Resources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Password expires every 90 days, please click link below to be taken to 'Expired Password' page.

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New User?

Please register for access.

For assistance with any technical problems (such as connecting to or accessing the site) please call our e-Support Help Line at 888-247-9311 during business hours Monday through Friday 8AM - 6PM ET or you can email an Applications Support Specialist at e-SupportServices@valueoptions.com

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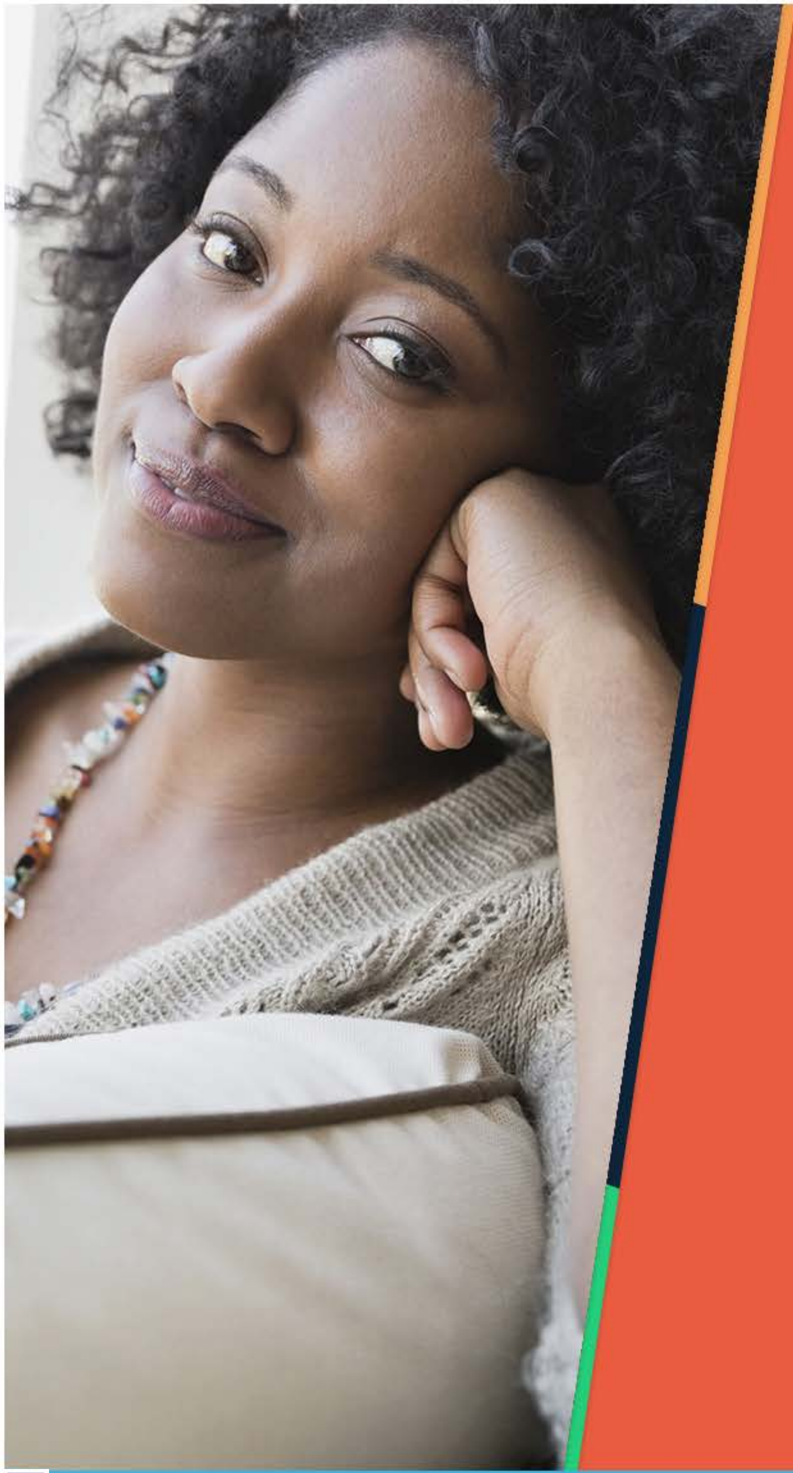
Questions?

