AGENDA

April 25, 2016
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

I. Welcome, Roll Call, Introduction, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

A. Introduction of Melody Anthony to the MAC

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. Action Item: Approval of Minutes of the March 10, 2016 Medical Advisory Committee Meeting

V. Summary of ODMHSAS Emergency Rule Changes: **Traylor Rains-Sims, Director, Policy and Planning, ODMHSAS**

- Item #16-04 – Agency Therapy Limits
- Item #16-05 – Independent LBHP Therapy Limits
- Item #16-06 – Treatment Plan Update Limits

VI. New Business: Chairman, Steven Crawford, M.D.

VII. Future Meetings:

May 19, 2016 at 1:00 PM
July 21, 2016 at 1:00 PM
September 15, 2016 at 1:00 PM
November 17, 2016 at 1:00 PM

VIII. Adjourn

Next Meeting
Thursday, May 19 , 2016
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd, Oklahoma City, OK 73105

MAC Minutes for March 10, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM. He also explained that we again have the capabilities of people to attend the MAC through the GoToMeeting option. He recognized Mr. Ed McFall, Chairman of the Board to the Oklahoma Health Care Authority (OHCA) who was in attendance in the audience today. He then asked that the roll call be taken. ***Delegates present were*****:** Dr. Steve Crawford, Dr. Joe Catalano, Dr. Stanley Grogg, Ms. Annette Mays, Mr. James Patterson, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Mr. David Rising, Dr. Kanwal Obhrai (arrived after roll call was taken), Mr. Rick Snyder, and Mr. Jeff Tallent.
Alternates present were: Ms. Sarah Baker, Ms. Lois Baer (phone), Ms. Joni Bruce, Ms. Frannie Pryor, Mr. Traylor Rains-Sims, Dr. Gail Poyner, and Dr. Mike Talley (phone) providing a quorum.

Delegates absent without an alternate were**:** Dr. David Cavallaro, Ms. Samantha Galloway, Dr. Melissa Gastorf, Mr. Steve Goforth, Mr. Mark Jones, Dr. Denae Kirkpatrick, and Ms. Liz Moran.

Public Comments

Dr. Crawford asked for public comments and there was one public comment made by Ms. Jolene Ring with the Oklahoma Psychiatric Hospital Association (OPHA). She wanted to voice the association's support of their letter of objections to some rule changes that was submitted to OHCA. She voiced their objection and admitted to not having seen the actual language, to WF #15-62 (317:30-5-95.24A) where the first part had a language change to the proposal at the last minute that states the subsidies be done in compliance with 42 CFR. They would like to have that tabled until they can see what that means. They also oppose the next section that refers to the restriction of "a unit", again trying to define what "a unit" means. They also object to WF #15-62 (317:30-5-95.24A part D), which would require an LPN for every 30 patients. This would be a huge expense. They also objected to WF #15-58 (317:30-5-95.34E2) stating that this would create a huge burden on the therapist and families because if they cannot get within the three days then they are out of compliance. No other public comments were made.

Member Comments Approval of Minutes

Dr. Crawford asked if any member of the MAC had a comment and there were none. Dr. Crawford explained the confusion over the minutes of the January 21st MAC Meeting by stating there were a lot of public comments and commotion over a particular rule that is well documented in the minutes. There was also a vote that was fairly contested and it ended up being a 10 to 10 tie and there were some concerns because there were some members of the MAC who left early and there needed to be confirmation on who left prior to the vote. There is a very detailed analysis of that vote in the minutes. Dr. Crawford then submitted that the approval of the January 21, 2016, be made. Mr. Jeff Tallent moved to accept the minutes and Dr. Stanley Grogg seconded the motion. Dr. Grogg then went on to explain that he was listening to the January meeting online but was unable to participate due to it being

