Behavioral Health Provider Manual

AUGUST 2010

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PURPOSE OF MANUAL

This manual is intended as a reference document for Oklahoma Health Care Authority contracted Behavioral Health Providers. The primary purpose of this manual is to assist providers who are serving our SoonerCare members. It contains requirements for participation in and reimbursement of behavioral health services. This manual explains policies and procedures, covered services, and requirements to receive SoonerCare compensation.

Additional information about the SoonerCare program is contained in the SoonerCare State Plan and administrative rules. The official rules are published by the Oklahoma Secretary of State Office of Administrative Rules as Title 317 of the Oklahoma Administrative Code. To order an official copy of these rules, contact the Office of Administrative Rules at (405) 521-4911.

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

Please send any comments, suggestions, or questions you have regarding this manual to the attention of:

Oklahoma Health Care Authority
Behavioral Health Department
2401 NW 23 Suite 1A
Oklahoma City, OK 73107
Erin.Meyer@okhca.org

Your questions, comments and suggestions will help us to increase the usefulness of this manual.

The Oklahoma Health Care Authority (OHCA) staff appreciates all of the individuals and agencies who provide behavioral health services to our SoonerCare members and it is our hope that this manual will better assist you in continuing to provide excellent service.

Section I:

Web Links to the Oklahoma Administrative Code

Oklahoma Health Care Authority
Web Links to the Oklahoma Administrative Code

A. Outpatient Behavioral Health Agency
- **OAC 317:30-5-240-249**
- **http://okhca.org/xPolicyPart.aspx?id=562&chapter=30&subchapter=5&part=21&title=OUTPATIENT%20BEHAVIORAL%20HEALTH%20SERVICES**

B. Psychologists
- **OAC 317:30-5-275-279**
- **http://okhca.org/xPolicyPart.aspx?id=564&chapter=30&subchapter=5&part=25&title=PSYCHOLOGISTS**

C. Case Management Agency
- **OAC 317:30-5-595-599**
- **http://okhca.org/xPolicyPart.aspx?id=588&chapter=30&subchapter=5&part=65&title=CASE%20MANAGEMENT%20SERVICES%20FOR%20OVER%2021**

D. Psychiatrists
- **OAC 317:30-5-11**
- **http://okhca.org/xPolicyPart.aspx?id=542&chapter=30&subchapter=5&part=1&title=PHYSICIANS**

E. Children's Inpatient Psychiatric
- **OAC 317:30-5-95.1 – 95.42**
- **http://okhca.org/xPolicyPart.aspx?id=547&chapter=30&subchapter=5&part=6&title=INPATIENT%20PSYCHIATRIC%20HOSPITALS**

F. Residential Behavior Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Centers
- **OAC 317:30-5-1040-1047**
- **http://okhca.org/xPolicyPart.aspx?id=610&chapter=30&subchapter=5&part=105&title=RESIDENTIAL%20BEHAVIORAL%20MANAGEMENT%20SERVICES%20IN%20GROUP%20SETTINGS%20AND%20NON-SECURE%20DIAGNOSTIC%20AND%20EVALUATION%20CENTERS**

G. Therapeutic Foster Care (Residential Behavior Management Services)
- **OAC 317:30-5-740-746**
- **http://okhca.org/xPolicyPart.aspx?id=597&chapter=30&subchapter=5&part=83&title=RESIDENTIAL%20BEHAVIOR%20MANAGEMENT%20SERVICES**

H. Telemedicine
- **OAC 317:30-3-27**
- **http://okhca.org/xPolicyPart.aspx?id=538&chapter=30&subchapter=3&part=1&title=GENERAL%20SCOPE%20AND%20ADMINISTRATION**

I. Uniform Electronic Transaction Act

- **OAC 317:30-3-4.1**
- **http://okhca.org/xPolicyPart.aspx?id=538&chapter=30&subchapter=3&part=1&title=GENERAL%20SCOPE%20AND%20ADMINISTRATION**

J. Insure Oklahoma (IO and IP)

- **OAC 317:45-1-11**
- **http://okhca.org/xPolicyTOC.aspx?id=48&chapter=45&title=INSURE%20OKLAHOMA/OKLAHOMA%20EMPLOYER%20AND%20EMPLOYEE%20PARTNERSHIP%20FOR%20INSURANCE%20COVERAGE**

K. Licensed Behavioral Health Provider

- **OAC 317:30-5-280-283**
- **http://okhca.org/xPolicyPart.aspx?id=655&chapter=30&subchapter=5&part=26&title=LICENSED%20BEHAVIORAL%20HEALTH%20PROVIDERS**

Section II:

Prior Authorization Process for Outpatient Behavioral Health Agencies

Prior Authorization Standards for OHCA and ODMHSAS Outpatient Behavioral Health Agencies

Individuals enrolled in the following plans require prior authorization for behavioral health services by APS Healthcare, Inc.:

- SoonerCare Choice,
- SoonerCare Traditional, and
- Insure Oklahoma - Individual Plan (aka OEPIC-IP)
- ODMHSAS contracted providers as specified by ODMHSAS

APS HOURS OF OPERATIONS

APS office hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except national holidays. APS staff members are available after hours for initial inpatient prior authorization calls only.

INFORMATIONAL WEB SITE FOR PROVIDERS SPONSORED BY APS

Forms and Manuals are located at www.SoonerPRO.com

In order to ensure that you will receive regular updates on system changes (changes in requirements, process, etc.) be sure to subscribe to e-mail updates on SoonerPRO.

The APS Help Desk can be reached at SoonerProHelpDesk@apshealthcare.com.

Please do not send requests, service plans or any other HIPPA Protected Health Information by e-mail or through the SoonerPro website.

PRIOR AUTHORIZATION OF BEHAVIORAL HEALTH SERVICES

- Providers can submit Customer Data Core (CDC), prior authorization requests and other information in one of the following ways:
  - APS CareConnection®, available through www.SoonerPRO.com (Click on the APS CareConnection® link on the homepage) or visit https://careconnectionok.apshealthcare.com.
  - EDI (electronic data interface) – Some local software vendors have developed systems to allow agencies to use their own paperwork and "upload" the required elements to CareConnection®.

- All electronically submitted requests will be completed within a five business day timeframe.
- SoonerCare and ODMHSAS outpatient prior authorizations are issued for 1-6 months, depending on request type or level of care.
- All Insure Oklahoma prior authorizations are issued for 1-3 months, regardless of level of care.
- Providers may also call APS at (800)762-1560 for assistance in completing the request forms, or any other questions regarding the PA process.
- Billing questions should be directed to the OHCA (HP) Provider Helpline at 1-800-522-0114.

WEB REQUESTS

Providers are encouraged to utilize the internet-based request system, CareConnection®. Providers who choose this option will need to register their staff with APS to obtain user log in identification information. The request form may be downloaded from www.SoonerPro.com (Resources tab, Downloadable Forms from the left hand

navigation bar, CareConnection Forms folder) and faxed to APS at 800-762-1639. Providers must designate staff as one of the following roles:

- Utilization Manager: able to submit requests to APS and view all requests submitted by the agency,
- Direct Service Provider: able to submit requests to APS as determined by the agency and able view only their own requests, or
- Delegate: not able to submit requests to APS but able to view their own requests.

Providers may register as many employees as they wish. All employees will have their own logons and passwords to APS CareConnection®.

APS CareConnection® and SoonerPro are different websites:

- Agencies and their staff members may subscribe for email Community Bulletin Board updates at www.SoonerPro.com. Registration is not required to download forms or view information.
- APS must process CareConnection® (secure) registrations. Assigned logons and passwords will be emailed to staff members within three business days.

