

SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services

OKLAHOMA HEALTH CARE AUTHORITY

Updated: February 8, 2019

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PURPOSE OF MANUAL

This manual contains the medical necessity criteria for Oklahoma Health Care Authority contracted behavioral medicine providers for inpatient services. All behavioral medicine services must be medically necessary. The medical record needs to reflect that medical necessity requirements/criteria are being followed.

Additional information about the SoonerCare program is contained in the SoonerCare State Plan and the administrative rules. The State Plan is posted at <http://www.okhca.org/> and official rules are published by the Oklahoma Secretary of State [Office of Administrative Rules](#) as Title 317 of the Oklahoma Administrative Code (OAC). To order an official copy of these rules, contact the Office of Administrative Rules at (405) 521-4911.

Providers are responsible for ensuring compliance with current contract requirements and state/federal Medicaid policies pertaining to the services rendered. This manual does not supersede state/federal Medicaid rules and is not to be used in lieu of them.

The staff of the Oklahoma Health Care Authority (OHCA) thanks all of the physicians/practitioners who provide behavioral medicine services to *SoonerCare* members. Your feedback and input is valuable to the OHCA behavioral medicine program. Please send any comments, suggestions, or questions you have regarding this manual to the attention of: ProvServicesAdmins@okhca.org

INPATIENT ACUTE, PRTF, CBT AND TFC MEDICAL NECESSITY CRITERIA

Inpatient psychiatric (24/7 care) services (including TFC) for SoonerCare members up to age 64 must be prior authorized before the service is provided. Initial and concurrent reviews to determine medical necessity criteria are required for the following services:

- Acute Care
- Psychiatric Residential Treatment Facility (PRTF)
- TFC services

OHCA INPATIENT REVIEW REQUEST LINE

(800) 522-0114 and have your Provider ID number ready. Select:

- Option 1 for Provider,
- Option 6 for Prior Authorizations, and
- Option 2 for Behavioral Health

Authorization of services is not a guarantee of payment. The provider is responsible for insuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met.

All billing/claims inquiries should be directed to the OHCA Provider Helpline at 1-800-522-0114, option 2 and for Provider Enrollment (contract) questions, select option 5 on the call tree.

PRIOR AUTHORIZATION REVIEW STEPS

1. Complete the required templates located on the OHCA Behavioral Health web page: <http://www.okhca.org/providers.aspx?id=406>
2. Fax the completed template to (405) 530-7260
3. Before transferring you to a reviewer, the Behavioral Health Unit staff will locate the faxed template in the fax queue and a case will be created in the system.
4. Reviews are conducted during business hours from 8:00am-5:00pm, Monday through Friday.
5. PRTF requests will only be processed during business hours.
6. If an emergency psychiatric admission (acute care) occurs after regular business hours, the acute initial template needs to be faxed by 10:00 a.m. on the next business day.

All requests will be reviewed according to the medical necessity criteria as listed in the OAC 317:30-5-95.24 – 317:30-5-95.31 for inpatient and 317:30-5-740 – 317:30-5-746 for TFC.

OHCA INPATIENT POLICY

<http://www.okhca.org/xPolicyPart.aspx?id=547&chapter=30&subchapter=5&part=6&title=INPATIENT%20PSYCHIATRIC%20HOSPITALS>.

OHCA THERAPEUTIC FOSTER CARE POLICY

<http://www.okhca.org/xPolicyPart.aspx?id=597&chapter=30&subchapter=5&part=83&title=RESIDENTIAL%20BEHAVIOR%20MANAGEMENT%20SERVICES>

A face-to-face admission assessment by a Licensed Behavioral Health Practitioner is required prior to initiating the review. Less restrictive levels of care should be implemented and appropriately utilized before submitting a request for residential treatment.

AFTER HOURS PROCEDURES – ACUTE ADMISSIONS ONLY

Only acute care admissions are allowed after regular business hours for retroactive review. The acute care facility is to perform a review of medical necessity for the admission on the next business day. If the admission meets medical necessity criteria for acute care, the date of the admission will be authorized.

The acute initial template needs to be faxed by 10:00 a.m. on the next business day. Acute initial requests received after 10:00 a.m. will receive a technical denial.

Residential Treatment and TFC are not considered to be emergent levels of care. The reviews for these levels of care are conducted during regular business hours.

INPATIENT SERVICES FOR CHILDREN UNDER 5 YEARS OF AGE

Under certain circumstances, inpatient services may be determined to be appropriate for children less than 5 years of age. Inpatient services for this age group are very difficult to locate and will only be approved in extraordinary cases. Reviewers will care manage these cases in an attempt to meet the child's needs at the least restrictive level of care. The physician consultant will review all the inpatient referrals for children under the age of 5. **Please Note: Psychotherapy is not covered for children under the age of 3 for inpatient behavioral health services.**

OUT-OF-STATE TREATMENT FOR ACUTE AND PRTF CARE

Out-of-state placements will only be authorized when it is determined that the needed services are not available in the state of Oklahoma or if it is considered general practice for recipients in a particular locality to use SoonerCare contracted resources in a bordering state due to proximity.

BORDER PLACEMENTS

If the facility is in another state, but is as close or closer than the nearest treatment facilities in Oklahoma, then it is not necessary to consider the placement an out-of-state placement.

Placement of a child in an out-of-state hospital in an adjoining border locality requires prior authorization when all of the following conditions are met:

- The border hospital must have an Oklahoma SoonerCare provider number for the level of care.
- The placement is chosen due to the close proximity to the family/guardian to facilitate participation in active treatment including discharge and reintegration planning.
- The client meets the Acute or PRTF criteria.
- The use of the border hospital is usual and customary within the community or there are no available beds for that level of care in state.
- This designation has been approved by OHCA.

DENIED REQUESTS AND RECONSIDERATION TIME LINE

All prior authorization requests go through a two level review process when a denial decision is issued. The final denial for an inpatient or TFC authorization request is issued by a Physician Consultant who is a Board Certified Child and Adolescent Psychiatrist.

Once the facility is notified of a denial for an initial or extension prior authorization request, the provider is allowed until 5pm the following business day to submit additional information for reconsideration.

- a. Example: If a review is denied on Wednesday 5/21/2014 then the reconsideration would need to be received by Thursday 5/22/2014.
- b. Example: If a review is denied on Friday 5/23/2014 then the reconsideration would need to be received by Monday 5/26/2014.

If the denial is upheld after the additional information is reviewed, the provider has another 24 business hours to schedule a physician to physician review.

When services have been denied, further extension requests CANNOT be considered. If a review is given partial days after review from the Psychiatric Consult then a physician to physician review can't be requested. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient prior authorization process. The clinical information must include **current, relevant information**. If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

FAX CONFIRMATIONS

It is the provider’s responsibility to monitor/track their prior authorization submissions. If the provider has not received notification of a decision regarding a prior authorization within 24 hours of submission then they should check the provider portal before contacting their clinical reviewer for resolution.

