Rules Agenda
May 8, 2008

I. Items subject to the Administrative Procedures Act (Emergency)

Page 2 A. Revising Program of All-Inclusive Care for the Elderly (PACE) rules to allow for the involuntary disenrollment of a participant in the program based on the threatening or disruptive behavior or actions of the participant's family or caregiver as well as for failure of the participant's caregiver or guardian to pay or make satisfactory arrangements to pay, any premium due the PACE organization. **(Reference APA WF # 08-01)**

Page 5 B. Revising inpatient psychiatric hospital rules to allow for review of individual plans of care for children in an inpatient setting no less than every 9 calendar days in acute care situations and every 16 calendar days in the longer term treatment program or specialty psychiatric residential treatment facility. **(Reference APA WF # 08-07)**

Page 9 C. Revising outpatient behavioral health rules to remove the language referring to the reimbursement methodology for Program of Assertive Community Treatment (PACT) services. **(Reference APA WF # 08-08)**

I. Items subject to the Administrative Procedures Act (Emergency)

A. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 18. Program of All-Inclusive Care for the Elderly
OAC 317:35-18-10. [AMENDED]
(Reference APA WF # 08-01)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions which would allow for the involuntary disenrollment of a participant in the Program of All-Inclusive Care for the Elderly (PACE) program based on the threatening or disruptive behavior or actions of the participant's family or caregiver. Emergency approval is also requested for rule revisions which would allow for involuntary disenrollment of a PACE program participant if the participant's caregiver or guardian fails to pay or make satisfactory arrangements to pay, any premium due the PACE organization. These revisions are required by the Center for Medicare and Medicaid Services (CMS) in order for CMS to approve the Waiver Request for the PACE program.

SUMMARY: Agency rules are revised to allow for involuntary disenrollment of PACE program participants based upon certain actions of the participant's caregiver or guardian. The requested change is based on the experience of the PACE programs whose ability to safely and effectively care for participants is potentially compromised by the behavior and decisions of the participant's family and/or caregiver that jeopardizes the health or safety of others. The enrollment agreement includes in writing the terms of enrollment in PACE and the responsibilities of the participant and their family/caregivers at enrollment and annually thereafter. All efforts will be made to work with the family/caregiver to rectify situations where the family/caregiver is deemed to be jeopardizing the health or safety of others. It will be the policy of Cherokee Elder Care to initiate an involuntary disenrollment only after the Interdisciplinary Team has determined that involuntary disenrollment is the only available course of action.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

RULE LENGTH IMPACT: These revisions have no significant

impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 1, 2008 or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 460

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Program of All-Inclusive Care for the Elderly (PACE) rules to allow for the involuntary disenrollment of a participant in the program based on the threatening or disruptive behavior or actions of the participant's family or caregiver as well as for failure of the participant's caregiver or guardian to pay or make satisfactory arrangements to pay, any premium due the PACE organization.

SUBCHAPTER 18. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
PART 10. DISENROLLMENT (VOLUNTARY AND INVOLUNTARY)

317:35-18-10. Disenrollment (voluntary and involuntary)

(a) The ~~client~~ member may voluntarily disenroll from PACE at any time without cause but the effective date of disenrollment must be the last day of the month.

(b) A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.

(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.

(5) The PACE program agreement with CMS and the State administering agency is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(e) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

B. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-95.33. [AMENDED]
(Reference APA WF # 08-07)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions which will increase the timeframe within which a provider of inpatient behavioral health services must review an individual plan of care (IPC) for children residing in their facility. This change will allow providers a more reasonable time frame to complete reviews which in turn will help bring providers who are making a good faith effort to file timely into compliance. Currently, if providers do not review the plan of care on the seventh day, they are subject to a partial per diem recoupment and can be required to complete additional updates to the plan of care in addition to the original review and documentation. Requiring the provider to complete the additional update when the provider falls short of the seven day deadline, does not improve quality of care but detracts from the care given in that it only increases the administrative burden placed upon the treatment team which in turn reduces the amount of time the provider is able to allow for actual treatment and consultation. Additional time constraints placed upon a provider's already laden schedule limits individuals' access to care in that the provider's window of availability within which to see and treat patients is reduced.

