SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95. General provisions and eligible providers

(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.

(b) **Definitions.** The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"AOA"** means American Osteopathic Accreditation.

(2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.

(3) ~~**"JCAHO"** means Joint Commission on Accreditation of Healthcare Organizations.~~ "TJC" means The Joint Commission.

(4) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.

(5) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.

(6) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a ~~patient~~ member to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the ~~patient's~~ member's behavior or restrict the ~~patient's~~ member's freedom of movement and is not the standard treatment or dosage for the ~~patient's~~ member's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a ~~patient~~ member for the purpose of conducting routine physical examinations or tests, or to protect the ~~patient~~ member from falling out of bed, or to permit the ~~patient~~ member to participate

in activities without the risk of physical harm (this does not include physical escort).

(7) **"Seclusion"** means the involuntary confinement of a ~~patient~~ member alone in a room or area from which the ~~patient~~ member is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the ~~patient~~ member, a staff member, or others.

(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:

(1) appropriately licensed and surveyed by the state survey agency;

(2) accredited by ~~JCAHO~~ TJC; and

(3) contracted with the Oklahoma Health Care Authority (OHCA).

(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. Section ~~1~~402 ~~and~~ accredited by TJC, CARF, COA or AOA and approved by the OHCA to provide services to individuals under age 21. Distinct PRTF units of state operated psychiatric hospitals serving individuals ages 18-22 are exempt from licensure pursuant to Title 63 O.S. Section 1-702. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:

(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.

(2) **Attestation letter.** The attestation letter at a minimum must include:

(A) the name and address, telephone number of the facility, and a provider identification number;

(B) the signature and title of the individual who has the legal authority to obligate the facility;
(C) the date the attestation is signed;
(D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;
(E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;
(F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and
(G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.

(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.4. Individual plan of care for adults ages 21 to 64

(a) Before admission to a psychiatric hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each ~~applicant or recipient~~ member age 21 to 64. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the ~~recipient's~~ member's care must review each plan of care at least every seven days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the ~~patient's~~ member's medical records. All must be signed and dated by the physician, RN, MHP, ~~patient~~ member, and other treatment team members that provide individual, family and group therapy in the required review interval. If the ~~patient~~ member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews.

(d) The plan of care must document appropriate ~~patient~~ member participation in the development and implementation of the treatment plan.

317:30-5-95.5. Physician review of prescribed medications for adults age 21 to 64

All prescribed medications for adults age 21 to 64 must be reviewed by the physician at least every seven days; the review must be documented in the ~~patient's~~ member's medical record by the physician signing his/her name and title and dating the orders.

317:30-5-95.6. Medical, psychiatric and social evaluations for adults age 21 to 64

The record for an adult ~~patient~~ member age 21 to 64 must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within 48 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within 48 hours of admission by a M.D. or D.O.

(C) Psychosocial Evaluation must be completed within 72 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) or a

mental health professional as defined in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.8. Nursing services for adults age 21 to 64

Each facility providing nursing services to adults age 21 to 64 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each ~~patient~~ member. A registered nurse must document ~~patient~~ member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the treatment plan goals and objectives.

317:30-5-95.9. Therapeutic services for adults age 21 to 64

An interdisciplinary team of a physician, mental health professional(s), registered nurse, and other staff who provide services to adult ~~patients~~ members age 21 to 64 in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(2) a mental health professional licensed to practice by one of the following boards:

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist; ~~or~~

(F) Licensed Alcohol and Drug Counselor; or

~~(F)~~ (G) Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided); and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.10. Discharge plan for adults age 21 to 64

Each adult ~~patient~~ member age 21 to 64 must have a discharge plan that includes a recapitulation of the ~~patient's~~ member's hospitalization, recommendations for follow-up and aftercare to include referral to medication management, out-patient behavioral health counseling and/or case management to include the specific appointment information (time, ~~dae~~ date and name, address and telephone number of provider and related community services), and a summary of the ~~patient's~~ member's condition at discharge. All discharge and aftercare plans must be documented in the ~~patient's~~ member's medical records.

317:30-5-95.13. Certification and recertification of need for inpatient care for inpatient acute psychiatric services for persons over 65 years of age

The certification and recertification of need for inpatient care for persons over 65 years of age must be in writing and must be signed and dated by the physician who has knowledge of the case and the need for continued inpatient psychiatric care. The certification and recertification documents for all ~~Medicaid patients~~ SoonerCare members must be maintained in the ~~patient's~~ member's medical records or in a central file at the facility where the ~~patient~~ member is or was a resident.

(1) **Certification.** A physician must certify for each applicant or ~~recipient~~ member that inpatient services in a psychiatric hospital are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a psychiatric hospital, before ~~the Medicaid agency~~ OHCA, or its designated agent, authorizes payment.

(2) **Recertification.** A physician must recertify for each applicant or ~~recipient~~ member that inpatient services in the psychiatric hospital are needed. Recertification must be made at least every 60 days after certification.

317:30-5-95.14. Individual plan of care for persons over 65 years of age receiving inpatient acute psychiatric services

(a) Before admission to a psychiatric hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or ~~recipient~~ member. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;
(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;
(5) Plans for continuing care, including review and modification to the plan of care, and
(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the ~~recipient's~~ member's care must review each plan of care at least every seven days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the ~~patient's~~ member's medical records. All must be signed and dated by the physician, RN, MHP, ~~patient~~ member and other treatment team members that provide individual, family and group therapy in the required review interval. If the ~~patient~~ member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews.

(d) The plan of care must document appropriate ~~patient~~ member participation in the development and implementation of the treatment plan.

317:30-5-95.15. Physician review of prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services

All prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services must be reviewed by the physician at least every seven days; the review must be documented in the ~~patient's~~ member's medical record by the physician signing his/her name and title and dating the orders.

317:30-5-95.16. Medical psychiatric and social evaluations for persons over 65 years of age receiving inpatient acute psychiatric services

The record of a member over 65 years of age receiving inpatient acute psychiatric services must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:
(A) History and Physical must be completed within 48 hours of admission by a licensed independent

practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within 48 hours of admission by a M.D. or D.O.

(C) Psychosocial Evaluation must be completed within 72 hours of admission by a licensed independent practitioner or a licensed behavioral health professional (LBHP) as defined in ~~OAC 317:30-5-240(c)~~ OAC: 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.18. Nursing services for persons over 65 years of age receiving inpatient acute psychiatric services

Each facility providing inpatient acute psychiatric services to adults over 65 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each ~~patient~~ member. A registered nurse must document ~~patient~~ member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the treatment plan goals and objectives.

317:30-5-95.19. Therapeutic services for persons over 65 years of age receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, LBHPs, registered nurse, and other staff who provide services to members over 65 years of age who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(2) a LBHP licensed to practice by one of the following boards:

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;
(E) Licensed Marital and Family Therapist; ~~or~~
(F) Licensed Alcohol and Drug Counselor; or
~~(F)~~ (G) Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided); and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.20. Discharge plan for persons over 65 years of age receiving inpatient acute psychiatric services

Each ~~patient~~ member over 65 years of age receiving inpatient acute psychiatric services must have a discharge plan that includes a recapitulation of the ~~patient's~~ member's hospitalization, recommendations for follow-up and aftercare to include referral to medication management, out-patient behavioral health counseling and/or case management to include the specific appointment information (time, date and name, address and telephone number of provider and related community services), and a summary of the ~~patient's~~ member's condition at discharge. All discharge and aftercare plans must be documented in the ~~patient's~~ member's medical records.

317:30-5-95.22 Coverage for children

(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.

(b) **Definitions.** The following words and terms, when used in Sections OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acute care"** means care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and

Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.
(3) **"Chemical Dependency/Substance Abuse services/ Detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.
(4) **"Community Based Extended"** means a PRTF with 16 beds or more but less than 30 beds. The typical facility is not a locked facility.
(5) **"Community based transitional residential treatment"** means a level of care designed for children that require the continued structure, psychiatric intervention of 24 hour care but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community based transitional are non-secure PRTFs with 16 beds or less.
~~(4)~~ (6) **"Designated Agent"** means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.
~~(5)~~ (7) **"Enhanced Treatment Unit or Specialized Treatment Unit"** means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.
~~(6)~~ (8) **"Evidenced Based Practice (EBP)"** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.
(9) **"Freestanding PRTFs"** are generally for profit secure facilities which range from 50 to over 100 beds and are generally staffed higher with RN personnel.
~~(7)~~ (10) **"Out-of-State Placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.
(11) **"Provider Based"** facilities are secure treatment facilities that are affiliated with private

medical/surgical hospitals. The RN hours per day average 2.4 hours.

(12) **"Public facilities"** are Oklahoma government owned or operated facilities.

~~(8)~~ (13) **"Residential Treatment services"** means psychiatric services that are designed to serve children who need longer term, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization.

~~(9)~~ (14) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of ~~patients~~ members.

317:30-5-95.23. Individuals age 21

Individuals eligible for ~~Oklahoma Medicaid~~ SoonerCare may be covered for inpatient psychiatric services before the ~~recipient~~ member reaches age 21 or, if the ~~recipient~~ member was receiving inpatient psychiatric services at the time he or she reached age 21. Services may continue until the ~~recipient~~ member no longer requires the services or the ~~recipient~~ member becomes 22 years of age, whichever comes first. Sections OAC 317:30-5-95.24 through 317:30-5-95.42 apply to coverage for inpatient services in acute care hospitals, freestanding psychiatric hospitals, and PRTFs.

317:30-5-95.24. Pre-authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. Residential treatment at this level is a longer term treatment that requires a higher staff to ~~patient~~ member ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic ~~patients~~ members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare

without prior approval of the OHCA behavioral health unit ~~and will require a contract addendum~~. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(b) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during awake hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the ~~patient~~ member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an

attempt to compensate through alternative modes of communication such as gesture or mime;
(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
(J) Stereotyped and repetitive use of language or idiosyncratic language;
(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
(M) Inflexible adherence to specific, nonfunctional routines or rituals;
(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
(O) Persistent occupation with parts of objects;

(3) ~~Patient~~ Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;
(4) Full scale IQ below 40 (profound mental retardation).

(c) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.
(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in ~~OAC 317:30-5-95.25 through 317:30-5-95.31~~ in the OHCA Behavioral Health Provider Manual.
(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. ~~The Agent designated by the~~ OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria and following the current ~~inpatient provider manual approved by the~~ OHCA Behavioral Health Provider Manual. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member.

317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children

~~Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (1), (2), (3), (4) and two of the terms and conditions in (5)(A) to (6)(C) of this subsection. Acute psychiatric admissions for children 12 or younger must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.~~

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.~~

~~(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:~~

~~(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.~~

~~(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.~~

~~(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.~~

~~(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.~~

~~(6) Requires secure 24-hour nursing/medical supervision as evidenced by:~~

~~(A) Stabilization of acute psychiatric symptoms.~~

~~(B) Needs extensive treatment under physician direction.~~

~~(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.~~

All acute psychiatric admissions for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

~~Continued stay - acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4) of this subsection.~~

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.~~

~~(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.~~

~~(A) Documentation of regression is measured in behavioral terms.~~

~~(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.~~

~~(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention~~

~~(this does not include placement issues, criminal behavior, status offenses).~~

~~(4) Documented efforts of working with child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.~~

All acute psychiatric continued stay authorizations for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.27. Medical necessity criteria for admission - inpatient chemical dependency detoxification for children

~~Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.~~

~~(1) Any psychoactive substance dependency disorder described in DSM-IV-TR with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.~~

~~(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).~~

~~(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.~~

~~(4) Requires secure 24-hour nursing/medical supervision as evidenced by:~~

~~(A) Need for active and aggressive pharmacological interventions.~~

~~(B) Need for stabilization of acute psychiatric symptoms.~~

~~(C) Need extensive treatment under physician direction.~~

~~(D) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.~~

All admissions for inpatient chemical dependency detoxification for children must meet the medical necessity criteria for a detoxification admission as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.28. Medical necessity criteria for continued stay - inpatient chemical dependency detoxification program for children

Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to seven to eight days based on a case-by-case review, per medical necessity criteria as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.29. Medical necessity criteria for admission - psychiatric residential treatment for children

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, status offenses).~~

~~(3) Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Patient demonstrates escalating pattern of self injurious or assaultive behaviors as evidenced by:~~

