HFS - Behavioral Health Providers and MCOs Meeting in Greater Chicago Region –IlliniCare and County Care Responses

Topic		Issue/Question	Vendor	Response
Authorizations	1	We would like to have links and/or contact numbers to secure authorizations for medications not on the approved lists. Where can we find the l inks and/or contact numbers?	Humana/ Beacon, Harmony Wellcare	
	2	A Member who has Transition of Care benefits is sometimes being told authorization is required and other times told authorization is not required from the same carrier. What is the plan to resolve some of these very preventable issues?	ALL	If this has happened with Cenpatico members then the CMHC should call customer service and ask to speak with a supervisor. Ongoing training is conducted within Cenpatico to ensure the requirements are clearly communicated.
	3	Authorization process cumbersome and lengthy. Response time slow or non-existent. Large administrative burden following up on approvals/denials that result in hours being spent trying to get an answer. What is being put in place to address the issue?	CCAI	
	4	If the MCO does not have 24 hour/7 day a week prior authorization capabilities – how are we to handle prior auth of an off-hours admission? We do not want to admit someone in the evening/overnight/over a weekend only to get a retro denial of the admit on the next business day. Especially, IP SA detox and Crisis admits.	ALL	For inpatient hospitalizations, clinical information will be collected by Cenpatico the next business day and medical necessity decision made back to the date of admission. For non-urgent requests, the state dictates that there is a 10 day turn-around time.
	5	Please explain why PsychHealth will not provide authorization for telephonic Crisis Intervention, and requires authorization to be secured after the face-to-face Crisis Intervention service has been rendered?	CountyCare/ PsychHealth	

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	6	Please explain why PsychHealth (for individuals with CCAI benefit) is only authorizing Mental Health Assessment for every client at a minimal level: • 4 units authorized for an initial assessment (Takes an average of 8 units to complete) • Annual re-assessment (per Rule 132) not authorized. • For returning clients, a new assessment will be authorized (4 units) but only if they have been out of services longer than 6 months.	CountyCare/ PsychHealth	
	7	We are finding that SA providers are underserved in Utilization Management departments at some MCOs. In one instance (Cenpatico) there is currently only one UM rep handling SA cases. This means that often, when pre-certification is required, staff at the treatment facility must wait for a return call from the UM rep, and then must spend 45+ minutes reading clinical documentation to the MCO employee, who is taking notes on the recited clinicals. Many medical specialties have pre-cert forms made available by payers to streamline the authorization process; can DASA assist MCOs in developing pre-cert forms that can be submitted along with clinical documentation? For services rendered to patients in crisis (i.e. medical detoxification) we would like to see MCOs relax the requirements for pre-certification; specifically, an increased allowed timeframe for notification. Some plans, like CountyCare, have done this for DASA providers, many of the ICPs however, still require pre-cert.	ALL	Cenpatico assigns each hospital to a Utilization Management staff member. There is not one sole staff that is assigned all DASA facilities. If you are having issues reaching your UM, then a discussion with our Supervisory staff is in order to ensure proper customer service is given. Yes, Cenpatico would consider a form, please outreach to discuss.

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	8	Beacon MMAI is revamping their auth process and requirements as of 8/8/14 and will be revising a new auth process as of 10/1, until then, they verbally notified providers that they are giving an additional 60 day "free" authorization starting as of 8/8. We have no formal documentation regarding this since they are not ready and still writing it up (per my conversation with them yesterday). When can providers expect this policy in writing?	Beacon	
	9	BCBS and Cigna require prior authorization for CST (before beginning services). Will you be authorizing in units or for a time frame?	BCBS and Cigna	
	10	CountyCare/IlliniCare require prior authorization for CST and SASS before beginning services). Will you be authorizing in units or for a time frame?	CountyCare/ IlliniCare	There is no prior auth for CST until 200 units have been used. There are no prior auths for SASS services for the 90 days of SASS eligibility.
	11	Some MCO's require pre-certification authorization and continued stay review, while others do not. In some cases we cannot speak with a case manager and must leave a message with clinical information, awaiting a call back. Our clients are typically in a crisis situation and our admits are considered urgent. We have many walk-ins seeking treatment and they are forced to sit, at times, for hours as we are waiting for a call back or are asked to return the following day because we have not heard back from the MCO. What can be done to make this a more timely process?	ALL	If this scenario has occurred with Cenpatico, a detailed 1:1 discussion needs to occur to remedy the situation. Please contact the Cenpatico Network team at 866-329-4701 with specific questions/concerns.

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	12	Currently, Aetna Better Health and CountyCare/Cenpatico do not require pre-authorizations for assessment and placement in outpatient and residential for in-network providers. Some MCOs require pre-certification for residential only and some for both residential and outpatient. Will all the MCOs consider adopting the policy and practice of not requiring pre-certifications? Most of our clients are referred to us in crisis situations from hospital emergency rooms, State mental health facilities, courts and jails, etc. Typically, the referral entity is looking for a transitional residential situation to stabilize and treat a client who otherwise....that is without our service.....would have to be admitted or treated in a more costly and more intensive or restrictive setting. Our experience with numerous cases of clients enrolled in MCOs is that the response for approvals for admissions and level of care is not always immediate or within a reasonable time period. Sometimes we need to leave messages on answering machines and are not returned calls in hours or days. This is an unacceptable practice for a client in crisis who then must be sent out while we await a response from the MCO. Usually, the client can't be found and is at risk of re-cycling various systems of care. This inadvertently becomes a costly venture for MCOs. This has even occurred with clients who are homeless. MCOs may find that more flexible admission and authorization policies will result in clinical common sense and cost efficient practices. Agencies are required to use ASAM criteria. Agency admission practices can be audited by MCOs to assure appropriate placement decisions.	ALL	N/A for Cenpatico
Billing	1	We would like an 835 return file for larger payers (that do not currently provide it). What is your reason for not offering this or are you in the process of developing it?	ALL	Cenpatico offers 835 files for providers enrolled in electronic funds transfers. More information is available on page 8 of the Cenpatico provider manual (www.cenpatico.com).

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	2	Claims are denied and services not submitted. Trying our best to get assistance to have resolved and have a sense that we are not supported by representatives. Is there any recourse when these types of errors occur? How can we recoup losses that are the mistakes on the MCO's systems?	Aetna Better Health, BCBS	
	3	For the past 3 years IlliniCare has refused to compensate BH providers for psychiatric evaluations completed by the MD which HFS has compensated us for in past. After much advocacy, last April the state director for IlliniCare indicated she had obtained authorization for payment. However, we have not received an official announcement or the billing codes with which to do so. Can this be confirmed? Can we be provided with the billing codes?	IlliniCare	The question does not provide us with enough detail to formulate a response. Psychiatric evaluations have always been a covered service for IlliniCare/Cenpatico. We would need to know the provider type billing and how they are submitting their claims to be able to respond to specific concerns.
	4	Psychiatrists are MDs who bill directly to HFS as physicians, utilizing CPT codes (E & M) not HCPCS codes. These bills are processed by HFS differently than Rule 132 billing claims. This option was removed from physicians who work for mental health providers and assign payments to their employer. What is the reason this exist?	IlliniCare	The reason is the contractual relationship between the provider and IlliniCare/Cenpatico. If the provider is contracted and credentialed as a facility (CMHC, DASA, Rule 132) then only the services listed as billable by that provider type are covered. We do not credential and load individuals employed by the facilities nor allow them to bill us for other services outside of those for their provider type. Please contact the Network Team at 866-329-4701 to discuss contracting specifics.
	5	Psychiatrists as physicians have their own documentation requirements for compliance to CPT coding standards and their work does not match the M0064 definition of "simple medication management". What can be done so an accurate account of the type of services is billed?	IlliniCare	MCOs are limited to the codes used by the State so that we may encounter the services we process to the State. Until the State designates an alternative code, Cenpatico will continue to use M0064 for medication management services.

