



Questions and Answers (Q&A) from the “ValueOptions® Something for Everybody” Webinar

1. Q: Will the Power Point presentation be posted on the website so that it can be saved and shared with other staff?

A: Yes, the PowerPoint presentation is posted on ProviderConnect and will also be distributed via email to those who registered for the Webinar.

2. Q: Is it 20 visits per provider, per year? And, can authorizations be backdated?

A: Non-priority members can receive twenty (20) visits per calendar year before an authorization is required. Keep in mind this would include traditional outpatient mental health services delivered by any in-network mental health provider. This is to encourage coordination of care between providers serving the same member.

To receive a backdated authorization, the provider should submit a request for a retrospective review.

3. Q: Is it correct that any BH client being seen for less than 20 hours does NOT need an auth? We were told this by a VO provider rep and wanted to double check.

A: Non-priority members can receive twenty (20) visits per calendar year before an authorization is required. Keep in mind this would include traditional outpatient mental health services delivered by any in-network mental health provider. This is to encourage coordination of care between providers serving the same member. Priority members can receive ten (10) visits per month without prior authorization (with four 15 minute case management encounters equaling one visit for auth purposes).

4. Q: When does the 20 visits for non priority members start over? Is it January 1st? or would it be Sept 1st since that when VO took over?

A: This is based on a calendar year, but for TennCare Select members, the start date is actually 9/1/09 and will begin again on 1/1/2010.

5. Q: Is everyone supposed to submit a quarterly report? Would our VO rep tell us if we were supposed to submit this?



A: Community Mental Health Centers are required to submit quarterly reports. If you are required to submit, you will be contacted by Provider Relations. As we committed to during the Webinar presentation, please see next quarter's reporting requirements in response to Question 9.

6. Q: Do the Substance Abuse Counselors need to complete a CRG/TPG?

A: If a substance abuse counselor happens to be certified by Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) as a CRG/TPG Rater and employed by a TDMHDD designated rater agency, then it would be appropriate to complete CRG/TPG assessments.

7. Q: Re: BH providers auth. not needed for less than 20 sessions a year. Does this include the Intensive Outpatient Programs i.e Substance Abuse

A: No. These services already require a separate authorization based on medical necessity.

8. Q: Do you have any information on the bus pass program that is slated to begin December 1? Can you confirm that SPMI/SED individuals will be waived from participating in this program?

A: There is no blanket waiver for SPMI/SED individuals, but exceptions can be made upon a provider's recommendation per the exception policy. If you do not have the policies and procedures regarding the Bus Pass program, please contact your Regional Provider Relations Representative.

9. Q: Who will receive the sampling methodology information for the 3 reports at each agency? Will the sampling methodology include sample size requirements?

A: Provider Relations will outreach their usual contacts for each report to communicate the next reporting period requirements. Because we failed to meet CRA standards during the last reporting period, we are still evaluating an ongoing reporting methodology. In response to the Bureau's request for a Performance Improvement Plan, we are requesting that each reporting agency, for the upcoming reporting deliverable in January 2010, provide information to VO for all intakes completed for BlueCare/TennCare Select members during the reporting period for the Initial Appointment Timeliness Report. Likewise, for the Mental Health Case Management Report, please report on all BlueCare/TennCare Select members for whom your agency received a referral for case management following discharge from an inpatient facility. There are no changes to the MCRT reporting requirements at this time. Should you have questions, please refer those to Dale Hawkins or Marie Link-Cannon as soon as possible to avoid any delays in submission of the needed reports. We appreciate your cooperation in this matter.



10. Q: If you complete an ORF form for continued treatment and the client does not have Priority status, and the information is medically necessary, would there be any reason that treatment would be denied?

A: Medical Necessity determinations are made based on the information provided on the Outpatient Request Form and not based on the member's priority or non-priority status.

11. Q: Are audit tools available to providers?

A: Some audit tools and resources are available on ProviderConnect at <http://www.valueoptions.com/providers/Adminforms.htm>. For certain types of audits, tools and resources are also provided during the audit scheduling process.

12. Q: When does the calendar year end for authorization purposes?

A: The calendar year is January through December.

13. Q: Do all TennCare recipients have to have authorization if being seen in a private practice?

A: Authorization is not required for in-network providers in private practice unless it is anticipated that the number of visits rendered will exceed twenty per year for non-priority members and ten per month for priority members. Please see answers to Questions 2 and 3.

14. Q: Will mental retardation count as an acceptable diagnosis for justifying Behavior Analysis services (with a problem behavior)?

A: A diagnosis of Mental Retardation with no other qualifying criteria would not meet Medical Necessity Criteria for ABA services.

15. Q: DIDS only provides ABA services for children and adults enrolled in the medicaid waiver. So other TennCare enrollees (children and adults) are eligible? For instance, some enrollees with autism over 12 are currently denied services for autism.

A: A denial of ABA services would not be based solely on the fact that the member is over the age of twelve. If a denial is issued, it includes the specific reasons for the denial.

15. Q: Are children and adults eligible for ABA services?



A: Yes, if they meet Medical Necessity Criteria.

16. Q: Can you provide the website to look at benefits again it was blue ...?

A: BlueAccess can be accessed by visiting www.VSHPTN.com. Like ProviderConnect, BlueAccess has secure and non-secure features. Additional information on BlueAccess is available on ProviderConnect (www.valueoptions.com) in previously posted Webinar presentations, or by contacting your Regional Provider Relations Representative.

17. Q: For purposes of an authorization, do we need to complete CRGs on clients entering CSU, Medical detox or residential rehab?

A: CRGs are not necessary for authorization purposes, but should be completed by the treating facility if that facility is a designated rater agency. If the facility is not a designated rater agency, a referral to a designated rater agency for a CRG assessment should be a part of the discharge plan.