TO ALL OUR PRIVATE PSYCHOLOGISTS AND LICENSED BEHAVIORAL HEALTH PROVIDERS, THIS DOCUMENT IS A STEP BY STEP GUIDE FOR THE CHANGES STARTING JULY 1, 2010. IT COVERS NEW RULES, AUTHORIZATIONS, AND CLAIMS INFORMATION.

We are aware that the changes in our systems came at a time when we were trying to handle many changes at once, as well as with damaged equipment and the need to move our offices to a new site because of the flooding that occurred at Lincoln Plaza. As a result, in July of 2010 we looked at the most frequently asked questions and concerns and provided the following guide for you. We have now updated this document with additional information to assist in problems we were unaware of at the writing of this first document. Just an FYI: there is always a grace period during times of serious transitions. However, our grace period ended August 31st 2010.

Rules:

On July 1, 2010, the following changes were implemented by the Oklahoma Health Care Authority:

- Private Providers – psychologists and licensed behavioral health providers are all allowed to have direct contracts with OHCA
- The benefits for the private providers are limited to 8 hours/sessions for the therapies per client per month (individual, group, family, multifamily).
- Testing per provider per client is limited to 8 hours per year with additional units reviewed for medical necessity.
- Assessments and crisis intervention codes can be billed without authorization. H & B codes (working with terminally and chronically ill children) have been opened for psychologists only. They also can be billed without authorization.
- A new level of care assessment, the CALOCUS, has been added as a service in order to insure the least restrictive level of care for Medicaid children. Only those trained by an OHCA trainer may provide this level of care assessment. Trainers have been trained in all parts of the state to be available to groups that desire this training. This level of care assessment does need an authorization in order to be available for billing.
- 12 hours of therapy can be billed for one day.

Authorizations

- The authorization body that provides reviews for authorization is APSHealthCare. Their provider site can be found at www.SoonerPro.com. This site has everything on it that you need to know – rules, rates, processes, manuals, the CDC, etc. Your first job, however, is to go to the home page and on the upper right hand side of the page enter your name and email address. You will then get frequent emails about changes in rules and processes.

- Prior to July 1, 2010, psychologists did not have to authorize their services as long as they did not do more than 5 units/sessions per month. Psychologists, therefore, were not familiar with the APS SoonerPro website. The new process for all private providers is that after you have provided an assessment and/or crisis intervention, you must fill out a Customer Data Core (CDC) online, submit it, then fill out and fax a document called the Notification of CDC submission so that the system will know the CDC is there. The CDC is a product of national initiatives to gather data on clients using behavioral health services in Oklahoma, as well as in the nation.
- The CDC is on the CARE CONNECTION site on SoonerPro. You will be prompted to get a secure ID and Password for this site and it may take a day or two before you receive them. Once you get into the Care Connection site, you will find the CDC SEARCH button. It will take you to the CDC Transaction type 23. Fill this out on line and submit it online.
  You will then fill out a form called the Notification of CDC Submission. It is found on the SonnerPro Website: click on "Resources", then "Outpatient Clinical Forms", and it is the last form on the list. Fill it out and fax it to APS right after the CDC submission to APS (fax number is on the form). NOTE: check the box on the form for testing and/or therapy. Both have a PG (Procedure Code) grouping – either PG 029 and/or PG 030. You may check both if you are doing testing and therapy. If you do not want to fax the form you can do a request for services on CareConnection and send it electronically. The request will then notify the system that the CDC 23 is in the system and ready for processing.
- On the Notification of Submission Form you must document the requested start date (APS will default to the date the fax was submitted if you don't put in the start date requested. You also must check the box for the PG code they are requesting on the form. You may do this through the request form mentioned in the item above. If the submission form is not filled out in full and APS does an authorization that is not correct, you will need to do an Outpatient Correction Request to APS in order for the authorization to be changed.
- After submitting the CDC and the Notification page, the system will then create an authorization number for you and it will automatically go into OHCA's database (MMIS)
- If you have made a mistake on your CDC and need for it to be changed, you will need to fill in a correction request and submit it. You will not be able to submit another CDC 23. There are certain fields in the CDC which allow changes and others that do not. Most of you are concerned about your provider numbers right now, and those fields will not allow a correction. If you are having any problems at all that you cannot resolve, you need to email David Melton at ODMHSAS dmelton@odmhsas.org. Be sure to give him your phone number, and he, or someone working with him, will call and assist you.
- You can check your authorization numbers by clicking the "Download Notification" on the blue navigation bar on CareConnection. It may take 10 working days at this point to show up because of the volume coming in. Once we get past processing so many CDCs, the turnaround will only be a few days.