SUMMARY: Agency rules are revised to allow for review of individual plans of care in an inpatient setting no less than every nine calendar days in acute care situations and no less than every 16 calendar days in the longer term treatment program or specialty Psychiatric Residential Treatment Facility (PRTF). The original rule allowed for only 7 days in acute care and 14 days in the longer term treatment programs. The intent of the rule is to have the plan reviewed and updated approximately every seven days, not exactly. Currently, the provider is penalized if the plan is not reviewed on the 7th or 14th day. Revisions are suggested in order to allow more flexibility for the providers while still giving credence to the original intent of the rule.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 1, 2008 or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.160

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising inpatient psychiatric hospital rules to allow for review of individual plans of care for children in an inpatient setting no less than every 9 calendar days in acute care situations and every 16 calendar days in the longer term treatment program or specialty psychiatric residential treatment facility.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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 (LBPH)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), 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. 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;
(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 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 ~~at least every seven calendar days~~ no less than every nine calendar days when in acute care and a regular PRTF and ~~every 14 calendar days~~ no less than every 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF 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 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 signatures are not allowed for any parent or member of the treatment team.

C. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-241. [AMENDED]
(Reference APA WF # 08-08)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with directives from our federal partner, the Centers for Medicare and Medicaid Services. The revisions would remove language referring to the reimbursement methodology for Program of Assertive Community Treatment (PACT) services. CMS is requiring that PACT services no longer be reimbursed using a bundled, per diem rate but as individual, fee for service rates billed in fifteen minute increments.

SUMMARY: Agency rules are revised to remove language referring to the reimbursement methodology for PACT services. PACT services are currently reimbursed using a per diem rate inclusive of all services provided by the PACT team. The revised methodology would reimburse PACT services using fee for service rates that correlate with each individual service which must be billed in fifteen minute increments. The suggested rule change also updates terminology which reflects recent changes in federal and state law and policy.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 1, 2008 or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.130

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does

hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising outpatient behavioral health rules to remove the language referring to the reimbursement methodology for Program of Assertive Community Treatment (PACT) services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241. Coverage for adults and children

(a) **Service descriptions and conditions.** Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occuring 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. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria and will require prior authorization. For all outpatient behavioral health facilities, the OHCA, or its designated agent, will comply with established medical necessity criteria. Non prior authorized services will not be SoonerCare compensable with the exception of Mental Health Assessment by a Non-Physician, Alcohol and Drug Assessment, Mental Health Service Plan Development (moderate complexity), Alcohol and/or Substance Abuse Services Treatment Plan Development (moderate complexity), Crisis Intervention, and Adult Facility Based Crisis Stabilization. ~~Services (by a LBHP and Facility based for adults), and Program of Assertive Community Treatment Services (PACT).~~ Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care unless authorized by the OHCA or its designated agent as medically necessary. Adults and children in Facility Based Crisis Intervention Services cannot receive additional ~~Outpatient Behavioral Health Services~~ outpatient behavioral health services outside of the admission and discharge dates. Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) **Mental Health Assessment by a Non-Physician.** All agencies

must assess the medical necessity of each individual to determine the appropriate level of care. The assessment must contain but is not limited to the following:

(A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;

(B) Source of information;

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

(D) Gender;

(E) Birth date;

(F) Home address;

(G) Telephone number;

(H) Referral source;

(I) Reason for referral;

(J) Person to be notified in case of emergency;

(K) Presenting reason for seeking services;

(L) Psychiatric social information, which ~~must include~~ includes: personal history, including; family - social; educational; cultural and religious orientation; occupational - military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; financial; clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations; legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate; substance abuse and dependence, both current and historical; gambling abuse and dependence, both current and historical; and present life situation.

(M) Mental status 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., and

(iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and

(iv) Full Five Axes DSM diagnosis.

(N) A section on health history and pharmaceutical information, with 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;

(iv) benefit(s) and side effects of medication; and

(v) level of functionality.

(O) Identification of the member's strengths, needs,

abilities, and preferences:

(i) LBHP's interpretation of findings;

(ii) signature and credentials of LBHP.

