

**FY'11 CHANGES FOR LICENSED BEHAVIORAL HEALTH PROVIDERS FOR
SOONERCARE AND INSURE OKLAHOMA**

1. **LBHPs:** As of July 1, 2010 all licensed Behavioral Health Providers will be able to contract directly with the Oklahoma Health Care Authority to serve children and their families. (Adults are not included in this benefit.) LBHPs who are currently contracted with Insure Oklahoma can also contract with OHCA to serve SoonerCare children and families. The provisions in this manual apply to those who already are Insure Oklahoma providers. These are the services that LBHPs may provide:
 - a. Allows LBHPs to provide a limited benefit for children and their families.
 - b. Services allowed include assessment, crisis intervention, individual, group, family, and multifamily therapy.
 - c. Only one assessment per member per provider is allowed per year, unless there has been a break in services for six months, at which time another assessment may be performed.
 - d. The maximum number of units/sessions allowable per month is eight units of psychotherapies and 8 units of psychological testing per year per patient.
 - e. For CALOCUS trained LBHPs, there will be a reimbursable service code for performing a level of care assessment, brief intervention, referral, and case management process.

2. **Outpatient BH Agencies:** LBHPs working in OPBH agencies will be able to provide the level of care CALOCUS assessment, brief intervention, referral, and case management process and be reimbursed for it through the agency, separate from their current assessment practices. The agencies will still provide their full array of services under the levels 1-4 system.

Processes and Procedures

There are three authorization tracks available to clinicians wishing to utilize the provisions in the rule.

A. Outpatient Behavioral Health Assessment/Therapy Track

1. This track utilizes the processes for a clinician in private practice:
 - a. 90801 assessment,
 - b. crisis intervention,
 - c. individual, family, group, and multifamily therapy
 - d. The 90801 will not require a prior authorization, nor will crisis intervention.

- e. Providers submit the Customer Data Core (CDC) within 30 days of the first date of service in order for an authorization to be generated for billing purposes.
 - i. Five units/sessions per month for six months will then be authorized.
 - ii. Should the clinician require the additional three units per month allowed, the clinician will need to send the APS 2-page prior authorization request form to APS for approval.
- f. An update to the CDC is required every six months as part of your extensions requests and when you discharge a patient.
- g. Once a CDC is in Care Connection, then further CDC submissions will auto populate most fields, and you'll only be required to update the applicable fields, in order to save provider time.

B. LBHP Testing/Evaluation Track

1. If psychological testing is indicated, then 8 hours of testing is allowed without prior authorization per client per provider per year. Authorization will be provided when the CDC is sent in to APS. Additional units must be prior authorized by sending in the 2-page APS prior authorization request form.
2. Testing requests will be manually/clinically reviewed by APS for clinical need should more than 8 hours of testing be required.
3. **All testing for children under the age of three years must be prior authorized**
4. Psychological Testing for Clients in Residential Behavior Management Settings: All psychological testing for a client in an RBMS (group home or TFC) **must be prior authorized**. The request should clearly document that the client resides in the RBMS.
5. Psychological Testing for Clients in Inpatient Residential Treatment Center Level of Care:
Effective October 1, 2006, inpatient RTC providers are reimbursed via an all-inclusive per diem. The per diem is to cover all services required by the SoonerCare/ OEPIC member during inpatient RTC treatment. Therefore, a prior authorization will not be provided if a SoonerCare/OEPIC member requires psychological testing while at the RTC level of care, unless the treating facility is considered a community based RTC facility. Prior authorization for psychological testing can not
6. Psychological Testing for Clients in Residential Behavior Management Settings: All psychological testing for a client in an RBMS (group home or TFC) **must be prior authorized**. The request should clearly document that the client resides in the RBMS.
7. Psychological Testing in Inpatient Acute Settings:
A child in inpatient acute care can receive psychological services separate from the acute facility
8. Sending Test Results to APS: OHCA is asking that all test results be faxed

to APS for purposes of care coordination exclusively.

9. Psychological Testing in Inpatient Acute Settings:

A child in inpatient acute care can receive behavior health services separate from the acute facility.