a one-way communication. He was present but unavailable to vote due to technology. The vote to accept the minutes as written was unanimous.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's fiscal year 2016 financial transactions through the month of December 2015. She reported that the total for FY 2016 variance a positive $8.7 million dollars. On the expenditure side, we were under budget with the Medicaid program by 0.1% for $2 million state dollars and the administration was under budget by 7.4% for $2.6 million state dollars. On the revenue side, over budget on Drug Rebates Collections by 4.4% for $2.3 million state dollars and tobacco tax collections and fees by 9.0% for $2.1 million state dollars and under budget in Overpayments/Settlements by 3.7% for a negative of $0.3 million state dollars. On March 3rd the Office of Management and Enterprise Services (OMES) announced that further reductions to agency general revenue allocations were needed. The revised revenue affiliator was asked by OMES to reduce OHCA allocations by an additional 4%. This resulted in a loss to OHCA in the amount of $36.5 million state dollars. At this point, the cumulative total loss of state funds for state FY2016 is $63.8 million state dollars. In order to balance our program budget for FY2016, the agency is proposing to push our weekly expenditure payment to state FY2017.

SoonerCare Operations Update

Melody Anthony, Director of Provider/Medical Home Services, stated that it seems we have stabilized in our enrollment but we did have a slight decrease between November and December of 2015. We work to continue to keep our costs and provider networks stable. On the chart we show the high cost and low cost of the population and even though the costs fluctuate, the trend lines remain stable. On the cost for Insure Oklahoma (IO), we have seen a slight decrease but we have seen a slight increase in enrollment. We increased the ESI employer's side in September of 2015 to employers who employ up to 250 employees so we continue to see growth in Insure Oklahoma. We have utilized a vendor in marketing this product through billboards and public service announcements to that population. We have had to provide rate reductions in our program in 2010-2015 and in 2016, which is why we monitor our SoonerChoice population and providers. We trend our choice providers by tiers and it was our intention that the providers would achieve Tier 3 status and it has increased over time. We initially started the Medical Home in 2009. In 2014 we were charged with trying to find out the best way to modify the Choice Program with the integration of behavioral health. We worked with the Department of Mental Health and Substance Abuse and we added mandatory behavioral health screening in medical homes for members age 5 and above. We eliminated the generic drug prescribing in SoonerExcel and replaced it with a Behavioral Health screening rate payment. In 2014 it was initially a matter of educating the behavioral health staff in the community as well as Primary Care Physicians on tools they could use. We have worked with finance and were able to raise the screening rate from $2.00/screening to $5.00/screening and the screenings have gone up substantially and our reimbursement to the doctors continues to rise. We are also working with the Department of Mental Health and Substance Abuse in getting their Health Home providers with our Primary Care Providers where they share the care coordination of the children that are in Health Home diagnosed with SMI

(Severely Mentally Ill) and adults diagnosed with SMI (Severely Mentally Ill). Dr. Crawford asked for questions or comments which there were none.

Legislative Update

Emily Shipley, Director of Governmental Affairs, stated that the legislative session is currently on a deadline week. They are in their second week of time on the floor and until they end their session tonight, they will be hearing bills that have gone through their prospective committees and are now getting full consideration by the full senate and house bodies. She gave updates on a couple of bills (SB 1340 and HB 2803). Senator A. J. Griffin and Representative David Derby are the authors of these bills. Representative Doug Cox has authored a bill (HB 2665) that addresses coverage for able bodied adults in our Medicaid program. Emily and Nico Gomez have met with members to make sure that they know that terminating coverage for this population; which is about 110,000-111,000 is not actually a possibility. It is a federal requirement to keep those individuals. The budget is not looking great for the Health Care Authority for the remainder of this fiscal year as well as fiscal year 2017. The Legislators are not really saying much at this point as to what the impact will be for each agency but we do know that the Health Care Authority will not be held harmless, as the agency has been in the past. We are working with our providers and looking through each of the programs and how the appropriation cuts will impact each of those. Dr. Crawford asked for any questions which there were none.

Health Policy-Proposed Rule Changes

Demetria informed the MAC that they had a meeting with the Tribal Council on the proposed rule changes on Tuesday, November 3, 2015 and again Tuesday, January 5, 2016. These meetings were held at OHCA.