(P) The assessment ~~must include~~ includes all elements and tools required by the OHCA. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the member. For children under the age of ~~18~~ 16, it ~~must include~~ includes an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an LBHP. The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. ~~This service can be billed in partial units to allow for shorter assessment sessions as needed by the member.~~ This service 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 services of more than six months and it has been more than one year since the previous assessment.

(2) **Alcohol and Drug Assessment.** All providers must assess the medical necessity of each individual to determine the appropriate level of care. The assessment ~~will contain~~ contains but is not limited to the following:

(A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;

(B) Source of information;

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

(D) Gender;

(E) Birth date;

(F) Home address;

(G) Telephone number;

(H) Referral source;

(I) Reason for referral;

(J) Person to be notified in case of emergency;

(K) Presenting reason for seeking services; and

(L) Psychiatric social information, which must include:

(i) personal history, including: family - social; educational; cultural and religious orientation; occupational - military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure;

and financial;
(ii) clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations;
(iii) legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate;
(iv) substance abuse and dependence, both current and historical;
(v) gambling abuse and dependence, both current and historical;
(M) Present life situation;
(N) Mental status 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.; and
(iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.;
(O) Full Five Axes DSM diagnosis;
(P) A section on health history and pharmaceutical information, with 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;
(iv) benefit(s) and side effects of medication; and
(v) level of functionality;
(Q) Identification of the member's strengths, needs, abilities, and preferences:
(i) AODTP OR ~~BHP's~~ LBHP's interpretation of findings; and
(ii) signature and credentials of AODTP OR LBHP;
(R) The assessment ~~must include~~ includes all elements and tools required by the OHCA; and
(S) For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the member. For children under the age of ~~18~~ 16, it must include an interview with a parent or other adult caretaker. For children, the assessment ~~must~~ also ~~include~~ includes information on school performance and school based services. This service is performed by an AODTP or LBHP. The minimum face to face time spent in assessment with the member (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is two hours or more. ~~This service can be billed in partial units to allow for shorter assessment sessions as needed by the member.~~

This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. The 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 services of more than six months and it has been more than one year since the previous assessment.

(3) **Mental Health Services Plan Development by a Non-Physician (moderate complexity).**

(A) Mental Health Services Plan Development by a Non-Physician (moderate complexity) is ~~to be~~ performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of ~~18~~ 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate.

(B) The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment and determined diagnosis by the practitioners and the member of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation 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.

(C) For adults, it ~~must be~~ is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan ~~must address~~ addresses school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(D) Comprehensive and ~~ingrafted~~ integrated service plan content ~~shall address~~ addresses the following:

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

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

(iii) specific goals for the member;

(iv) objectives that are specific, measurable, attainable, realistic, and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed);

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

(vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;
(vii) the ~~practioner(s)~~ practitioner(s) name and credentials that will be providing and responsible for each service;
(viii) any needed referrals for services;
(ix) specific discharge criteria;
(x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(xi) service plans are not valid until all signatures are present (signatures are required from the member, the parent/guardian when applicable, and the primary LBHP); and
(xii) changes in service plans can be documented in a service plan update (low complexity) or in the progress notes until time for the update (low complexity).

(E) One unit per SoonerCare member per provider is allowed without prior authorization. If determined by the OHCA or its designated agent, one additional unit per year may be authorized.

(4) **Mental Health Services Plan Development by a Non-Physician (low complexity).**

(A) Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the member and treatment progress assessed.

(B) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the six month review/update is due.

(C) Service plan updates ~~shall~~ must address the following:

(i) progress, or lack of, on previous service plan goals and/or objectives;
(ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(iv) change in frequency and/or type of services provided;
(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;
(vi) change in practitioner(s) who will be responsible for providing services on the plan;
(vii) additional referrals for needed services;

(viii) change in discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and
(x) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age ~~18~~ 16 or otherwise applicable), and the primary LBHP.

(D) Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(5) **Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity)**.

(A) Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria or other required tool is to be utilized and followed.

(B) The service 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~~ 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation 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.

(C) For adults, it ~~must be~~ is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and ~~assisting~~ assist the family in caring for the child in the least restrictive level of care.