10. Testing authorizations end twelve months from the start date of the PA.

11. APS will review for previous Prior Authorizations for testing within the current year.

12. Psychological Testing Requirements: *Appropriate*

(Must meet ALL of the following conditions)

a) Client is experiencing behavioral health difficulty in functioning, origins not clearly determined; AND

b) An evaluation has been recommended and/or requested; AND

c) Results of evaluation may directly impact current treatment strategies.

d) If client has been tested recently a different testing battery will be performed.

13. Psychological Testing: *Inappropriate*

a) Evaluation results will not directly impact current treatment; AND/OR

b) Evaluation results will be utilized for academic placement/purposes only; AND/OR

c) An equivalent psychological evaluation has been conducted by another provider(including private psychologists)within the current calendar year; AND/OR

d) Patient resides in an inpatient residential facility.

14. Psychological Testing: *Assessment Results*

(DSM-IV-TR (in ICD-09 format) Diagnosis)

a) Axis I primary diagnosis (INCLUDING V and 900 codes, Deferred, and Provisional Diagnosis).

b) All five Axes MUST be completed

15. Psychological Testing: *Submission Requirements* (must include ALL the following information)

a) What tests will be used?

b) How many hours will the testing require?

c) Who will be performing the tests, and what are their credentials?

d) What is the reason for the testing?

e) How might the evaluation results specifically affect treatment for the client?

f) How will the test results be used to benefit the client?

16. Psychological Testing: *Amount/Array of Services*

The maximum allotment is 8 hours/units per calendar year, unless a completely different set of psych tests are utilized or there is clear, clinically stated rationale for retesting using equivalent instruments.

C. Level of Care Assessment, Brief Intervention, Referral, and Case Management Process Track

1. Of particular importance to this track is the expectation that trained clinicians provide:
 - a. a level of care assessment tool, chosen by OHCA and known as the CALOCUS, for children who might otherwise enter inpatient psychiatric hospital treatment,
 - b. crisis intervention for those children and their families,
 - c. provide case management to find an appropriate resource in their communities for those children and their families, and
 - d. follow up to insure the client has made the appropriate contact with any referrals made.
 - e. The totality of these services will be required in order to bill for this.
 - f. In order for an authorization to be generated, the clinician will:
 - 1) enter into the APS Care Connection the CALOCUS assessment scores, the Customer Data Core, which includes, the CAR scores, diagnosis, clinical summary information, if the client requires a referral, and follow up information.
 - 2) The clinician will call APS to discuss the assessment results and member's needs.
 - 3) APS will determine appropriate level of care and make appropriate referral(s).
 - 4) If you are the most appropriate provider for this child, then you will then receive an authorization from APS.
 - 5) If another provider is determined the most appropriate, then APS will coordinate with the accepting provider.
 - 6) After you have contacted the accepting provider for follow-up on whether the member made their first appointment, then you'll complete your "pending authorization", by calling APS to provide this information. APS will generate your authorization.
 - g. Of note: crisis intervention services provided before, during, or after the level of care assessment will not require authorization.
 - h. The clinician may choose to use a release form for the parent or guardian to sign in order to share information with other resources in the community. A sample release form will be made available on SoonerPro or you can use a release that you currently use to cover other potential providers who may be asked to serve the client.
 - i. All LBHPs wishing to provide the level of care assessment, brief intervention, referral, and case management process must be trained

in how to use the CALOCUS, either through an OHCA state-approved trainer or other training approved by OHCA.

- j. The CALOCUS is a nationally validated tool and is in the public domain (paper form, there is an electronic version available that does cost). Individuals from a variety of settings and parts of the state have become trainers through a “training of trainers” by CALOCUS and will be available to do trainings in areas of the state in which they currently practice. A list of trainers will be made available to you. In addition, some trainers are already committed to offering training at the conferences and workshops offered by the associations representing licensed providers (OCA, OKAMFT, OPA, NASW, ODAPCA, OSASA, NAMP, etc.)
- k. If an untrained clinician sees a client who requires a CALOCUS assessment and no trained clinician is available to provide this assessment quickly, the clinician can call the APS reviewer team, provide the clinical information to the available reviewer, and that reviewer can go through the CALOCUS questions with the clinician, score the tool, and collaborate with the clinician regarding the best resource for the client.
- l. Should the level of care assessment indicate that the member can be seen in outpatient services in the community, the provider can proceed with treatment through the allowed therapies. The Customer Data Core, however, will need to be sent to APS in order for an authorization number to be generated which allows the provider to bill for all services.