A) **Item #15-01:** After the reading of the summary and a brief clarification, Dr. Joe Catalano moved for acceptance; Ms. Annette Mays seconded the motion and it passed unanimously.

B) **Item #15-07A:** After the reading of the summary, Mr. Jeff Tallent moved for acceptance; Dr. Stanley Grogg seconded the motion and it passed unanimously.

C) **Item #15-07B:** After the reading of the summary, Mr. Jeff Tallent moved for acceptance; Dr. J. Daniel Post seconded the motion and it passed unanimously.

D) **Item #15-08:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Dr. Kanwal Obhrai seconded the motion and it passed unanimously.

E) **Item #15-17:** After the reading of the summary there was a brief discussion of the language used in Sections A, C, and F and a request was made to change "pair of frames" to "pair of glasses". Dr. Jason Rhynes moved for acceptance; Dr. Edd Rhoades seconded the motion and it passed unanimously.

F) **Item #15-18:** After the reading of the summary, Mr. Jeff Tallent moved for acceptance; Mr. Traylor Rains-Sims seconded the motion and it passed unanimously.

G) **Item #15-21:** After the reading of the summary, Dr. Edd Rhoades moved for acceptance; Ms. Joni Bruce seconded the motion and it passed unanimously.

H) **Item #15-24:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Dr. J. Daniel Post seconded the motion and it passed unanimously.

I) **Item #15-28:** After the reading of the summary, Ms. Joni Bruce moved for acceptance; Mr. Rick Snyder seconded the motion and it passed unanimously.

J) **Item #15-36:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Dr. J. Daniel Post seconded the motion and it passed unanimously.

K) **Item #15-38:** After the reading of the summary, Dr. J. Daniel Post moved for acceptance; Dr. Edd Rhoades seconded the motion and it passed unanimously.

L) **Item #15-41:** After the reading of the summary there was some concern about paragraph 7 being against federal policy and being factually incorrect. Mr. Rick Snyder referenced federal regulation 42 CFR 447.15. He also referenced a Provider Letter back in 1997 that reinforces the fact that providers have the option of billing a liability insurance over Medicaid in a third party situation. There was a motion by Mr. Rick Snyder to accept the proposed rule change without paragraph 7 and hold that for further discussion; Dr. J. Daniel Post seconded the motion. Dr. Crawford then recognized Nicole Nantois from the agency to respond. Nicole stated that it is written according to federal regulations and asked that it be passed as written. The different interpretations between CMS and OHCA were further discussed. It was pointed out that this is already taking place and that this is just a cleanup of the language. It was asked that the agency provide clarification and Susan Eads, Deputy General Counsel, from Legal provided that. She also referenced a Provider Letter that came out in 2005 that addressed Third Party Liability. Mr. Rick Snyder voiced that this is not going to be solved today and that is why he moved to accept this rule with the elimination of paragraph 7 and Nicole stated that the agency did not agree to this but Dr. Crawford reminded everyone that the MAC is advisory only and asked for any other comments. Mr. Rick Snyder thanked everyone for the discussion. Dr. Crawford asked that paragraph 7 be held for further discussion and the rest of the rule be forwarded to the OHCA Board for their approval. The motion was passed with all in favor with the exception of Dr. Jason Rhynes who voted nay. A call vote was turned down. The members on the phone are currently abstaining from the voting process due to technology.

M) **Item #15-42:** After the reading of the summary, Mr. Traylor Rains-Sims moved for acceptance; Ms. Frannie Pryor seconded the motion and it passed unanimously.

N) **Item #15-43:** After the reading of the summary, Mr. Jeff Tallent moved for acceptance; Mr. Rick Snyder seconded the motion and it passed unanimously.

O) **Item #15-48:** After the reading of the summary, Dr. Edd Rhoades moved for acceptance; Mr. Traylor Rains-Sims seconded the motion and it passed unanimously.

P) **Item #15-50:** After the reading of the summary, Mr. Traylor Rains-Sims moved for acceptance; Mr. Jeff Tallent seconded the motion and it passed unanimously.