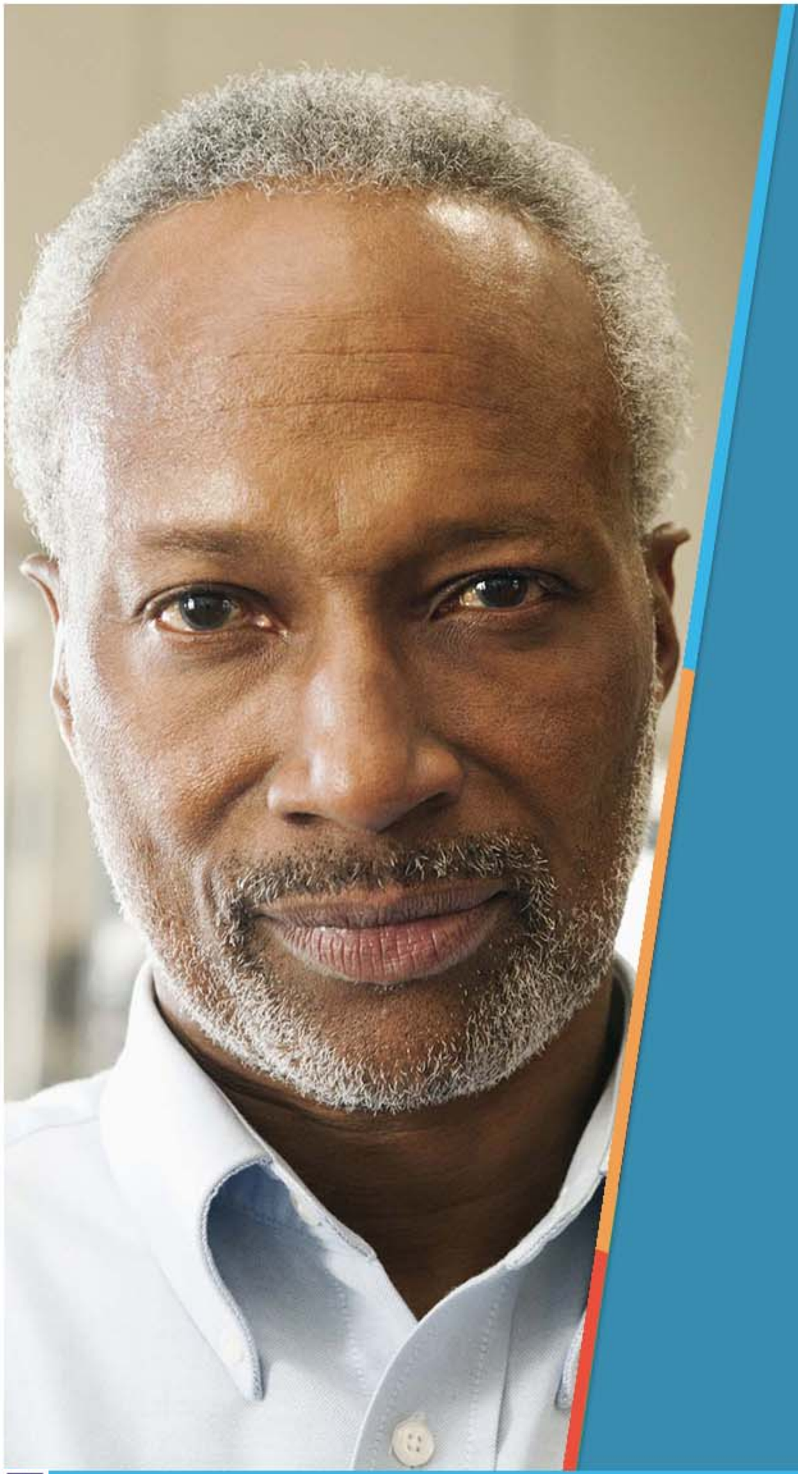
Thank you

For Georgia Collaborative ASO general inquiry or questions please email:

GACollaborative@beaconhealthoptions.com



Parking Lot



Changes to the Data Process Flow

Process Flow

The business processes of the MICP System are similar to the ProviderConnect System however they serve different purposes

APS Healthcare (MICP System)	GA Collaborative ASO (ProviderConnect)
• Registration • The purpose of the Registration MICP type was to authorize an initial set of short term CORE services for 90 days	• Registration • Provides demographics for individuals enrolling into services, special programs, and assign the most appropriate fund source for DBHDD
• Authorization • The purpose of the MICP authorization data elements was to request services, document outcomes measures, collect federal/state reporting data elements.	• Request for Services (Authorization) • The purpose of the RFS is to request services, document outcomes measures, collect federal/state reporting data elements.
• Discharge • The purpose of the discharge request was to discharge the individual from services and document the necessary outcomes measures and federal/state reporting data elements.	• Discharge • The purpose of the discharge request was to discharge the individual from services and document the necessary outcomes measures and federal/state reporting data elements, with aftercare information.

Process Flows (continued)

What are the major changes to the process?

Each file type will require separate files and responses.

Registration:

- Instead of using one file for the Registration / Authorization / Discharge in the MICP system, the functionality will be separated in the new GA Collaborative's system.
- Most registrations will last for 12 months and unless an individual's demographics change or the individual is being enrolled into one of the special programs, providers will not have to continuously submit these demographics.

Request for Services:

- Instead of using the Service Packages / Service Groups terminology, the ASO system will employ Level of Care and Service Class terms.
- Providers may have multiple open authorizations at the same time for different levels of care (e.g. Supported Employment & Non-Essential)

Discharges:

- Providers will submit a discharge when individuals leave service.

Process Flows (continued)

Process Flow for the MICP System

MICP Send File

Authorization Requests / Discharges

- Registration
- New Episode Requests
- Ongoing Requests

Process flow for the ProviderConnect System

Registration

- Initial
- Demographic Update

Request for Services

- Initial
- Concurrent

Discharge

Data Elements

Data Elements

DBHDD examined existing data elements collected in the MICP system and any new requirements in order to identify what data must be collected from providers.

