Description:
This class will review the SoonerCare outpatient behavioral health program. It will include an overview of commonly asked questions by behavioral health provider type.

Target Audience:
Contracted outpatient behavioral health providers, i.e. outpatient agencies, behavioral health groups, and privately contracted LBHP’s.
Disclaimer

This presentation was compiled by Oklahoma Health Care Authority behavioral health unit.

- The information contained within this presentation is intended as reference only and is current as of April 30, 2018. Content is subject to change.
Agenda

• Oklahoma behavioral health program overview.
• SoonerCare eligible members.
• SoonerCare behavioral health provider types.
• Populations served by behavioral health provider type.
• Covered services by behavioral health provider type.
• Frequently asked questions by behavioral health provider type.
• Prior authorization status and claim submission.
• Contact information.
Oklahoma Behavioral Health Program

• Goal #1: To better understand the partnership between OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services.

• Goal #2: To better understand behavioral health coverage within SoonerCare programs.
Oklahoma Behavioral Health Program

OHCA administers two health programs:

• **SoonerCare** - A federal program administered by the state.
  – In Oklahoma, Medicaid is referred to as “SoonerCare”.

• **Insure Oklahoma** - Assists qualifying adults and small-business employees in obtaining health care coverage for themselves and their families.
Oklahoma Behavioral Health Program

- ODMHSAS provides services to Oklahoman's affected by mental illness and substance abuse.
- ODMHSAS was established through the Mental Health Law of 1953.
- ODMHSAS’s statewide network of programs includes outpatient, community-based, prevention efforts, drug and mental health courts, and education initiatives.
Oklahoma Behavioral Health Program

• OHCA is the single state agency that administers the SoonerCare program, which is financed by federal and state funds and managed by the state according to federal guidelines.

• During the fiscal year 2012 state legislative session, responsibility for the behavioral health portion of SoonerCare was shifted from OHCA to ODMHSAS.
Oklahoma Behavioral Health Program

• While OHCA may not delegate full policymaking responsibility to another state agency, Oklahoma designed an approach where another state agency is integral in the policymaking process and provides influence on what policies are ultimately adopted by OHCA.

• ODMHSAS currently sets rates and policy for SoonerCare’s outpatient behavioral health program.
Eligible Members

Behavioral health services are self-referred.

Programs that cover outpatient behavioral health services:
• Title 19.
• Insure Oklahoma.
• Breast and cervical cancer.
• *MHSAS at ODMHSAS-contracted facilities only.

Programs that do not cover OPBH services:
• Family planning (SoonerPlan).
• Soon-to-be-Sooners (limited pregnancy benefits).

*see next slide for more info on MHSAS
Eligible Members

• If the member has only MHSAS showing when checking eligibility, the member **must** be seen at a ODMHSAS contracted provider.

• MHSAS is not a benefit but a place holder for customers seeking services from ODMHSAS contracted providers.
Eligible Members

Example

• If the member seeks services at an ODMHSAS contracted community mental health center, the individual center will assess the member’s full ODMHSAS eligibility. This would include financial and clinical eligibility, as well as ability to pay.

• If the customer meets ODMHSAS eligibility criteria, ODMHSAS will provide and pay for the designated, appropriate services. This is not a coverage benefit that the member can take with them to another facility and expect payment.
Eligible Members

![Eligibility Verification Request](image)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title 19</td>
<td>02/26/2018</td>
<td>02/26/2018</td>
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<tr>
<td>Waiver Advantage</td>
<td>02/26/2018</td>
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</tr>
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<td>Non Emergency Transportation</td>
<td>02/26/2018</td>
<td>02/26/2018</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>02/26/2018</td>
<td>02/26/2018</td>
</tr>
</tbody>
</table>
SoonerCare Behavioral Health Provider Types

Outpatient behavioral health agency:

• Physicians.
• LBHP’s including licensure candidates under board approved supervision.
  – LCSW, LPC, LMFT, LBP, LADC.
• Paraprofessionals.
  – BHCM I, BHCM II, CADC.
• DMH only paraprofessionals.
  – Peer recovery support specialist, family support provider, behavioral health aide.
SoonerCare Behavioral Health Provider Types

- **Private LBHP/Psychologist:**
  - Must be licensed.
  - Chooses to be set up as a “yes” biller or linked to a behavioral health group contract.

- **Behavioral health group:**
  - Must be fully-licensed.
  - Multiple fully-licensed LBHPs or psychologists may join the group.
  - Receives reimbursement for services rendered as a group.