~~(A) suicidal ideation and/or threat.~~

~~(B) History of or current self-injurious behavior.~~

~~(C) Serious threats or evidence of physical aggression.~~

~~(D) Current incapacitating psychosis or depression.~~

~~(6) Requires 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

All psychiatric residential treatment admissions for children must meet the medical necessity criteria for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.30. Medical necessity criteria for continued stay - psychiatric residential treatment center for children

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.~~

~~(2) conditions are directly attributed to a mental disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).~~

~~(3) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.~~

~~(B) Patient has made gains toward social responsibility and independence.~~

~~(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.~~

~~(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.~~

~~(4) child's condition has remained unchanged or worsened.~~

~~(A) Documentation of regression is measured in behavioral terms.~~

~~(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.~~

~~(5) There is documented continuing need for 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

~~(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.~~

All psychiatric residential treatment continued stay authorizations for children must meet the medical necessity criteria for continued stay for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.

317:30-5-95.31. Pre-authorization and extension procedures for children

(a) Pre-admission authorization for inpatient psychiatric services for children must be requested from the OHCA designated agent. The OHCA or its designated agent will evaluate and render a decision within 24 hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from ~~the~~ OHCA ,or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through ~~the~~ OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension following the guidelines in the ~~Inpatient Provider~~ OHCA Behavioral Health Provider Manual ~~published by the OHCA designated agent~~. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 15 days and in a psychiatric residential treatment facility for 3 months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by ~~the~~ OHCA~~'s~~, or its designated agent, the member receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.

317:30-5-95.32. Quality of care requirements for children

(a) At the time of admission of the child to an inpatient psychiatric program, the admitting facility will provide the ~~patient~~ member and their family or guardian with written explanation of the facility's policy regarding the following:

(1) ~~Patient~~ Member rights.

(2) Behavior Management of ~~patients~~ members in the care of the facility.

(3) ~~Patient~~ Member Grievance procedures.

(4) Information for contact with the Office of Client Advocacy.

(5) Seclusion and Restraint policy.

(b) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the ~~patient~~ member and their family or guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in "Active Treatment". The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in "Active Treatment" while the ~~patient~~ member remains in the care of the facility. The conditions include provisions of participation required for the continued ~~Medicaid~~ SoonerCare compensable treatment. ~~Patients~~ Members 18 and over are exempt from the family participation requirement. Families of ~~patients~~ members that have been placed out of state for behavioral health treatment may not be able to attend family therapy each week but should remain active in the ~~patient's~~ member's treatment by telephone and attendance for family therapy at least once a month.

(c) Documented evidence must exist that the treatment program is trauma-informed.

317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP),licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the ~~patient's~~ member's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to

accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, ~~and~~ every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for ~~patients~~ members under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA

worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or ~~Xeroxed~~ photocopied signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.34. Active treatment for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(2) **"Family therapy"** means interaction between a LBHP, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(3) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(4) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between a LBPH and a member to promote emotional or psychological change to alleviate disorders.

(6) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between a LBHP as defined in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3, and two or more ~~patients~~ members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) The components of Active Treatment consist of integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Sixty minutes is the expectation to equal one hour of treatment. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Individual treatment provided by the physician. Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten days between sessions in PRTFs, ~~and~~ never exceed seven days in a specialty PRTF and never exceed 30 days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(2) Individual therapy. LBHPs performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing

techniques appropriate to the individual ~~patient's~~ member's plan of care and the ~~patient's~~ member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a LBHP as described in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(3) Family therapy. The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment for members under the age of 18. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a LBHP as described in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3.

(4) Process group therapy. The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by a LBHP as defined in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(5) Expressive group therapy. Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care, ~~and~~ three hours per week

in residential treatment and twice a week in CBT. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(6) Group Rehabilitative treatment. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care with the exception of CBT. Group rehabilitative treatment in CBT must be provided 6 times a week. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(7) Individual rehabilitative treatment. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the ~~patient's~~ member's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(8) Modifications to active treatment. When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a ~~mental~~ behavioral health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner ; Licensed Alcohol and Drug Counselor (LADC),(or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner, Licensed Alcohol and Drug Counselor and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not ~~Medicaid~~ SoonerCare compensable and can not be billed to the ~~Medicaid recipient~~ SoonerCare member.