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	6	Inappropriate denials for "duplicate services" The MCO's do not have their system configured correctly to pay out legit claims billed under the same CPT/HCPCS code on same DOS for different providers. Example: we are working with a client to transition them to an independent center; we bill for case management service and so does the indep center. The entity that gets their claim in first gets paid – other one denied for dup service. Both are legit claims. What can be done to correct this?	ALL	If the claims are submitted by different providers under different Tax ID numbers and different NPI numbers, then the claims should not deny as duplicates. We have no examples of this denial situation happening for Illinicare/Cenpatico. If specific examples are identified, please forward to Cenpatico for research and resolution.
	7	What can providers expect in terms of timeframes for resolutions to concerns over reimbursement?	ALL	Timeframes vary depending on the steps needed to resolve the specific concern -- from a couple of days to reprocess a claim to a couple of months to amend a contract and/or reconfigure the system.
	8	Numerous issues remain regarding billing among most MCOs. How can MCOs solve provider billing problems in a more effective and efficient way? The issues tend to be specific in nature and extremely difficult to resolve. The following are just a few of countless examples: Harmony/WellCare refuses to approve residential services stating it is not a covered service and should be billed to DASA. Yet it is an identified billable service in our Harmony contract.	ALL	Billing issues tend to be provider specific and should be discussed with the Illinicare/Cenpatico Network Manager or Provider Relations Representative for appropriate resolution. *This question is directed specifically to Harmony/WellCare. Does not apply to Illinicare/Cenpatico.*
	9	Cenpatico/Illini Care has instructed us to use billing code H2036 for IOP (not a correct code for IOP according to HCPCS 2013) and H0005 for BCP. When we bill H2036 as instructed, the service gets denied stating "service not in contract." This denial comes to us even though we are following their instructions for payment and Cenpatico has already pre-authorized the service.	ALL	The question does not provide us with enough detail to formulate a response. We need to know the specific provider who has this concern so we can review their contract since the denial is related to the contents of the contract.

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	10	Instances have occurred with Cenpatico/IlliniCare where rejection letters on claims have been received. Well after the fact it was discovered that claims with rejection letters are NOT entered into the claim system at the MCO offices. Can all the MCOs enter ALL claims received, rejected or not, into their systems? We have several claims they are now denied for timely filing reasons even after providing the MCO with written documentation that the claim was handled and sent to their offices in a timely manner.	ALL	The question does not provide us with enough detail to formulate a response. We need to know the specific reason the claims were rejected. Please provide us with specific examples. Rejected claims cannot be entered into our system.
	11	Timely filing rules are currently 90 days for the initial submission. The MCO will use the first day of service as their start date. Many of our clients, especially in the case of inpatient, may be in our care for up to 28 days. It has always been our practice to wait for discharge to submit the claim. By doing so we are automatically losing up to 1/3 of that restricted filing allowance. Can the MCO use 90 days from day of discharge rather than admission for clients treated in a residential program as the rule? The 90 count currently used is not 'business days' meaning MCOs count weekends and holidays.	ALL	Illinicare/Cenpatico uses 90 calendar days from the day of discharge for inpatient claims and 90 calendar days from date of service for outpatient claims. However, when multiple dates of service are billed on the same outpatient claim, the first date of service on the claim is used as the starting date.

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	12	Nearly 3/4 of our clients are insured under Medicaid. Our problem is that we are unable to provide needed services to many of these clients because they have been switched from one provider to another. It is difficult for us to know when our clients have been switched. The clients get notification by mail but no notification is sent to the providers. Additionally we have lost a tremendous amount of revenue and are receiving many billing rejections due to these switches. We must call the DHS eligibility number at least twice weekly per client to determine if that client is eligible to continue to receive services. Some of our questions are- How are we to bill past services to the relevant MCOs for current clients? How far back are we able to bill for services to each MCO?	ALL	MCOs are only responsible for dates of service while the member is assigned to that MCO. Services provided to current clients that were not members of Illinicare/Cenpatico on the date of service may not be billed to Illinicare/Cenpatico. Please contact the State to find out the appropriate entity for filing claims on the particular date of service. Claims for dates of service past the timely filing deadlines will be denied.
	13	Do we need CPT codes for billing MCOs?	ALL	Use of CPT codes depends on the services being billed to Illinicare/Cenpatico and the provider type. Please refer to the Covered Services & Authorization Guidelines in the Provider Manual (pages 45-55) for identification of covered services and appropriate codes to bill (www.cenpatico.com).
	14	If we miss the relevant MCO cutoff date is there still a way to recoup payment for services?	ALL	Please see the Claims Reconsideration process described in our Provider Manual (page 68) which can be found on our website at www.cenpatico.com.
	15	Are we able to bill for new patients who have already been switched if we are not part of the provider's network, specifically, County Care.	County Care	