A fax confirmation sheet can be submitted as proof of timely submission of the clinical template only if the member can be verified. No general fax confirmation sheets will be allowed.

If a fax confirmation sheet is being submitted as proof of timely submission of the clinical template then the date/time, name, and/or Medicaid number must appear on one of the following:

1. The cover letter
2. The first or last page of the clinical template if a cover letter is not being used

INITIAL ACUTE REQUESTS

Based on the Medical Necessity Criteria, the length of stay is authorized by the reviewer utilizing the following guidelines:

- The reviewer will determine the number of days authorized based on the clinical information submitted by the treating facility.
- The initial authorization for payment for acute care admission or upgrade to Acute may be up to **five (5) days**.
- In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.
- If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

Medical necessity criteria for acute psychiatric admissions for children (OAC 317:30-5-95.25)

Acute psychiatric admissions for children must meet the terms or conditions contained in (1), (2),(3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

1.	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-21 years of age may have any sequential personality disorders.	
2.	Yes	No	Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary to the primary diagnosis.	
3.	Yes	No	It has been determined by the reviewer that the current disabling symptoms could not have been managed, or have not been manageable, in a less intensive treatment program.	
4.	Yes	No	Child must be medically stable.	
5.	Yes	No	Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:	
	A.	Yes	No	Specifically described suicide attempts, suicide intent, or serious threat by the patient.
	B.	Yes	No	Specifically described patterns of escalating incidents of self-mutilating behaviors.

C.	Yes	No	Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
D.	Yes	No	Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
6.	Yes	No	Requires secure 24-hour nursing/medical supervision as evidenced by:
A.	Yes	No	Stabilization of acute psychiatric symptoms.
B.	Yes	No	Needs extensive treatment under physician direction.
C.	Yes	No	Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

ACUTE EXTENSION REQUESTS

Acute concurrent reviews are to be made on the last business day of the current authorization before 5 p.m. However, if received by 2 p.m. you will receive a response by 5 p.m. Failure to follow these time frames could result in loss of day(s).

Based on the OHCA Medical Necessity Criteria, acute extensions may be authorized up to five (5) days, based upon the documented need for the extended care. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

Medical necessity criteria for continued stay – acute psychiatric admission for children (OAC 317:30-5-95.26)

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4).

1.	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-21 years of age may have any sequential personality disorders.
2.	Yes	No	Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting. Documentation of regression is measured in behavioral terms. If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.
3.	Yes	No	Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).
4.	Yes	No	Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

ADULT PRIOR AUTHORIZATION (EFFECTIVE SEPTEMBER 17, 2018)

Medical necessity criteria for acute psychiatric admissions for adults (OAC 317:30-5-41.1)				
Acute psychiatric admissions for adults must meet the terms or conditions contained in (1), (2),(3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.				
1.	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, adults 22-64 years of age may have any sequential personality disorders.	
2.	Yes	No	Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary to the primary diagnosis.	
3.	Yes	No	It has been determined by the reviewer that the current disabling symptoms could not have been managed, or have not been manageable, in a less intensive treatment program.	
4.	Yes	No	Child must be medically stable.	
5.	Yes	No	Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:	
	A.	Yes	No	Specifically described suicide attempts, suicide intent, or serious threat by the patient.
	B.	Yes	No	Specifically described patterns of escalating incidents of self-mutilating behaviors.
	C.	Yes	No	Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
	D.	Yes	No	Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
6.	Yes	No	Requires secure 24-hour nursing/medical supervision as evidenced by:	
	A.	Yes	No	Stabilization of acute psychiatric symptoms.
	B.	Yes	No	Needs extensive treatment under physician direction.
	C.	Yes	No	Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

For Adult Prior Authorizations the provider must submit the PA template to OHCA on the business day by 5 pm following the member's admission date or the admission will be denied for no prior authorization. OHCA will respond to the PA request within 24 working hours. If the provider submits the request prior to 10 am, OHCA will respond back to the provider by 5 pm that same day. The provider is at risk if the request is denied due to lack of medical necessity

The Oklahoma Health Care Authority (OHCA) will require prior authorization (PA) for adult acute inpatient psychiatric and medical detox admissions for ages 22-64, effective September 17, 2018. This procedural change will ensure compliance with utilization control policy for acute inpatient psychiatric services at OAC [317:30-5-41.1](#).

- Member's with Medicare as primary WILL NOT require prior authorization.

- Ages 22-64 can only admit to a General Hospital (DRG facility).
- A PA will be required for Inpatient Mental Health and Medical Detox treatment in a psychiatric or medical bed.

Based on the Medical Necessity Criteria, the length of stay is authorized by the reviewer utilizing the following guidelines:

- The reviewer will determine the number of days authorized based on the clinical information submitted by the treating facility.
- The initial authorization for payment for acute care admissions may be up to **five (5) days**.
- In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.
- If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

PRTF LEVEL OF CARE

INITIAL PRTF REQUESTS

PRTF admissions are not considered emergent. PRTF admissions should be arranged during regular business hours between the hours of 8 a.m. and 5 p.m. However, any PRTF admissions done after 5 p.m. are done at the facilities own risk. Any PRTF admissions done after 5 p.m. must be received by 10 a.m. the following business day or it may result in a technical denial. If a clinical template is received after 2 p.m. it may NOT be processed until the following business day. Failure to follow these time frames could result in loss of day(s).

After the treatment facility has completed a face to face assessment of the child, the facility should fax the completed prior authorization request. To expedite the review, facilities are encouraged to call the reviewer to discuss the assessment findings, current mental status, and the medical necessity criteria for the requested level of care. Downgrades to PRTF should be submitted on the Acute and PRTF Initial Admission template.

The number of days authorized is based on the clinical information submitted by the treating facility. The initial authorization for PRTF admission or downgrade to PRTF may be up to seven (7) days. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

From the time of the initial review, a child must admit to an PRTF facility within three business days. After three business days, a new review will be required to determine if the child still meets Medical Necessity Criteria for PRTF admission. An exception may be made for out of state treatment that requires a more complex plan for travel arrangements.

Downgrade to PRTF

For DRG facilities downgrade PA requests must be submitted by 10am the following day after the downgrade occurs and the provider will be notified on this day. For Freestanding facilities the downgrade PA requests must be submitted by 5 p.m. the last covered day of the acute authorization. With freestanding facilities if a request is received by 2:00 pm we will provide an answer back to the provider the same business day, however if it is received after 2:00 pm then the provider will be notified the following business day if medical necessity criteria is met.