The organization/agency logon for CareConnection® will be created by APS with the receipt of the first request to register an employee in APS CareConnection® and the agency record will be associated with the SoonerCare numbers on the request.

If you did not include all locations/SoonerCare numbers, you may not be able to submit a request for that SoonerCare provider number. Please notify APS, by calling or sending an email to SoonerProHelpDesk@apshealthcare.com, to add your SoonerCare provider number to the correct site.

Providers using the web application will have the ability to save the request on the APS system and to print a hardcopy of the document.

PROVIDER ELIGIBILITY

Each site must be clearly affiliated with and under the direct supervision and control of the contracting facility. Each site operated by an outpatient behavioral health facility must have a separate provider number. Failure to obtain and utilize site-specific provider numbers will result in disallowance of services. Questions about how to become a SoonerCare Provider may be addressed with OHCA's Contracts Services Division (Provider Enrollment), or with ODMHSAS for ODMHSAS contracted facilities.

NEWLY CERTIFIED FACILITIES/SITES

Facilities need to submit information (mailing address, telephone and fax numbers) to the Director of Provider Relations and Training at APS (See Provider Change of Demographic Information Request). Providers begin submitting requests prior to receiving their new provider number from OHCA. In this situation, complete requests will receive a "Courtesy Review" decision which will suffice until the facility acquires their new provider number. When the new provider number has been acquired, the provider will be responsible to notify APS immediately, by fax or mail. Once the provider number has been verified and entered into the APS database, PA numbers can be issued to the facility.

Download the APS provider registration request from www.SoonerPro.com and submit via fax to 1-800-762-1639.

CLOSED SITES

If you have a closed site or agency office, please fax a letter to Provider Enrollments at (405) 530-3224. The faxed letter needs to include the following information:

- The letter needs to be on the agency letterhead,
- It needs to be signed by someone who is authorized to sign contracts for the agency.
- They need to request OHCA to "terminate the contract for the site."
- Name of the closed agency/site.
- Provider number of the closed site.
- Address of the closed site.

This will help all of us. OHCA and the public, to have an accurate, active provider list for referrals. If you have any questions about this process, please call provider enrollment at (800) 522-0114, option 5.

SOONERCARE MEMBER ELIGIBILITY

APS CareConnection® verifies if the member's benefits are active in the Medicaid Management Information System (MMIS) eligibility file.

For providers, if the eligibility file indicates that the member does not currently have active SoonerCare benefits, providers may submit a "Courtesy Review" request and APS will complete the review based on the information submitted. The review will remain in "Courtesy Review" status until benefits have been determined, at which time it is the provider's responsibility to notify APS, by fax or mail. Once APS has verified the SoonerCare benefits, an authorization number will be assigned. A prior authorization number will not be assigned if the member does not have active SoonerCare benefits or if the Health Program does not include behavioral health benefits. The PA will date back to when the request was originally received by APS, subject to the eligibility dates contained in the MMIS system.

Providers may check the OHCA Recipient Eligibility Verification System (REVS) at 1-800-522-0310. For instructions on using REVS, call 1-800-767-3949. Providers can also check for active benefits on the SoonerCare Secure Site with their 8-digit pin number, or call the OHCA Provider Helpline at 1-800-522-0114 for assistance.

ODMHSAS MEMBER ELIGIBILITY

For ODMHSAS providers, if the individual does not have SoonerCare, or ODMHSAS eligibility, providers will need to request a Member ID on the SoonerCare secure site. For ODMHSAS Adolescent Inpatient patients who are identified as being qualified for ODMHSAS, but not qualified for SoonerCare benefits, providers will need to complete a telephonic review with APS (in case it is found that the individual does qualify).

SOONERCARE LIMITATIONS AND EXCLUSIONS

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.

Payment is not made to outpatient behavioral agencies or providers for SoonerCare members who are residents of nursing facilities. The individual provider may contract with the nursing facility to seek reimbursement; the OHCA is not a party to these relationships and is not liable for payment.

Payment is not made to outpatient behavioral agencies or providers for SoonerCare members who have medically necessary IEP health-related services provided by the school. In these circumstances, the school is the SoonerCare contracted provider. Individual therapists and other medical providers may not directly bill the OHCA for these services. The individual provider may contract with the school to seek reimbursement from the school; the OHCA is not a party to these relationships and is not liable for payment. If you have further questions regarding IDEA (Individuals with Disabilities Education Act) medical billing related questions, you can contact Sue Robertson with OHCA at (405) 522-7269.

In accordance with 42 CFR 435.1009 children in correctional institutions do not qualify for BH services. 435.1009 states FFP is not available in expenditures for services provided to: (1) Individuals who are inmates of public institutions as defined in 435.1010. 435.1010 In part- Inmate of a public institution means a person who is living in a public institution.

PCP BEHAVIORAL HEALTH SCREENING AND REFERRAL

PCPs who are Medical Home providers have been encouraged to conduct a screening and brief intervention for their members for the purpose of identifying behavioral health problems, and to make referrals to LBHPs for a more thorough assessment and services, if needed. All agencies are encouraged to make contact with the PCP/Medical Home offices in the areas they serve so that the physician can refer easily to agencies for an LBHP evaluation, it is expected that the member be seen within 72 hours after seeing the physician. The LBHP in the agency is expected to contact the referring physician with results of the assessment and plan of service, in order to work collaboratively with the member's Medical Home.

EDUCATIONAL OPPORTUNITIES

APS offers monthly Introduction to the Outpatient Prior Authorization Process and CareConnection® training via the web. Please click on the News tab on www.SoonerPro.com and select Provider Trainings for details.

APS will announce additional training sessions on www.SoonerPro.com website.

Providers are encouraged to recommend training topics to APS. APS will also work with providers to identify locations, training topics, develop specific training programs and conduct on-site training sessions at the request of providers.

All training materials and requests must be approved by OHCA in advance.

PRIOR AUTHORIZATION PROCESS

There are two types of processes for Prior Authorization (PA):

1). Instant Prior Authorization: These services are authorized automatically with the submission of a Customer Data Core (CDC).

The Instant PA process applies to the following:

- Activation of Pre-admission Services for both SoonerCare and ODMHSAS members (additional information below*); and
- Activation of the following services for ODMHSAS members:
  - Detox- level of care SN, 7 day authorization period;
  - Halfway house- level of care CL, 6 month authorization period;
  - Residential Treatment (Substance Abuse and Mental Health)- level of care CI, 6 month authorization period;
  - Community-Based Structured Crisis Care (CBSCC)- level of care SC, 5 day authorization period;

- Mental Health Housing and Residential Care Services- service focus 11, level of care CL, 6 month authorization period;
- Mental Health Inpatient- level of care HA, 10 day authorization period;
- Recovery Services- service focus 11, level of care OO, 6 month authorization period;
- Day School and Divorce Arbitration- service focus 23, 6 month authorization period;
- Prison-related Services - service focus 09, 6 month authorization period.

Providers are encouraged to utilize the Pre-admission Services prior to submitting an Outpatient Request for Prior Authorization.

