**HOW TO COMPLETE A PRIVATE LBHP REQUEST IN CARECONNECTION**

1. Access CareConnection either thru www.soonerpro.com or directly entering https://careconnectionok.apshealthcare.com in the address bar on your web browser screen.
2. Enter in your CareConnection User Name and Password.
3. On the left hand side of the screen you will see a navy blue box.
4. If this is an **initial (new clients never seen before)** request, click on "New Request".
   a. Organization will default based upon your user name. You may have to choose the provider ID if you have more than one. For authorization purposes as well as the CDC, you need to choose your individual provider ID not the group/agency ID. The ID on the CDC and request must match in order for the authorization to issue.
   b. Enter start date – cannot be earlier than date request is submitted.
   c. Request Type – Prior Authorization
   d. Review Type – Private LBHP (or Insure Oklahoma if that is the member's health program)
   e. Client Information – enter SoonerCare ID number and member's last name. Click "Verify". If the member is eligible, it will auto-populate client fields. If member is not eligible, you will get a red error message telling you that. You will need to go back to the Request Type and change it to Courtesy Review. Do not change any of the fields that auto-populate as that will create a mismatch with eligibility information from OHCA and the authorization will not process.

   **Please Note** - Do Not use CareConnection to verify eligibility as a general practice. Use either the OHCA secure site Medicaid on the Web or the REVs system.

   If the eligibility only shows MHSAS, the member is not eligible for SoonerCare Services as this is an ODMHSAS only health program code.

   Also, remember, not all SoonerCare eligibility includes behavioral health benefits. You are looking for the following health programs:

   - TXIX (Title 19).
   - CUST (for kids in custody),
   - CCP (Crippled Children's Program),
   - S-CHC (SoonerCare Choice) or
   - S-IHS (SoonerCare I.H.S./A.S.O.)
   - PUB (Insure Oklahoma, aka OEPIC)

   f. Diagnosis – for PG029 and PG030 for SoonerCare (PG026 or PG027 if Insure OK)

      Axis I & II – can use 799.9 (if you have a diagnosis, you can enter that, even if a rule-out, but it is not required)
      Axis III – can use "unknown"
      Axis IV – defaults to "none" which is acceptable
      Axis V – Current/Past/Change – can use "unknown"

   For PG040 (PG028 for Insure OK) – all five Axes must be fully completed. Details of the PG040 (PG028) requirements can be found at http://www.soonerpro.com/Files/Manuals/LBHPRequestingSpecialPriorAuths.pdf.

   g. Current section – document requested start date (can backdate up to 30 days) as well as documentation regarding any letters of termination or collaborations with other providers.
   h. Service Requested – for Level, choose Private LBHP. Then choose service, billing provider ID (your individual provider ID), and number of units, tab thru the remaining box(es) then click on "Add Service" at the bottom of the Services Requested section to add to the request. You will get a pop-up telling you it was successfully added.
   i. CAR scores – enter 0 (zero) for Past and Current
   j. If the request is for a PG040 (PG028), you are required to document in the Interpretive Summary the current, critical clinical information in behaviorally descriptive terms to support the additional units per month. More details of the PG040 requirements can be found at http://www.soonerpro.com/Files/Manuals/LBHPRequestingSpecialPriorAuths.pdf.
   k. If the request is for PG029, you can enter "unk" or N/A for the required testing fields. (Although it is helpful for APS to know the reason for the testing and the tests to be administered to ensure the testing request is not for educational purposes, which is not eligible for reimbursement and could set you up for recoupment if billed.)
   l. Click on "Save" at bottom or top of page. You will get a pop-up telling you it was successfully saved.
   m. Click on "Submit to APS" at bottom or top of page. You will get a pop-up telling you it was successfully submitted. If you do not get this message, go to the top of the request and in red will be items needing completion before submitting to APS.

5. If it is an **extension (established, ongoing clients)** request, click on the "Search Request "box.
    a. When the Request Search screen appears, enter the current CareConnection APS Record ID if you have it. If not, enter the client's Medicaid ID number.
    b. Click on the "Search" button at the bottom of the "Request Search" screen.
    c. When the "Request Search Result" screen appears it will show only the single record if you have searched by Record ID. If you search by Medicaid ID number, the result will list all previously created requests for your provider ID. Locate the APS record ID that you need to complete an extension request for but do not click on the blue ID.
    d. Next to the APS Record ID is a column that says "Copy" and under it is the choice "EXT" for extension.
    e. Since you are completing an extension request, click on EXT.
    f. You have now created a copy of the previous request that requires updating before submission, including but not limited to:
        - Verify eligibility to ensure client continues to be Medicaid eligible
        - New start date – cannot be earlier than date request is submitted.
        - Axis V – can use "unknown" for all three fields
        - Services requested – Level – choose Private LBHP. Choose service, provider ID (use individual provider id), and number of units and tab then "Add Service" to save to request.
    g. In Current section, document the requested start date – can be no more than 30 days back. Also document here any letters of termination or collaborations with other providers.
    h. Once you have completed the extension, "Save" your work.
    i. "Submit to APS" for final processing.

If you receive a Clinical Correction Notice from APS notifying you that the member has current authorization with another provider and we need documentation of letter of termination or collaborating with other provider or that there is something missing on the request, you can pull up the request in CareConnection by clicking on the "Search Request" button on the left side navigation bar, make the appropriate correction in the record and submit again to APS for final processing.

You can look up the status of your requests at anytime on CareConnection by pulling up the requests individually. But to save time you can click on the "Download Notification" from the left side navigation bar and you will see the status of all your requests for the past two weeks and if you click on "Archive", you will see the previous two weeks for a total of four weeks of request status. The main status' are:

- Final-Approved – request is done and authorization issued
- Final-Denied – request has been denied for not responding to a clinical correction with 10 calendar days or denied by consultant for lack of MNC
- Correction – APS needs further information to complete review. See Note to Provider in Services Requested section of request for details.
- Submitted or CM_REV – in queue for review
- Hold_PA – a CDC has not yet been submitted for this request

**PLEASE NOTE** –
APS has been entering your faxed requests into CareConnection. Even if you have never submitted a request on CareConnection for an established client, please follow the steps noted above. You may find that the initial work has already been done for you and all you have to do is to go in and complete the extension request with the updated information.

DO NOT use "New Request" for extensions for clients already entered into CareConnection. "New Request" (initial request) is meant for new clients or established clients who do not have a current record in CareConnection.

Remember you still have to submit the CDC 23 for new requests and the CDC 42 for extensions prior to submitting the auth request.