Medical necessity criteria for admission - Psychiatric Residential Treatment for children (OAC 317:30-5-95.29)			
Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) through (5) (D) of this subsection.			
1	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	Yes	No	Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).
3	Yes	No	Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.
4	Yes	No	Child must be medically stable.
5	Within the past 14 days the patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by:		
A	Yes	No	Suicidal ideation and/or threat.
B	Yes	No	Current self-injurious behavior.
C	Yes	No	Serious threats or evidence of physical aggression.
D	Yes	No	Current incapacitating psychosis or depression.
6.	Requires 24-hour observation and treatment as evidenced by:		
	<input type="checkbox"/> Intensive behavioral management. <input type="checkbox"/> Intensive treatment with the family/guardian and child in a structured milieu. <input type="checkbox"/> Intensive treatment in preparation for re-entry into community.		

PRTF EXTENSION REQUESTS

PRTF concurrent reviews should be made no earlier than 2 business days prior to the last day of the current authorization by 5 p.m. Clinical reviewers have until the end of the following business day to make a clinical determination based on the medical necessity criteria presented. Failure to follow these time frames could result in loss of day(s).

Based on the OHCA Medical Necessity Criteria, PRTF extensions may be authorized up to ten (10) days for standard PRTF programs or up to twenty-one (21) days for specialized programs.

In some instances, the reviewer may choose to refer to a physician consultant before making a determination.

The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient authorization process. The clinical information must include current, relevant information.

Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care

Medical necessity criteria for continued stay – psychiatric residential treatment center for children (OAC 317:30-5-95.30)			
For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).			
1	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	Yes	No	Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).

3	Yes	No	Patient is making measurable progress toward the treatment objectives specified in the treatment plan: <ul style="list-style-type: none"> <input type="checkbox"/> Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans. <input type="checkbox"/> Patient has made gains toward social responsibility and independence. <input type="checkbox"/> There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge. <input type="checkbox"/> There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.
OR			
4.	Yes	No	Child's condition has remained unchanged or worsened: <ul style="list-style-type: none"> <input type="checkbox"/> Documentation of regression is measured in behavioral terms. <input type="checkbox"/> If condition is unchanged, there is evidence of reevaluation of the treatment objectives and therapeutic interventions.
5	Yes	No	There is documented continuing need for 24-hour observation and treatment as evidenced by: <ul style="list-style-type: none"> <input type="checkbox"/> Intensive behavioral management <input type="checkbox"/> Intensive treatment with family/guardian and child in a structured milieu <input type="checkbox"/> Intensive treatment in preparation for re-entry into the community
6	Yes	No	Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

COMMUNITY BASED TRANSITIONAL RESIDENTIAL TREATMENT (CBT)

INITIAL CBT REQUEST

CBT admissions are not considered emergent. CBT admissions should be arranged during regular business hours between the hours of 8 a.m. and 5 p.m. Monday-Friday. The CBT request needs to be submitted by 3 p.m.

After the treatment facility has completed a face to face assessment of the child, the facility should fax the completed prior authorization request. To expedite the review, facilities are encouraged to call the reviewer to discuss the assessment findings, current mental status, and the medical necessity criteria for the requested level of care. CBT request should be submitted on the Acute and PRTF Initial Admission template.

The number of days authorized is based on the clinical information submitted by the treating facility. The initial authorization for CBT admissions may be up to seven (7) days. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

From the time of the initial review, a child must admit to a CBT facility within three business days. After three business days, a new review will be required to determine if the child still meets Medical Necessity Criteria for CBT admissions. An exception may be made for out of state placements that require a more complex plan for travel arrangements.

**Medical necessity criteria for admission -
Community Based Transitional Residential Treatment for children (OAC 317:30-5-95.29)**

Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) through (5) (D) of this subsection.

1	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	Yes	No	Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).
3	Yes	No	<p>Patient has received treatment in an acute, PRTF, or children’s crisis unit or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.</p> <p>(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.</p> <p>(B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, or intensive outpatient services</p> <p>(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.</p> <p style="margin-left: 40px;">(i) Personal safety</p> <p style="margin-left: 40px;">(ii) Cognitive functioning</p> <p style="margin-left: 40px;">(iii) Family relations</p> <p style="margin-left: 40px;">(iv) Interpersonal relations</p> <p style="margin-left: 40px;">(v) Educational/vocational performance</p>
4	Yes	No	Child must be medically stable and not require 24 hour on-site nursing or medical care.
5	Patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by:		
A	Yes	No	Suicidal ideation and/or threat.
B	Yes	No	Current self-injurious behavior.
C	Yes	No	Serious threats or evidence of physical aggression.
D	Yes	No	Current incapacitating psychosis or depression.
6.	Requires 24-hour observation and treatment as evidenced by:		
	<input type="checkbox"/> Intensive behavioral management. <input type="checkbox"/> Intensive treatment with the family/guardian and child in a structured milieu. <input type="checkbox"/> Intensive treatment in preparation for re-entry into community.		

CBT EXTENSION REQUEST

CBT concurrent reviews should be made no earlier than 2 business days prior to the last day of the current authorization by 3 p.m. Failure to follow this time frame will result in loss of day(s). If an authorization expires on a weekend or holiday, the provider may request a concurrent review the last business day prior to the weekend or holiday before 3 p.m.

Based on the OHCA Medical Necessity Criteria, CBT extensions may be authorized **up to twenty-one (21) days**.

In some instances, the reviewer may choose to refer to a physician consultant before making a determination.

The number of days issued is determined by the reviewer. The length is based on the level of the impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests **CANNOT** be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient authorization process. The clinical information must include current, relevant information.

Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

**Medical necessity criteria for continued stay –
Community Based Transitional Residential
Treatment for children (OAC 317:30-5-95.30)**

For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).

1	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	Yes	No	Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).
3	Yes	No	<p>There is documented continued need for 24 hour observation and treatment as evidenced by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient making measurable progress toward the treatment objectives specified in the treatment plan. <input type="checkbox"/> Clinical documentation clearly indicates continued significant functional impairment in tow of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors: <ul style="list-style-type: none"> (i) Personal Safety (ii) Cognitive functioning (iii) Family relations (iv) Interpersonal relations (v) Educational/vocational performance
4.	Yes	No	Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.
5	Yes	No	Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment at this level of care.

SUBSTANCE ABUSE DETOXIFICATION

An initial maximum of five (5) days for substance abuse detoxification (detox) is allowable based on medical necessity. If serious physiological evidence of detoxification persists after the initial authorization, up to three (3) additional days may be issued based on a case-by-case review of medical necessity criteria. An inpatient review is not necessary for detox if a medical emergency exists and the detox takes place on a medical unit. Substance Abuse detoxification will not be authorized for SoonerCare reimbursement for caffeine, nicotine or cannabis substances.

Medical necessity criteria for admission - inpatient chemical dependency detoxification for children (OAC 317:30-5-95.27)				
Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.				
1	Yes	No	Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.	
2	Yes	No	Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses).	
3	Yes	No	It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.	
4	Yes	No	Requires secure 24-hour nursing/medical supervision as evidenced by:	
	A	Yes	No	Need for active and aggressive pharmacological interventions.
	B	Yes	No	Need for stabilization of acute psychiatric symptoms.
	C	Yes	No	Need extensive treatment under physician direction.
	D	Yes	No	Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

Medical necessity criteria for continued stay - inpatient chemical dependency detoxification program for children	
Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to seven to eight days based on a case-by-case review, per medical necessity criteria as identified in the OHCA Behavioral Health Provider Manual as described in OAC 317:30-5-95.27.	

THERAPEUTIC FOSTER CARE (TFC)

INITIAL TFC REQUESTS

All initial Therapeutic Foster Care requests will be conducted with a reviewer. TFC admissions are not considered emergent. TFC admissions should be arranged to occur during regular business hours.

After a DHS/OJA custody child has received a Medical Necessity Criteria review, the reviewer will fax a notice indicating that the child appears appropriate for TFC assessment to the Placement Office at OJA, (405) 530-2892 and the local OJA worker, or to the identified DHS Area Resource Coordinator (ARC).

The clinical information will be on-hold until the admitting TFC provider has completed a face to face assessment and calls for the prior authorization for SoonerCare payment.

The TFC provider is responsible for notifying when the TFC admission is later than the date of the call for the initial admission authorization. Clinical information may be held for forty-five (45) days while the child is awaiting TFC placement, unless they have admitted to an inpatient psychiatric facility. At forty-five (45) days, the clinical information is no longer considered current. If forty-five (45) days have passed and the child is NOT placed, a new admission request must be completed. The time frame for TFC will be counted in calendar days.

The treating TFC facility must call with the clinical information derived from their face to face assessment of the child. The length of stay authorized for SoonerCare payment may be **up to three (3) months (90 days)**.

If client is being readmitted to a TFC provider following discharge from an Acute or PRTF facility, refer to section titled "PRTF Clients That Are Placed in Acute or RTC" for length of stay guidelines. If a client is discharged to a lower level of care and later re-admitted, the initial authorization process must be repeated.

In cases where the face to face assessment may occur (or is not completed until) after regular business hours, the TFC agency will call the next business day to notify of the admission. If the child meets TFC criteria, the authorization will be backdated to the date of admission.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria.

The clinical information must include current, relevant information. TFC agency staff should provide crisis management for all clients. For crisis situations, the therapist is to see the child face-to-face before calling for an inpatient authorization, except in situations where the need for hospitalization does not allow for this to occur.

If a child is out of the TFC placement due to being either AWOL or placed in a shelter for behavioral issues more than five (5) days, the child is discharged from the agency and the authorization will end. If the child returns to the TFC home (or another home within the same agency) within five (5) days, the authorization will remain active. The agency will document the time and behaviors leading to the AWOL or placement in a shelter and the time out of the TFC home.

Children downgrading from acute or PRTF levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified ARC or the OJA worker so an appropriate TFC placement and treatment can be arranged.

THERAPEUTIC FOSTER CARE ADMISSION MEDICAL NECESSITY CRITERIA (OAC 317:30-5-741)			
<i>A child must meet ALL of the following conditions.</i>			
1	Yes	No	A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-5-240.3(a) within the 30 day period resulting in a primary diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.
2	Yes	No	Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.
3	Yes	No	It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.
4	Yes	No	Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.
5	Yes	No	The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.
6	Yes	No	The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

TFC EXTENSION REQUESTS

Although reviews are conducted by phone, the faxed template is required. Extensions are reviewed by phone between the hours of 8 a.m. and 5 p.m. Monday - Friday. Calls should be made within 30 days from the expiration of the current authorization. Failure to follow this time frame will result in loss of day(s).

After the first TFC extension, authorizations may be **up to 90** days for subsequent extensions.

The number of days allowed will be determined by the reviewer and based on the level of impairment, severity and chronicity of the symptoms that meet Medical Necessity Criteria, including the need for 24 hour crisis intervention.

All denials will be reviewed by a physician consultant during working hours within (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The clinical information must include current, relevant information.

The TFC Provider will be responsible for providing the reviewer with information regarding DHS/OJA participation in the child's treatment needs and planning.

CONTINUED STAY THERAPEUTIC FOSTER CARE MEDICAL NECESSITY CRITERIA (OAC 317:30-5-741)

The criteria for continued stay in TFC are the same as the TFC admission criteria above. Utilize these same criteria when determining the need for continued stay in TFC.

TFC CLIENTS FIVE YEARS OF AGE AND YOUNGER

Under certain exceptional circumstances, TFC may be approved for children five years of age and younger. Special procedures are in place within the DHS system to ensure that the TFC provider is trained to work with children of this age. For children five years of age and younger, the length of stay authorized on all TFC placements will not exceed 90 days for initial or extension requests.

TFC CLIENTS THAT ARE PLACED IN ACUTE OR PRTF

If a child is admitted to an acute care or RTC facility while authorized for TFC, the provider may utilize any of the remaining days of the TFC dates authorized on existing PA once the child is discharged from the higher level of care. The child must be admitted directly from the TFC home and return directly to a TFC home upon discharge from the higher level of care. If the authorization dates on the existing PA for TFC expire while the child is receiving inpatient care, a new prior authorization request must be submitted prior to discharge from the inpatient facility or the TFC provider runs the risk of losing days. The number of days authorized for the new admission after discharge will up to 90 days.

If a child is discharged from TFC level of care, *except to a higher level of care*, a new admission request must be submitted if the child returns to TFC.

TFC PG GROUPS WITH REHAB CHANGES (Effective September 12, 2014)

Psychosocial Rehabilitation (PSR) services for children below age 6 are disallowed unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) laws. Two additional PG groups have been added to accommodate this change.

PG056 is a 30 day authorization for children ages 0-5 without Psychosocial Rehabilitation and PG057 is an extension authorization for children ages 0-5 without Psychosocial Rehabilitation.

The requirements to be approved for Psychosocial Rehabilitation are as follows:

- Psychosocial Assessment
- Developmental appropriateness (how can the child benefit from a curriculum based treatment intervention?)
- Please provide the name of the curriculum used to determine developmental appropriateness.

A denial for Psychosocial Rehabilitation will go through a two level review process:

- The initial request for Psychosocial Rehabilitation (PSR) will be given by the clinical reviewer.
- If the TFC agency request a reconsideration for PSR once the initial denial is given then it will go to the Psychiatric Consultant for final determination.

STEPDOWN FROM ACUTE OR PRTF TO TFC

Children downgrading from acute or RTC levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified DHS ARC or the OJA Placement office (405-530-2892) and the local OJA/ DHS worker so an appropriate TFC placement and treatment could be arranged.

TELEMEDICINE FOR TFC

The purpose of this section is to implement telemedicine policy that improves access to health care services, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of telemedicine, hands-on-assessment and/or in person care must be provided for the member.

The following conditions apply to all services rendered via telemedicine.

- (1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telemedicine information transmitted. As a condition of payment the member must actively participate in the telemedicine visit.
- (2) The telemedicine equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.
- (3) The medical or behavioral health related service must be provided at an

appropriate site for the delivery of telemedicine services. An appropriate telemedicine is one that has the proper security measures in place. Appropriate telemedicine equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telemedicine services outside of Oklahoma when medically necessary.

(4) The provider must be contracted with SoonerCare and appropriately licensed for the service to be provided.

(5) If the member is a minor child, a parent/guardian must preset the minor child for telemedicine services unless otherwise exempted by State or Federal law.

(6) The member retains the right to withdraw at any time.

(7) All telemedicine activities must comply with the HIPAA Security Standards, and all applicable state and federal laws and regulations.

(8) The member has access to all transmitted medical information, which the exception of live interactive video as there is often no stored data in such encounters.

(9) There will be no dissemination of any member images or information to other entities without written consent from the member.

Reimbursement

(1) Services provided by telemedicine must be billed with appropriate modifier.

(2) If the technical component of an X-ray, ultrasounds or electrocardiogram is performed during a telemedicine transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(3) The cost of telemedicine equipment and transmission is not reimbursed by SoonerCare.

Documentation

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telemedicine and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(E) The OHCA has discretion and the final authority to approve or

deny any telemedicine services based on agency and/or SoonerCare members' needs.

SERVICES UNDER ARRANGEMENT ATTESTATION

Separate payment may be made directly to practitioners for services provided under arrangement for transitional case management services, Health Home transitioning services and evaluation and psychological testing by a licensed psychologist. In order to ensure optimal collaboration and help assure there is no duplication of service, there must be a written agreement in the medical record between the OPBH provider and the inpatient facility outlining transitional case management and Health Home transitioning activities including a differentiation in the responsibilities between the two providers. The written agreement includes but is not limited to the following assurances:

- A. The inpatient facility arranges for and oversees the provision of all services;
- B. The inpatient facility maintains documentation in the medical record of the collaborative efforts engaged in with the OPBH provider for the provision of transitional case management or Health Home transitioning services;
- C. The inpatient facility ensures that all services are included under the direction of a physician.

For evaluation and psychological testing, the medical record must include a copy of the results as well as documentation of a review of the results and how the information guided treatment.

A review of paid claims for transitional case management and Health Home transitioning services will be conducted annually to ensure that documentation requirements have been met. Any findings that the above assurances have not been met may result in recoupment.

Psychologists may contact OHCA at 405-522-7597 for assistance in processing their claims for payment. OHCA will contact the inpatient facility to confirm appropriate medical record documentation prior to payment.

BEHAVIORAL HEALTH CARE MANAGEMENT AND COORDINATION

Reviewers will provide care coordination to improve treatment at all levels of care, which includes inpatient and outpatient providers, as well as the member's family/guardian. Reviewers will also inquire as to entitlements the child may have such as DDS or SSI. In cases in which the member may be eligible but not currently receiving such, the reviewer will work with the provider to facilitate the steps that are taken to apply for the entitlements.

On every review, the reviewer will question progress in treatment or lack thereof, discuss plans for follow up care upon discharge including provider name, telephone number, appointment date and time. In addition, questions regarding the plans for placement upon discharge will be asked. If the plan is for the child to not return to his/her former home, the reviewer will work with the treating facility to assist the guardian/responsible party to arrange for alternative placements on an ongoing

basis. All options including those not SoonerCare compensable will be explored. Every attempt will be made to refer each of these children to a local system of care program in their home community prior to discharge. This referral should be coordinated by the hospital and the reviewer to ensure a seamless transition to the lower level of care.

NON-VERBAL PRIOR AUTHORIZATION REQUIREMENTS

Children must have a diagnosis of Autistic Spectrum Disorder and the following:

- Early Childhood onset before the age of 3.
- Have a diagnosis of intellectual disability that includes a social domain in the profound category in the DSM V.
- Pervasive since early childhood, the making of sounds that have no correlation to any known languages as the only form of communication.
- Pervasive since early childhood, speaking one or two words repetitively with no correlation to any particular object, person, event or relationship as the only form of communication.
- Not able to communicate by use of sign language or other alternative communication forms or languages.

Non-Verbal Prior Authorizations are reviewed by OHCA supervisor(s) for approval. If a denial is given by the OHCA supervisor, a reconsideration can be requested with new clinical information. The reconsideration will then go to our Psychiatric Consults for review. If the denial is upheld by the Psychiatric Consultant, further reviews will not be reconsidered unless a new request is submitted with additional information.

1:1 CRITERIA

1:1 Authorization MNC -Initial

1. Extent, frequency, severity and consistency of behaviors resulting in imminent danger to self/others cannot be managed with less than 1:1 staffing.
2. Consistent failure of other interventions including active medication treatment.
3. A clear specific individualized patient plan to transition off 1:1 and a realistic d/c date.

1:1 Authorization MNC –Extension

1. Day to day, shift to shift or hour to hour extent, frequency, severity and consistency of severe behaviors resulting in imminent danger to self/others cannot be managed with less than 1:1 staffing.
2. Consistent failure of other interventions including active medication treatment.
3. A clear specific individualized patient plan to transition off 1:1 and a realistic d/c date.

4. Failed attempts to reduce and transition off 1:1 with specific documentations of what worked and what failed and why.

Exclusions for 1:1 staffing authorizations (Initial and Extension):

- Medical conditions (such as a seizure disorder)
- Attendance to ADL's
- AWOL risk or behaviors
- Group attendance

CASE MANAGEMENT

Case management is considered an integral part of discharge planning. Case management is to be offered to all non-state custody SoonerCare members under the age of 21. This includes those members admitted to inpatient services, both acute and PRTF, or those deemed ineligible according to medical necessity criteria for reimbursement for care.

When a SoonerCare member is admitted to an inpatient facility, case management will be offered as a part of the discharge planning that begins at admission. A parent/guardian has the right to decline. If a parent/guardian accepts the case management referral, the treating facility will contact the appropriate case management agency and make the referral. The reviewer may be contacted to assist in the case management referral if necessary.

TRANSFERS

TRANSFERRING A MEMBER REMAINING AT THE SAME LEVEL OF CARE TO AN INTERNAL UNIT OR EXTERNAL PROVIDER

All internal unit and external provider transfers require prior authorization. Observe the following protocol for both internal unit and external provider transfers.

- ORIGINATING facility/unit will specify on the Acute/PRTF Extension template that the Level of Care is a "Transfer".
- ORIGINATING facility/unit will provide the clinical rationale why the member needs to be transferred to the RECEIVING facility/unit. The clinical rationale should be documented in the "Reserve this field to provide additional information requested by OHCA physicians/reviewers" section of the template.
- If the request is approved, the RECEIVING facility/unit will be authorized the number of days remaining from the ORIGINATING facility/unit's authorization at the time the transfer actually occurs. If a child transfers with five (5) days or less remaining on the authorization, the ORIGINATING facility/unit is expected to provide the next extension

request for the RECEIVING facility/unit.

The same procedure applies to TFC clients transferring with less than 30 days remaining on the current authorization. Authorization is NOT required for a transfer. If an extension is not requested by the transferring facility prior to the expiration of the authorization, the new facility will lose days.

CHANGES IN LEVEL OF CARE

If a child is downgraded from acute care to PRTF within the same facility, a new request must be made with the new provider number and the current prior authorization must be end dated.

The initial length of stay for PRTF will be determined based on the clinical information received from the provider. If a child downgrades from acute to PRTF prior to using all the acute days that were prior authorized, the provider will contact the reviewer to request the remainder of the acute days to be switched to PRTF on the day of the downgrade. If the child is going to be downgraded at the time the acute care days expire, then the provider will need to do a phone review on the last business day of the acute authorization.

If a child is in need of a more restrictive level of care and is currently authorized for PRTF, the reviewer is to be contacted by telephone. The provider must clinically justify how the acute level of care will benefit the client (i.e. the need for increased services). Children downgrading from acute or PRTF levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified ARC or the OJA worker so an appropriate TFC placement and treatment can be arranged.

DISCHARGE REFERRAL INFORMATION

Discharge referral information should include information that would adequately prepare those providing follow up care. Information should include:

- Behaviors that can be expected upon discharge.
- Supports that need to be in place for the family & in the community. Educational needs.
- After school needs: daycare vs. to home after school.
- Recreational needs. Day to day activities:
 - Those that are good for the child.
 - Those that should be avoided for the child.

Information about family dynamics and sibling relational issues:

- Safety plan.
- Specific recommendations:
 - If TFC, number of children in the home. Family setting vs. group setting.
 - If child is better with groups or individuals

If child is better with males or females Intimacy needs
Interactions with younger children in the home Interactions with older children in the home

AUTOMATIC STEP DOWN SERVICES AFTER DISCHARGING

For those children preparing to discharge or who have discharged from a higher level of care, automatic step down outpatient services can be utilized for the first 30 (thirty) days. For continuity and expediency, the Individual Plan of Care and Assessment from the higher level of care facility should be sent to the outpatient provider. This will serve as the treatment guide for the outpatient provider/agency the first 30 days of outpatient care.

If during the first 30 days, the client/guardian does not respond to letters, phone calls or other attempts to engage them in initiating services or continuing in services, the outpatient provider/facility will provide this information to a Behavioral Health Review Coordinator either by fax or phone.

DISCHARGE FROM ACUTE, PRTF, or CBT (Effective September 12, 2014)

Inpatient psychiatric programs must provide “Active Treatment”. Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend.

Discharge planning is the responsibility of the provider and should begin at the time of admission. Discharge planning requires active collaboration with the patient, family and all involved outpatient practitioners, agencies, and should be ongoing throughout treatment so that effective connections remain intact. Discharge information should be documented in the patient record as soon as possible and no later than two weeks prior to discharge, including dates and times of the appointments. Needed services may consist of the Wraparound process through Systems of Care, counseling, case management, and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition. Appointments should be no later than 7 days after discharge. Reasons for outlier appointment times should be documented in the member’s chart.

Transition/Discharge Planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff. Examples of appropriate discharge planning are as follows:

- Appointment scheduling and sharing documentation by UR/case management.
- Phone attempts, messages, and contact with guardian regarding treatment and discharge planning.
- Contact and/or staffing with follow up treatment providers (ex: outpatient counseling

agencies, Wraparound, medication management, etc.).

- Scheduling appointments for aftercare services.
- Sharing documentation (copying, scanning, faxing for follow-up care).
- Assist guardians with accessing DDSD, SSI/SSDI
- If a parent/or guardian takes the NAMI education class then it will satisfy the requirement for discharge planning.
- Discharge groups – specific curriculum focused on patient’s discharge goals, what they need to do to achieve them and why follow up treatment is necessary (all issues with not wanting to do follow up care, etc.)
- Treatment plan staffing (only time discussing that patient) – the treatment plan staffing must be noted as a written document that states the discussion is related to transition/discharge planning.

If a member is discharged from an inpatient facility AMA, court ordered out of treatment, or discharge is unplanned, then it is still required that the discharge/stepdown plan is completed. When a member is discharged from the PRTF level of care to outpatient services, the PRTF provider must fax the discharge plan. Please place a copy of the discharge plan in the record showing that it was faxed.

CORRECTION REQUESTS

When a facility finds that a data entry error has been made (e.g., typographical error, wrong provider number, wrong procedure code, wrong SoonerCare member number, etc.), the facility will notify the reviewer by phone with the information to be corrected or may fax in a correction request form.

TRAVEL ASSISTANCE

Each inpatient facility must have a travel assistance policy/plan to assist those SoonerCare families that need assistance with the expenses of traveling to attend family therapy while their child is receiving inpatient psychiatric care. The inpatient facility is responsible for notifying the families of this assistance and the procedure the family must follow.

FAMILY THERAPY ‘In an Instance’/ Exception Request Procedures

1. Family therapy means interaction between a LBHP, member, and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.
2. Family therapy is a part of active treatment and this involves the member and their family/guardian from the time of an admission throughout the treatment and discharge process.
3. Family therapy must be provided one hour per week for acute and residential treatment for members under the age of 18.
4. One hour of individual therapy addressing relevant family issues may be substituted for a family session ‘in an instance’ in which the family is unable to attend a scheduled session by a LBHP

(ex: family emergency, family illness, death, inclement weather, etc).

- ‘In an instance’ is not an ongoing circumstance that will prevent the family from coming to family therapy.
 - ‘In an instance’ should be rare.
 - The therapist is required to document the ‘in an instance’ situation in the clinical template submitted when conducting individual therapy in lieu of family therapy.
5. An exception request is an on-going chronic significant illness or situation that will render the parent/guardian incapable of attending the weekly family therapy sessions (ex: ongoing illness, distance of guardian from facility, etc).
- The exception to conducting weekly family therapy needs to be reported to the behavioral health specialist.
 - The inpatient reviewer will need to staff the ‘exceptions’ to family therapy with the OHCA Behavioral Health Supervisor. The exception designation ‘needs to be approved’ in the medical necessity review prior authorization process.
 - Reasons for exceptions to this requirement must be well documented in the member’s treatment plan.
 - On the clinical template it should be outlined the specifics of the request for an exception and when it went into effect.
6. Children in state custody with no family involvement **are not required** to have their DHS/OJA worker participate in family therapy.

TELEMEDICINE GUIDELINES FOR INPATIENT/RESIDENTIAL PSYCHIATRIC TREATMENT PROVIDERS

The Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have collaborated with the provider community to develop guidelines for the use of telemedicine in the inpatient/residential psychiatric facility setting. It is the expectation that services be provided in person whenever possible, but these guidelines are intended to provide flexibility in certain circumstances. The following guidelines are effective for services provided on and after March 1, 2017:

Family Therapy

- If the family lives more than 60 miles away from the facility;
- In the case of inclement weather preventing the family from physically attending a family session;
- The family member is physically unable to leave the home in order to attend the family session;
- Weekends/after hours.

Individual and Group Therapy

- Weekends and after regular business hours;
- In the case of inclement weather preventing the licensed behavioral health professional from physically attending a session;
- In the event that a client is experiencing a crisis and a licensed behavioral health professional is not on site.

Physician Services

- One in three physician visits may be done via telemedicine.

- The History and Physical **must** be done in person.

Documentation

- Documentation must be maintained by the rendering provider to substantiate the services rendered.
- Documentation must indicate the services were rendered via telemedicine, and the location of the services.
- All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:
 - Chart notes
 - Start and stop times
 - Service provider's credentials
 - Provider's signature

RECREATIONAL THERAPY (Effective September 12, 2014)

Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

PHYSICIAN SERVICES

Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed thirty (30) calendar days in a CBT, seven (7) calendar days in a specialty PRTF, and ten (10) calendar days in a regular PRTF. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs. Due to policy changes physician progress notes must be dated, signed, and time stamped in order for it to count towards the core hours for each specified level of treatment.

ACTIVE TREATMENT

Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services. Individuals in PRTFs must

receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services.

Elective categories for treatment consist of Expressive Therapy (ET), Individual Rehab (IR), Occupational Therapy (OT), Wellness Resource Skills Development (WRSD), and Recreational Therapy (RT), and Group Rehab (GR).

Elective treatment services will be prorated as follows:

Day 1 in Acute is orientation. Day 2, 2 hours of treatment is required. Day 3, 4 hours of treatment is required. Day 4, 6 hours of treatment is required. Day 5, 8 hours of treatment is required. Day 6, 9 hours of treatment is required. Day 7, 10 hours of treatment is required.

Day 1 in Residential Treatment is Orientation. Day 2, 1 hour of treatment is required. Day 3, 3 hours of treatment is required. Day 4, 5 hours of treatment is required. Day 5, 7 hours of treatment is required. Day 6, 9 hours of treatment is required. Day 7, 9.5 hours of treatment is required.

Day 1 in Community Based Treatment is Orientation. Day 2, 1 hour of treatment is required. Day 3, 2 hours of treatment is required. Day 4, 3 hours of treatment is required. Day 5, 4 hours of treatment is required. Day 6, 5 hours of treatment is required. Day 7, 6 hours of treatment is required.

REIMBURSEMENT

Acute psychiatric units within general medical surgical hospitals and Critical Access hospitals will be paid utilizing a DRG methodology. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable and not included in the DRG.

Acute psychiatric units within freestanding psychiatric hospitals will be paid a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable.

Residential treatment in psychiatric hospitals or inpatient psychiatric programs will be reimbursed a pre-determined all-inclusive per diem for routine, ancillary and professional services.

Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at pre-determined per diem to private PRTFs with 16 beds or less for routine services. All other services are separately billable.

Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at a pre-determined all-inclusive per diem to private PRTFs with 16 beds or more for routine, ancillary and professional services.

THIRD PARTY LIABILITY

As the state Medicaid agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. In accordance with OAC 317: 30-3-24, when other health coverage resources are available, those resources must first be utilized by a member prior to filing a SoonerCare claim. This includes coverage by health maintenance organizations (HMO), preferred provider organizations (PPO) and any other insuring arrangements which provide a member access to health care. Members must comply with all requirements of their primary insurance and SoonerCare in order to take advantage of both coverages.

For more information, refer to Chapter 14 of the OHCA billing manual on our website: www.okhca.org/billing-manual, or contact OHCA provider services at 800-522-0114 for onsite training.

NODOS PROCESS

NODOS is an electronic request made by a hospital to reserve a date of service. It allows hospitals to notify OHCA of needed medical services for potential members. The NODOS allows a SoonerCare application to be backdated no more than five (5) days from the date the NODOS is submitted. An application must be completed and the member found eligible within fifteen (15) days of the NODOS being created.

- Example: A NODOS is submitted on 4/10/2016.
 - The member has until 4/25/2016 to submit a completed application.
 - Coverage can be backdated to 4/5/2016.

The only way the provider can be reimbursed for services rendered is if the patient becomes eligible for that date of service. The NODOS is the only way to have eligibility backdated. Those with access to the eligibility screen on the SoonerCare Provider Portal have access to submit a NODOS.

All users should have a clear understanding that:

- The NODOS feature is site specific; meaning the Provider ID submitting the NODOS is the location where the patient was seen. Admission records should be available in the event of an audit.
- The NODOS must be submitted before an application is submitted. Failure to do so may cause the provider to miss payments for compensable services.
- Before starting a NODOS, please have the patient's first/last name, date of birth, gender, citizenship status, social security number, and mailing address.
- Submission of multiple NODOS forms for the same individual will cause delays in processing and payment of claims.
- The original NODOS is good for 15 days after submission.

Protocol for Prior Authorization Requests for Newly Eligible Members when a NODOS is completed:

- Once the member's eligibility is activated in OHCA's MMIS system, the provider has

up to 5 business days to submit a Prior Authorization request to OHCA using the PA Admission template to request up to 5 days for an acute admission or up to 7 days for an PRTF admission.

- If the member's eligibility is not activated in OHCA's MMIS system until after the PA Admission timeframes, the provider will also complete the PA extension template and submit both the PA Admission and Extension template to OHCA at the same time.
- Choose "Newly Eligible" as the REQUEST TYPE when filling out the PA templates.
- Submit the NODOS confirmation with the PA templates.

OHCA APPROVAL OF OUT-OF-STATE PLACEMENTS

When a child is in parental, DHS or OJA custody and admission to an out-of-state facility that is not a border placement is requested, OHCA must approve the placement prior to the child admitting to a facility outside of Oklahoma. Many factors are considered by OHCA in approving a child for placement out-of-state. The primary issues to be considered are lack of appropriate treatment resources in Oklahoma or if the child has exhausted the resources currently available in Oklahoma.

