SoonerCare Fax Blast

Date: July 13th, 2007
Subject: Disregard Forms attached to OHCA 2007-41

Dear Provider:

Please discard and DO NOT USE the Psychosocial Assessment Form and instructions that were attached to the Provider Letter OHCA 2007-41 dated 07/02/07. The form has been revised and that version will be placed on the website by 7/13/07. We apologize for any inconvenience that this may have caused.

May 1, 2007

Dear SoonerCare Provider,

A combined workgroup of inpatient, residential and outpatient behavioral health providers, as well as OHCA, ODMHSAS, and DHS has been working for a few months to address issues that are being experienced by providers and SoonerCare members.

The group first has addressed the issue of children not being able to begin outpatient behavioral health services quickly once they have been discharged from residential level of treatment. In this context we are referring to residential as acute care, residential care, group home and therapeutic foster care. A plan has been developed for an automatic authorization process for one month for 62 RVUs and 48 case management RVUs (if applicable) once the child has been discharged in which the outpatient provider will utilize the residential providers treatment plan and assessment for that month to be able to immediately begin providing services. This authorization must be prior authorized by APS Healthcare. Services must begin within 7 days and the outpatient provider must commit to follow up with the family if the first appointments are not kept. This is a general description of the process. Training will be scheduled toward the end of May for this process to give you the specifics.

For this process, each residential provider and each outpatient provider is being asked to identify one contact person, with name, telephone number and FAX number. They will be the person in each facility that should be trained and thoroughly understand the process and to whom the information will be faxed. That person will be the one within the agency to disseminate the information to the appropriate persons. To get this organized, we need you to send the name, telephone number, and FAX number of the person you identify within your facility to be the contact to Jennifer King or Nichole Burland by May 11, 2007. (Nichole.Burland@okhca.org or Jennifer.King@okhca.org). If you fail to identify a contact person(s), then the referral process will be difficult for the referring agency to complete.

We will notify you of the training date and place soon. I am sure you will have questions and we will address many of these at the training at that time. We certainly welcome anyone that would like to join this workgroup to address the issues of both children and adults. Let us know if you are interested and we will notify you of the next meeting.

Sincerely,
Jolene Ring, LMFT
Oklahoma Health Care Authority
Behavioral Health Unit
4545 N. Lincoln, Ste. 124
OKC, OK 73105

Admittance and Discharge Form
APS Notification
FAX 800-762-1639
Phone 800-762-1560

Client Name:_____
(Last name) (First name) (M)

DOB:_____/_____/_____

RID:_____

Admit Date ___/___/___ Level of Care_____

Facility name:_____ Provider #_____
Physician:_____ Provider #_____

Discharge Date____/____/____ Level of Care_____

Facility_____

If a consumer transfers, please enter the appropriate facility name in the admit and discharge area.

Admit to Outpatient Services

Provider Agency Name: _____ Provider #: _____

Initial 30 day authorization for outpatient services immediately following discharge from acute, RTC, group home, crisis stabilization unit or TFC level of care.

This form must be submitted prior to the start of outpatient services. With submission of this form and acceptance of this specialized 30 day authorization, we agree services will begin within 7 calendar days of the client's discharge. In cases when the client does not keep their appointment, outreach services will be implemented immediately to include case management and home-based services.

Client Name: _____

(Last name) (First name) (MI)

Date of Birth: _____/_____/_____

Medicaid Number: __ __ __ __ __ __ __ __ __ __

Start date for 30 day authorization for outpatient behavioral health services: Date: ____/_____/_____

62 RVUs will be divided as below. APS will authorize these RVUs. A correction request may be submitted if a different array of services are clinically indicated not to exceed the 62 RVUs.

Child Individual Psychotherapy (for ages 10 and over)	8 - 75-80 min sessions (Circle psychotherapy you are requesting)
or	
Child Interactive Psychotherapy (for ages 9 and under)	8 - 75-80 min sessions
Child Family Psychotherapy with client	8 - 60 min sessions
Child Group Psychotherapy	4 - 60 min sessions
Child Group Rehab	44 – 60 min sessions
Child Individual Rehab	8 – 60 min sessions

Case Management (T1017-T1017 TF) Provider #: _____
48 RVU's_____

If this is an existing client, do you need a treatment plan review? Yes No

Discharged from Acute, RTC, crisis stabilization unit, group home or TFC on (date): ___/ _____/_____
Name of facility discharging client: _____
_____

Date form completed: _____/_____/_____

FAX to 1-800-762-1639

Date_____

Dear Provider,

This letter is to inform you that (name) _____

(RID#)_ _ _ _ _ _ _ _ _ was admitted for psychiatric care at our facility

_____ on this date (_ _-_ _- _ _).

Upon discharge from our facility the following information will be faxed to

you in order to ensure continuity of care:

- Individual Plan of Care
- Psychosocial Assessment
- Discharge Form (PCP's will only receive this form)

Sincerely,

_____