Q) **Item #15-52:** After the reading of the summary, Dr. J. Daniel Post moved for acceptance; Dr. Stanley Grogg seconded the motion and it passed unanimously.

R) **Item #15-53:** After the reading of the summary, Mr. Traylor Rains-Sims moved for acceptance; Dr. J. Daniel Post seconded the motion. Dr. Crawford asked for comments and Mr. Rick Snyder expressed concern that the rule would require a provider to testify in person at hearings and asked that is be considered to allow telephonic attendance to continue. A motion for approval by Traylor Rains-Sims; Dr. J. Daniel Post seconded the motion and it passed unanimously.

S) **Item #15-54:** After the reading of the summary, Dr. Crawford expressed concern about the budget impact and there was discussion on "emergency transportation". It was explained that there were guidelines through CFR and state legislation which lay out the criteria for ambulance transportation. Mr. James Patterson moved for acceptance; Dr. Kanwal Obhrai seconded the motion and it passed unanimously.

T) **Item #15-55:** After the reading of the summary, Dr. J. Daniel Post moved for acceptance; Mr. Jeff Tallent seconded the motion and it passed unanimously.

U) **Item #15-56:** After the reading of the summary, Ms. Toni Pratt-Reid moved for acceptance; Dr. Edd Rhoades seconded the motion and it passed unanimously.

V) **Item #15-57:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Dr. Edd Rhoades seconded the motion and it passed unanimously.

W) **Item #15-58:** After the reading of the summary, Dr. Crawford asked for comments and Mr. Rick Snyder asked for clarification on the 10 day waiting period between services. It was explained that there should be no more than 10 days between the first day that the patient is seen and the follow up visit occurs. Dr. Gail Poyner asked for explanation of the Quality Review. Demetria explained that the review may occur at any time in the form of a "Quality Audit" for inpatient. Dr. J. Daniel Post asked how this would affect out-of-state reviews and it was stated that they would have these as well. Ms. Frannie Pryor moved for acceptance; Mr. Traylor Rains-Sims seconded the motion and it passed unanimously.

X) **Item #15-61:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Mr. Jeff Tallent seconded the motion and it passed unanimously.

Y) **Item #15-62:** After the reading of the summary, Dr. Crawford asked for comments and there was discussion on the “line of sight” and the cost of the staffing ratios being implemented. Dr. Stanley Grogg moved for acceptance; Dr. Joe Catalano seconded the motion and it passed unanimously.

Z) **Item #15-65:** After the reading of the summary, Dr. Crawford asked for comments and there was concern expressed that some of the staff coming in would not have been taught how to administer testing but it was explained that this rule did not include the administering of tests. Ms. Frannie Pryor moved for acceptance; Mr. James Patterson seconded the motion and it passed unanimously.

AA) **Item #15-66:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Mr. Jeff Tallent and Ms. Joni Bruce seconded the motion and it passed unanimously.

Informational Item Only

Melinda Thomason explained that the Access Monitoring Review Plan is the new requirement in regulation from CMS and we are to consult with our Medical Advisory Committee to develop such a plan. It is an analysis and review of certain monitoring items. The last four pages of the agenda are the regulations word for word. There has been a committee formed to work on this as an agency project under the auspices of our Project and Portfolio Management Office. We have a project manager. This will probably be a 200 page document. There are certain designated areas to include. There will be information about our SoonerCare Program and Indian Health Services, Tribal and Urban Indian Organization (I/T/U) Program. This will also contain reference to Sooner Ride, Telemedicine, Telehealth, and Virtual Visits. It will be presented to the MAC on April 2 and will post it on the agency website on April 18th right up until the MAC May 19th meeting at which time they would be able to present feedback. This will have impressions of Access to Care and it will look at comparisons between rural and urban care, and will be a comprehensive document that will be used by the agency for years to come. They will be providing annual reports and strategic plans to information CMS of what we are doing for monitoring access to care. Ultimately, this document will go into CMS by July 1st at that point, any state plan amendment that we submit after July 1st with any kind of rate impact with it, will require this plan be submitted with it and perhaps a focus study of the area being touched. This document will be our benchmark document. It also comes with a mandate to annually update and revise it but there can be periodic revisions as needed especially with respect to targeted areas.