(D) Comprehensive and integrated service plan contents must address the following:
(i) member strengths, needs, abilities, and preferences;
(ii) identified presenting challenges and problems, needs, and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, measurable, attainable, realistic and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan,

then objectives may be broad while the progress notes are detailed);

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

(vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;

(vii) the practitioner(s) name and credentials who will be providing and responsible for each service;

(viii) any needed referrals for services;

(ix) specific discharge criteria;

(x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;

(xi) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age ~~18~~ 16 or otherwise applicable), and the primary LBHP; and

(xii) changes in service plans can be documented in a Service Plan Update (low complexity) or in the progress notes until time for the Update (low complexity).

(6) **Alcohol and/or Substance Abuse Treatment Plan Development (low complexity)**.

(A) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria or other required tool ~~will be~~ is utilized in the development of the Plan. All elements of the plan ~~must be~~ are reviewed with the member and treatment progress assessed.

(B) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) ~~will be~~ are provided by the treatment team members.

(C) Service plan updates ~~shall~~ are to address the following:

(i) progress, or lack of, on previous service plan goals and/or objectives;

(ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(iv) change in frequency and/or type of services provided;

(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;

(vi) change in practitioner(s) who will be responsible for providing services on the plan;

(vii) additional referrals for needed services;
(viii) change in discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present. The required signatures are the:
(I) member (if over age 14),
(II) parent/guardian (if under age ~~18~~ 16 or otherwise applicable), and
(III) primary LBHP.

(D) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the ~~6~~ six month review/update is due.

(E) Service Plan updates are required every six months during which services are provided. Updates can be conducted whenever needed as determined by the provider and member.

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

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

(B) Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical devices in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting

(20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the member and the LBPH or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a ~~MHP~~ LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) **Group Psychotherapy.**

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the ~~MHP~~ LBHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

(B) Group Psychotherapy must take place in a confidential setting limited to the LBHP or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. ~~The typical length of time for a group psychotherapy session is one hour to one and one-half hours. A maximum of two Group Psychotherapy sessions per day are allowed.~~ A maximum of three units per day per member are allowed. ~~Partial units are acceptable when the whole unit of time/service is not utilized.~~ Individual or group breaks will be discounted from the overall time and are not required to be noted separately. The individual member's behavior, the size of the group, and the focus of the group must be included in each member's medical record. As other members' personal health information cannot be included, the agency may keep a separate group log which contains detailed data on the group's attendees. A group may not consist solely of related

individuals.

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

(9) **Family Psychotherapy.**

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or an ~~AOD~~ AODTP 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.

(B) ~~The length of a Family Psychotherapy session is one hour to one and one-half hour. No more than two sessions~~ A maximum of three units of Family Psychotherapy are allowed per day per member/family. ~~This is also the maximum per family unit (unless prior authorization is given by OHCA or its designated agent). Partial units are acceptable when the whole unit of time/service is not utilized.~~ Family Psychotherapy must be provided by a LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) **Psychiatric Social Rehabilitation Services (group).**

(A) Psychiatric Social Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery. This service is generally performed with only the members, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. ~~Each day of~~ PSR services must be reflected by documentation (daily or weekly summary notes) in the member's records, and must include the following:

(i) date;

(ii) start and stop time(s) for each day of service;

(iii) signature of the primary rehabilitation clinician;

(iv) credentials of the primary rehabilitation clinician;

(v) specific goal(s) and/or objectives addressed (these must be identified on ~~recovery~~ service plan);
(vi) type of skills training provided;
(vii) progress made toward goals and objectives;
(viii) member's report of satisfaction with staff intervention; and
(ix) any new needed supports identified during service.

(B) Compensable Psychiatric Rehabilitation Services are provided to members who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the member's current service plan. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

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

(D) A PSRS, AODTP, or LBHP may perform group psychiatric social rehabilitation services, using a treatment curriculum approved by a ~~MHP~~ LBHP.

(11) **Psychiatric Social Rehabilitation Services (individual).**

(A) Psychiatric Social Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the

same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the member present, but may include the member's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives. This service may include the Evidence Based Practice of Illness, Management, and Recovery.