Case Management:

Case management is a critical piece of the integrated assessment process. It is considered a specialized aspect of any assessment and therapeutic process. The case management component can be understood in the following sections. A child may be referred to an LBHP to provide a level of care assessment through several avenues: 1) self-referral, 2) APS, 3) an OHCA care coordinator, 4) DHS/OJA, 5) another service provider in the community, or 6) a hospital which determines that the child does not require immediate inpatient care.

- The clinician doing the assessment is expected to be familiar with the resources in the community so that the appropriate level of care can be implemented within a community based context. The clinician along with APS shall determine the appropriate services for the client. This collaboration is especially important if the clinician is not familiar with appropriate resources that might exist in a nearby community. Once a resource is determined, The LBHP or psychologist is responsible for arranging for those services and doing a follow up to make sure the client has connected with that service.

- **If the client does not show up for his/her referral appointment, additional follow up for that client is no longer the responsibility of the clinician. APS will then complete the authorization for the level of care assessment and will take over the tracking of the client until follow up can be established.**
- **Should the CALOCUS indicate that inpatient treatment is the appropriate level of care for the child, the LBHP will need to contact APS and a coordinated effort by the APS reviewer team and the clinician will result in a decision regarding which inpatient level of care might be appropriate and any other pertinent information that would be helpful for the inpatient provider.**

Hospitalization and Therapeutic Foster Care

- **Hospital process: Should a child and guardian show up at the hospital for an assessment, the hospital will do their assessment.**
- **Should a hospital level of care not be deemed as necessary, the hospital will call APS to get a referral in the member's community for further evaluation and treatment.**
- **Should there be an automatic stepdown from a higher level of care to a lower level, the hospital will call APS to get a referral in the member's community for further evaluation and treatment.**
- **Therapeutic Foster Care has its own process and is handled by the Department of Human Services. If the child is in the custody of DHS or OJA, the custodial worker will take care of that child. If, however, the child has a case worker who is part of a prevention case, the clinician can do the CALOCUS and inform the case worker of the results, and the DHS case worker will do the case management of the case.**
- **Therapy Services for Clients in a Residential Behavior Management Settings (RBMS): All therapy services for patients who are in an RBMS (defined as a group home or a Therapeutic Foster Care placement) must be prior authorized. The request for services must include the treatment plan from the group home or TFC and must clearly document why additional services beyond what the RBMS can provide are required. Additionally, documentation must indicate how the additional services**

Authorization Requirements

The start date for prior authorization period begins the day the request is received. Requests cannot be back dated per OHCA guidelines. However, Diagnostic Interviews, Assessments for Level of Care, and Crisis Intervention for the purpose of stabilization and hospital diversion do not require prior authorization. Starting on July 1, 2010, after these services are provided, a Client Data Core must be

received by APS within 30 days of the first date of service, at which time an initial authorization will be provided for five units per month for 6 months. If the additional 3 sessions for the month are needed, they can be requested through the prior authorization process and for these the authorization begins the day the request is received.

Requests cannot be back dated per OHCA guidelines. However, Diagnostic Interviews, Assessments for Level of Care, and Crisis Intervention for the purpose of stabilization and hospital diversion do not require prior authorization. Starting on July 1, 2010, after these services are provided, a Customer Data Core must be received by APS within 30 days of the first date of service, at which time an initial authorization will be provided for five units per month for 6 months. If the additional 3 sessions for the month are needed, The start date for prior authorization period begins the day the request is received. they can be requested through the prior authorization process and for these the authorization begins the day the request is received.

Submitting Requests for Additional Units

Submit the LBHP Request for Prior Authorization via CareConnection® along with any additional information required. The request must include:

- The provider's name, provider number, fax and phone number.
- The client's full name, Recipient ID (SoonerCare) number, social security number, date of birth, age, sex, and placement if applicable.
- DSM-IV-TR (in ICD-09 format) diagnosis (including rule-out and provisional diagnoses).
- All five Axes must be completed
- Clinical behavioral health justification for additional testing and/or therapy.
- List of the testing instruments to be used.
- How the evaluation results may impact current treatment.
- Results of previous testing (most recent if known).
- The total number of requested the total number of requested additional units for psychological testing and/or units of additional counseling.

