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Notes on this Manual

 This symbol indicates a helpful fact or activity.

 This symbol indicates an area of concern or caution.

Outpatient Behavioral Health Rehabilitation Services

OVERVIEW

In an effort to promote effective and efficient health care for Oklahoma fee-for-service SoonerCare/OEPIC recipients receiving behavioral health rehabilitative services, the Oklahoma Health Care Authority (OHCA) has contracted with the APS Healthcare, Inc. (APS) to conduct prior authorization (PA) of Outpatient Behavioral Health Rehabilitative Services. SoonerCare recipients enrolled in the SoonerCare Choice Primary Care Physician Case Manager (PCPCM) program, traditional fee-for-service and Insure Oklahoma (Oklahoma Employee/Employer Partnership for Insurance Coverage-Individual Plan (O-EPIC (IP))) must be prior authorized for these services by APS. The PCPCM does not have responsibility for referring, approving or gatekeeping these or any other behavioral health services.

OPERATIONS

APS office hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except national holidays. Requests must be submitted on APS CareConnection® available through www.SoonerPRO.com (Click on the APS CareConnection® link) or visit <https://okcareconnection.apshealthcare.com>. . All new requests that have complete documentation will be reviewed and responded to via APS CareConnection® or OHCA's Medicaid on the Web/SoonerCare Secured Site within 5 (five) business days. Incomplete requests will be returned to the provider for the needed corrections.

Oklahoma SoonerCare QIO Website

Forms and Manuals are located on the website.

www.SoonerPRO.com

The APS Help Desk can be reached at SoonerCareHelpDesk@apshealthcare.com.

✘ Please! Do not send treatment plans or any other Protected Health Information by e-mail or through the SoonerPro website.

Providers can access the APS web page, <http://www.apshealthcare.com>, for more information about APS Healthcare, Inc. Providers may also call APS at 1-800-762-1560 for assistance in completing the request forms, or any other questions regarding the PA process.

GUIDELINES FOR PSYCHOLOGISTS REQUEST FOR PRIOR AUTHORIZATION

Services provided by private psychologists are for clients under the age of 21. Each psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA), and follow the guidelines set out by Oklahoma Administrative Code (OAC) 317:30-5-275–278.1.

Types of Requests

Therapy

- A) Psychiatric Diagnostic Interview Exam/Assessment
- B) Individual psychotherapy—one-to-one treatment with the client.
- B) Group Therapy—must consist of two or more unrelated patients over the age of 4 years. Maximum group size is six patients. No more than one group session is allowed per member per day.
- C) Family Therapy—face-to-face interaction with the family/patient.
- D) Multi Family Groups (no more than 8 family units per group)

Each SoonerCare member may receive a combined total of five units (hours) per month of any combination of the above therapies after submission of the Customer Data Core (CDC) to APS. Beyond these 5 units, therapy services may be approved for 3 additional units per month after submission of a Psychologist Prior Authorization Request via APS CareConnection®.

Only one Diagnostic Interview/Assessment for Level of Care per year per provider is allowed, unless there has been a break in services for six months.

No more than eight hours per day may be billed in any given day unless prior authorized for an additional four hours per day (12 hours) due to extenuating circumstances.

Beginning July 1, 2010, Health and Behavior codes may be used only for chronically or terminally ill children.

Only Children's services (under 21) may be performed by Psychologists under your SoonerCare Provider contract.

More than 5 hours of treatment/testing per month per recipient requires a prior authorization (Contact APS HealthCare, Inc. at 1-800-762-1560)

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 clearly document why additional services beyond what the RBMS can provide are required. Additionally, documentation must indicate how the additional services are differentiated from the therapy provided by the RBMS to document that services are not being duplicated.

Psychological Testing

Eight hours of psychological testing are allowed per client per provider per year.. If more than eight units are required, a Psychologist Prior Authorization Request must be submitted to APS via APS CareConnection®. The reimbursement rate for psychological testing includes the time for writing and analyzing test results and providing feedback to the member on the testing results.

All testing for children under the age of three years **must be prior authorized**.

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.