Reporting Requirement	Data Elements (examples)
ADA Settlement Agreement with U.S. DOJ	ADA Target Population Questions: • SPMI • Frequent admissions to ER's • Frequent Admissions to Psychiatric Hospitals • Recently Released from Jail/Prison • Chronically Homeless
Belton Settlement Agreement (Deaf Services)	Language, Communication, Vision, and Hearing
Support of DBHDD Quality Management, Fidelity, and Outcomes System Reporting	Income, Employment, VocRehab Information, Living Situation, Homeless Days, Jail/Prison Admissions/Days
Support and Enhance Care Coordination of Individuals	Additional Contact Information, Legal Guardian/ Representative, Medical Information, Discharge Planning, After Care Screens
Federal Reporting Requirements	Substance Abuse Treatment Episode Dataset (SA TEDS) Mental Health Treatment Dataset (MH TEDS)

In addition, it is intended that the ProviderConnect System be an integrated system for both Behavioral Health and IDD individuals. Thus for some data elements a coordinated effort was made to be inclusive of the valid values to be reported. Also, options for Unknown/Refused have been added to a number of data elements to improve data validity if value is truly unknown.

Registration Data Elements

Registration

Changes to Existing Data Elements

Data Element Name	Changes (new valid values in red)
Gender	1 = Male 2 = Female **3 = Transgender Male to Female** **4 = Transgender Female to Male** **5 = Other/Unknown**
Race	1 = American Indian/Alaskan Native 2 = Native Hawaiian/Other Pacific Islander 3 = Black/African American 4 = White/Caucasian 5 = Asian 6 = Multiracial 7 = Other Single Race **8 = Unknown/Refused**
Hispanic/Latino Origin (Ethnicity)	1 = Yes 2 = No **3 = Unknown/Refused**
Marital Status	1 = Single 2 = Separated 3 = Divorced 4 = Married 5 = Widowed **6 = Partnered** **7 = Unknown/Refused**
Veteran (previously collected in a different manner in MICP)	Y = Yes **N = No** **U = Unknown/Refused**

Registration

New Data Elements – Income & Family Size

NOTE: Similar data elements are currently collected in the MICP system. Individual's Income is being added.

Data Element Name	Changes (some may be required/optional)
Individual's Monthly Income	$0 ; Unknown/Refused
Household Monthly Income	$0 ; Unknown/Refused
Household size	Number in Family

Registration

New Data Elements – Individual Information & Special Programs

Data Element Name	Changes (some may be required/optional)
Individual's Information (additional)	Address Unknown No Address (Homeless) Individual's Phone Number Individual's Secondary Phone Number Email Address Maiden or Birth Name Preferred Name
Are you registering an individual for short-term, immediate services? (NOTE: this is a TEMPORARY 7 day registration)	Y = Yes N = No
If yes, do you know the individual's Last Name, First Name AND Date of Birth?	Y = Yes N = No
Are you registering the individual for CBAY?	1 = CBAY MFP 2 = CBAY BIP 3 = CBAY State Funds 9 = Not Registering for CBAY Services
Is the individual in a Women's Treatment & Recovery Services Program?	1 = WTRS - Residential 2 = WTRS – Outpatient 9 = Not Registering for WTRS
Women's Treatment & Recovery Services Program End Date	A re-registration is required to update this date when the individual is no longer in the WTRS Program.
Are you registering for Treatment Court services?	1 = Mental Health Court 2 = Drug Court 9 = Not Registering for Treatment Court Services

Registration

New Data Elements – Contact Information

Data Element Name	Changes (some may be required/optional)
Alternate Contact Person	Name Address1, Address2, Ciity, State, Zip Phone Number Email
Relationship to Individual	01 = Spouse/Significant Other 02 = Parent 03 = Sibling 04 = Child 05 = Grandparent 06 = In-Law / Relative 07 = Other family member 08 = Friend 09 = Neighbor 10 = Roommate 11 = Case Worker 12 = School Counselor/Teacher 13 = Substitute Decision-Maker 14 = Other
Is the individual a minor or does s/he have a Legal Guardian/Representative?	Name Address1, Address2, City, State, Zip Phone Number Email

Registration

New Data Elements – Communication & Language

NOTE: These data elements will replace how English Proficiency is currently collected in the MICP system.

Data Element Name	Changes (some may be required/optional)
How well do you speak English?	1 = Very Well 2 = Well 3 = Not Well 4 = Not at all 5 = Unknown/Refused
Does the individual prefer to speak or use a language other than English?	Y = Yes N = No U = Unknown/Refused
If Yes, what language?	01 = ASL 02 = Spanish 03 = Chinese 04 = Tagalog 05 = French 06 = Vietnamese 07 = German 08 = Korean 09 = Russian 10 = Italian 11 = Portuguese 12 = Japanese 13 = Arabic 14 = Yiddish 15 = Hebrew 16 = Other 17 = Unknown/Refused

Registration

New Data Elements – Communication & Language

NOTE: These data elements will replace how Communication is currently collected in the MICP system.

Data Element Name	Changes (some may be required/optional)
What modes of Communication does the individual utilize? (select all that apply)	• Communicates verbally (regardless of proficiency) • American Sign Language (ASL) • Other Manual Communication (cued speech, gestures, signed exact English, other signed languages, etc.) • Communication Aids (any type of device used for communication) • Other Communication
What is the individual's preferred mode of communication?	• Communicates verbally (regardless of proficiency) • American Sign Language (ASL) • Other Manual Communication (cued speech, gestures, signed exact English, other signed languages, etc.) • Communication Aids (any type of device used for communication) • Other Communication

Registration

New Data Elements – Hearing Loss & Vision Loss

NOTE: These data elements will replace how Hearing and Vision Impairment is currently collected in the MICP system.

Data Element Name	Changes (some may be required/optional)
Is the individual deaf or have serious difficulty hearing?	Y = Yes N = No U = Unknown/Refused
Is there indication from sources other than the individual (e.g. third party report; interviewer's observation; medical records, etc.) that the individual has hearing loss?	Y = Yes N = No U = Unknown/Refused
Is the individual blind or have serious difficulty seeing, even when wearing glasses?	Y = Yes N = No U = Unknown/Refused
Is there indication from sources other than the individual (e.g. third party report; interviewer's observation; medical records, etc.) that the individual has serious difficulty seeing, even when wearing glasses?	Y = Yes N = No U = Unknown/Refused

Registration

New Data Elements – Medicaid / Health Insurance / Peachcare

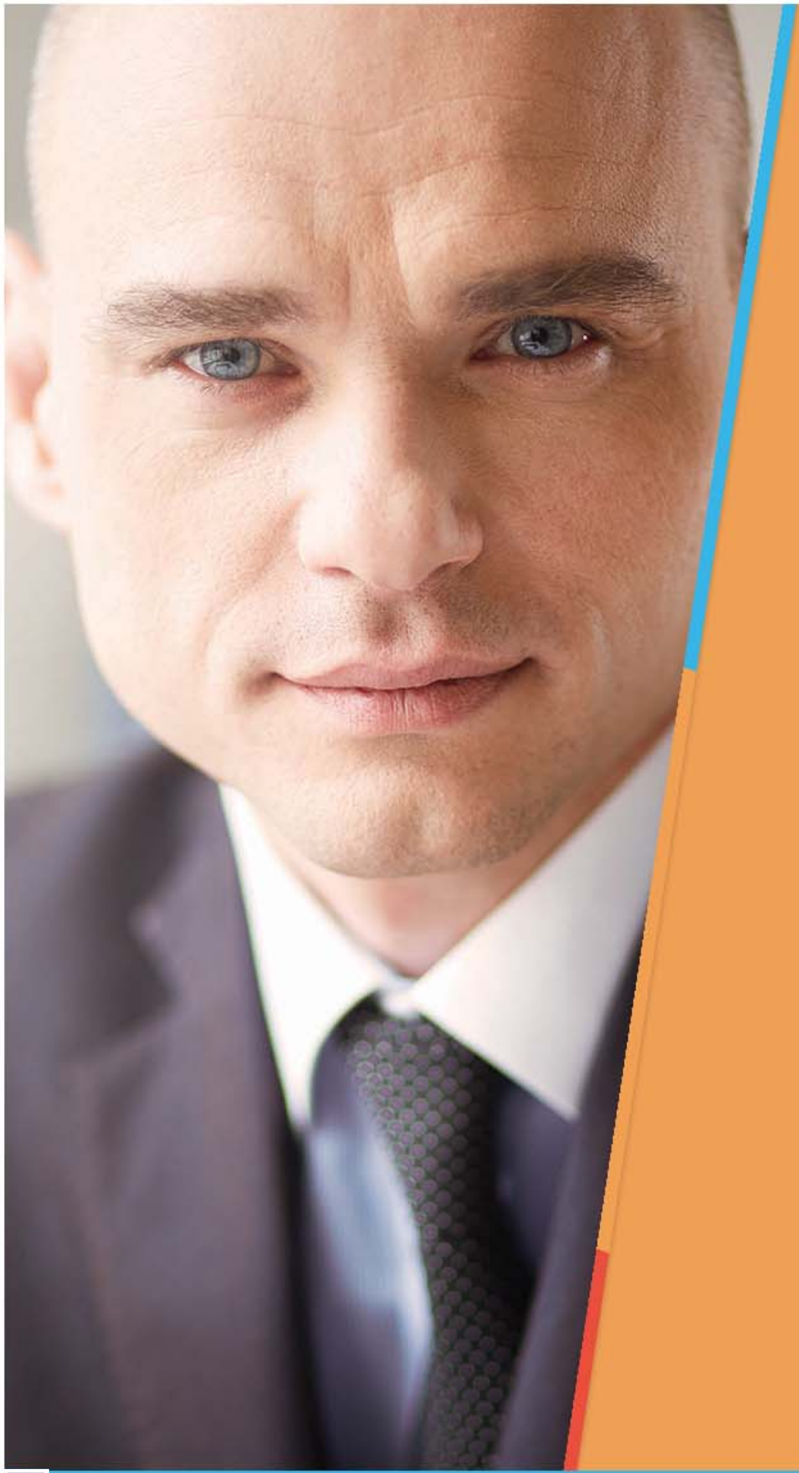
NOTE: These data elements are only applicable for individual age 18 and under.