Information about the Pre-admission Services is as follows:

- In CareConnection®, submission of Section One which is Transaction Type 21 on the Customer Data Core (CDC) is required for all outpatient behavioral health *agencies*.
- Once the CDC Transaction Type 21 has been submitted in CareConnection® an instant authorization number for the Pre-admission Services (PG038) will be issued. The start date of the authorization will be the Transaction Date listed on the CDC.
- The CDC section one (Transaction Type 21) can be submitted in CareConnection® up to seven days after the date of the first appointment (transaction) with the member/customer. The Pre-admission Services authorization is the *only time* that a retroactive authorization can be issued.
- The length of the authorization for PG038 is 30 days.
- The end date of PG038 can be extended if needed by submitting a Correction Request. The new end date needs to be included on the correction request.
- PG038 *includes* the initial assessment code (H0031) and Service Plan Development code (H0032).
- The maximum benefit amount for PG038 is $483.00. This total of $483.00 includes the assessment (H0031) and the Service Plan Development (H0032).
- The Pre-admission Services, Procedure Code Group PG038 has a listing of procedure codes which can be used as clinically appropriate and medically necessary. Daily limits still apply. The procedure codes in the Pre-Admission services can be utilized in any order and frequency.
- The services listed as Pre-admission Services can be located at http://www.soonerpro.com/Resources/Manuals.aspx under Outpatient ("Procedure Code Groups").
- Once the Initial Prior Authorization Request has been approved in CareConnection®, the PG038 will be end dated. The PG038 will end date the day prior to the start of the initial prior authorization request.
- For SoonerCare, a *completed* initial assessment and a valid service plan are required before providing any of the services approved in the *initial request for treatment authorization (level of care procedure code groups)*.
- One per consumer, per agency unless there has been a gap in service of more than six months and it has been more than one year since the previous Pre-Admission PA was issued.

2). Outpatient Request for Prior Authorization: Services are authorized with the submission of a CDC and a PA Request which must meet medical necessity criteria.

CUSTOMER DATA CORE (CDC)

- The Customer Data Core (CDC) is a multi-purpose form. This form records pre-admissions, admissions, changes in treatment, level of care, and discharges. The CDC collects socio-demographic information about the customer in addition to diagnostic information. The CDC is designed to collect National Outcome Measures (NOMs).
- The collection of CDC information or NOMs will allow agencies to obtain outcome monitoring reports. The reports were designed for each agency to look at its own practices and to compare agency to agency.

- For questions, please call the ODMHSAS Helpdesk at (405)522-0318 or 1-877-522-0318 or you may send an email to the helpdesk@odmhsas.org.
- For all initial and extension requests, section two of the CDC will be required.
- When you cannot complete the data fields for the CAR, ASI, or T-ASI, please enter the following numbers:
  - CAR: 99
  - ASI: 9
  - T-ASI: 9
- If the customer is younger than 18, section three will be required.
- The CDC must be completed within 30 days of the PA Request.

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

In addition to submitting a CDC, the Outpatient Request for Prior Authorization also requires a completed PA Request:

- PA Requests need to be submitted no less than five (5) calendar days and no more than fifteen (15) calendar days in advance of the expiration of the current authorization period.
- All PA Requests must be dated within 30 days of receipt by APS.
- Requests that are more than 30 days old, based on the date the CAR, ASI or T-ASI evaluation was completed and the date that APS received the request, will be technically denied.
- APS will not retroactively authorize or back date any Outpatient Behavioral Health Services, unless so specified, for example the Pre-Admission Services PA or the Admit to Outpatient/Step-Down PA. The start date for services cannot precede the date that APS received the complete PA Request. Time required for APS to complete the review process will not change the start date for services.
- The PA Request that is submitted to APS for review is not the same thing as a service plan.
- The responsible Licensed Behavioral Health Providers (LBHP) must ensure the accuracy and the appropriateness of the PA Request. Clinicians submitting a web Request are responsible for ensuring that their agency has all required signatures and signature dates on the service plan by submitting their electronic signature.
- Since PA numbers are facility/site specific, all services and the corresponding facility/site must be identified in the request.

Types of PA Requests

Initial Request for Treatment:

- An Initial Request for Treatment is submitted when an individual has not received outpatient behavioral health services, except for Pre-admission Services, within the last six (6) months.
- Completion of the CDC is required within 30 days of the PA Request.
- PA numbers are not issued until a completed PA Request and CDC have been received.
- The PA Request and CDC can be submitted on CareConnection® or uploaded to CareConnection® via EDI.

Extension Request:

- The member has been receiving outpatient behavioral health services within your agency within the last six (6) months, and the member meets medical necessity criteria for continued treatment.
- Completion of the CDC on is required within 30 days of the PA Request.
- If the member changes levels of care to or from a specialized level such as RBMS or ICF-MR during an authorization period, a modification request must be submitted to begin the new level of care. APS will adjust the current PA accordingly.
- If the member has an inpatient behavioral health admission during an authorization period, the provider may continue to bill on the existing PA number from the day of the inpatient discharge forward through the end of the PA. ODMHSAS-funded providers may provide a limited number of outpatient services to the individual while in inpatient, if included in their contract and authorized. These services include Case

Management, Intensive Case Management, Community Recovery Support/ Recovery Support Specialist, Family Training and Support, and Behavioral Health Aide.

- If the member's PA number has expired during the inpatient stay, an extension request will need to be submitted to resume services. An Automatic Step Down/After Care- PG014 can be requested or whatever level of care is clinically appropriate.
- The PA Request and CDC can be submitted on CareConnection® or uploaded to CareConnection® via EDI.

Substance Abuse/Integrated Request:

- If you are submitting a Substance Abuse/Integrated Request, you will complete either the CAR or the ASI/T-ASI. If you choose to complete the ASI/T-ASI, enter 0 (zero) for the CAR scores and you will complete the ASI/T-ASI scores. For ODMHSAS recipients, the ASI/T-ASI is required on all Substance Abuse Requests, and both the ASI/T-ASI and CAR are required on all Integrated Requests.

Modification of Current Authorization Request:

- The member symptoms require more frequent services than the procedure group allows. Current monthly limit must be near exhaustion before a modification can be requested.
- If the member changes levels of care to or from a specialized level such as RBMS or ICF-MR during an authorization period, a modification request must be submitted to begin the new level of care. APS will adjust the current PA accordingly.
- The Modification Request must be within the current PA period.
- The time period of an authorization will not be modified.
- The number of Modification Requests submitted within an authorization period should not exceed one per month.
- The start date of the modified authorization will be the date the Modification Request is received by APS.
- The end date of the Modification Request will remain the same as the current authorization.
- The modification must clearly state the reason for the requested modification.
- A new CAR, ASI, or T-ASI will need to be submitted if it has been more than 30 days since the current PA was issued.
- Interpretive summary needs to be updated to include the current, critical, clinical information in behaviorally descriptive terms to support the need for the higher procedure group.
- APS processes these requests within 3 business days.

The modification request can be submitted on CareConnection® if the original request was submitted on CareConnection®. If the original request was uploaded to CareConnection® via EDI, the modification can be submitted by faxing either a completely new Outpatient Request for Prior Authorization, OR the last Request with updated information, to APS.

Correction Request:

- A Correction Request must be submitted when a provider finds any errors or discrepancies on a PA (i.e., typographical error, wrong provider number, wrong procedure group code, wrong Recipient ID number, etc.) regardless of who made the error. APS processes these requests within five (5) business days.
- A Correction Request must also be submitted if the PA needs to be split between two different sites within the same agency. Be sure to provide the dollar amounts of how the monthly cap will be split.
- If the request was submitted via CareConnection®, the correction request can be submitted on CareConnection®.