- **Physicians:**
  - Choose to be set up as a yes biller or linked to a medical group contract.
## Populations Served
by behavioral health provider type

<table>
<thead>
<tr>
<th></th>
<th>TXIX Adult (21 yrs +)</th>
<th>TXIX Child (20 yrs and younger)</th>
<th>IO Adult (21 yrs +)</th>
<th>IO Child (20 yrs and younger)</th>
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<tbody>
<tr>
<td>BH Agency</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Private LBHP</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BH Group</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Physician</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Compensable Services
by behavioral health provider type

OPBH Agency:
- Screening and referral.
- Assessment.
- Treatment planning.
- Psychotherapies.
- Crisis intervention.
- Behavioral health case management.
- Behavioral health rehabilitation services.
- Testing.

Private LBHP/BH Group:
- Evaluation.
- Psychotherapies.
- Crisis intervention.
- Testing.
Frequently Asked Questions

Outpatient Behavioral Health Agency
FAQs from Behavioral Health Agencies

• Can we be reimbursed for screening?
  – Yes! Screening is conducted for determining whether the member meets medical necessity criteria, need for further assessment and possible treatment services.
  – Screening is compensable on behalf of a member who is seeking services for the first time from the behavioral health agency. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by OHCA and ODMHSAS and appropriate for the age or developmental level of the member.
  – May be performed by any credentialed staff member as listed under OAC 317:30-5-240.3.
FAQs from Behavioral Health Agencies

• How much time do I need to spend completing the assessment? What is an event?
  – Recent documentation and billing revisions to the behavioral health assessment removed minimum time-based requirements for this service and allow the provider greater flexibility in the assessment process.
  – Event billing is service-based and untimed.
    • Removed moderate complexity (two or more hours) and low complexity (one-and-a-half hours) and shifted to a serviced-based billing.
  – Billing.
FAQs from Behavioral Health Agencies

• What are the new assessment documentation requirements?

317:30-5-241.1 (2) (D) In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child’s level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition.
FAQs from Behavioral Health Agencies

The information in the assessment must contain but is not limited to the following:

I. Behavioral, including substance use, abuse and dependence.
II. Emotional, including issues related to past or current trauma.
III. Physical.
IV. Social and recreational.
V. Vocational.
VI. Date of the assessment sessions as well as start and stop times.
VII. Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members older than 14 years old.
VIII. Signature and credentials of the practitioner who performed the face to face assessment.
FAQs from Behavioral Health Agencies

What is the process for adding a new clinician to a case?

- You will need to complete a service plan modification in order to add the new clinician’s goals and objectives.
- 317:30-5-241.1 Service plan updates are required every six months during active treatment. Updates can be conducted whenever clinically needed as determined by the provider and member, but are only compensable twice in one year. The date of service is when the service plan is complete and the date the last required signature is obtained.
- If there is an under-supervision LBHP conducting the service plan or updates, the clinical supervisor or on-site supervisor must review and sign the service plan or any addendums to it.
FAQs from Behavioral Health Agencies

• Does the behavioral health case manager need to sign the treatment plan?
  - Yes! The service plan must be signed by the BH case manager.

317:30-5-241.6 (C) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(D) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member’s (and family, if applicable) needs.

(6) Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is younger than 18 years old), the behavioral health case manager and a licensed behavioral health professional or licensure candidate.
FAQs from Behavioral Health Agencies

- Can I bill one hour of psychotherapy a week?
  - Psychotherapies have both daily and weekly limits.

<table>
<thead>
<tr>
<th></th>
<th>Daily Limit</th>
<th>Weekly Limit</th>
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</thead>
<tbody>
<tr>
<td>Individual</td>
<td>4 units/ 1hr</td>
<td>Cumulative total of 8 units/ 2 hrs</td>
</tr>
<tr>
<td>Family</td>
<td>4 units/ 1hr</td>
<td>Cumulative total of 8 units/ 2 hrs</td>
</tr>
<tr>
<td>Group</td>
<td>6 units/ 1 ½ hrs</td>
<td>12 units/ 3 hrs</td>
</tr>
</tbody>
</table>

- The weekly limits run from Sunday to Saturday, regardless of month or holidays.
- The weekly limit for individual/family and group therapy are separate. For example, a member may receive up to eight units of individual and/or family AND up to 12 units of group in a week.
FAQs from Behavioral Health Agencies

• Can I bill one hour of psychotherapy a week?
  – For individual or family therapy, there are multiple ways the limits can be used.
  – Family therapy and individual therapy can be billed on the same day, but neither can exceed four units in a day or eight units in a week.