Psychological Testing for Clients in Inpatient Residential Treatment Center (RTC) 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 be provided until the member is discharged from inpatient RTC treatment. A technical denial will be issued if prior authorization for testing is requested while a member is under inpatient RTC treatment. If testing is required while the member is at the RTC level of care, the psychologist should discuss reimbursement with the treating hospital.

Psychological Testing in Inpatient Acute Settings:

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

Sending Test Results to APS:

OHCA is requesting that all test results be faxed to APS where they will be used only for care coordination purposes.

Clinical Psychology Interns:

Psychology interns and post-doctoral fellows who are in APA accredited training programs may provide compensable psychological services under their supervisor's OHCA contract number. Refer to OHCA Behavioral Health Rules at www.okhca.org.

Clinical Psychologists under Supervision for Licensure:

Psychologists under supervision for Licensure must provide all services under the Supervisor's OHCA contract and follow all rules pursuant to that contract, including the prior authorization process as described.

Procedures not covered:

- Sensitivity training
- Encounter groups
- Workshops
- Sexual Competency Training
- Marathons or Retreats for mental disorders
- Strictly educational training
- Psychotherapy to persons under three years of age unless specifically approved through the prior authorization process

Authorization Dates

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 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, they can be requested through the prior authorization process and for these the authorization begins the day the request is received.

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

Submitting Requests for Additional Units

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

- The psychologist'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 additional units for psychological testing and/or the total number of requested 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.

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

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. This form can be located at www.SoonerPro.com, Resources tab, Downloadable Forms link on the left side navigation bar, Outpatient Forms folder.

Provider Response to Status Requests:

- 1) If the psychologist receives a response reflecting that the original request for services or the response to the Clinical Correction was not received at APS, then the psychologist 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 psychologist 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).

Medical Necessity Criteria for Psychological Testing

Psychological Testing Requirements

A. Evaluation

1. 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.

2. 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.

B. Assessment Results

1. 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

C. Submission Requirements (must include ALL of the following information)

1. What tests will be used?
2. How many hours will the testing require?
3. Who will be performing the tests, and what are their credentials?
4. What is the reason for the testing?
5. How might the evaluation results specifically affect treatment for the client?
6. How will the test results be used to benefit the client?

Regimen

A. 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.

General Prior Authorization Information

Turnaround Time from APS:

Psychologist requests are processed within 5 (five) business days. The psychologist may view the authorization on Medicaid on the Web secure website or on APS CareConnection®.

Authorization Period

The start date for the authorization period begins the day the request is received. Requests **cannot** be back dated per OHCA guidelines.

- Testing authorizations end twelve months from the start date of the PA.
- Therapy authorizations end after 30 sessions or six months from the start date of the PA, which ever comes first.

Authorization Numbers

APS will assign a member and provider site-specific PA number to each approved PA request. This member and provider site-specific PA number will be submitted to MMIS on a batch basis each night. Each PA number will be associated with from/through dates by service and month to indicate the length of time and the amount of service being authorized by APS. Once the facility has received a prior authorization number, the facility must utilize the EDS HCA-12A (formerly the MS-MA-5) form when filing a claim for the stated services covered. (Submit the PA number on the HCFA-1500, now CMS-1500 form, in Item 23, or on the electronic 837 format.) Facilities must follow the OHCA Provider Manual for submitting claims requiring PA numbers, as specific procedure codes are to be utilized when filing claims for Outpatient Behavioral Health Rehabilitative Services.

Billing Issues

Any billing questions should be directed to the OHCA Provider Helpline at 1 (800) 522-0114.

Educational Opportunities

APS will announce training sessions on www.SoonerPro.com website. Providers are encouraged to recommend training topics to APS through SoonerPro. APS will also work with providers to develop specific training programs and conduct on-site training sessions at the request of providers. APS will work with providers to identify locations and training topics. All training materials and requests must be approved by OHCA in advance.

- Please refer to the Provider Manual for more information on requesting services.
- Find rates at Medicaid on the Web <https://www.ohcaprovider.com/Oklahoma/Security/logon.shtml>