317:30-5-95.36. Treatment team for inpatient children's services

An interdisciplinary team of a physician, mental health professionals, registered nurse, ~~patient~~ member, parent/legal guardian for members under the age of 18, and other personnel who provide services to members in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be:

(1) capable of assessing the member's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities;

(2) capable of assessing the potential resources of the member's family, and actively involving the family of members under the age of 18 in the ongoing plan of care;
(3) capable of setting treatment objectives;
(4) capable of prescribing therapeutic modalities to achieve the plan objectives;
(5) capable of developing appropriate discharge criteria and plans; and
(6) trained in a recognized behavioral/management intervention program such as MANDT System, Controlling Aggressive Patient Environment (CAPE), SATORI, Professional Assault Crisis Training (PRO-ACT), or a trauma informed methodology with the utmost focus on the minimization of seclusion and restraints.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The ~~patient's~~ member's medical record must contain complete medical, psychiatric and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within 48 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O and within 7 days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission ~~and~~ , within seven days of admission to a PRTF and within 7 days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) or a mental health professional as defined in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the ~~patient~~ member changes levels of care if the existing evaluation is more than 30 days from admission. Evaluations remain current for 12 months from the date of admission and must be updated annually within seven days of that anniversary date.

(4) The history and physical evaluation, psychiatric evaluation and psychosocial evaluation must be completed within the time lines designated in this section or

those days will be rendered non-compensable for ~~Medicaid~~ SoonerCare until completed.

317:30-5-95.38. Nursing services for children ~~(inpatient psychiatric acute only)~~

Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each ~~patient~~ member. In a Community Based Transitional RTC, an RN must be on site at least one hour each day and be available 24 hours a day when not on site. A registered nurse must document ~~patient~~ member progress at least weekly except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the individual plan of care goals and objectives.

317:30-5-95.39. Seclusion, restraint, and serious incident reporting requirements for children

(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used.

(1) Each facility must have policies and procedure to describe the conditions in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be

renewed in accordance with the following limits for up to a total of 24 hours:

(A) four hours for children 18 to 20 years of age;

(B) two hours for children and adolescents nine to 17 years of age; or

(C) one hour for children under nine years of age.

(2) The documentation required to insure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) an order for seclusion/restraint including the name of the LIP, date and time of order;

(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;

(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;

(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:

(i) member's immediate situation;

(ii) member's reaction to intervention;

(iii) member's medical and behavioral conditions; and

(iv) need to continue or terminate the restraint or seclusion.

(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;

(H) debriefing of the child within 24 hours by a LBHP;

(I) debriefing of staff within 48 hours; and

(J) notification of the parent/guardian.

(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation

of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the ~~patient~~ <u>member</u> population in at least the following:

(1) techniques to identify staff and ~~patient~~ <u>member</u> behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;

(2) the use of nonphysical intervention skills;

(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;

(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;

(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

(6) monitoring the physical and psychological well being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and

(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.

(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.

(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up

to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to ~~patient~~ member outcome, staff debriefing and programmatic changes implemented (if applicable).
(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).
(4) ~~Patient~~ Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.
(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.

317:30-5-95.40. Other required standards

The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, ~~JCAHO~~ TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Psychiatric Residential Treatment Facilities may substitute CARF accreditation in lieu of ~~JCAHO~~ TJC or AOA accreditation.

317:30-5-95.42. Inspection of care of psychiatric facilities providing services to children

(a) There will be an on site Inspection of Care (IOC) of each psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team.
(b) The IOC team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.
(c) The inspection will include observation and contact with members. The Inspection of Care Review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.
(d) Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The

facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.
(e) Deficiencies found during the IOC may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment and must be completed within the time lines designated in ~~OAC 317:30-5-95.37(a)(1) and 317:30-5-95.35(a)(2)~~ OAC 317:30-5-95.37:
(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.
(f) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and Individual Plan of Care are not contained within the member's records, those days will warrant a full per-diem recoupment of the compensation received. Full per-diem recoupment will only occur for those documents.
(g) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.
(h) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

317:30-5-96.2. Payments definitions

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable costs" means costs necessary for the efficient delivery of ~~patient~~ member care.