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	16	Are SUD Providers to submit claims for residential treatment or split bill for day of treatment and room and board? If any companies want us to continue to split bill what are the appropriate SUD billing codes for the day of treatment and for room and board? SUD Providers were previously given the Standardization Initiative billing codes; according to those codes 944 or 945 and H0047 is to be used for adult residential and 944 or 945 and H2036 is to be used for residential services under 20. We have received conflicting information regarding billing codes for adolescent residential treatment services; are providers to use H0047 or H2036 for services provided in an adolescent residential treatment program.	ALL	Illinicare/Cenpatico does not require DASA providers to split bill these claims. Services may be billed together on a HCFA-1450 (UB) claim form or electronic equivalent. Illinicare/Cenpatico requests DASA provider to bill room and board with REV code 126 or 128 and bill the day treatment with REV code 944 or 945 with supporting HCPCS code H2036. Services may be billed together on a HCFA-1450 (UB) claim form or electronic equivalent. Illinicare/Cenpatico requests DASA providers to bill 944 or 945 with H0047 for Residential Rehabilitation. We request 944 or 945 with H2036 be billed for Day Treatment. We do not have any distinction for age of member for such services. Please refer to the Covered Services & Authorization Guidelines in the Provider Manual (page 54) for our allowed codes for DASA providers (www.cenpatico.com).
	17	In the past, if you were not a network provider with Harmony or Family Health Network, you were informed that there were no out of network benefits available, therefore you were able to bill Medicaid or DASA. Additionally, Harmony/Wellcare continues to state that residential is not a covered benefit. Who can the providers bill in this case? Will providers need to become a network provider with Harmony or Family Health Network in order to receive payment for services rendered, and will they be required to pay the Medicaid rates?	Harmony, FHN	

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	18	How would the MCO's want the providers to bill for residential treatment? Do they want us to bill as an all-inclusive rate or break out the residential rate for the treatment/Medicaid portion and domiciliary/DASA portion, and what revenue and procedure codes would like us to use? There seems to be some confusion on their end with revenue and procedure codes, as well as tying those codes to the bill type	ALL	Illinicare/Cenpatico requests DASA providers to break out the residential rate for the treatment/Medicaid portion and the domiciliary/DASA portion. Illinicare/Cenpatico requests DASA provider to bill room and board with REV code 126 or 128 and bill the day treatment with REV code 944 or 945 with supporting HCPCS code H2036. Services may be billed together on a HCFA-1450 (UB) claim form or electronic equivalent. Illinicare/Cenpatico requests DASA providers to bill 944 or 945 with H0047 for Residential Rehabilitation. We request 944 or 945 with H2036 be billed for Day Treatment. Please refer to the Covered Services & Authorization Guidelines in the Provider Manual (page 54) for our allowed codes for DASA providers (www.cenpatico.com).
	19	With programs that have multiple rates for the same level of care in the same location, does the MCO have to create some modifiers to distinguish the program/rate?	ALL	Illinicare/Cenpatico uses a variety of coding options to distinguish the program/rate, including the use of modifiers and provider specific codes (known as Area codes to us) to identify rates by different locations for the same provider. Please refer to the Covered Services & Authorization Guidelines in the Provider Manual (pages 45-55) for identification of covered services and appropriate modifiers (www.cenpatico.com).