New Business / Member Comments

No new business was discussed.

Future Meetings

Dr. Crawford informed the MAC that it has been asked by the Agency to meet on April 25th at 1:00 PM which has been set aside specifically to discuss the Department of Mental Health rules. Dr. Crawford asked if the Agency could look at alternate dates for the meeting since some could not attend on that date.

Adjournment

Dr. Crawford asked for a motion to adjourn. It was provided by Dr. Stanley Grogg. There was no dissent and the meeting was adjourned.

AGENDA

April MAC

Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Wednesday, April 6, 2016 in the Board Room of the OHCA.

The following rules are posted for comment from March 28, 2016 through April 24, 2016.

16-04 Reduction in limits for psychotherapy provided in Outpatient Behavioral Health Agencies — Outpatient behavioral health agency rules are amended in order to set daily and weekly limits for the amount of individual, group and family psychotherapy that are reimbursable by SoonerCare. The current daily limits of 6 units of individual, 12 units of group and 12 units of family therapies will be reduced to 4 units, 6 units and 4 units respectively. In addition, weekly limits will be imposed that limit the total amount of group therapy in a week to 3 hours and Individual and Family therapy will cumulatively be limited to 2 hours per week. Additionally, revisions include adding language that excludes therapy limitations to outpatient behavioral health services provided in a foster care setting. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.

Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $3,031,168 Total; $1,182,459 State share. Estimated savings to ODMHSAS for SFY 2017 is $36,374,029 Total; $14,189,509 State Share.

16-05 Reduction in limits for psychotherapy provided by Independently Contracted Licensed Behavioral Health Professionals — Rules for Licensed Behavioral Health Professionals who choose to practice on their own are amended in order to reduce the monthly limits of psychotherapy reimbursable by SoonerCare. The current limit of 8 units/sessions per month will be reduced to 4 units/sessions per month. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.
Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $305,298 Total; $119,097 State share. Estimated savings to ODMHSAS for SFY 2017 is $3,663,583 Total; $1,429,164 State share.

16-06 Reduction in limits for reimbursable service plan updates — Outpatient behavioral health agency rules are amended in order to reduce the number of SoonerCare compensable service plan updates to one every six months. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended

revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.
Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $12,817 Total; $5,000 State share. Estimated savings to ODMHSAS for SFY2017 is $205,075; $80,000 State share.

AGENDA

Item #16-04 – Reduction in limits for psychotherapy provided in Outpatient Behavioral Health Agencies

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy.**

(1) **Definition.** 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. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.
(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners.** Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate in a setting that protects and assures confidentiality.

(4) **Limitations.** A maximum of ~~6~~4 units per day per member is compensable. A cumulative maximum of 8 units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the qualified practitioner 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 member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/IID where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners.** Group psychotherapy will be provided by an LBHP or Licensure Candidate. Group Psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of ~~12~~6 units per day per member is compensable, not to exceed 12 units per week. Group Psychotherapy is not reimbursable for a child younger than three. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between ~~anqualified~~ a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified practitioners.** Family Psychotherapy must be provided by an LBHP or Licensure Candidate.

(3) **Limitations.** A maximum of ~~12~~4 units per day per member/family unit is compensable. A cumulative maximum of 8 units of individual psychotherapy and family psychotherapy per week per member is compensable. The practitioner may not bill any time associated with note taking and/or medical record upkeep. The practitioner may only bill the time spent in direct face-to-face contact. Practitioner must comply with documentation requirements listed in OAC 317:30-5-248. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or Licensure Candidates.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or Licensure Candidates.

