Duncan-Sanford, Judy A

From: Duncan-Sanford, Judy A on behalf of sdu_Provider Services Help
Sent: Thursday, May 23, 2019 3:15 PM
Subject: Optum Public Sector: Updated Psychiatry Outpatient Authorization Request (OAR) Form for Immediate Use
Attachments: Outpatient_Authorization_Request_Psychiatry_4.11.19.pdf; Outpatient_Authorization_Request_Psychiatry_Required Fields4.11.19.pdf

High

Public Sector San Diego

Updated Psychiatry Outpatient Authorization Request (OAR) Form

Dear Provider,

We appreciate you acting as a vital part of San Diego County's Mental Health Plan (MHP) and serving our community. This communication is to keep you informed that the Outpatient Authorization Request Form (OAR) has been slightly updated and the newest version is available on our Optum San Diego website. The updates are intended to accurately authorize Psychiatric Diagnostic Evaluation and/or Evaluation and Management CPT Codes, and set up of interpreter services as needed. The following updates have been made and are required fields:

- On page 2

  Date of 1st Appointment/Assessment with you:

  1st Appointment with you was a (check one): ❑ 90792 OR ❑ 99201-99205

- **Interpreter needed for these sessions with Optum's interpreter services provider: ❑No ❑Yes, Language:_____**

As of August 1, 2019, if a request is not submitted with the required fields on the updated Psychiatry Outpatient Authorization Request (OAR) Form, request will be returned as incomplete. Please refer to the required fields on each document. The new Psychiatry OAR is available on our website at www.optumsandiego.com under the "BHS Provider Resources", then "Fee for Service Providers", on the "Forms" tab.

We thank you for your continued commitment to providing services to Medi-Cal beneficiaries. The County of San Diego HHSA and Optum greatly appreciate the work you do and look forward to our continued collaboration in the future. If you have any question regarding these changes please contact the provider line at 1-800-798-2254, option 3, option 4.

Sincerely,

Utilization Management Department, Optum Public Sector

P.O. Box 601340
San Diego, CA 92160-1340

Our United Culture. The way forward.
■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance

This form should be used to request outpatient treatment. Revised 4.11.19	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN **OUTPATIENT AUTHORIZATION REQUEST- PSYCHIATRY** Please check: ❑ Initial Request ❑ Continuing Request **PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS**	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800) 798-2254, option #3

CONFIDENTIAL **Client Information** *CONFIDENTIAL*

Client Last Name: First: Middle:	Medi-Cal CIN #:	Birth Date:	Current Health Plan:

If Child, current IEP: ❑ Yes ❑ No	San Diego Regional Center Client: ❑ Yes ❑ No If Yes, contact name and number:
Current Child Welfare Services: ❑ Yes ❑ No	If Yes, PSW name and number:
If Hx of CWS, when and why?	

DSM IV/ ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis:	ICD 10 Code:
Other Diagnoses (Mental & Physical Health):	

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current symptoms and severity: How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis? Please list symptoms with frequency and duration.

Hx of Trauma and/or Abuse? ❑ Yes ❑ No	If Yes, explain:
Substance Use: ❑ N/A ❑ Hx ❑ Current	Drug(s) of choice:
Describe current substance use impact on functioning:	

Medications (Psychiatric, Medical, & OTC medications) **Have you checked CURES: ❑ Yes ❑ No**

Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support): How have you coordinated with these providers? If not, please explain:
Progress: ❑N/A (Initial Request) ❑ Near completion ❑ Improving ❑ Stabilizing ❑ Regressed due to new stressor ❑ Little/no progress
Expected length of treatment: **Date of 1st Appointment/Assessment with you:** **1st Appointment with you was a (check one): ☐ 90792 OR ☐99201-99205**
Referrals made to other community supports and/or aftercare plans for client's recovery:
(Signed client plan required in client's chart within 30 days of commencing treatment)

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: ❑ Adult ❑ Child

Interpreter needed for these sessions with Optum's interpreter services provider: ❑No ❑Yes, Language:_____

Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
Outpatient Office Visit DO/MD/PNP only – E/M codes & therapy (max 26)				
DO/MD/PNP only – Psychotherapy Add on Code (max 26)				
Case Management				
Team Conference				

Provider Information		
Name/Licensure:	Phone:	
Provider Signature: Date:	Fax:	If Modified or Denied, Date Provider Called: _____ Date NOA sent: _____
If Group Practice, name of Group:		

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature

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If Hx of CWS, when and why?	

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Substance Use: ❑ N/A ❑ Hx ❑ Current	Drug(s) of choice:
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DO/MD/PNP only – Psychotherapy Add on Code (max 26)				
Case Management				
Team Conference				

Provider Information

Name/Licensure:		Phone:	
Provider Signature:	Date:	Fax:	If Modified or Denied, Date Provider Called: _____ Date NOA sent: _____
If Group Practice, name of Group:			

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature