PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241. Coverage for adults and children
(a) Service descriptions and conditions. Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the client. The client must be able to actively participate in the treatment. Active participation means that the client must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria. For ODMHSAS Contracted and Private facilities, an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCs), the medical necessity criteria will be self-administered following the same required elements as the private and contracted (ODMHSAS) agencies under OAC 317:30-5-241(b)(4)(B)(i). Non prior authorized services will not be Medicaid compensable with the exception of Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development, Crisis Intervention Services (by a MHP and Facility based), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care with the exception of Psychotherapy services which must be authorized by the OHCA or its designated agent as medically necessary and indicated, and Crisis Intervention Services (facility based). Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) Mental Health Assessment by a Non-Physician includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). The service must also include an evaluation of the client's strengths and information regarding the client's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the client. For children under the age of 18, it must
include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP. The minimum face-to-face time spent in assessment with the client and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. This service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for AOD providers.

(2) **Alcohol and Drug Assessment.** Alcohol and Drug Assessment includes an assessment of past and present alcohol and other drug use. The ASI is to be completed. This service includes an evaluation of current and past functioning in all major life areas and an evaluation of potential mental illnesses that may also impact treatment. It includes a full five axes diagnosis. The service must also include an evaluation of the client's strengths and weaknesses and information regarding the client's treatment preferences. For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP. The minimum face to face time spent in assessment with the client (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. The service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for Mental Health Providers.

(3) **Mental Health Services Plan Development by a Non-Physician (moderate complexity).** Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise
the treatment team. It is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment by the practitioners and the client of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(4) Mental Health Services Plan Development by a Non-Physician (low complexity). Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated...
to reflect the improved client's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(5) **Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity).** Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria is to be utilized and followed. The service is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the client. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible AODTP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date
of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(6) **Alcohol and/or Substance Abuse Treatment Plan Development (low complexity).** Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria will be utilized in the development of the Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible AODTP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(7) **Individual/Interactive Psychotherapy.**

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is generally furnished to children and involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the client who has not yet developed or who has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of a language
interpreter due to language barriers.
(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the client and the MHP or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the client's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the client's developmental and cognitive abilities.
(D) Individual/Interactive counseling must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) **Group Psychotherapy.**
(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the MHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual client's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.
(B) Group Psychotherapy must take place in a confidential setting limited to the MHP or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. The typical length of time for a group psychotherapy session is one hour. A maximum of two Group Psychotherapy units per day are allowed. Partial units are acceptable. The
individual client's behavior, the size of the group, and the focus of the group must be included in each client's medical record. A group may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(9) **Family Psychotherapy.**

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a MHP or an AOD and the client's family, guardian, and/or support system. It is typically inclusive of the identified client, but may be performed if indicated without the client's presence. When the client is an adult, his/her permission must be obtained. Family psychotherapy must be provided for the direct benefit of the Medicaid recipient to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting.

(B) The length of a Family Psychotherapy session is one hour. No more than two hours of Family Psychotherapy are allowed per day. Partial units are acceptable. Family Psychotherapy must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) **Psychosocial Rehabilitation Services (group).**

(A) Psychosocial Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the client's ability to function in the community. They are performed to improve the skills and abilities of clients to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. Each day of PSR must be reflected by documentation in the client records, and must include the following:

(i) date;
(ii) start and stop time(s) for each day of service;
(iii) signature of the rehabilitation clinician;
(iv) credentials of the rehabilitation clinician;
(v) specific goal(s) and/or objectives addressed (these must be identified on recovery plan);
(vi) type of skills training provided;
(vii) progress made toward goals and objectives;
(viii) client satisfaction with staff intervention; and
(ix) any new needed supports identified during service.
(B) Compensable Psychosocial Rehabilitation Services are provided to clients who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each BHRS or MHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE. In order to develop and improve the client's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS or MHP must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(D) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder), or MHP may perform group psychosocial rehabilitation services, using a treatment curriculum approved by a MHP.

(11) **Psychosocial Rehabilitation Services (individual).**

(A) Psychosocial Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the client present, but may include the client's
family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder, or MHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(12) **Psychological testing.**

(A) Psychological testing is provided by a psychologist utilizing tests selected from currently accepted psychological test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Psychological testing will be provided by a psychologist, certified psychometrist, or a psychological technician of a psychologist.

(13) **Alcohol and/or Substance Abuse Services, Skills Development (group).**

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of clients regarding their AOD addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, luncheons and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each AODTP for adults and eight to one for children under the age of eighteen. This service may be performed by an AODTP or a BHRS. In order to develop and improve the client's community and interpersonal functioning and self care abilities, services may take place in settings away from the Outpatient Behavioral Health agency site. When this
occurs, the AODTP or BHRS must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. (C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP.

(14) Alcohol and/or Substance Abuse Services, Skills Development (individual).

(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services, Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) An AODTP or BHRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable.

(15) Medication Training and Support.

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a client's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the client on the appropriate level of the least
intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for Medicaid recipients who reside in ICF/MR facilities. 

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(16) **Crisis Intervention Services.**

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for Medicaid recipients who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster home, or recipients who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month and 40 units each 12 months per recipient. 

(B) Crisis Intervention Services must be provided by a MHP.

(17) **Crisis Intervention Services (facility based stabilization).** Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include MHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult Medicaid recipients. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code.

(18) **Program of Assertive Community Treatment (PACT) Services.**

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community
based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

(i) Assessment and evaluation;
(ii) Treatment planning;
(iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;
(iv) Symptom assessment, management, and individual supportive psychotherapy;
(v) Medication evaluation and management, administration, monitoring and documentation;
(vi) Rehabilitation services;
(vii) Substance abuse treatment services;
(viii) Activities of daily living training and supports;
(ix) Social, interpersonal relationship, and related skills training; and,
(x) Case management services.

(B) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. The unit is a per diem inclusive of all services provided by the PACT team. No more than 12 days of service per month may be claimed. Medicaid recipients who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization).

(19) Behavioral Health Aide. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing
interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit to meet the requirement as a BHRS or may substitute one year of relevant employment and/or responsibility in the care of emotionally disturbed children for up to two years of college experience, and:

(i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
(ii) must be directly and closely supervised by a licensed Mental Health Professional; and
(iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent).

(b) Prior authorization and review of services requirements.

(1) General requirement.

(A) All Medicaid providers who provide outpatient behavioral health services are required to have the services they provide either prior authorized or retroactively reviewed by a contractor of OHCA. Private behavioral health providers and providers identified by the ODMHSAS as contracted providers are required to have all services prior authorized with the exception of the three services listed in paragraph (2)(A) of this subsection.

(B) CMHC's, as identified by the ODMHSAS, are required to have all services retroactively reviewed by a contractor of OHCA.

(2) Prior authorization and review of services.

(A) All Medicaid services identified in subsection (a) of this Section must be prior authorized or reviewed as set forth in paragraph (1) of this subsection except for the following services:

(i) Mental Health Assessment by a Non-Physician [see subsection (a)(1) of this Section];
(ii) Mental Health Services Plan Development by a Non-Physician (moderate complexity) [see subsection (a)(2) of this Section]; and
(iii) Crisis Intervention Services and Adult Facility Based Crisis Intervention [see subsection (a)(17) and (18) of this Section]. Children's Facility Based Stabilization requires prior authorization.

(B) Prior authorization means the authorization of
services prior to services being rendered. Should a provider perform services prior to the authorization, those services are performed at the risk of nonpayment by OHCA.

(3) Contractor for prior authorization and review of services. The contractor who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(4) Prior authorization process.
(A) Definitions. The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

(i) "Outpatient Request for Prior Authorization" means the form used to request the OHCA contractor to approve services.
(ii) "Authorization Number" means the number that is assigned per recipient and per provider that authorizes payment after services are rendered.
(iii) "Initial Request for Treatment" means a request to authorize treatment for a recipient that has not received outpatient treatment in the last six months.
(iv) "Extension Request" means a request to authorize treatment for a recipient who has received outpatient treatment in the last six months.
(v) "Modification of Current Authorization Request" means a request to modify the current array or amount of services a recipient is receiving.
(vi) "Correction Request" means a request to change a prior authorization error made by OHCA's contractor.
(vii) "Provider change in demographic information notification" means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.
(viii) "Status request" means a request to ask the OHCA contractor the status of a request.
(ix) "Important notice" means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.
(x) "Letter of collaboration" means an agreement between the recipient and two providers when a
recipient chooses more than one provider during a course of treatment.

(B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA contractor, prior to rendering the initial services or any additional array of services, with the exception of the three services noted in paragraph (2) of this subsection.

(i) These request forms must be fully completed including the following:
   (I) pertinent demographic and identifying information;
   (II) complete and current Client Assessment Record (CAR) unless another appropriate assessment tool is authorized by contractor;
   (III) complete multi axial, Diagnostic and Statistical Manual (DSM) diagnosis using the most current edition;
   (IV) psychiatric and treatment history;
   (V) service plan with goals, objectives, treatment duration;
   (VI) services requested;
   (VII) signature of client on service plan; and
   (VIII) appropriate provider signature on all forms.

(ii) The OHCA contractor may also require supporting documentation for any data submitted by the provider. The request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.

(iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.

(C) **Authorization for services.**

(i) Services are authorized by the contractor exercising independent medical judgment based upon the medical data provided by the provider. The medical data provided, including the functional assessment (including frequency, duration and severity of behaviors), diagnosis and other medical history, is of paramount importance. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon six levels of care for children and five levels of care for adults. The numerically based levels of care are designed to reflect the client's acuity as each level of care, in ascending order, provides for more
services for the recipient's care. For example, a Level I (adult) designation provides for 1-12 RVU's while a Level II provides for 1-20 RVU's per month. The range of RVU's between the Level I and Level IV for both children and adults is 1 RVU per month to 62 RVU's per month. Other levels of care are known as Exceptional Case, 0-36 months, ICF/MR, and RBMS. (ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.
(D) **Appeals process.** (i) After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered.

(ii) If a reconsideration request is made, the contractor's decision is a final decision and notice is sent to the client as required by 42 CFR 431.211. Notice is also sent to the provider. If a reconsideration request is not made, the initial decision of the contractor constitutes the final decision regarding the authorization and notice is sent to the recipient as required by 42 CFR 431.211.

(iii) In the event a recipient disagrees with the decision by OHCA's contractor, it may appeal the decision regarding the prior authorization under OAC 317:2-1-2. An appeal must commence within 20 calendar days of the prior authorization reconsideration decision (in the event the provider asks for reconsideration) or within 20 days of the initial decision (in the event no reconsideration request is filed).