
Provider Questions 2009

From the

2nd Annual Collaborative Behavioral Health Provider Training
(OHCA, ODMHSAS and APS)

June 11-12, 2009

Volume II

1. **Question:** When are we going to use DSM-IV codes?

Answer: MMIS system is required to use only HIPAA compliant systems codes, therefore, we will continue to use the ICD-9 (soon to be 10) coding system which includes the majority of DSM-IV codes.

2. **Question:** Since many people are computer illiterate and afraid of stigma, how can agency therapists be reimbursed for enrolling clients in SoonerCare and/or other state services?

Answer: There is no reimbursement for agency staff to enroll SoonerCare clients.

3. **Question:** Is there a specific list of OHCA codes and modifiers available?

Answer: The rates and codes sheet is available on the SoonerPro Web site at www.soonerpro.com

4. **Question:** Why does the treatment plan have to be done as part of the prior authorization?

Answer: OHCA has contracted with APS to complete a medical necessity review and looking at the treatment plan is part of the review process.

5. **Question:** Is Medicaid planning to pay for:
- Competency to stand trial evaluations
 - Outreach to the community

- c. SOC family team meetings
- d. Referral
- e. Telephone emergency services
- f. Supportive counseling
- g. Will ODMHSAS and OHCA billable services be compatible?

Answer: No, these are not Medicaid compensable services. These ODMHSAS only services will continue to be paid through ODMHSAS state/grant dollars.

6. **Question:** Can we get the PowerPoint presentations to download or view from the presenters that focused on outpatient documentation?

Answer: On June 17, 2009, all PowerPoint presentations and outpatient handouts from the 2nd Annual Collaborative Behavioral Health Provider Training 2009 were posted on the SoonerPro Web site at www.soonerpro.com. You will find them under the "Provider Trainings" tab.

7. **Question:** Can the time-out period on APS CareConnection® be increased before it times us out?

Answer: The time-out period was set in 2006 to the longest period of time possible (45 minutes). The time-out function is associated with communication with the data base for APS CareConnection® and not how much information is being entered by the provider. Communication with the data base includes the following types of actions: using the "Save" function; "Verifying Eligibility"; using the "Add" function for "Services Requested"; "the "Add" function on the service plan; and the "Add" function on the "Medications" and "Substances Used" sections on the Client Assessment Record (CAR).

Be sure to save the prior authorization request frequently. Do not try to type the entire request without saving it as you go along or you will lose everything you have entered if the time-out occurs.

8. **Question:** If an inpatient provider is having trouble locating or accessing aftercare services, what should we do?

Answer: Contact either APS Care Improvement Planners at 888.571.0252, ext. 4653 or OHCA Care Managers at 405.522.7475 for information and resources.

9. **Question:** What is the CMS regulation for medication consents?

Answer: Consents are required for psychotropic medications. The consent needs to indicate the information provided to the patient, including reason for medication, other possible treatments, including no medication, possible side effects and interactions.

10. **Question:** If the content of the documentation of active treatment does not meet requirements, is this a partial recoupment issue for SFY 2010?

Answer: This issue is under review by the OHCA legal division.

11. **Question:** Is there a CMS regulation disallowing PRN sleep medications?

Answer: No. CMS regulations disallow PRN psychotropic medications, except when they are prescribed to alleviate symptoms, such as anxiety or psychosis. Sleep medications are not cited as psychotropic medications.

12. **Question:** Can felons qualify for Insure Oklahoma coverage?

Answer: Yes, they can qualify. They must be working for an employer with 99 or fewer employees and meet the income guideline.

13. **Question:** How does this new system (No Wrong Door) take care of re-certification for eligibility for clients who are unable to go to their local DHS offices or have access to computer systems?

Answer: Members will be allowed to call-in to get re-certified. They could also request a paper application be mailed to them.

14. **Question:** While on-line applying for SoonerCare, will we be able to scan and attach needed documentation such as a positive pregnancy test from the Department of Health?

Answer: For now the documentation should be mailed in with the ATN (application tracking number) provided from the online application. Based

on how OHCA builds relationships with our community partners we can find new ways to store this type of information. Scanning and attaching the information are possibilities.

15. **Question:** Who will have access to all information generated by the CDC?
- a. How will this information be used?
 - b. Who will insure that the consumer's information is protected?