Children who are placed out of state have a serious behavioral health disorder, along with a complicating medical disorder and/or handicap. Some examples might include children with severe autism, brain injury, hearing or vision impairment.

- 1.** The parent/ guardian must contact the OHCA.
- 2.** A face to face assessment referral will be facilitated. If there is a current LBHP (licensed practitioner), this provider needs to contact the OHCA with his/her clinical findings and recommendations for treatment.
- 3.** Medical necessity criteria must be met.
- 4.** The reviewer will request the following information:
 - a. Complete treatment history of the client, including inpatient and outpatient treatment stays must be submitted. The current treating facility and/or guardian can submit this information.
 - b. Medical records from the current treating facility and past treatment providers may be requested.
 - c. A physician's referral letter recommending specialized treatment and noting the unavailability of treatment within the state of Oklahoma, including supportive clinical information such as diagnosis and symptomology must be submitted.
 - d. An Interstate Compact on Placement of Children (ICPC) must be in place between the sending and receiving states.
 - e. This information will be submitted *by fax*. The submitted information will be reviewed with OHCA for final approval.

DEPARTMENT OF HUMAN SERVICES CUSTODY CHILDREN

Prior to placing a DHS custody child in an out-of-state inpatient psychiatric facility, the Juvenile Judge who has jurisdiction and the child's attorney must agree with the placement. There must be prior approval between the sending and receiving states via Interstate Compact on Placement of Children (ICPC). The DHS Child Welfare worker must complete forms, which are submitted to the

Oklahoma ICPC director (405-522-0672) and ICPC approval must be received from the state's ICPC director before the child can be transported to the out-of-state facility. This information will be submitted *by fax*. The submitted information will be reviewed with OHCA for final approval. Initial inquiries can be made by calling the OHCA.

RECONSIDERATION

Effective **July 1, 2006**, the behavioral health reconsideration process ended. The review decision issued is considered by the OHCA to be a final administrative determination and not appealable to the OHCA for any further administrative hearings.

SERVICE QUALITY REVIEW

- 1.** All facilities contracted with the state of Oklahoma that provide acute, residential, and TFC services to SoonerCare recipient under the age of 21 during the past fiscal year will be reviewed by the OHCA contractor.
- 2.** Service Quality Reviews (SQR) will be done as a combination of desktop or on-site audits.
- 3.** Records must be submitted **electronically** through our secure Provider Portal (www.ohcaprovider.com) when a desktop review is done.
- 4.** All documents must be scanned when onsite. Scanner issues will be the only exception to this.
- 5.** Each facility will be reviewed one time within the fiscal period, but OHCA has the right to request the OHCA SQR team to perform an additional ad hoc review at any time.
- 6.** Local/in-state and boarder facilities and agencies may have a complete onsite review. The SQR team may also choose to conduct complete onsite reviews if the facility has special issues that the team believes are best monitored directly or could be missed when records are submitted by the facility or agency.
- 7.** When a facility or agency is found by the review team to have issues that are considered unsafe, or fail to provide services that meet minimum treatment standards as determined by the entire team then a second review is conducted within 60 days. The facility or agency may also be referred to the OHCA Quality Assessment team.
- 8.** Service Quality Reviews are performed as referenced in OAC 317:30-5-95.42 for inpatient providers and in OAC 317:30-5-743.1 for TFC providers.
- 9.** Out of State facilities with existing contracts with the Oklahoma Health Care Authority will receive audit reviews through the following steps:
 - Out of State facilities will have an annual desktop review and three year rotations for onsite visits.
 - Out of State facilities that may have one Oklahoma Medicaid Behavioral Member under 21 that admits occasionally will have a desktop review within the fiscal year following the date of admit and will be asked to provide reports from their state agencies' onsite inspections (fire marshal, licensing, accreditation, etc).
 - The following fiscal year is used because data is pulled from claims billed, (providers have 6 months to bill) and prior authorizations.

- The member's medical record and those documents determine appropriate to request by the OHCA legal department will be requested.

10. The documentation reviewed during inpatient provider SQR includes (but is not limited to)

- DSM-V primary diagnosis
- Clinical information supporting medical necessity criteria and the need for requested level of care. Medical, psychiatric, and social evaluation were completed within the time frame specified by OAC 317: 30-5-95.37.
- Parent(s)/Guardian received copies of the information of behavioral management of patient, guidelines, conditions, grievance procedures, address, and phone number for DHS Advocacy office, patient bill of rights, seclusion/restraint policy and consent for case management.
- Informed consent signed by parent/guardian for use of psychotropic medications; Medical issues are identified and receiving appropriate care.
- Individual Plan of Care (service plan) completed and addresses areas specified by OAC 317:30-5-95.33, including dated signatures of treatment team members, collaboration of parent/guardian medications and dosages and discharge plan.
- RN documentation every 24 hours for acute and every 7 days for PRTF levels of care.
- Services provided for SoonerCare member with developmental disabilities or any disability are rendered appropriately.
- Use of Seclusion/Restraint.
- Frequently of active treatment components as specified in OAC 317: 30-5-95.34.
- Facility accreditation, policies, and procedures.
- Employee licensure, CPR, and crisis management competencies and background checks.
- Telemedicine
 - The facility must document in the member record the method and rationale for utilizing telemedicine.
 - It must be documented in the record if the services provided were done via telemedicine (i.e. individual therapy, family therapy, group therapy, or physicians services).
 - The facility will provide the SQR team with the IT policy surrounding the electronic media utilized to provide telemedicine as to assure that a secure network is being used.
 - Interactive audio and video telecommunication must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member.
 - The medical or behavioral health related service must be provided in an appropriate site for deliver wherein proper security measures are in place.
 - The consent for telemedicine is no longer required.
 - A Physician (M.D. or D.O.) is the only one who can render the one in

- three physicians visits via telemedicine
- The HMP must still be done in person.

11. The documentation reviewed during TFC provider SQR reviews includes (but is not limited to)

- DSM-V primary diagnosis.
- Clinical information supporting the need for requested level of care.
- Medical, psychiatric, and social evaluation were completed within the time frame specified by OAC 317:30-5-95.42.
- Individual Plan of Care (service plan) completed and addresses areas specified by OAC 317:30-5-742.2, including dated signatures of treatment team members, collaboration of guardian, medications, dosages, and discharge plan.
- Frequency of active treatment components as specified in OAC 317:30-5-742.
- Involvement of biological parents, as clinically indicated.
- The facilities use of crisis intervention.
- The facilities accreditation, policies, and procedures; employee licensure and background checks.