Examples below are not all inclusive of every scenario:
  1. Individual therapy at four units on one day, and individual therapy at four units on another day.
  2. Individual therapy at four units on one day, and four units of family therapy on the same day.
  3. Individual therapy at four units on one day, and four units of family therapy on another day.
  4. Family therapy at four units on one day, and four units of family therapy on another day.
  5. Individual therapy at three units on one day, family therapy at three units on another day, and two units of family therapy on another day.
FAQs from Behavioral Health Agencies

• My therapy claim is denying. If we have a letter of collaboration with another agency, how do we know when they billed psychotherapy units on the member?
  - The agency psychotherapy limits apply to the member not the provider. The weekly limits apply regardless of how many agencies are serving the member.
  - It is the providers responsibility to closely collaborate to avoid duplication of services and ensure both providers can be paid for services rendered during the same treatment week.
FAQs from Behavioral Health Agencies

Denied claims

- Treatment history on the provider portal:
  - Allows you to see if a submitted claim has been paid to another SoonerCare contracted provider for the same service.
  - Treatment history is a role and must be added for clerks.
Treatment History
Behavioral Health Agency

Search Treatment History

Member Information

Service Information

Search Results

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Units</th>
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<tbody>
<tr>
<td>03/16/2018</td>
<td>T1017</td>
<td>TARGETED CASE MANAGEMENT</td>
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<tr>
<td>03/15/2018</td>
<td>T1017</td>
<td>TARGETED CASE MANAGEMENT</td>
<td>4</td>
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</table>
FAQs from Behavioral Health Agencies

• Are behavioral health case management services compensable for SoonerCare members in state custody?
  – No. The following SoonerCare members are not eligible for BHCM services 317:30-5-241.6 (4):
    A. Children and families for whom BHCM services are available through OKDHS or OJA staff without special arrangements with OKDHS, OJA and OHCA.
    B. Members receiving residential behavioral management services in a foster care or group home setting, unless transitioning into the community.
    C. Residents of ICF/IID and nursing facilities unless transitioning into the community.
    D. Members receiving services under a home and community-based services waiver program.
    E. Members receiving services in a health home program.
### FAQs from Behavioral Health Agencies

#### Compensable BHCM Services

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Coverage</th>
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<tr>
<td>SoonerCare Choice</td>
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<td>Non Emergency Transportation</td>
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<tr>
<td>Mental Health and Substance Abuse</td>
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<td>03/16/2018</td>
<td>03/16/2018</td>
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#### Managed Care Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Phone</th>
<th>Health Plan Name</th>
<th>Health Plan Phone</th>
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</thead>
<tbody>
<tr>
<td>ABC Clinic, Inc.</td>
<td>405-123-1234</td>
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</table>

#### Health Home Information

<table>
<thead>
<tr>
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<th>End Date</th>
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</thead>
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<tr>
<td>Scissortail Behavioral Health Services</td>
<td>123 Main Street</td>
<td>405-599-1234</td>
<td>04/06/2016</td>
<td>12/31/2299</td>
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<tr>
<td></td>
<td>Your City, OK 11111</td>
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</table>

#### CCBHC

<table>
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<th>Provider Name</th>
<th>Provider Address</th>
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<th>Effective Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>Scissortail Behavioral Health Services</td>
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<td>08/02/2017</td>
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<tr>
<td></td>
<td>Your City, OK 11111</td>
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</table>

#### Visits

<table>
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<th>Service</th>
<th>Last Service</th>
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</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>03/13/2015</td>
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</tbody>
</table>
FAQs from Behavioral Health Agencies

• Which members are eligible for more than 16 units of BHCM services a year?

  1. Members who have been admitted to behavioral health inpatient, crisis unit, mobile crisis or urgent care in the last five years. The end date for eligibility is five years after the last discharge. A PICIS report identifies those individuals which meet this requirement.

  2. Adults 18 years and older who are either: (a) enrolled at a certified substance abuse agency and have a substance abuse service focus on the customer data core, or (b) enrolled in a specialty court program. Eligibility is only maintained while enrolled in these programs.

  3. Member is currently homeless, as identified on the customer data core as “Homeless-Shelter” or “Homeless-Streets”. Only applies if currently homeless.
FAQs from Behavioral Health Agencies

• How do I get a member approved for more than 16 units of BHCM services a year?
  – If the member meets medical necessity criteria but is not identified in PICIS as such, the provider must submit a prior authorization adjustment with supporting documentation in PICIS.
FAQs from Behavioral Health Agencies

Billing for BHCM Services

– If the member meets medical necessity criteria for BHCM services beyond the 16 units per year and the provider has secured the appropriate prior authorization, providers must include a “GD” modifier on the claim at the end of the current service.
  • Example: If the current service is billed T1017 HE HM, you would change it to T1017 HE HM GD. (Before the 16 unit limit has been reached, it will not matter if you include the GD modifier or not.)