(B) A PSRS, AODTP, or LBHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

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

(A) Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Mental Health, Substance Abuse, or Integrated Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessment conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

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

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

(B) Travel time to and from Alcohol and/or Substance Abuse

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

(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP or LBHP.

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

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

(B) An AODTP, LBHP, or PSRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable.

(15) **Medication Training and Support.**

(A) Medication Training and Support is a documented review

and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for SoonerCare member who reside in ICF/MR facilities. One unit is allowed per month per patient without prior authorization.

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

(16) **Crisis Intervention Services.**

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

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

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

Intervention Services (facility based stabilization) are compensable for child and adult SoonerCare member. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code. Children's facility based stabilization (0-18 years of age) requires prior authorization.

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

(A) The reimbursement methodology for PACT services will end effective June 30, 2008.

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

(i) Assessment and evaluation;

(ii) Treatment planning;

(iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;

(iv) Symptom assessment, management, and individual supportive psychotherapy;

(v) Medication evaluation and management, administration, monitoring and documentation;

(vi) Rehabilitation services;

(vii) Substance abuse treatment services;

(viii) Activities of daily living training and supports;

(ix) Social, interpersonal relationship, and related skills training; and,

(x) Case management services.

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

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

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit or may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience, and:

(i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(ii) must be supervised by a bachelor's level individual with a minimum of two years case management experience. Treatment plans must be overseen and approved by a LBHP; and

(iii) function under the general direction of the established systems of care team and the current treatment plan.

(B)These services must be prior authorized by OHCA (or its designated agent). The Behavioral Health Aide cannot bill for more than one individual during the same time period.

(20) **Family Support and Training.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance ~~who~~ that is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody residing within a RBMS Level of care and who without these services would require psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the

specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements, such as the crisis plan and plan of care process; training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. Parent Support ensures the engagement and active participation of the family in the treatment planning process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management. Services are goal directed as identified in the child's individualized plan of care and provided under the direction of a child and family treatment team and are intended to support the family with maintaining the child in the home and community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the member.

(A) The family support and training worker must meet the following criteria:

(i) have a high school diploma or equivalent;

(ii) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(iii) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS prior to providing the service;

(iv) pass OSBI and OKDHS child abuse check as well as adult abuse registry and motor vehicle screens; and

(v) receive ongoing and regular supervision by a person meeting the qualifications of a LBHP. A LBHP must be available at all times to provide back up, support, and/or consultation.

(B) These services may be retrospectively reviewed by OHCA or its designated agent.

(21) **Community Recovery Support.** Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the mental health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff that usually work from the perspective of their training and/or their status as a licensed mental health provider; rather, this provider works from the perspective of their experiential expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery. Each provider must successfully complete over 40 hours of specialized training, demonstrate integration of newly acquired skills and pass a written exam in order to become credentialed. A code of ethics and continuing education opportunities are components which inform the continued professional development of this provider.

(A) The community/recovery support worker must meet the following criteria:

(i) High School diploma or GED;

(ii) minimum one year participation in local or national member advocacy or knowledge in the area of mental health recovery;

(iii) current or former member of mental health services; and

(iv) successful completion of the ODMHSAS Recovery Support Provider Training and Test to be credentialed.

(B)These services may be retrospectively reviewed by OHCA or its designated agent.

(C)Example of work performed:

(i) Utilizing their knowledge, skills and abilities will:

(I) teach and mentor the value of every individual's recovery experience;

(II) model effective coping techniques and self-help strategies;

(III) assist members in articulating personal goals for recovery; and

(IV) assist members in determining the objectives needed to reach his/her recovery goals.

(ii) Utilizing ongoing training may:

(I) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;

(II) facilitate peer support groups;

(III) assist in setting up and sustaining self-help (mutual support) groups;

(IV) support members in using a Wellness Recovery Action Plan (WRAP);
(V) assist in creating a crisis plan/Psychiatric Advanced Directive;
(VI) utilize and teach problem solving techniques with members;
(VII) teach members how to identify and combat negative self-talk and fears;
(VIII) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(IX) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(X) assist other staff in identifying program and service environments that are conducive to recovery; and
(XI) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

(iii) Possess knowledge about various mental health settings and ancillary services (i.e., Social Security, housing services, and advocacy organizations).