Recipient Eligibility

APS CareConnection® verifies member eligibility against the Medicaid Management Information System (MMIS) eligibility file. If the eligibility file indicates that the member is currently not eligible, providers may submit a "Courtesy Review" request and APS will complete the review based on the information submitted. The review will remain in "Courtesy Review" status until benefits have been determined, at which time it is the provider's responsibility to

notify APS by fax. Once APS has verified the eligibility, an authorization number will be assigned.

A PA number will not be assigned when the recipient is currently not eligible or whose Health Program does not include behavioral health benefits.

The PA will date back to when the request was originally received by APS, subject to the eligibility dates contained in the MMIS system. No services can be prior authorized prior to the eligibility date.

Providers *may* check the OHCA Recipient Eligibility Verification System (REVS) at 1-800-522-0310. For instructions on using REVS, call 1-800-767-3949. Providers can also check eligibility through Medicaid on the Web secure website with their 8-digit pin number, or call the OHCA Provider Helpline at 1-800-522-0114 for assistance.

Types of Responses

Clinical Correction Notice:

An APS Reviewer will assess each request for overall completeness of the required elements and all necessary supporting documentation. If the request is incomplete, or the reviewer needs additional information to determine the medical necessity of the requested services, the request will be returned for correction with a Note to Provider in the Services Requested section of the request stating what additional information is needed to process the request. The facility has ten (10) calendar days from the date of the Note to Provider to respond. If there is no response within the required 10 days, the request will be technically denied.

Note: All requests with a Clinical Correction Notice generated will be dated from the date the original request was received if the provider responds within the 10 calendar days.

Provider Response to a Clinical Correction:

When a provider responds to an APS Clinical Correction all requested information must be addressed to avoid a Technical Denial.

Approval:

Issued when all required documentation is present, medical necessity is evident; the client is eligible in MMIS and, if testing has been requested, the client has had no equivalent previous testing within the past year.

Modification:

Based on the information provided a reviewer may modify a provider's request by reducing the total units requested for an authorization period. Modifications are made based on the most appropriate array and frequency of services for each request, utilizing the guidelines established in the Outpatient Manual and Part 21 Administrative Code.

The type and amount of testing within the last year will also be considered when determining medical necessity.

Denial:

Issued when there has been (1) no response to the Clinical Correction within the required 10 calendar days, (2) guidelines for prior authorization are not met, or (3) when the requested testing/therapy does not meet Medical Necessity Criteria. Cases may be referred to an APS Clinical Consultant for final review as needed.

Courtesy Review:

If the MMIS file shows the member as not currently eligible, the request will be reviewed based on the information provided in the request and a Courtesy Review decision will be issued. A PA number will not be assigned when the member is not currently eligible. The PA will date back to when the request was received by APS, subject to the eligibility dates contained in the MMIS system (e.g., PA request received 02/14/05 and eligibility determined from 03/01/05, no services will be prior authorized before 03/01/05).

It is the provider's responsibility to notify APS when a member becomes eligible for SoonerCare/OEPIC.

Note: It is the provider's responsibility to notify APS when a client becomes eligible for SoonerCare/OEPIC when a Courtesy Review decision has been issued.

Correction Request:

A Correction Request must be submitted when a provider finds any errors or discrepancies on a PA (i.e., typographical error, wrong provider number, wrong service code, wrong Recipient ID number, etc.) regardless of who made the error. APS processes these requests within 5 (five) business days.

Status Request:

If a response to a request is not received within 5 (five) business days and after verifying the Status on CareConnection®, a Status Request form may be submitted.

This request documents your submitted request 5 (five) business days prior and reserves the original start date if the request is not on file at APS.

Provider Response to Status Requests:

- 1) If the LBHP receives a response reflecting that the original request for services or the response to the Clinical Correction was not received at APS, then the LBHP has ten business days (from the date the Status Request Response was faxed from APS) to re-submit the request/response. If the documentation is not re-submitted within the ten business days, the original submit date (as supported by the Status Request) will not be honored. If the documentation is received after the ten business days allowed (as supported by the submitted information), the start date of services assigned is the date the response is received at APS.**

- 2) If the LBHP receives a response indicating the request for service has been processed and a Clinical Correction was issued requesting additional documentation or information, the psychologist has ten calendar days (from the date the Status Request Response was faxed from APS) to submit the required Clinical Correction. If the Clinical Correction response is not submitted within the allowed ten calendar days, a Technical Denial decision will be issued (i.e. due to no response within the time frame allowed).**

Codes, Forms, Requests for Services can be found at the end of this manual.