– Note: If provider bills a claim with a “GD” modifier and it is later determined the client did NOT meet MNC, a report in PICIS will be available to assist provider in identifying claims that need correction. If not corrected within 30 days of payment, claim will be recouped.
FAQs from Behavioral Health Agencies

• Which services are not compensable for health home members?
  – 317:30-5-254 (b)
    1. Targeted case management.
    2. Service plan development, low complexity.
    3. Medication training and support.
    4. Peer to peer support (family support).
    5. Medication management and support and coordination linkage when provided within a program of assertive community treatment.
    7. Medication administration.
    8. Outreach and engagement.
Frequently Asked Questions

Private LBHP/BH Groups
FAQs from LBHPs/BH Groups

• Is there any way to get a member approved for more than four units per month?
  – Yes! Exceptional case criteria for LBHPs.
  – There may be periods in which the member’s condition is severe enough to require a higher intensity of psychotherapy services than the four sessions allowed per month.
FAQs from LBHPs/BH Groups
Requesting additional psychotherapy services

– Providers may request additional psychotherapy services (up to four additional services per month) beyond the four sessions allowed when the following criteria are met:

1. The member is medically stable.
2. Documentation clearly supports the member meets level 4 MNC and one of more of the items listed as “appropriate” in the next slide.
3. Documentation clearly supports the need for additional exceptional case psychotherapy services above and beyond the four sessions allowed.
FAQs from LBHPs/BH Groups
Requesting additional psychotherapy services

- Members appropriate for exceptional case.

<table>
<thead>
<tr>
<th>Appropriate (Any/or all of the following)</th>
<th>Inappropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiencing extreme functional impairment but does not meet MNC for acute inpatient hospitalization</td>
<td>Imminent danger to self and/or others (medically unstable)</td>
</tr>
<tr>
<td>Stepping down from a higher level of care (Acute/ RTC/Inpatient)</td>
<td>Extreme level of functional impairment, meeting MNC for inpatient hospitalization</td>
</tr>
<tr>
<td>There is an escalation of symptoms without intensive services (e.g., increase in aggressive behavior, or a decreased ability to perform ADLs but is medically stable)</td>
<td></td>
</tr>
</tbody>
</table>
FAQs from LBHPs/BH Groups

Requesting additional psychotherapy services

– When submitting a PA adjustment request for exceptional case for LBHPs, the following information is required:

• A narrative justification summary in the text field of the electronic request in PICIS. This summary should address the following elements:
  a) Documented support for the need for a 30-day period of increased psychotherapy services beyond four sessions (up to four additional sessions can be requested).
  b) Any other documentation needed to clarify that the member meets requirements for the MNC for exceptional case for LBHPs.
FAQs from LBHPs/BH Groups
Requesting additional psychotherapy services

– The following documentation must be uploaded in PICIS:
  • Clinical assessment including:
    a) Biopsychosocial assessment, including a narrative of any updates if the assessment was not completed within the last 30 days (the updated information provided in the descriptors for the current Client Assessment Record or Addiction Severity Index assessment may provide sufficient update).
    b) Current CAR or ASI, including descriptors of narrative that supports the scores (the CAR/ASI must be no more than 30 days old).
  • Current service plan (must be no more than 30 days old).

*Failure to provide all of the information requested will result in an automatic denial. A new, complete request will need to be submitted.
FAQs from LBHPs/BH Groups

• Why is my claim denying? How can I tell if another LBHP billed on the same day?
  – Timed psychotherapy codes may only be billed **once per day**, regardless of how many private LBHPs are serving the member.
  – It is the providers’ responsibility to closely collaborate to avoid duplication of services and ensure both providers can be paid for services rendered during the same treatment week.
  – Treatment history on the provider portal:
    • Allows you to see if a submitted claim has been paid to another SoonerCare contracted provider for the same service.
    • Is a role and must be added for clerks.
### Treatment History

#### LBHPs/BH Groups

![Image of EHR system interface showing search for treatment history]

#### Search Treatment History

**Medical**

*Indicates a required field.*

This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure type/code, then click **Search**. Select **Lifetime** to view treatment history for the procedure identified over the lifetime of the patient. Click **Reset** to clear all fields.

#### Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

- **Member ID**: 000000002
- **Last Name**: Doe
- **First Name**: Jane
- **Birth Date**: 05/18/2010

#### Service Information

- **Service From Date**: 01/01/2018
- **To Date**: 03/21/2018
- **Procedure Code Type**: CPT/HCPCS
- **Procedure Code**: 90837

#### Search Results

<table>
<thead>
<tr>
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<th>Units</th>
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</thead>
<tbody>
<tr>
<td>03/19/2018</td>
<td>90837</td>
<td>PSYTX PT&amp;/FAMILY 60 MINUTES</td>
<td>1</td>
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<tr>
<td>03/13/2018</td>
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<td>PSYTX PT&amp;/FAMILY 60 MINUTES</td>
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<td>02/20/2018</td>
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<td>02/09/2018</td>
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</table>
FAQs from LBHPs/BH Groups

Claim is Denying

<table>
<thead>
<tr>
<th>Timed psychotherapy codes</th>
<th>Event psychotherapy codes</th>
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</thead>
<tbody>
<tr>
<td>*Once per day.</td>
<td>*One event code may be billed on same DOS as a timed code.</td>
</tr>
<tr>
<td>90832 (30 minutes)</td>
<td>90846 Family psychotherapy without member present.</td>
</tr>
<tr>
<td>90834 (45 minutes)</td>
<td>90847 Family psychotherapy with member present.</td>
</tr>
<tr>
<td>90837 (60 minutes)</td>
<td></td>
</tr>
</tbody>
</table>
Prior Authorization Status and Claim Submission
Prior Authorization Status

View Authorization Status

Prospective Authorizations  Search Authorizations  Authorization Notices

Enter at least one of the following fields to search for an authorization.
For Advanced search PA or Member ID/day range is required.

Authorization Information

Advanced Search

Prior Authorization Number

Assignment Code

Code Type

Code

Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.

Authorized Day Range

OR Authorized Service Date

Member Information

Member ID

Provider Information

Provider NPI

This Provider is the Servicing Provider on the Authorization

Search Results

The Search criteria selected in the Search Authorizations panel reflect the Search Results displayed.

Total Records: 2

<table>
<thead>
<tr>
<th>Prior Authorization Number</th>
<th>Authorized Service Date</th>
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<th>Member ID</th>
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<th>Requesting Provider</th>
<th>Servicing Provider</th>
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<td>000000000</td>
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<td>Sooner Therapy Services</td>
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<td>000000000</td>
<td>BEHAVIORAL HEALTH SERVICES</td>
<td>Sooner Therapy Services</td>
<td>Sooner Therapy Services</td>
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</table>
## Approved Authorization

### Agency

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<th>Authorized To Date</th>
<th>Requested From Date</th>
<th>Requested To Date</th>
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<th>Units Used</th>
<th>Dollars</th>
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<td>11/24/2017</td>
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## Approved Authorization

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Submit Professional Claim

Professional Claim Step 1
Submit Professional Claim

Professional Claim Step 2

Diagnosis Codes

Select the row number to edit the row. Click the Remove link to remove the entire row.

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[Add] [Reset]

Back to Step 1

Continue [Cancel]
Submit Professional Claim

### Professional Claim Step 3

**Service Details**

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- *From Date*
- *To Date*
- *Place of Service*
- *Diagnosis Pointers*
- *Procedure Code*
- *Charge Amount*
- *Units*
- *Action*

**Attachments**

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**NDC for Item 1**

Add

**Notes:**

1. If applicable
2. If applicable – DMH Contracted Providers only

### Additional Information

- A-MH Case Management-Adult
- C-MH Case Management-Child
- DA-MH Case MGMT-Adultcentrcnt
- DC-MH Case MGMT-Childcentrcnt
- DM-Contract Provider
- G-Group
- NI-Non Indian Provider
- T-Teaching Physician
- TS-Teaching Specialist
Contact Information

Crystal Hooper MA, LPC  
Behavioral Health Specialist  
Crystal.Hooper@okhca.org  
405-701-1317

Mary Ann Dimery MHR, LPC  
Behavioral Health Specialist  
Mary.Dimery@okhca.org  
405-522-7543

OHCA Call Tree (see OHCA Quick Reference Guide)  
800-522-0114
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<td>BHA</td>
<td>Behavioral Health Aide</td>
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<td>BHCM I</td>
<td>Behavioral Health Case Management I</td>
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<td>CAR</td>
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<td>DOS</td>
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<td>Frequently Asked Questions</td>
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