Data Element Name	Changes (some may be required/optional)
Does the individual have Medicaid?	Y = Yes N = No U = Unknown/Refused
Does the individual have private health insurance?	Y = Yes N = No U = Unknown/Refused
If no health insurance, select one:	01 = Parent/Guardian has never applied for Peachcare 02 = Parent/guardian has applied for Peachcare and application is currently pending 03 = Parent/guardian has a denial letter for Peachcare/Medicaid that was issued more than 10 months ago 04 = Individual is in transition from foster care to parental custody 05 = Individual was granted an exception for 60 days of funds access and provider has documentation from DBHDD **06 = Other allowable situation for temporary funds access** 07 = Individual's status is undocumented (not considered lawfully present in the United States) 08 = Individual is 18-21 years old and not eligible for other benefits 09 = Parent/guardian has a denial letter for Peachcare/Medicaid within the past 10 months (for other than procedural reasons) 10 = Individual was granted an exception for 12 months of funds access and provider has documentation from DBHDD 11 = Parent/guardian has applied for Peachcare/Medicaid and has denial letter for procedural reasons (not following through on requirements for application completion, missed appts, etc) 12 = Parent/guardian refused to provide additional required information 13 = DBHDD State Office has determined that individual is no longer eligible for C&A funds 14 = Unknown
If Other Allowable Reason:	Enter text to describe other allowable reason

Registration

Discontinued Data Elements

Data Element Name
Primary Caregiver
Payor / Funding Source
Contract Type
Special Population: • SSI Disabled • IV Drug User • HIV +



Request For Services (Authorization)

Request for Services (Authorizations)

Changes to Existing Data Elements

Data Element Name	Changes (new valid values in red)
Referral Source	Self / Applicant Family **Legal Guardian/Representative** **BH/DD Provider** Access/Crisis Line **Mobile Crisis Team** Physician **Professional/Therapist** **State Hospital – Adult MH** **State Hospital – Forensic** **State Hospital – ICF/MR** **State Hospital – Skilled Nursing** **Private Psychiatric Hospital** **Crisis Stabilization Unit** General Hospital **Emergency Room** **Jail** **Prison** Law Enforcement Criminal Court Juvenile Justice **Probation/Parole Officer** School DFCS **Support Coordinator** **Aging and Disability Resource Center** **Central Office** **Regional Office** Clergy/Faith-Based Other

Request for Services (Authorizations)

New Data Elements – Diagnostic / Assessment Information

Data Element Name	Changes (some may be required/optional)
ICD-9 Diagnosis	Up to 5 Behavioral Diagnoses can be added Up to 3 Medical Diagnoses can be added
Social Elements Impacting Diagnosis	• None • Educational Problems • Financial Problems • Problems with access to health care services • Problems related to interaction w/ legal system/crime • Problems with primary support group • Problems related to the social environment • Occupational problems • Other psychosocial and environmental problems • Unknown
ANSA / CANS	These are new functional assessment tools
Additional Functional Assessments	Up to 2 additional assessment scores may be added • LOCUS • CALOCUS • CDC HRQOL • FAST • GAF • OMFAQ • SF12 • SF36 • WHO DAS • OTHER

Request for Services (Authorizations)

New Data Elements – SPMI / SED

Data Element Name	Changes (some may be required/optional)
Does the individual have a mental illness that meets the definition of a Serious and Persistent Mental Illness (SPMI)?	YES / NO / UNKNOWN To answer Yes, BOTH the following must be true: a) a mental, behavioral, or emotional disorder diagnosable currently or within the past year with sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders b) the mental illness leads to a serious functional impairment, which substantially interferes with or limits one or more major life activities
Does the child/youth have a have a diagnosable mental, behavioral, or emotional disorder that meets the definition of a Serious Emotional Disorder (SED)?	YES / NO / UNKNOWN To answer Yes, Must meet both criteria: (a) currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM AND (b) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities

Request for Services (Authorizations)

New Data Elements – Living Situation / Housing Status

Data Element Name	Changes (new valid values in red)
What is the individual's living situation at the present time? (NOTE: This is the same as Living Situation currently collected in the MICP system however options have been modified.)	• Independent Living - Individual owns or leases • Independent Living - With family/friends • Independent Living - Provider/Agency owns or leases • Dependent Living - Individual owns or leases • Dependent Living - With family/friends • Dependent Living - Provider/Agency owns or leases • Homeless -Shelter • Homeless - Not in Shelter • Mental Health Residential Care • Substance Abuse Residential Care • Group Home/Personal Care Home • Host Home/Foster Home • Crisis Stabilization Unit • Crisis Residence • Psychiatric Residential Treatment Facility (PRTF) • Psychiatric Hospital or other Psychiatric Facility • Assisted Living • Nursing Home • Hospice • Rehabilitation Facility • Other Healthcare Facility/Institution • Prison • Jail • YDC/RYDC • Unknown • Other