Status Request:

- If a facility has not received a response from APS on an Initial, Extension, Modification Request, Clinical Correction Notice Response or Correction Request within five (5) full business days, providers may locate the review status in APS CareConnection®.
- All submission types; faxed Modification or Correction Requests, any CareConnection®, or any EDI upload can check the status of their request anytime on CareConnection.

Request for an Extra Unit BH Service Plan Development, Low Complexity:

- This procedure code group (H0032 TF) is available when the authorization has expired, but the time requirement to complete another behavioral health service plan development, moderate complexity is not met.

Types of Responses

Clinical Correction Notice:

- An APS Reviewer will assess each request for overall completeness of the required elements and all necessary supporting documentation.
- If the faxed request is incomplete, or the review coordinator needs additional information to determine the medical necessity of the requested services, the facility responsible for the request will receive a fax titled "Clinical Correction Notice" stating what additional information is needed to process the request.
- If the CareConnection® request is incomplete, it will be returned to the provider for correction. The status of the request in CareConnection® will be "CORRECTION"; the Note to Provider in the Services Requested section of the request will state what additional information is needed to process the review. Once the corrections are complete, submit the request to APS for final processing.
- The facility has ten (10) calendar days from the date on the Clinical Correction Notice in which to respond. If there is no response within the required 10 days, the request will be technically denied.
- All requests with a Clinical Correction Notice generated will be dated from the date the original request was received if the provider responds within the 10 calendar days.

Clinical Correction Notice Response:

- When a provider responds to an APS Clinical Correction Notice, all requested information must be addressed to avoid a Technical Denial.
- Add the information to the CareConnection® request as indicated in the Note to Provider, save the request and then submit to APS.

Courtesy Review Decision (For SoonerCare Only Providers):

- A Courtesy Review Response is required from a provider when responding to an APS Courtesy Review decision notice.
- The one page "Courtesy Review Response" and requested information regarding member's eligibility. The Courtesy Review Response notifies APS that the member qualifies for services, and requests a PA number for the services that have been authorized. This applies to EDI uploaded requests and those submitted via CareConnection®.
- It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/Insure Oklahoma.

Courtesy Review Decision Response (For SoonerCare Only Providers):

- A Courtesy Review Response is required from a provider when responding to an APS Courtesy Review decision notice. It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/Insure Oklahoma.
- Forms to Submit: The one page "Courtesy Review Response" and requested information regarding member's eligibility. The Courtesy Review Response notifies APS that the member qualifies for services, and requests a PA number for the services that have been authorized. This applies to faxed requests, EDI uploaded requests and those submitted via CareConnection®.
- It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/Insure Oklahoma.

Technical Denial Decision:

- APS will issue a Technical Denial when a provider fails to show that a member meets the Medical Necessity Criteria for the services being requested.
- APS may issue a Technical Denial in response to Initial, Extension, and Modification Requests, or Clinical Correction Notice Response.

REFERRALS AND APPEALS PROCESS

Referral to a Consultant

- If the Clinical Reviewer is unable to determine the medical necessity of a request based upon the criteria, the case will be referred to a Clinical Consultant. APS will provide notification back to the provider within 5 business days of receiving the completed request concerning the outcome of the REFERRAL. The referral decision may be an approval of the original request, a modification of the request, or a denial. When a consultant requires more information, the Clinical Reviewer will indicate the needed information in the Note to Provider in the Services Requested section of the CareConnection® request and return the request to the provider for correction. The provider has ten (10) calendar days to submit the needed information to APS. The start date for services will be the date the request was submitted to APS and the provider will not lose days based on the provider's response time if the information is received within the ten calendar days. If there is no response within the ten calendar days, a technical denial will be issued.

Appeals Process

SoonerCare:

- If the member (or parent/guardian of a minor) wishes to appeal a decision, a hearing with OHCA may be requested. This request must be filed within twenty (20) days of receipt of the denial decision. Contact the Docket Clerk, OHCA, (405) 522-7217. The member will be further instructed on filing appeals through the Oklahoma Health Care Authority and the appropriate forms necessary for completion.

ODMHSAS:

- If the recipient (or parent/guardian of a minor) wishes to appeal a decision, they may contact Jacki Millspaugh, Director of Treatment and Recovery, at (405) 522-3863.

MEMBER CHANGES SERVICE PROVIDER FACILITY

- There are several instances when members may change their service provider. A member may choose to discontinue receiving behavioral health services from one facility and receive those services from another facility. When this occurs, the latter facility submits a complete PA request and in the first line of the interpretive summary documents a letter of termination has been signed and includes the date the member and/or legal guardian signed the letter indicating his/her desire to change behavioral health service providers.
- If an agency does not have a letter of termination, one can be found on www.SoonerPRO.com.
- If a facility submits a PA request for a member who has a current authorization with another facility, a Clinical Correction Notice will be issued to the facility requesting a termination letter or a letter of collaboration.
- The current PA will be end-dated and a new PA will be issued when a termination letter is received.

MEMBERS TRANSFERING FROM ONE AGENCY SITE TO ANOTHER

- A member may choose to transfer to another site/location within the same agency, because of a clinician transfer, convenience of location, or the facility will close a site and transfer members to another. Each site operated by an outpatient mental health facility must have a site-specific provider identification number. Authorizations are member and site-specific. Therefore, the site the member transfers to faxes the one page "Outpatient Transfer Request" found on www.SoonerPro.com showing the required end date for the old site and begin date for the new site. The current PA will be end-dated and a new PA will be issued for the new site with the same end date of the original PA. The procedure group will be prorated based upon the original PA.

TRANSFERING MULTIPLE MEMBERS FROM ONE SITE TO ANOTHER

- This procedure has been set up for providers with multiple sites that may need to move a large group of members from one facility site to another. This will occur when a new site is opened or a current site is closed. To request the transfer process for a group of members the provider will need to contact the APS BH Manager to discuss the specific facility.
- If the APS BH Manager approves the group for the transfer process, the facility will fax the one page ”Outpatient Transfer Request” for each member being transferred.
- The request must include the date of the transfer. APS will then end date the current authorization at the old site the day prior to the transfer date. The procedure group will be pro-rated based on the original PA. A new PA number will be generated for the new site. The start date will be the date indicated on the request with the end date being the end date of the original authorization from the old site.
- The transfer procedure is not designed for clinicians that are changing provider agencies and their members who are following them.

COLLABORATION BETWEEN PROVIDERS ON MEMBER CARE

- Many facilities are not able to provide a full array of services to members in need and/or members may not choose to receive all of their services from one facility. It is expected that facilities will collaborate on behalf of the member’s best interests and choice of facility.
- When there are two agencies requesting behavioral health services for a member, a letter of collaboration is required. The letter of collaboration should be signed and dated by both the providers and by the member and/or legal guardian indicating his/her desire for services to be provided by both facilities. The letter must indicate how the facilities will split the monthly dollar cap for the level of CAR/ASI/T-ASI indicated.
- When two or more agencies, or two or more sites within the same agency, are collaborating on a member’s care, they will share the monthly limit based the Level of Care indicated by the CAR/ASI/T-ASI; each agency does not get the maximum monthly limit.
- If the authorization for one of the agencies has been issued, it will be modified if it is different from what is indicated on the letter of collaboration.
- SoonerCare covers children who receive hospice services. When a child is in hospice they can only receive continued BH services and medication training/support IF these services were initiated prior to the Hospice admission, or when needed for other BH issues outside of their terminal illness diagnosis and treatment. Once the child is admitted to hospice APS will need a letter of collaboration to ensure there is no duplication of services.
- If an agency does not have a letter of collaboration, one can be found on www.SoonerPRO.com.
- If the request is being submitted via CareConnection®, the provider will document that the Letter of Collaboration is on file and include the name of each agency as well as how the facilities will split the monthly dollar cap for the level of CAR/ASI/T-ASI indicated in the “Current” section of the CareConnection® request.
- If there is a question about the letter of collaboration or the dollar values are being disputed, the APS reviewer may require the providers fax the Letter of Collaboration.

MEMBER NAME AND/OR SOONERCARE ID NUMBER CHANGES

- A member’s name and/or SoonerCare ID number may change as the result of an adoption or change in custody. Authorizations are member and site-specific. Therefore, the agency will need to fax the one page “Outpatient Transfer Request” found on www.SoonerPro.com showing the member’s old name and SoonerCare ID number as well as the member’s new name and new SoonerCare ID number. The current PA will be end-dated and a new PA will be issued for the name and/or ID with the same end date of the original PA. The procedure group will be prorated based upon the original PA.

AUTHORIZATION NUMBERS

APS will assign a recipient and provider site-specific PA number to each approved PA request. This recipient and provider site-specific PA number will be submitted to the MMIS on a batch basis each night. Each PA number will be associated with from/through dates by service and month to indicate the length of time and the procedure group being authorized by APS.

SERVICES REQUIRING NO PRIOR AUTHORIZATION

The following services for each SoonerCare Traditional member do not require prior authorization. The annual (calendar year) maximum allotted is identified.

Medication Training and Support	1 unit is allowed per month, per member, without prior authorization.
Crisis Intervention	All units allowed w/o PA, following OAC 317:30-5-241.

The following services for ODMHSAS consumers do not require prior authorization.

Generic ID Services	e.g. consultation, training, outreach
Non-ID Crisis Services	Crisis when the customer can't be identified
Disaster Services	Invoked for specific disasters

AXIS IV DIAGNOSIS INFORMATION

- There is a scale on DSM-IV-TR--called Axis IV--which divides stressors into general categories. Axis IV is a six point rating scale for psychosocial stressors that contribute to the presentation of the current disorder. The coding ranges from none to catastrophic.
  - None: No identifiable stressors.
  - Mild: Starting graduate school, having a child leave home.
  - Moderate: Marriage, marital separation, loss of job.
  - Severe: Divorce, birth of first child, extreme poverty.

Here are a few examples:

- AXIS IV: PSYCHOSOCIAL STRESSORS
  - Problems with primary support group--e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling

  - Problems related to the social environment--e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)

  - Educational problems--e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment

  - Occupational problems--e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers

- Housing problems--e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- Economic problems--e.g., extreme poverty; inadequate finances
- Problems with access to health care services--e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance
- Problems related to interaction with the legal system/crime--e.g., arrest; incarceration; litigation; victim of crime
- Other psychosocial and environmental problems--e.g., exposure to disasters, war, other hostilities; discord with non-family caregivers such as counselor, social worker, or physician; unavailability of social service agencies

LEVELS OF CARE AND SPECIALIZED SERVICES

Levels/Services	OHCA and ODMHSAS	OHCA Only	ODMHSAS Only
Pre-admission	X		
Prevention and Recovery Maintenance, I, II, III, and IV	X		
0-36 months levels of care	X		
RBMS		X	
ICF/MR		X	
Psychological Evaluation		X	
Exceptional Case	X		
Automatic Step Down/After Care	X		
Children's Day Treatment		X	
TANF/ Child Welfare	X		
Adult Drug Court Outpatient			X
Prison Related Services			X
Recovery Services			X
Non-ODMHSAS/Non-OHCA Funded Services			X
Detox			X
Halfway House			X
Residential Treatment			X
Day School			X
CBSCC			X
Mental Health Housing and Residential Care Services			X
Mental Health Inpatient			X
Generic ID Services			X
Non ID Crisis Services			X
Disaster Services			X
Mobile Crisis			X
Long-Term Inpatient			X
Med Clinic Only			X

Family Support Contacts			X

Levels of Care and Specialized Services can include other categories as determined by OHCA, and ODMHSAS. For a list of current Levels of Care/Specialized Services Prior Authorization Groups, including the dollar cap allowed and the list of services for each group, go to http://www.soonerpro.com/Resources/Manuals.aspx under Outpatient ("Procedure Code Groups").

The numerically based levels of care are designed to reflect the member's acuity as each level of care, in ascending order. Some examples of additional levels of care are Exceptional Case, 0-36 months, ICF/MR, Recovery Maintenance/Relapse Prevention, RBMS, Med Clinic Only, Halfway House, and Mental Health Inpatient.

In order to be qualified for any type of outpatient authorization, the individual must be able to actively participate in and derive a reasonable benefit from treatment as evident by sufficient affective, adaptive and cognitive abilities, communication skills and short term memory.

Individuals who fall into one of these categories would be considered inappropriate for an outpatient authorization:

a. Imminent danger to self and/or others (medically unstable.)
b. Extreme level of functional impairment, meeting medical necessity criteria for inpatient hospitalization

The OHCA, ODMHSAS, or their 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 Clinical Correction Notice.

Adult Mental Health Criteria

(OHCA- 21 and older; ODMHSAS- 18 and older)

Level One – Adult General Requirements:
1. Experiencing ***slight to moderate*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality Disorder
3. CAR Scores (a minimum of the following): a. 20 – 29 in 4 domains (Domains 1 – 9) OR b. 30 – 39 in 2 domains (Domains 1 – 9) OR c. 20 – 29 in 3 domains and 30 – 39 in 1 or more domains (Domains 1 – 9)
Level Two – Adult General Requirements:
1. Experiencing ***moderate*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality Disorder
3. CAR Scores (a minimum of the following): a. 30 – 39 in 3 domains (Domains 1 – 9) OR b. 40 – 49 in 1 domains (Domains 1 – 9)
Level Three – Adult General Requirements:
1. Experiencing ***moderate to severe*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality Disorder
3. CAR Scores (a minimum of the following): a. 30 – 39 in 4 domains with 2 domains being in 1,6,7, or 9 OR b. 40 – 49 in 2 domains with 1 domain in 1,6,7 or 9 OR c. 30 – 39 in 2 domains AND 40 in 1 domain with EITHER the 40 or 2 of the 30's being in domains 1,6,7 or 9
Level Four – Adult General Requirements:
1. Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality Disorder
3. CAR Scores (a minimum of the following): 40 in 4 domains, with 1 being in 1, 6, 7 or 9
Prevention and Recovery Maintenance Level Criteria – Adult
1. Experiencing ***slight*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR BOTH a AND b): a. Axis I primary diagnosis: • Prevention – may include 799.9 Deferred Diagnosis or Provisional Diagnosis • Recovery Maintenance – excludes 799.9 Deferred Diagnosis and Provisional Diagnosis b. Axis II personality disorders
3. CAR Scores must be listed on the prior authorization form

SUBSTANCE ABUSE/INTEGRATED ADULT

(OHCA- 21 and older; ODMHSAS- 18 and older)

Level One – Adult SA/Integrated General Requirements:
1. Experiencing ***slight to moderate*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis: a. Axis I Substance-Related Disorder
3. Assessment Results (Use the CAR or ASI*) 1. CAR Scores (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.) a. 20 – 29 in 3 domains (Domains 1 – 9) OR b. 30 – 39 in 2 domains (Domains 1 – 9 OR c. 20 – 29 in 2 domains and 30 – 39 in 1 or more domains (Domains 1 – 9) 2. ASI Scores: a. 4 or above in 2 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Two – Adult SA/Integrated General Requirements:
1. Experiencing ***moderate*** impairments in functioning.
2. DSM IV-TR (in ICD 9 Format) Diagnosis: a. Axis I Substance-Related Disorder
3. Assessment Results (Use the CAR or ASI*) 1. CAR Scores (A minimum of ONE of the following) (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a or b AND domain 3 must have a score of 20 or higher.) a. 30 – 39 in 3 domains (Domains 1 – 9)OR b. 40 – 49 in 1 domains (Domains 1 – 9 OR 2. ASI Scores a. 5 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Three – Adult SA/Integrated General Requirements:
1. Experiencing ***moderate to severe*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis: a. Axis I Substance-Related Disorder
3. Assessment Results (Use the CAR or ASI*): 1. CAR Scores (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.) a. 30 – 39 in 4 domains, with 2 domains being in 1,6,7 or 9; OR b. 40-49 in 2 domains, with 1 domain in 1,6,7 or 9; OR c. 30 – 39 in 2 domains and 40-49 in 1 domain, with either the 40 or 2 of the 30's being in domain 1,6,7 or 9 2. ASI Scores a. 6 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Four – Adult SA/Integrated General Requirements:
1. Experiencing ***very severe* (incapacitating)** functional impairment and potential risk for 24-hour inpatient type care without intensive outpatient services.
2. DSM IV-TR (in ICD 9 Format) Diagnosis: a. Axis I Substance-Related Disorder
3. Assessment Results (Use the CAR or ASI*): 1. CAR Scores (Substance Abuse and Integrated Requests using the CAR assessment must have a score of 20 or higher in domain 3.) a. 40-49 in 4 domains, with 1 domain being in 1, 6, 7, or 9 2. ASI Scores a. 7 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Prevention and Recovery Maintenance Level Criteria – Adult SA/Integrated
1. Experiencing ***slight*** functional impairment
2. DSM IV-TR (in ICD 9 Format) Diagnosis: a. Axis I Substance-Related Disorder
3. CAR Scores or ASI Scores* must be listed on the prior authorization form

***For ODMHSAS the ASI is required for all Substance Abuse Requests and both the ASI and the CAR are required for all Integrated Requests.**

Child Mental Health Criteria (Younger than 21)

Level One – Child MH General Requirements:
1. Experiencing ***slight to moderate*** functional impairment.
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis (a OR BOTH a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality disorders only for 18 – 20 years of age. (If younger than 18 must include well documented psychiatric supporting evidence.)
3. CAR Scores (a minimum of the following): a. 20 – 29 in 4 domains (Domains 1 – 9) OR b. 30 – 39 in 2 domains (Domains 1 – 9) OR c. 20 – 29 in 3 domains and 30 – 39 in 1 or more domains (Domains 1 – 9)
Level Two – Child MH General Requirements:
1. Experiencing ***moderate*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality disorders only for 18 – 20 years of age. (If younger than 18 must include well documented psychiatric supporting evidence.)
3. CAR Scores (a minimum of the following): a. 30 – 39 in 3 domains (Domains 1 – 9) OR b. 40 – 49 in 1 domains (Domains 1 – 9)
Level Three – Child MH General Requirements:
1. Experiencing ***moderate to severe*** functional impairment.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality disorders only for 18 – 20 years of age. (If younger than 18 must include well documented psychiatric supporting evidence.)
3. CAR Scores (a minimum of the following): a. 30 – 39 in 4 domains with 2 domains being in 1,6,7, or 9 OR b. 40 – 49 in 2 domains with 1 domain in 1,6,7 or 9 OR c. 30 – 39 in 2 domains AND 40-49 in 1 domain with EITHER the 40 or 2 of the 30's being in domains 1,6,7 or 9
Level Four – Child MH General Requirements:
1. Experiencing ***very severe* (incapacitating)** functional impairment and potential risk for hospitalization without intensive outpatient services.
2. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR both a AND b): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5, and provisional diagnosis. b. Axis II personality disorders only for 18 – 20 years of age. (If younger than 18 must include well documented psychiatric supporting evidence.)
3. CAR Scores (a minimum of the following): 40-49 in 3 domains, with 1 being in 1, 6, 7 or 9
Prevention and Recovery Maintenance Level Criteria – MH Child
1. Experiencing ***slight*** functional impairment
4. DSM IV-TR (in ICD 9 Format) Diagnosis (a OR BOTH a AND b): a. Axis I primary diagnosis: • Prevention – may include 799.9 Deferred Diagnosis or Provisional Diagnosis • Recovery Maintenance – excludes 799.9 Deferred Diagnosis and Provisional Diagnosis b. Axis II personality disorders (If younger than 18 must include well documented psychiatric supporting evidence.)
2. CAR Scores must be listed on the prior authorization form

SUBSTANCE ABUSE/INTEGRATED Criteria Child (Younger than 21)

Level One – Child SA/Integrated General Requirements:
1. Experiencing ***slight to moderate*** functional impairment.
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis a. Axis I Substance-Related Disorder
3. Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher. a. 20 - 29 in 3 or more domains (domains 1 - 9); OR b. 30 - 39 in 2 domains (domains 1 - 9); OR c. 20 - 29 in 2 domains AND 30 - 39 in 1 domain or more (domains 1 - 9) 4. T-ASI Scores a. 2 or above in 3 areas, must include at least a 2 in Chemical Use Problem Area 5. ASI Score a. 4 or above in 2 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Two – Child SA/Integrated General Requirements:
1. Experiencing ***moderate*** functional impairment.
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis b. Axis I Substance-Related Disorder
3. Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a or b AND domain 3 must have a score of 20 or higher a. 30 - 39 in 3 domains (domains 1 - 9); OR b. 40 - 49 in 1 domain (domains 1 - 9) 4. T-ASI Scores a. 3 or above in 2 areas; must include at least a 2 in Chemical Use Problem Area OR b. 4 in one area; must include at least a 2 in Chemical Use Problem Area 5. ASI Scores a. 5 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Three – Child SA/Integrated General Requirements:
1. Experiencing ***moderate to severe*** functional impairment.
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis a) Axis I Substance-Related Disorder
3. Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher. a. 30 - 39 in 4 domains, with 2 domains being in 1, 6, 7, or 9; OR b. 40 - 49 in 2 domains, with 1 domain being in 1, 6, 7, or 9; OR c. 30 - 39 in 2 domains AND 40 – 49 in 1 domain, with EITHER the 40 OR 2 of the 30's being in domains 1, 6, 7, or 9 4. T-ASI Scores a. 3 or above in 3 areas; must include at least a 2 in Chemical Use Problem Area OR b. 4 in 2 areas; must include at least a 2 in Chemical Use Problem Area 5. ASI Scores a. 6 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Level Four – Child SA/Integrated General Requirements:
1. Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis a. Axis I Substance-Related Disorder
3. Substance Abuse and Integrated Requests using the CAR assessment must have a score of 40 or higher in domain 3 a. 40 - 49 in 3 domains, with 1 domain being in 1, 6, 7, or 9 4. T-ASI Scores a. 4 in 3 areas; must include a 4 in the Chemical Use Problem Area 5. ASI Scores a. 7 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area
Prevention and Recovery Maintenance Level Criteria – SA/Integrated Child
1. Experiencing ***sligh***t functional impairment
2. DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis a. Axis I Substance-Related Disorder
3. CAR Scores, T-ASI, or ASI Scores must be listed on the prior authorization form