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	20	When a client comes in for treatment and is identified as a Medicaid or DASA client, and during the course of treatment their coverage changes to an MCO and we are not aware until after the fact. What is the billing process?	ALL	If a client switches to Illinicare/Cenpatico during a course of treatment without notification, you still have 90 days from the date of service to submit the claim. If the 90 days has past and you receive denials from the previous payor, please follow Cenpatico's Claims Reconsideration process described in our Provider Manual (page 68) to have your claims considered for payment (www.cenpatico.com).
Case Management	1	There is a huge difference between mental health case management and care management as the Health Plans practice it. Why is it that the Health Plans are not including or authorizing Case Management services?	ALL	Cenpatico authorizes those services. If a group has concerns please contact the Cenpatico Network team at 866-329-4701 with specific questions/concerns.
Contracting	1	Can the MCO's outline their role (if any) in working with the FHP and ACA adult populations? Can they describe their method of contracting w/existing providers? Can they indicate differences in services and credentialing?	ALL	Cenpatico is working with both the FHP and ACA adult populations. This includes Care Coordination, Utilization Management, and claims payment. Cenpatico has recently amended its provider contracts to include the specific product requirements for both products. Each of our providers provide a PSP or Facility profile that self discloses what type of provider and services they provide.
	2	BCBS is way behind in loading PCP's into their system. We have had a contract w/ them for months – our providers are still not loaded. Makes it very difficult for our Case Management staff to assist our clients in signing up for an MCO and selecting their PCP. What is the status of loading PCPs in your system?	BCBS	

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	3	Are some providers getting different rates than the Medicaid rates or are all the contracts the same in terms of reimbursement?	ALL	Cenpatico Provider Agreements and rates are proprietary, please refer to your specific Agreement.
	4	Back in June we completed applications with both BC ICP and Meridian and the contracts are still not loaded. How do we see participants and bill for them if the contracts are not loaded?	BCBS, Meridian	
	5	The contracts/agreements are not written for behavioral health organizations or free standing facilities like many of the SUD's. We can spend months red lining and negotiating contract language to ensure that the language applies to our organization and the services we provide. These agreements do not address our services and problematic language includes line items related to drug formularies, staffing privileges and medical services. We have received Medical Group Agreements and Provider (Physician) Agreements rather than Facility or Ancillary Provider Agreements. Is it possible for an agreement specific to SUD, or Behavioral to be created?	ALL	Cenpatico Provider Agreements are specific to the type of provider rendering behavioral health services.

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	6	There is currently a lack of consensus between MCOs regarding billing procedures and appropriate CPT/HCPCS codes for SA services. This is leading to confusion during the credentialing process and for billing departments. Many provider relations reps at MCOs still are unaware that DASA providers have state-assigned rates that are not published by HFS. This is creating substantial delays in provider credentialing as the MCO attempts to reconcile rate issues. These facility specific rates must then be included in the reimbursement methodology article in the contract which must then be amended any time a program or rate is changed. What can be done to properly communicate these challenges to MCO credentialing departments and streamline the contracting process?	ALL	Please contact the Cenpatico Network team at 866-329-4701 with specific questions about your Provider Agreement or rates.
	7	Community Care Alliance is currently using PsychHealth to manage their behavioral health. In order to become a Community Care Alliance provider one must contract with PsychHealth. They have ridiculously low rates. Will they be required to pay the provider's Medicaid rates?	PsychHealth	
Credentialing	1	Rule 132 does not require services be provided by licensed clinicians. The credentialing documentation we have received from Harmony, BCBS, Aetna Better Health and Cenpatico, is indicating they will only credential and pay for services provided by licensed clinicians. We don't understand why the some MCO's have put in an extra layer of credentialing that the state never required and is there any possibility of this being changed?	Aetna Better Health, BCBS, Cenpatico, Harmony Health Plan	Cenpatico follows the NCQA standards unless there is some other standard required by the state.

