

HOW TO IMPROVE CHANCES FOR AUTO-AUTHORIZATION OF OUTPATIENT REQUESTS SUBMITTED ON CARECONNECTION ®

1. These statuses will exist in CareConnection® when a request executes the auto authorization rules:
 - a. Request status = Final-Approved or CR-Approved; service status = CM_AUTH. The request has passed all auto auth rules and is approved.
 - b. Request status = Submitted, service status = CM_REV. The request will not auto auth and is forced to manual review.
 - c. Request status = Hold_Submit, service status = FAIL_AUTH. The request has failed one or more checks and is NOT forced to manual review. The user will have the opportunity to correct errors and resubmit, both thru the web application AND thru EDI re-submission.
2. Any CDC meeting qualifications defined by DMHSAS will automatically generate a PA request in the background. This request will immediately be approved (PA number assigned) and exported to MMIS that evening. The term for this is “instant authorization”. These are limited to transaction 21 (generates PG038 for initial services), and some DMH only codes.
3. The requested start date cannot be earlier than the date the request is submitted to APS Healthcare:
 - a. On the web, the submit date is when the “Submit” button is pressed and no errors are generated.
 - b. For EDI files, the submit date is the <CreateDate> in the header record of the file.
4. If this is an extension request, be sure that the new requested start date does not overlap the end date of the old authorization. The only exception is if a request for initial services (PG038) is the only historical record. The issues discussed above still apply.
5. The only review types subject to auto authorization are:
 - Mental Health - OP
 - Substance Abuse - OP
 - Integrated - OP
 - Prevention and Recovery
 - Admit to Outpatient
6. The requesting facility must be the treating provider.
7. Axis I must be completed. Deferred (799.9) and None (V71.09 or V65.5) are not acceptable for a primary Axis I diagnosis.

For substance abuse/integrated requests, a substance abuse diagnosis is required in Axis I (301...301.9).

8. Axis II must be completed. The “None” codes above are allowed (v65.5, v71.09 or 799.9), as are MR diagnoses (317, 318, 318.1, 318.2, 319), borderline intellectual functioning (v62.89), and personality disorders (301....301.9).

If a personality disorder diagnosis is for a minor consumer, the request will be forced to manual review. This is not true for an adult.

9. Axis III is a free field text that must be completed. Report medical issues only.
10. Axis IV – at least one psychosocial stressor must be something other than None/NA.
 - Level 1 - At least one stressor should be mild or moderate. Does not allow severe
 - Level 2 - At least one stressor should be moderate. Does not allow severe
 - Level 3 - At least one stressor should be moderate or severe
 - Level 4 - At least one stressor should be severe

When you are rating these areas, think of them as you would the CAR score ranges for the related CAR domains. If the CAR score is 20-29, that would be mild; 30-39 moderate; 40-49 severe.

For example:

If you score the CAR family domain a 34, then the rating for the Primary Support in the Axis IV would be Moderate.

11. Axis V must be completed. This is the GAF score outlined in the DSM-TR. If this is an initial request, unknown or 0 (zero) are acceptable values for the past score.
12. The first item in the Services Requested section of the request is “Level” with a drop-down of I, II, III, IV, etc. To improve your auto-auth chances, be sure to indicate the CAR or ASI/T-ASI level as supported by the scores in this section. If you have questions, please refer to the Provider Manual on SoonerPro (<http://www.soonerpro.com/Resources/Manuals.aspx>) .
13. The procedure group (PG) code requested must not exceed the level as indicated and must be supported by the CAR or ASI/T-ASI scores. It can be a lower level PG code if that is the frequency of services being provided, but it cannot be higher.
10. PG033 should ONLY be requested if there is a gap between the end date of a previous PA period and the start date of the current request. Adding this service to an initial or extension request will stop the request from auto-auth’ing, so it should only be added when needed and explanation supplied for why it is requested.

(R 03-26-10)

GENERAL CARECONNECTION® TIPS

1. CareConnection® is going to default for the majority of requests to 6 months. If you are requesting a shorter PA, enter the number of months in the Length of Service and when you **tab** to the end date, it will automatically calculate the correct end date.
2. The Current section of the request is not a required field in CareConnection® for outpatient services; the Interpretive Summary is required and that is where the *current*

critical clinical information supporting the need for the client to receive services or continue in services with your agency is to be documented.

3. The Current section of the request is a good place to place comments for the reviewers that you want to stand out from the rest of the request. This is where you will:
 - a. Clearly state the reason for submitting a Correction or Modification.
If this is a Modification or Correction, do not request all the services again; only request the services that need modification or correction.
 - b. Document that you have a letter of termination on file. Include the date the client/guardian signed the letter.
 - c. Document that you have a letter of collaboration on file. Include the name of all collaborating agencies, date the letter was signed, the level of care agreed upon by the agencies, and amount of money to be allotted to each agency.
4. If you upload your requests via EDI and the Current section is not part of your EDI program, the above items in #3 are to be placed in the first line of the interpretive summary.
5. If you are submitting a Substance Abuse/Integrated Request, you do not have to complete both the CAR and the ASI/T-ASI. If you choose to complete the ASI/T-ASI, you will enter 0 (zero) for the CAR scores and complete the ASI/T-ASI scores.
6. If the client has an Axis II diagnosis of Mental Retardation, the IQ score is still required. This is usually documented in the Thinking/Mental Process section of the CAR, but is accepted in the interpretive summary as well.
7. If the request is an extension request, progress must be included and is acceptable either in the objectives section or in the interpretive summary.

(R 03-26-20)