***For ODMHSAS the T-ASI (ages 12-17) or ASI (ages 18 and above) is required.**

Child (0 – 36 Months of Age) Criteria
All prior authorization decisions will be based upon the following criteria for children 0-36 months of age:
1. Therapist's credentials must include degree and licensure. In addition, the services being provided to this population must be within the scope of practice of the therapist. Competency in the one of the following areas is required: a) Early Childhood Development, diagnosis, and treatment b) Infant Mental Health, diagnosis, and treatment. c) Clinical experience with this age group. d) Under supervision with a clinician with training/experience with this age group. **2.** Service plan goals and objectives must be age and developmentally appropriate. **3.** Developmental level of the child. **4.** DC: 0-3 R (IN ICD-9 FORMAT) Diagnosis for the member/child. Diagnosis is for the child, not the parent. **5.** Presenting Problem(s) listed. **6.** Interactive Counseling is considered appropriate when: a) The above conditions (#1-5) are met b) For short-term assessment purposes c) Clear evidence that the child can engage in symbolic play **7.** CAR domains 1 - 9 must meet the level of care being requested and Caregiver Resources noted on the Addendum page as part of the member record
FOR CHILDREN 0-18 MONTHS of Age (IN ADDITION TO #1-7): **1.** Developmentally APPROPRIATE therapeutic modalities, services, and/interventions must have a primary focus on the attachment between the child and parental figure(s): a) Family Psychotherapy **2.** Developmentally INAPPROPRIATE therapeutic services: a) Interactive Psychotherapy b) Group Psychotherapy and/or Psychosocial Rehabilitation (Individual or Group)
OR CHILDREN 19-36 MONTHS of Age (IN ADDITION TO #1-7): **1.** Developmentally APPROPRIATE therapeutic modalities, services, and/or interventions: a) Family Psychotherapy **2.** The following MAY be deemed developmentally APPROPRIATE in SOME cases: a) Interactive Psychotherapy (Limited - primarily used for observation for assessment purposes with clear evidence child can engage in symbolic play) b) Psychosocial Rehabilitation (Individual) (FOR PARENTING SKILLS TRAINING ONLY)

CRITERIA FOR CHILDREN IN RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES (RBMS), THERAPEUTIC FOSTER CARE (TFC) AND THERAPEUTIC GROUP HOMES (Levels C and E) WHO NEED ADDITIONAL OPBH SERVICES

General Requirements (Must meet all of the following conditions):

1. Appropriate (Must meet ALL of the following conditions)
- a) Experiencing severe functional impairment, illustrating the need for additional treatment beyond the required services; AND
- b) Demonstrates the need for specialized treatment to augment the services provided by the RBMS; AND
- c) Able to actively participate in and derive a reasonable benefit from treatment as evidenced by sufficient affective, adaptive and cognitive abilities, communication skills, and short-term memory

2. Inappropriate
- a) Imminent danger to self and/or others (medically unstable); AND/OR Extreme level of functional impairment, meeting medical necessity criteria for acute inpatient hospitalization

Assessment Results (Must meet ONE condition in BOTH 1 AND 2):

1. DSM-IV-TR (IN ICD-9 FORMAT) DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis (a or both a and b)
- a) Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5 , and provisional diagnoses.
- b) Axis II personality disorders, ONLY for 18 - 20 years of age (If younger than 18, must include well documented psychiatric supporting evidence)

2. CAR Scores (A minimum of ONE of the following) (CAR descriptors for domains 1 – 9 must be appropriately documented. Caregiver Resources must be documented as noted on the Addendum as part of the member record.). .
- a) 30 - 39 in 4 domains, with 2 domains being in 1, 6, 7, or 9; OR
- b) 40 - 49 in 2 domains, with 1 domain being in 1, 6, 7, or 9; OR
- c) 30 - 39 in 2 domains AND 40 - 49 in 1 domain, with the 40 or 2 -30's being in 1, 6, 7, or 9

The T-ASI can be used for those children in need of SA treatment. T-ASI Scores:
- a) 3 or above in 3 areas; must include at least a 2 in Chemical Use Problem Area OR
- b) 4 in 2 areas; must include at least a 2 in Chemical Use Problem Area

3. An explanation of the need for the specialized or additional treatment or therapeutic intervention employed by the therapist that is not being provided by the TFC or group home under their per diem treatment services requirement.

OPBH Agency Services NOT allowed for SoonerCare Traditional members receiving RBMS:

1. Case Management
2. Psychosocial Rehabilitation (Individual or Group)
3. Mental Health Service Plan Development

ICF/MR Criteria

General Requirements (Must meet all of the following conditions):

1. Appropriate (Must meet ALL of the following conditions)
- a) Functional improvement is a realistic expectation; AND
- b) Potential risk for hospitalization without intensive outpatient services; AND
- c) Able to actively participate in and derive a reasonable benefit from treatment as evidenced by sufficient affective, adaptive and cognitive abilities, communication skills, and short-term memory

2. Inappropriate
- a) Imminent danger to self and/or others (medically unstable); AND/OR
- b) Inability to actively participate in treatment

1. DSM-IV-TR (IN ICD-9 FORMAT) DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis (BOTH a AND b)
- **b.** Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, No Diagnosis V71.09 or V65.5 , and provisional diagnoses.
- **c.** Axis II diagnosis, with documented IQ score

2. Submission of a letter from the ICF/MR facility indicating the DSM-IV-TR (IN ICD-9 FORMAT) DSM-IV-TR (IN ICD-9 FORMAT) (IN ICD-9 FORMAT) multi-axial diagnoses, specific behavioral concerns, reason for referral, and signed by an ICF/MR representative.

3. Submission of the Individual Habilitation Plan that reflects the member's need for the requested behavioral health services. The current annual plan is required including signature page and legible date of most recent update/revision.

4. Major discrepancies between information obtained from the ICF-MR and providers documentation are to be resolved by the provider. It must be clear the member can benefit from outpatient counseling services.

5. Submission of Psychological Testing documenting IQ Score, Vineland Adaptive Scale, and any additional clinical assessment reports that support the requested services.

6. Communication domain at the end of the CAR must be completed; AND

7. For SEVERE or PROFOUND MR diagnosis, the approach(s) to treatment, such as behavior modification, applied behavior analysis, or another widely accepted theoretical framework for treating members with this diagnosis, must be noted in the Addendum as part of the member record.

Services NOT allowed for SoonerCare Traditional members in a 24-hr setting

1. Case Management
2. Psychosocial Rehabilitation (Individual or Group)
3. Medication Training and Support

Exceptional Case Criteria

General Requirements (Must meet all of the following conditions):

1. It is recognized that there may be cases in which the member's condition is severe enough to require a higher intensity of services than is allowed by the Medical Necessity Criteria in the Level(s) of Care. Providers may request additional services beyond the maximum allowed in the Level(s) of Care when cases would fit into this category. These cases will be considered "Exceptional" and will not be maintained at this same level of intensity each PA period.

2. This level of care is allowed for exceptional cases in which the child or adult's condition requires more than is offered in the Level(s) of Care, but who are not in need of the level of services provided at Acute inpatient level of care.

3. The provider must submit a request to APS using the standard PA Request Packet and specify that this is a request for Exceptional Case. A Clinical Reviewer will review the first request.

4. Subsequent, additional requests for exceptional case will be automatically referred to a Clinical Consultant to evaluate the appropriateness of the requested services for the clinical manifestations identified. Supporting documentation will be required to substantiate the additional requested services above and beyond the Level(s) of Care.