- On the CDC there is a section called the Client Assessment Record (CAR). It is a simple assessment with 9 domains. You can find a description of the CAR by going to SoonerPro, Resources, then Manuals. Click on Outpatient, then on Outpatient Provider Manual, and you will find the instructions on page 36. It will describe the domains and give you a scoring range for each domain.
- When these tasks are completed, you will be automatically authorized for five units/sessions a month for therapies for 6 months. For testing, you will be authorized for 8 hours of testing for 12 months per client. To get authorized for testing will have 30 days from the first service date after July 1st to complete the CDC and Notification form. You will then have an authorization in the system so that you can submit your claim for payment. Be sure your CDC and Notification have been processed and you have an authorization number (as described above) before you bill.
- Reasons why a CDC/23 Authorization will go "on hold": 1) if the provider name and ID do not match up on the information on the first page of the CDC or on the request form on Care Connection; 2) If the CDC 23 was not completed in its entirety; 3) If the client name does not match the OHCA records; 4) If the client was discharged before the authorization request/record was entered and approved by APS.
- Should you still be treating the client after 6 months, you will need to fill in a CDC transaction type 42 as an update. You will then need to send in a Notification of CDC Submission, in order to be authorized again for 5 units a month for 6 months. You will not use any CDC transaction types other than a 23, a 42, and an appropriate discharge type (types 60-72). For those of you who just do testing you will file a discharge #60 when you complete your testing, but you have to allow time for the CDC23 to enter an authorization before you file the CDC60. You cannot file both on the same day. An important reminder to providers, you need to make sure that your PA status in CareConnection is on **'Final-Approved'** status before entering a discharge. If your PA is on hold, or has not been entered yet, your PA will not be able to go through, resulting in an arduous work-around process.
- Should you wish to have the three more units per month that is allowed under the new rules, you will go to the CareConnection site, click on the blue navigation bar on the left and click "prior authorization requests", then go to "Private LBHP request" and complete it. One of the APS reviewers will review the request. If you are asking for more than the 8 units of testing in the new request, the Medical Director at APS will review for appropriateness.
- Note: the system uses an ICD-9 code for a prior authorization (e.g., the new request for additional units). You may put in a DSM-IV-TR diagnosis and the system is programmed to put in the closest ICD-9 code.

Claims/Codes/Provider IDs

- You can bill a 90801, crisis intervention, and, for psychologists, the H & B codes, without any authorization, i.e., without a CDC 23 or Notification form.

- You cannot bill a 90887 and a 96101 on the same day. You can do a family feedback and bill it under the 96101 or the 90887. However the 90887 is considered part of the 8 hours available for testing, so if you bill 8 hours of a 96101, and then a 90887 (even on a different day) the 90887 will be denied. It is up to you as to how you want to bill the eight hours. If you plan to meet with the family after an 8 hour 96101, be sure to mark your Notification of Submission form as both testing and therapy and then do a family therapy without the patient code.
- There is an updated list of CPT codes for psychologists and another list for LBHPs. There is also a list of codes that are slightly different for Insure Oklahoma. These lists will be posted on the SoonerPro site as soon as they have been formally approved.
- If you are a private practitioner, your provider type is 53. As a "53" you only bill the CPT codes except for special HCVC ("H" codes) for the CALOCUS assessment and Crisis Intervention. Using the "H" codes for anything else will cause a denial as they are only codes used by agencies.
- A unit/session for a private provider is timed based on the code descriptions that will accompany your rate form on SoonerPro.
- You must put your Individual Provider ID in the "Agency" section of the CDC. You put your actual individual name in the "Agency" slot; then in the "Agency Site" slot you will put your Individual Provider ID (your OHCA contract number). You will also put your Individual Provider ID on the Notification of Submission form. Your authorization will be in your individual provider number. When you send in a claim, if you do not have a group OHCA contract number, you will put your Individual Provider ID in both the "rendering" and the "payee" sections. If you have a group number you still put your individual provider number as the "rendering provider" and your group number in the "Payee" slot. The authorization number and the rendering provider must always match up for both the authorization and the claim. But your "Payee" on your claim can be your group number.
- Private providers splitting units – Each sends in a CDC23 and a Request Form explaining the split in the units and giving clinical info to support it. The maximum number of units for the same Medicaid number is still 8 so you will explain how many of those 8 will be used by each provider. The request form is found in Care Connection, go to New Request, use Private LBHP as the review type, and Private LBHP as the level. All fields with a red asterisk to the left are required fields and must be completely filled out. The interpretive summary needs to include the current, critical clinical information in behaviorally descriptive terms to support why the member needs services from you. Once this is completed save the request and submit, in fact, you will want to save several times thru-out to avoid losing any previously entered information..
- Private providers asking for all 8 sessions – send in CDC23 plus the same request form as described above, requesting both the PG030 and the PG040. If you see the member/family for more than one hour each time, in the "current" section you will need to put a note advising the reviewer to move one unit of the PG040 to the PG030 because you see the member for more than one hour each time. You need

to do this because the PG groups are set up differently and you will want to avoid billing issues when you file your claims.

- If you are Under Supervision for Licensure, you will not have an individual OHCA contract number. You will bill under your supervisor's Provider ID number. But for the codes you are billing, you will add an "HL" modifier, so that your billing can be distinguished from your supervisor's billing on the claim.
- If you have a problem with a claim, your first line of inquiry will be with HP (Hewlett Packard) our claims partner. Call 800-522-0114, and go to option 1.
- If the HP claims section cannot give you enough information, you will be transferred to Provider Relations for more detailed policy information or for additional claims inquiries.