Request for Services (Authorizations)

New Data Elements – Living Situation / Housing Status

Data Element Name	Changes (some may be required/optional)
How long has the individual been in this living situation?	• One day or less • Two days to one week • More than one week, but less than one month • One to three months • More than three months, but less than one year • One year to five years • More than five years • Unknown
What is the individual's housing status/stability at the present time?	• Homeless • At imminent risk of losing housing • At risk of homelessness • Stably housed • Unknown
Total days of homelessness in the past 90 days.	Number 0 to 90
Does the individual meet the federal definition of chronically homeless? (Note: this is not the same as being currently homeless.)	YES / NO / UNKNOWN According to the federal definition, chronically homeless means either: (1) An unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years. Homelessness is defined by HUD defines as "a person sleeping in a place not meant for human habitation (e.g. living on the streets, for example) OR living in a homeless emergency shelter."

Request for Services (Authorizations)

New Data Elements – Inpatient/CSU Care

Data Element Name	**Changes** **(some may be required/optional)**
Has the individual been seen in a hospital emergency room for a behavioral health condition three (3) times in the 12 months prior to the authorization start date?	YES / NO / UNKNOWN
Has the individual been admitted to an inpatient psychiatric hospital (not CSU) three (3) or more times in the 12 months prior to the authorization start date?	YES / NO / UNKNOWN
How many admissions to inpatient psychiatric hospitals and crisis stabilization units has the individual had in the past 90 days?	Number 0 to 90
What is the total number of days the individual has been in inpatient psychiatric hospitals and crisis stabilization units in the past 90 days?	Number 0 to 90

Request for Services (Authorizations)

New Data Elements – Medical Implications

Data Element Name	Changes (some may be required/optional)
Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?	YES / NO / UNKNOWN
Is the individual receiving appropriate medical care for the comorbid medical conditions?	YES / NO / UNKNOWN
Is the individual currently pregnant? (NOTE: previously collected in a different manner)	• Yes • No • Not Applicable • Unknown
Has the individual had a baby (live birth) during this episode of treatment? (NOTE: only required for Women’s Treatment and Recovery Supports – Residential Treatment Program)	• Drug Dependent at Birth • Not Drug Dependent at Birth • Unknown
Does the individual have dependent children under the age of 19?	• No dependent children • Yes, with custody • Yes, without custody

Request for Services (Authorizations)

New Data Elements – BMI & Medications

Metabolic Assessment Tool / BMI

Data Element Name	Changes (some may be required/optional)
Weight	Pounds
Height	Feet / Inches
Waist	Inches
BMI	• Underweight= <18.5 • Normal Weight = 18.5-24.9 • Overweight = 25-29.9 • Obese = BMI of 30 or greater

MEDICATIONS

Data Element Name	Changes (some may be required/optional)
Medication	Can enter up to XX medications
Start Date	Date Medication was started
Date Discontinued	Date Medication was discontinued
Narrative	Enter details concerning current dosage, side effects, adherence, effectiveness, prescribing provider, and any specific target symptoms.

Request for Services (Authorizations)

New Data Elements – Detox Services

NOTE: ONLY REQUIRED FOR DETOX SERVICES

Data Element Name	Changes (some may be required/optional)
WITHDRAWAL SYMPTOMS	• None • Nausea • Vomiting • Cramping • Sweating • Agitation • Hallucinations • Tremors • Blackouts • Current DTs • Past DTs • Current Seizures • Past Seizures
VITALS AND SYMPTOMS	Blood Pressure Temperature Pulse Respiration Blood Alcohol Urine Drug Screen / Outcome Date of Urine Drug Screen (MMDDYYYY) Longest Period of Sobriety Most Recent Relapse Date (MMDDYYYY)

Request for Services (Authorizations)

New Data Elements – Detox Services

NOTE: ONLY REQUIRED FOR DETOX SERVICES

Data Element Name	Changes (some may be required/optional)
UDS Positive For: (Check all that apply)	• Cannabis • Opiates • Cocaine • Amphetamines • Tricyclic Antidepressants • Phenylpropanol • Benzodiazapines • Barbiturates • Methamphetamines • PCP (Phencyclidine) • LSD (Lysergic Acid Diethylamide) • Methadone • Other

Request for Services (Authorizations)

New Data Elements – ASAM

NOTE: ONLY REQUIRED FOR SUBSTANCE ABUSE SERVICES

Data Element Name	Changes (some may be required/optional)
Dimension 1 Intoxication Withdrawal Potential	• Low • Medium • High
Dimension 2 Biomedical Conditions	• Low • Medium • High
Dimension 3 Emot/Beh/Cogn Conditions	• Low • Medium • High
Dimension 4 Readiness to Change	• Low • Medium • High
Dimension 5 Relapse Potential	• Low • Medium • High
Dimension 6 Recovery Environment	• Low • Medium • High

Request for Services (Authorizations)