Codes for Insure Oklahoma and LBHP Contractors. July 1, 2010

Service Name	CPTCodes (Per Unit)
Psychiatric Diagnostic Interview Examination	90801
CALOCUS assessment, brief intervention, referral and follow-up**	H0031
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, face-to-face with the patient. -or-	90804 (20-30 min.)
	90806 (45-50 min.)
	90808 (75-80 min.)
Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient.	90810 (20-30 min.)
	90812 (45-50 min.)
	90814 (75-80 min.)
Group Psychotherapy *	90853 (60 min.)
Family Psychotherapy without patient present *	90846 (60 min.)
Family Psychotherapy with patient present *	90847 (60 min.)
Hypnotherapy	90880
Psychological Testing face-to-face with the patient, time interpreting test results and preparation of the report	96101 (60 min.)
Psychological Testing per hour of technician time- w/ qhcp (qualified health care professional; limited to certified psychometrist) interpretation and report, admin. by a tech (face to face only)	96102 (60 min.)
Psychological Testing by a computer w/ qhcp interpretation and report (<i>flat rate, one per recipient per calendar year without PA</i>)	96103 (flat rate, one per recipient per calendar year w/o PA)
Neuropsychological Testing per hour	96118 (60 min.)
Neuropsychological Testing per hour of Technician time - w/qhcp interpretation and report, administered by a Technician (face to face only)	96119 (60 min.)
Neuropsychological Testing by a computer w/qhcp interpretation and report (<i>flat rate, one per recipient per calendar year without PA</i>)	96120 (flat rate, one per recipient per calendar year w/o PA)
Interpretation of Testing Results (untimed event code)	90887
Developmental testing	96111

***Note: the sessions for family therapy and group therapy must continue for at least 45 minutes.**

***Note: only those officially trained in the CALOCUS can bill for this level of assessment.**

APS HealthCare, Inc.

4545 N. Lincoln Blvd., Suite 103 Oklahoma City, OK 73105
Phone 1-800-762-1560 Fax 1-800-762-1639



PLEASE REFER TO PAGE 7 FOR MORE INFORMATION IF CHILD IS IN
INPATIENT RTC TREATMENT

LBHP PRIOR AUTHORIZATION REQUEST FORM

Type of Request: ___ Authorization ___ Status ___ Correction

Provider Name: _____ **Provider ID#:** _____

Provider Phone #: _____ **Provider Fax #:** _____

Patient Name: _____ **Medicaid #:** _____

Social Security #: _____ **DOB:** _____ **Age:** _____ **Sex:** _____

If a child, do they reside in a TFC or Group Home setting? ___ Yes ___ No

DSM-IV-TR (in ICD-09 format) Diagnoses (All five axes *must* be completed)

Principal Axis I code: _____ Title: _____

Secondary Axis I Code: _____ Title: _____

Axis II Code: _____ Title: _____

Axis III: _____

Axis IV: _____

Axis V: _____ Current _____ Highest Level in the Past Year

Medications/ Dosages: (optional):

Request Clinical Rationale (include (a) the reason for testing, (b) how the results will be used to affect treatment *and* (c) how the results will benefit the client):

SERVICES AND UNITS REQUESTED

Psychological Testing

Psychotherapy

APS HealthCare, Inc.

4545 N. Lincoln Blvd., Suite 103 Oklahoma City, OK 73105
Phone 1-800-762-1560 Fax 1-800-762-1639

STATUS REQUEST

Provider Name: _____ **Provider #:** _____

Provider Phone #: _____ **Provider Fax #:** _____

Patient Name: _____ **Medicaid #:** _____

REQUESTING STATUS ON: _____ **PA Request** _____ **Important Notice Response**

Original Request was submitted on: _____

APS Clerical Staff Response to the Status Request:

_____ **Please Resubmit PA Request**

_____ **Request is in process at APS**

_____ **PA number is:** _____

Confidentiality

The documents included in this transaction may contain confidential information from APS HealthCare, Inc. The information is intended for the use of the person or entity name on this transmittal sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this transmission is prohibited. If you have received this transmission in error, please immediately telephone APS so that we can arrange for the disposition of the transmitted documents