(C) Substance use disorder specific services are provided by LBHPs or Licensure Candidates qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC), LBHP, or Licensure Candidate who meets the professional requirements listed in 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified practitioners.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) or Licensure Candidates listed in 30-5-240.3(a) and (b).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and

paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of 1 session per week;

(ii) Family therapy - a minimum of 1 session per week; and

(iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified practitioners.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or Licensure Candidate, a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP or Licensure Candidate.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Behavioral Health

Rehabilitation Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services);

(ii) Group therapy at least two hours per week; and

(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Behavioral health case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

Agenda

Item #16-05 – Reduction in limits for psychotherapy provided by Independently Contracted Licensed Behavioral Health Professionals

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Coverage for adults by a LBHP is limited to ~~Bio-Psycho-Social Assessments~~ bio-psycho-social assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) ~~Bio-Psycho-Social and Level of Care Assessments.~~Bio-psycho-social and level of care assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for ~~Children's Level of Care~~children's level of care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It

may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy

records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) ~~Assessment/Evaluation~~Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to ~~eight~~four sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving ~~Residential Behavioral Management~~residential behavioral management in a foster home, also known as therapeutic foster care, or a child receiving ~~Residential Behavioral Management~~residental behavioral management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.
(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

Agenda

Item #16-06 – Reduction in limits for reimbursable service plan updates

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

~~(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.~~

~~(D)~~(C) **Target population and limitations.** The Behavioral Health Assessment by a Non-Physician, moderate complexity, is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

~~(E)~~(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

~~(i) Date, to include month, day and year of the assessment session(s);~~

~~(ii) Source of information;~~

~~(iii) Member's first name, middle initial and last name;~~

~~(iv) Gender;~~

~~(v) Birth Date;~~

~~(vi) Home address;~~

~~(vii) Telephone number;~~

~~(viii) Referral source;~~

~~(ix) Reason for referral;~~

~~(x) Person to be notified in case of emergency;~~

~~(xi) Presenting reason for seeking services;~~

~~(xii) Start and stop time for each unit billed;~~

~~(xiii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14;~~

~~(xiv) Bio-Psychosocial information which must include:~~

~~(I) Identification of the member's strengths, needs, abilities and preferences;~~

~~(II) History of the presenting problem;~~

~~(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;~~

~~(IV) Health history and current biomedical conditions and complications;~~

~~(V) Alcohol, Drug, and/or other addictions history;~~

~~(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;~~
~~(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;~~
~~(VIII) Educational attainment, difficulties and history;~~
~~(IX) Cultural and religious orientation;~~
~~(X) Vocational, occupational and military history;~~
~~(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;~~
~~(XII) Marital or significant other relationship history;~~
~~(XIII) Recreation and leisure history;~~
~~(XIV) Legal or criminal record, including the identification of key contacts, (e.g., attorneys, probation officers, etc.);~~
~~(XV) Present living arrangements;~~
~~(XVI) Economic resources;~~
~~(XVII) Current support system including peer and other recovery supports.~~
~~(xv) Mental status and Level of Functioning information, including questions regarding:~~
~~(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;~~
~~(II) Affective process, such as mood, affect, manner and attitude, etc.;~~
~~(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and~~
~~(IV) Full DSM diagnosis.~~
~~(xvi) Pharmaceutical information to include the following for both current and past medications;~~
~~(I) Name of medication;~~
~~(II) Strength and dosage of medication;~~
~~(III) Length of time on the medication; and~~
~~(IV) Benefit(s) and side effects of medication.~~
~~(xvii) Practitioner's interpretation of findings and diagnosis;~~
~~(xviii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment;~~
~~(xix) Client Data Core Elements reported into designated OHCA representative.~~
(i) Behavioral, including substance use, abuse, and dependence;
(ii) Emotional, including issues related to past or

current trauma;
(iii) Physical;
(iv) Social and recreational;
(v) Vocational;
(vi) Date of the assessment sessions as well as start and stop times;
(vii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14; and
(viii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. 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, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable once every six months.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and
(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.
(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.
(xiii) Service plan updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and

the primary LBHP or Licensure Candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member, but are only compensable once every six months. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements.** All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention;

and
(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of three, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

Agenda