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	2	Credentialing and re-credentialing as a CMHS provider is a concern that also involves: Contracts, Customer service and Claims and is currently a cost to our agency of $70,000. In good faith, we provide service to the payers' consumers without interruption. Yet, there is a significant payment problem due to the correct processing of our credentialing status. Specifically, that our agency's location NPIs are correctly in the payer's electronic system. When the contract is completed, it is not clear that the payer has entered our correct payee information to their EDI. It is discovered too late, when all claims to the payer are getting denied.	Aetna Better Health, BCBS	
	3	We have been informed that as of 7/1/14 Harmony/Wellcare will be operating as the other MCO's and covering rule 132 services and credentialing agencies as facilities. Can we get this confirmed in writing? Can they provide agencies with written confirmation of their credentialing status?	Harmony Wellcare	
	4	Many of the agreements we have seen are medical, individual or professional agreements and require credentialing of the staff and/or a list of credentialed staff. This is not applicable to SUD Providers. Alcohol and Drug treatment services are billed as facility services; reimbursement and rates are not based on staff credentials. Requiring staff rosters with credentials is an unnecessary use of an organization's resources. Can the contracts be revised to eliminate the staff credentialing/staff roster requirements?	ALL	Cenpatico does contract with DASA/SUD providers at the facility level, and does also require the submission of a complete provider roster as part of the credentialing process. The Cenpatico Provider Agreement & Provider Manual will not be revised to exclude the submission of the provider's roster.
Customer Service	1	Specifically for Billing and Claim concerns, it has been difficult to find contacts who understand the question regarding MMAI and ICP group/plan of their own company. Several instances of being passed around and not getting concern resolved. What is being done to correct this issue?	Aetna Better Health, BCBS	

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	2	Some MCO's have only 1 person to provide over site and serve as liaison to the BH agencies working with ICP and MMAI. Given the scope of responsibility it is difficult for them to respond to anything in a timely manner. We often wait weeks/months for a response to voice mails and emails. Does the MCO's have plans to expand staff? Is there a certain time frame in which they are expected to respond?	ALL	If this pertains to Cenpatico please call for individual discussion. We are not aware of being weeks to months behind in any clinical discussions.
	3	The workers at some benefit plans are giving out wrong information. Example - a call to HealthSpring – "Yes member is with us through Advocate and your agency does not show as in network". A call to Advocate – "HealthSpring handles all of the mental health benefits for this plan." A call back to HealthSpring – again told to call Advocate. At a request for a supervisor - "HealthSpring does handle this member's benefits and your agency is in network."	ALL	Cenpatico is continuously providing training to our staff.
	4	How will the clinicians know who the care coordinator is for each client?	Beacon	
	5	When there is a change (for example a code or policy change), how will the MCOs communicate this to the contracted providers?	ALL	All Cenpatico notifications are posted to our website at www.Cenpatico.com. In addition, we mail, fax blast, and email blast notifications to providers.
Enrollment Verification	1	Currently we must call BCBS to obtain the Member's ID# (XOG...) and Group #, at time of enrollment (or after the SASS call) in our system, which is prior to the member's first visit. This information is not shown in the state's MEDI system when eligibility is verified. Will this information be available in MEDI in the near future?	BCBS	

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Manual	1	Are the MCO's required to have a provider manual reflective of practices and programs in Illinois? Many have a manual that is nationwide and not applicable. This makes rules/procedures confusing.	ALL	The Cenpatico Provider Manuals for IlliniCare & CountyCare are specific to the practices and programs in Illinois and can be found at www.Cenpatico.com.
Quality	1	How are MCOs defining and measuring quality?	ALL	The Cenpatico Quality Improvement (QI) program is based on the principles of continuous performance improvement (CPI) which is adopted and utilized throughout the organization. Cenpatico believes quality is an organizational value synonymous with performance and incorporates monitoring, evaluation and analysis of access to clinical services for members and providers; network adequacy and management; utilization management; operations measures and member and provider satisfaction in the identification of performance improvement opportunities. All operational measures (appointment access and network adequacy) are measured using state defined performance targets or goals. Clinical outcomes are primarily measured using the Healthcare Effectiveness Data and Information Set (HEDIS) measures and state defined performance goals for priority outcomes. Where the state does not define performance targets/goals for specific HEDIS measures, performance is compared to the Illinois state performance on these measures and tracked for performance improvement opportunities. All performance data (clinical and operational) are reviewed together to identify systemic and provider level areas for improvement.