(iv) Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.
(I) attend continuing education assemblies when offered by or approved by the ODMHSAS's Office of Consumer Affairs; and
(II) develop and share recovery oriented material at member specific continuing education trainings.

(v) Serve by:
(I) providing and advocating for effective recovery oriented services;
(II) assisting members in obtaining services that suit that individual's recovery needs;
(III) informing members about community and natural supports and how to utilize these in the recovery process; and
(IV) assisting members in developing enpowerment skills through self-advocacy.

(vi) Develop specific competencies which will enhance their work skills and abilities. Identified tasks include, but are not limited to:
(I) becoming a trained facilitator of Double Trouble in Recovery (DTR);
(II) becoming a trained facilitator of Wellness Recovery Action Plan (WRAP);
(III) pursuing the USPRA credential of Certified

Psychiatric Rehabilitation Practitioner (CPRP).

(b) **Prior authorization and review of services requirements.**

(1) **General requirement.** All SoonerCare providers who provide outpatient behavioral health services are required to have the services they provide ~~either~~ prior authorized by the OHCA or its designated agent. ~~Private behavioral health providers, public and private community mental health centers, providers identified by the ODMHSAS as contracted providers, FQHCs, CHCs, RHCs, and I/T/U facilities are required to have all services prior authorized with the exception of~~ Services that do not require prior authorization are as follows:

(A) Mental Health Assessment by a Non-Physician~~,~~;

(B) ~~the~~ The initial four individual or family sessions before finalization of the ~~Assessment~~ service plan;

(C) Mental Health Service Plan Development by a Non-Physician (moderate complexity); ~~and~~

(D) Crisis Intervention Services; and

(E) Adult Facility Based Crisis Intervention.

(2) **Prior authorization and review of services.** The OHCA or its designated agent who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) **Prior authorization process.**

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

(i) **"Outpatient Request for Prior Authorization"** means the form used to request the OHCA or its designated agent to approve services.

(ii) **"Authorization Number"** means the number that is assigned per member and per provider that authorizes payment after services are rendered.

(iii) **"Initial Request for Treatment"** means a request to authorize treatment for a member that has not received outpatient treatment in the last six months.

(iv) **"Extension Request"** means a request to authorize treatment for a member who has received outpatient treatment in the last six months.

(v) **"Modification of Current Authorization Request"** means a request to modify the current array or amount of services a member is receiving.

(vi) **"Correction Request"** means a request to change a prior authorization error made by the OHCA or its designated agent.

(vii) **"Provider change in demographic information notification"** means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(viii) **"Status request"** means a request to ask the OHCA or its designated agent the status of a request.

(ix) **"Important notice"** means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(x) **"Letter of collaboration"** means an agreement between the member and two providers when a member chooses more than one provider during a course of treatment.

(B) **Process**. A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA or its designated agent, prior to rendering the initial services or any additional array of services, with the exception of the first four sessions prior to completion of the Services Plan, Mental Health Assessment by a Non-Physician; Mental Health Service Plan Development by a Non-Physician (moderate complexity); and Crisis Intervention Services; and Adult Facility Based Crisis Intervention.

(i) These request forms must be fully completed including the following:

(I) pertinent demographic and identifying information;

(II) complete and current CAR or ASI unless another appropriate assessment tool is authorized by the OHCA or its designated agent;

(III) complete multi axial, DSM diagnosis using the most current edition;

(IV) psychiatric and treatment history;

(V) service plan with goals, objectives, treatment duration; and

(VI) services requested.

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

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

(C) **Authorization for services.**

(i) Services are authorized by the OHCA or its designated agent using independent medical ~~judgement~~ judgment to perform the review of prior authorization requests to determine whether the request meets medical necessity criteria. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon ~~six~~ seven levels of care for children and ~~five~~ six levels of care for adults. The numerically based levels of care are designed to reflect the member's acuity as each level of care, in ascending order. Additional levels of care are known as Exceptional Case, 0-36 months, ICF/MR, Recovery Maintenance/Relapse Prevention, and RBMS.

(ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.