Answer: OHCA, ODMHSAS, and the providers will have access (to their own data and to the overall aggregate data, but will not be able to access another provider's data). The database is protected following HIPAA standards. Only these entities will have access to this data.

16. **Question:** Will the CDC also provide data for each agency so that we can compare our agency's performance to the performance of all CDCs collected by SoonerCare?

Answer: Yes, you can view these types of reports by going to the ODMHSAS website. Here is a link to the outcome reports:
<http://www.odmhsas.org/eda/reports/index.htm>

17. **Question:** (Level IV) regarding payment.....Current OHCA rules allow 6 hours of group rehab/PSR per day for 16 days per month. Our program runs M-T-W-Th for 5.5 hours/day. In the month of June, we have 18 days. Since 04/01/09 changes, we planned on billing Medicaid for the first 16 days and DMH (a pay source after all others were exhausted) for the last 2 days. With the forthcoming changes on 10/01/09, can DMH dollars be used for the last 2 days since the service is a Medicaid reimbursable service?

Answer: There is no limit per month. There is only a day limit on BHRS services. The daily limits for Group rehab for adults are 24 units, and for children it is 16 units. Individual rehab is 6 units per day.

18. **Question:** Will Case Management continue to be a separate contract? If yes, can an agency apply on-line and if so, when?

Answer: As of 4/1/09, prior authorizations for Case Management are now on the agency's outpatient BH agency site number. Case Management provider numbers are only used now to bill out old (prior to 4/1/09) PAs and for CM ONLY provider sites. We are phasing out all of the CM provider numbers over time as part of the BH Collaborative's goal of streamlining administration requirements for providers.

19. **Question:** Does the consumer have to apply for SoonerCare prior to being assessed?

Answer: For Medicaid compensation, the eligibility is going to be retroactive back to the date of application. From a reimbursement standpoint, if you see the client before they apply, if they meet the eligibility requirements, this service will not be reimbursed because it is outside the effective date which is typically the date that the application was made.

20. **Question:** My current clients have ICIS numbers. When this change happens, that will be a "Medicaid" kind of number?
- a. How do we access their # to input activities, therapies, and treatment plan?
 - b. When will clinicians have these numbers?
 - c. When I write a progress note, does it automatically go to payee?
Or, do I copy/print and put in paper chart?

Answer: All clients will have a Medicaid type number in the MMIS system. You will access them through your provider secured website, REVS, etc. as you do for Medicaid clients now. As of 10/1/09 you'll have access to all of this. Your progress notes will go into the client's medical record as usual.

We will let DMHSAS providers know which clients have Medicaid numbers through a certain date (maybe 6/30/2009). After that, once a month for clients admitted during that time period, we will provide DMHSAS providers with the Medicaid numbers.

21. **Question:** Re auto-authorization - Can the start date be changed?

Answer: If your request fails auto auth because the start date is < date submitted, you can change the date but it takes some work.

1. Go to “Services Requested” and delete the service.
2. Go up to the “Administrative” section and change the request start date.
3. Re-verify consumer eligibility (eligibility is linked to the start date).
4. Re-add the service in the “Services Requested” section.

When you delete the service, you will see all the following sections (CAR, service plan, etc) disappear. DO NOT PANIC! The data still exist even though they are not displayed. When you re-add the service these sections will also re-display.

Save and submit.

How soon can CDC’s be entered for existing PAs?

APS intends to create a partial CDC for existing consumers in CareConnection. If your service is already authorized, the next time you attempt to modify (extension, etc) you will be prompted to complete the CDC.

22. **Question:** Will XIX and ODMHSAS have one pot of money or will client have 2 pots with accurate level dollars in each pot?

Answer: Each separate agency will maintain their separate funding sources. This will not change.

23. **Question:** Is there a separate authorization needed for ODMHSAS (for travel, etc.)? I thought there was one (1) request and the service/billing would go to the appropriate pot of money.

Answer: In late August, providers will be given detailed information regarding the 10/1/09 changes. This will include the listing of all of the prior auth procedure code groupings. The DMHSAS only procedure code groups may be authorized at the same time or separately than the Medicaid/ODMHSAS authorizations if they are a separate program.

24. **Question:** How are we to submit eligibility prior to “No Wrong Door” database?

Answer: Once the NWD system is ready, then providers will go on the Web to enter applications for their consumers who do not have Medicaid eligibility.