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	2	What are the MCO procedures for clinical record reviews and where can we find that information?	ALL	Cenpatico conducts medical treatment record reviews to monitor quality and to ensure the member is progressing through care and the services are being titrated appropriately. Should your CMHC be chosen for a record review, you would be given ample notice, given the record review tool and the list of charts to be reviewed by Cenpatico. Following the review, the results are shared with the provider and corrective actions discussed as needed. Additional information may be found in our Provider Manual (page 26) at www.cenpatico.com.
Services	1	We would like clear, written crosswalk of covered services including service limitations be made available. When can we expect this?	CCAI, Family Health Network, Harmony, HealthSpring, Humana, Meridian	
	2	Why are your current service limitations so out a line with other providers?	IlliniCare	The question does not provide Illinicare/Cenpatico with enough detail to formulate a response. We need to know what specific service limitations are being questioned.
	3	Community Support Services – all Cenpatico staff not aware that first 200 units do not need prior auth. What can you do to educate all your staff?	Cenpatico	Cenpatico is aware of this situation and have re-educated all staff. If it continues to be a concern, please call for individual discussion.
	4	Why is Cenpatico placing max benefit limits on H0004 and H0005 (both 8 units/day)?	Cenpatico	A request to remove the 8 units/day limit on H0004 and H0005 has been submitted to Cenpatico's configuration team and is now in process. Illinicare/Cenpatico will inform providers when this change has been completed.

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	5	We were informed that the service limitations attached to the Rule 132 services in Cenpatico/CountyCare's distributed "Cenpatico Illinois Covered Services and Authorizations Guidelines (version 8/5/14) are at the same level as originally imposed by the State. Crisis Intervention, for example, has limits to the service through Cenpatico; however, it is an unlimited benefit for all eligibility groupings through the state. Why is there an overly restrictive service limitation on Rule 132 services? What will you do to bring your policies in line with your practice?	CCAIL , CountyCare, IlliniCare	A request to remove the units/day limit on crisis intervention (H2011) has been submitted to Cenpatico's configuration team and is now in process. However, the units allowed before authorization is required will remain in place. H0004, and H0005 has also been submitted to remove the units/day limit. Illinicare/Cenpatico will inform providers when this change has been completed. Please notify us of any other codes you feel are overly restrictive so we may review.
	6	Case Management-LOCUS is not an authorized service by PsychHealth for individuals with CCAI benefit. How can providers meet DMH requirements to complete a LOCUS without authorization for payment?	CountyCare/ PsychHealth	
	7	Treatment Planning is not an authorized service by PsychHealth for individuals with CCAI benefit. How can a provider meet DMH requirements to complete a Treatment Plan without authorization for payment?	CountyCare/ PsychHealth	
	8	We have been having many issues with Cenpatico claims – codes changing, authorizations being denied…so it would be helpful to meet them in person. They are having trouble relating to what we do – they can't give us a definition of "DASA facility" … it's been a colossal waste of time to not get paid for services.	ALL	Please contact the Cenpatico Network team at 866-329-4701 with specific questions regarding contracts and billing for DASA services. You may also refer to the Cenpatico Covered Services and Authorizations Guidelines which can be found at www.Cenpatico.com.

HFS - Behavioral Health Providers and MCOs Meeting in Greater Chicago Region –IlliniCare and County Care Responses

Topic		Issue/Question	Vendor	Response
	9	Some MCO's are requiring APL coding and rates; these codes do not seem applicable to SUD services nor are the rates the same as the DHS DASA SUD Provider rates (for example there are no codes for residential services and group is per event not time based and the rate for individual is lower than the DHS DASA rate.). Do the MCO's that are not utilizing DHS DASA codes and rates have any plans to do so that Provider reimbursement is in line with the State SUD Medicaid rates?	ALL	APL coding only applies to hospital outpatient services unless specifically mentioned as the reimbursement methodology in a provider's Rate Exhibit attached to their Participation Agreement with Cenpatico.
Sub-Contracting	1	Some of the MCO's contracts indicated you may not subcontract services. Does this mean all psychiatrists must be employees of the provider agency? Can you use contractors who work at your site? Can you use a locum tenens to fill needed psychiatry time?	ALL	This section of the Cenpatico Provider Agreement is intended to secure the services of the Facility not to dictate the manner by which you employ staff. This will depend on the type of agreement you hold with Cenpatico, please contact the Cenpatico Network team to discuss your specific situation at 866-329-4701.
Training	1	Can the providers obtain copies of the training materials from the MCO's so they may hold group trainings at the facilities if web based training are not an option?	ALL	Many of the documents presented in training can be found on www.Cenpatico.com. You may also contact your Provider Relations Representative with specific training requests.