"Ancillary Services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not

limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

"Border Status" means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.

~~**"Community-Based, transitional (CBT)"** means a non-secure PRTF that furnishes structured, therapeutic treatment services in the context of a family-like, small multiple resident home environment of 16 beds or less.~~

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

"Eating Disorders Programs" means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.

~~**"Free-standing, Small"** means generally a small, non-secure PRTF with 16 beds or more but less than 32 beds. These facilities may or may not have lock-down.~~

~~**"Free-standing, Medium"** means generally a secure PRTF with bed size ranging from 32 to 49 beds. Some may be non-secure.~~

~~**"Free-standing, Large"** means generally a for-profit, secure PRTF with bed size ranging for 50 to over 100 beds. Some may be non-secure.~~

"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

~~**"Provider-Based PRTF"** means a PRTF that is part of a larger general medical surgical main hospital, and the PRTF is treated as "provider based" under 42 CFR 413.65 and operates under the same license as the main hospital.~~

"Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.

~~**"Public"** means a hospital or PRTF owned or operated by the state.~~

"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:

(A) room and board;

(B) treatment program components;

(C) psychiatric treatment;
(D) professional consultation;
(E) medical management;
(F) crisis intervention;
(G) transportation;
(H) rehabilitative services;
(I) case management;
(J) interpreter services (if applicable);
(K) routine health care for individuals in good physical health; and
(L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, mentally retarded, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

~~**"Sub-Acute Services"** means a planned regimen of 24-hour professionally directed evaluation, care, and treatment for individuals. Care is delivered by an interdisciplinary team to individuals whose sub-acute neurological and emotional/behavioral problems are sufficiently severe to require 24-hour care. However, the full resources of an acute care general hospital or medically managed inpatient treatment is not necessary. An example of subacute care is services to children with pervasive developmental disabilities including autism, hearing impaired and dually diagnosed individuals with mental retardation and behavioral problems.~~

"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most ~~patients~~ members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most ~~patients~~ members regardless of the type of ~~patient~~ member treated or the party responsible for payment of such services.

317:30-5-96.3. Methods of payment

(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:

(1) Diagnosis Related Group (DRG);

(2) cost based; or

(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **~~Psychiatric~~ Residential ~~Treatment Facility (PRTF).~~ Level of Care**

(1) **Instate ~~Levels of Service~~ Services.**

(A) ~~Community-Based, extended~~ Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(B) ~~Community-Based, transitional~~ Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by

<u>analyses of the cost reports (Form 2552) filed with the OHCA.</u>

~~(C) Freestanding, Private. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.~~

~~(D) Freestanding, Public. Facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.~~

~~(E) Provider based. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.~~

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state <u>hospitals or</u> PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units ~~and/or subacute services~~. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. <u>The 1:1 staffing adjustment is limited to 60 days annually.</u>

317:30-5-96.4. Outlier intensity adjustment

Subject to approval by the Centers for Medicare and Medicaid Services (CMS), an outlier payment may be made to instate hospitals and PRTFs on a case by case basis, to promote access for those ~~patients~~ <u>members</u> who require expensive care. The intent of the outlier adjustment is to reflect the increased staffing requirements, co<u>-</u>morbidities and longer lengths of stay, for children with developmental disabilities or eating disorders. <u>This adjustment is limited to 60 days annually.</u>

317:30-5-96.7. Cost reports

Each hospital <u>or PRTF</u> submits to the OHCA its Medicare Cost Report (HCFA 2552), including Medicaid-specific information (as appropriate), for the annual cost reporting period. <u>PRTFs who do not file a Medicare Cost Report must submit a cost report in a format designated by the OHCA.</u>

Failure to submit the required completed cost report is grounds for the OHCA to determine that a provider is not in compliance with its contractual requirements. The OHCA enters into a Common Audit Agreement with a designated fiscal intermediary to audit Medicaid cost reports.
Hospitals submit a copy of their cost reports to this designated fiscal intermediary. All payments made to providers are subject to adjustment based upon final (audited) cost report information.