New Data Elements – Legal Information

Data Element Name	Changes (some may be required/optional)
Is the individual currently in jail/RYDC or prison/YDC or has the individual been released within the 6 months prior to the authorization start date?	• Currently in jail • Released within 6 months • No • Unknown
What is the date the individual was released from jail/RYDC or prison/YDC?	DATE
How many times has the individual been admitted to jail/RYDC or prison/YDC in the past 90 days?	Number 0 – 90
How many days has the individual spent in jail/RYDC or prison/YDC in the past 90 days?	Number 0 – 90

Request for Services (Authorizations)

New Data Elements – Income & Sources

Data Element Name	Changes (some may be required/optional)
Does the individual have income from any source?	If YES, Specify amounts for: • Earned Income • Unemployment Insurance • Supplemental Security Income/ Social Security Disability Insurance • VA Service-Connected Disability • Temporary Assistance for Needy Families (TANF) • Trust Fund Payments • Pension or Retirement Income from a Former Job • Child Support • Alimony or Other Spousal Support • Other Source of Regular Income
Does the individual have Non-Cash Benefits?	If YES, Select all that apply: • Supplemental Nutrition Assistance Program (SNAP) • Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) • TANF Child Care Services • TANF Transportation Services • Other TANF-Funded Services • Georgia Housing Voucher (DBHDD) • Section 8, Public Housing, or Other Ongoing Rental Assistance • Temporary Rental Assistance • Other Source

Request for Services (Authorizations)

New Data Elements – Employment

NOTE: ONLY REQUIRED FOR ACT & SUPPORTED EMPLOYMENT SERVICES

Data Element Name	Changes (some may be required/optional)
Enter the date of the individual's first contact with an employer following enrollment in ACT or SE services.	DATE
What is the current status of the individual's enrollment in Vocational Rehabilitation services?	• Enrolled • Not Enrolled
Select the option that describes the individual status with respect to Vocational Rehabilitation services during the previous authorization period.	• Enrolled but not Discharged • No VR Enrollment • Closed Successfully • Discharged Unsuccessfully
How many competitive jobs did the individual start since the start date of the previous authorization?	NUMBER
How many competitive jobs did the individual leave since the start date of the previous authorization?	NUMBER

Request for Services (Authorizations)

New Data Elements – Health Insurance

Data Element Name	Changes (some may be required/optional)
Is the individual covered by Health Insurance?	If YES, indicate all insurance types that apply: • Medicaid • Medicare • State Children’s Health Insurance Program • Veteran’s Administration (VA) Medical Services • Employer-Provided Health Insurance • Health Insurance obtained through COBRA • Private Pay Health Insurance • Other

Request for Services (Authorizations)

New Data Elements – Aftercare Contact Information

Data Element Name	Changes (some may be required/optional)
Individual's Contact Information for Aftercare	Phone Number / Phone Number Not Available Text for Clarification if not available Email
Admitting Physician	Name Phone Number
Attending Physician	Name Phone Number
Preparer	Name Phone Number
Utilization Management Contact	Name Phone Number Fax Number

Request for Services (Authorizations)

New Data Elements – Discharge Planning

Data Element Name	Changes (some may be required/optional)
Planned Discharge Level of Care	• Inpatient • CSU • Residential Detox • PRTF • CBAY • Structured Residential - C&A • Intensive Family Intervention • SAIOP - C&A • Women's Treatment & Recovery Supports - Residential • Intensive Residential • Assertive Community Treatment • Community Support Team • Intensive Case Management • Case Management (ADA) • Psychosocial Rehabilitation Program • Peer Support Program • Women's Treatment & Recovery Supports - Outpatient • SAIOP - Adult • Ambulatory Detox • Treatment Court - AD • Treatment Court - MH • Semi-Independent Residential • Independent Residential • Opioid Maintenance • Non-Intensive Outpatient

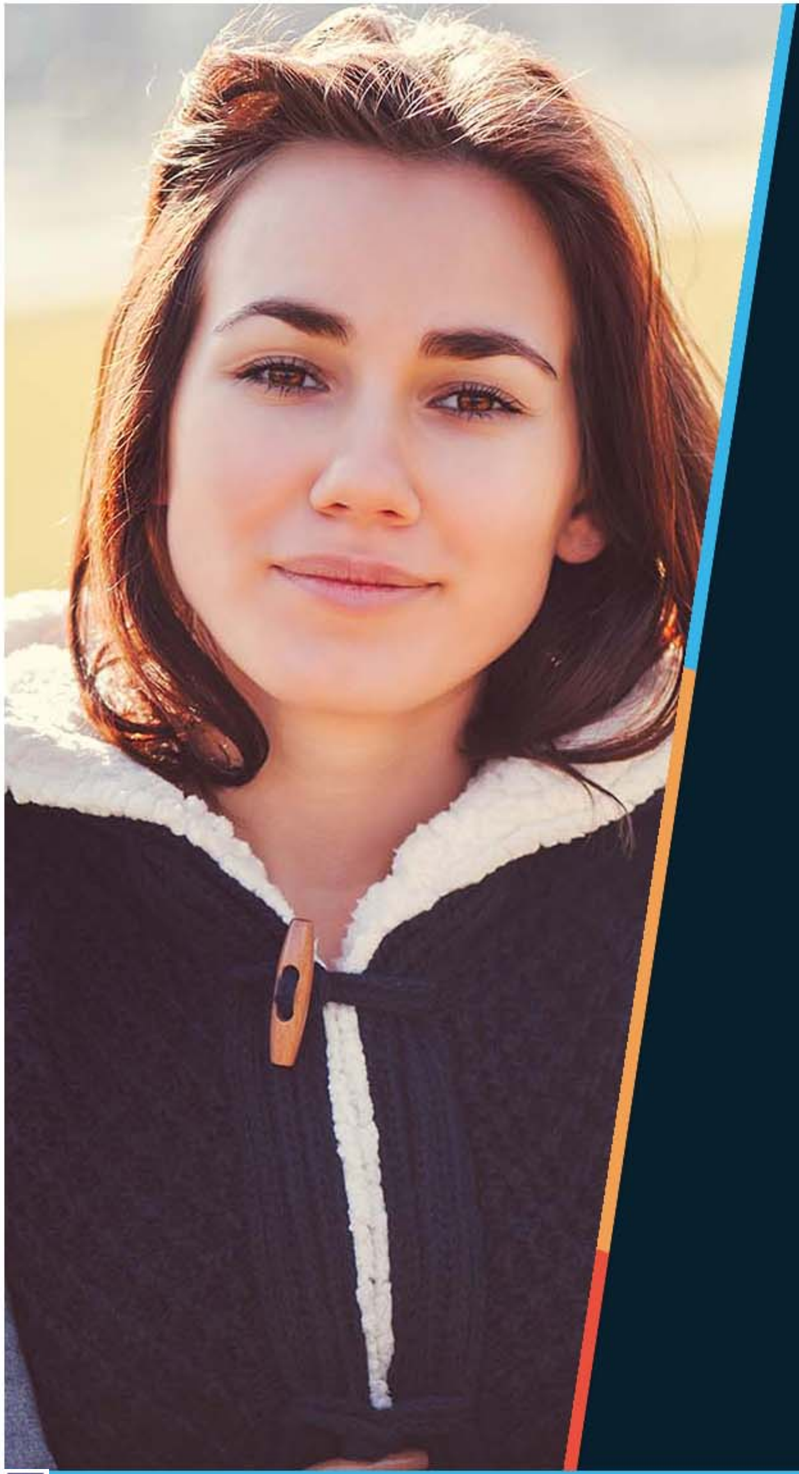
Request for Services (Authorizations)
New Data Elements – Discharge Planning

Data Element Name	Changes (some may be required/optional)
Planned Discharge Residence	• Independent Living - Individual owns or leases • Independent Living - With family/friends • Independent Living - Provider/Agency owns or leases • Dependent Living - Individual owns or leases • Dependent Living - With family/friends • Dependent Living - Provider/Agency owns or leases • Homeless -Shelter • Homeless - Not in Shelter • Mental Health Residential Care • Substance Abuse Residential Care • Group Home/Personal Care Home • Host Home/Foster Home • Crisis Stabilization Unit • Crisis Residence • Psychiatric Residential Treatment Facility (PRTF) • Psychiatric Hospital or other Psychiatric Facility • Assisted Living • Nursing Home • Hospice • Rehabilitation Facility • Other Healthcare Facility/Institution • Prison • Jail • YDC/RYDC • Unknown • Other
Expected Discharge Date	MMDDYYYY

Request for Services (Authorizations)

Discontinued Data Elements

Data Element Name
Service History • # ER/Crisis Team Involvements • # Substance Abuse Detoxification Attempts
Legal Status • Agency Requiring Consumer to Obtain Services
Employment • Monthly Wage • Volunteer time
School Setting
LOCUS / CAFAS Scores
Life Hope / Service Expectations
Treatment Plans (Goals/Objectives/Interventions)
ADA Target Population – this data element has been separated into various component questions and asked differently.



Discharges

Discharge

New Data Elements – Discharge

In addition to many of the same data elements collected at the time of the Request for Services, these additional data elements are being added at time of discharge.

Data Element Name	Changes (new valid values in red)
Discharge Reason	01 = Treatment Completed 02 = Individual/Family Chose to Withdraw from Treatment 03 = AWOL/Elopement (Only for CSU & PRTF) 04 = Administrative Discharge by Agency 05 = Transferred to Another Provider/Program 06 = Transferred/Referral Out of State 07 = Incarcerated 08 = Death 09 = Discharged due to Medical Issue/Hospitalization 10 = Discharged to Psychiatric Hospital 12 = Individual Moved 13 = Administrative Discharge (Reserved for DBHDD Use) 14 = Medicaid Ineligible (DD Waiver only) 15 = Exceeds DD Waiver Level of Care 16 = Other
Date of Death	If reason above is = 08 - Death Enter Date

Discharge

New Data Elements – Aftercare

In addition to many of the same data elements collected at the time of the Request for Services, there will be some additional data elements collected at the time of discharge when discharging from Inpatient, Crisis Stabilization, Residential Detox, and PRTF. (may not apply to your agency)

Data Element Name	Changes (some may be required/optional)
Aftercare Information	Additional data elements related to the aftercare of the individual
Follow-up appointment information	Provider Date / Time of appointment