Appropriate (Any/or all of the following)

1. Experiencing extreme functional impairment, but does not meet medical necessity criteria for Acute inpatient hospitalization;
2. Medically stable (i.e., not an imminent danger to self and/or others);
3. Stepping down from a higher level of care (Acute/RTC/Inpatient.);
4. Without intensive services, there is an escalation of symptoms (e.g., an increase in aggressive behavior or a decreased ability to perform ADL's, but is medically stable).

Inappropriate

1. Imminent danger to self and/or others (medically unstable); AND/OR
2. Extreme level of functional impairment, meeting medical necessity criteria for inpatient hospitalization.

Amount of Service Allowable	Requests for this level of service will be covered for a period of one (1) to three (3) months. Prior authorization will be required monthly.

Psychological Evaluation Criteria for OPBH Agencies

General Requirements	Assessment Results
1. Appropriate (Must meet ALL of the following conditions) a) Member is experiencing difficulty in functioning with origins not clearly determined; AND b) An evaluation has been recommended and/or requested by a psychiatrist, psychologist, or a licensed mental health professional; AND c) Results of evaluation will directly impact current treatment strategies. d) If member has been tested recently a different testing battery will be performed. **2.** Inappropriate a) Evaluation results will not directly impact current treatment or discharge; AND/OR b) Evaluation results will be utilized for academic placement/purposes only; AND/OR c) An equivalent psychological evaluation has been conducted by another provider (including private psychologists) within the current calendar year.	**1.** DSM-IV-TR (IN ICD-9 FORMAT) DSM-IV-TR (IN ICD-9 FORMAT) Diagnosis – all five axes must be completed: a) Axis I primary diagnosis (INCLUDING V and 900 codes, Deferred, and Provisional Diagnosis). **Submission Requirements (must include ALL of the following information):** **1.** Entire prior authorization form; AND **2.** Treatment plan must document: a) What tests will be used? b) How many hours will the testing require? c) Who will be performing the tests, and what are their credentials? d) What is the reason for the testing? e) How the evaluation results will specifically affect goals and objectives for the member? Notes: **1.** A psychological technician is defined by the State Board of Examiners of Psychologists as being "under the direct supervision of a licensed psychologist" (Title 59 O.S. 1991, Section 1353.6) and "the Rules of the Board (Section 575:10-1-7) describe the hiring of a psychological technician, a dependent assistant to the psychologist." **2.** *Outpatient Behavioral Health Agencies (OPBH) can use a Licensed Behavioral Health Provider (LPBH) to perform psychological testing as long as it is in their scope of practice.*

Automatic Step Down / After Care Criteria

General Requirements (Must meet all of the following conditions):

1. The OHCA State Plan targets those members who are discharging from, or are denied an admission to acute, residential treatment center, crisis stabilization, group home or TFC levels of care.

2. For continuity and expediency, the Individual Plan of Care and Assessment from the higher level of care facility will be provided at the time of the member's discharge from that facility or at time of being denied for admission. This will serve as the treatment guide for the outpatient provider/agency the first 30 days of outpatient care.

3. If this PA is being issued for a consumer new to the agency, a treatment plan review will not be issued as the initial assessment and service plan do not currently require prior authorization.

4. If this PA is being issued for a consumer that is already receiving outpatient services from the requesting provider, a treatment plan review will need to be included in the request by checking the appropriate box. If the current outpatient provider requests this 30 day PA, their current PA will be end dated to avoid overlapping authorization of services and dates.

5. Following the initial step down authorization, an extension of services may be requested from APS by submitting the request via CareConnection or faxing an Outpatient Prior Authorization Request Packet. The extension should be received by APS not more than 15 calendar days and no later than five (5) calendar days before the end of the current authorization period. An APS Behavioral Health Review Coordinator will review the extension request within three (3) business days of receipt, utilizing the Medical Necessity Criteria for continued care.

Amount of Service Allowable	For those members preparing to discharge or who have been denied admission to acute, RTC, crisis stabilization, group home or TFC, PHP/Day Tx/IOP, APS will authorize services for the first 30 (thirty) days at the time the provider accepts the initial referral and faxes the Admit to Outpatient Services form to APS at 1-800-762-1639.

Recommended Protocol for Automatic Authorization Period	Time Frame Requirement	Provider
▪ First outpatient appointment with the OPBH Agency	No more than 7 days	Agency Provider
▪ Continuing face to face visits	One or more per week	LBHP/Case Manager
▪ For new consumers, the assessment and service plan	Within 30 days of discharge	LBHP
▪ For established consumers, service plan	Within 30 days of discharge	LBHP
▪ Continued counseling services: Appointments must be kept. Follow up efforts must be documented if appointments are missed.	On going	Staff
▪ Outreach: Home visits or phone contact by case manager if appointments are missed.	Within 24 hours of missed appointments	Case Manager

After the first 14 day of missed appointments, if the member/guardian does not respond to letters, phone calls or other attempts to engage them in initiating or continuing in services, the outpatient provider/facility will provide this information to an APS Behavioral Health Review Coordinator either by fax or phone.

Children's Partial Hospitalization Program

Service Definition and Requirements

- At least 5 days per week, up to 4 hours therapeutic services per day. Closed on legal holidays.

Required Therapeutic Services:

- Psychiatrist/physician face to face\visit 2 times per month (Medication Evaluation is billed separately by the physician)
- Crisis management services are available 24 hours a day, 7 days a week

- Psychotherapies– Minimum of 4 hours per week:
  - IT and/or FT, minimum of 2 sessions per wk. Programs need to focus strongly on family involvement in the treatment.
  - GT minimum of 2 sessions per wk

- Interchangeable Therapeutic Services to include the following:
  - Diagnostic Services (Comprehensive psychological testing by a licensed psychologist is billed separately.)
  - BHRS / alcohol and other drug education
  - Case management
  - Medication Training & Support
  - Expressive Therapy

- OT/PT/Speech should come from the ISD (Independent School District)
- Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.
- Therapeutic holds are strongly discouraged but if necessary for the welfare of the child MUST follow accreditation requirements**.**
- Trauma-Informed Care (TIC) recommended. NCTIC@abtassoc.com. www.mentalhealth.samhsa.gov/nctic

Target Population

- SoonerCare eligibility and meets PHP MNC.
- 20 and younger (only)

Documentation Requirements

- A nursing health assessment within 24 hours of admission. A physical examination and medical history is coordinated with the Primary Care Physician.

1. Service Plan updates are required every 3 months or more frequently based on clinical need.
2. The length of the program varies based on the Individual's needs and medical necessity.
3. Active involvement of the Individual, family, caretakers, or significant others involved in the Individual's treatment is required.

Staffing Requirements

- RN trained and competent in the delivery of behavioral health services is available on site during program hours to provide necessary nursing care and/or psychiatric nursing care. (1 RN at minimum for program that can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.
- Medical Director is a psychiatrist.
- A psychiatrist/physician is available 24 hours a day, 7 days a week
- Per OAC 317:30-5-240.

Service/Reimbursement Limitations

- Accreditation required (CARF, JCAHO, COA)
- Monthly cap (Benefit Limit):
  - 4 hours x $42.80 = $171.20 x 5 days = $856.00 per week, w/ a $3,424 monthly cap
  - Physician services and medications are separately billable and not part of this cap.
  - Can bill up to 4 hours per day, but the monthly cap does not change.

Service Code Modifiers

HE – Mental Health
HF – Substance Abuse or Integrated

Prior Authorization

A. GENERAL REQUIREMENTS FOR ADMISSION AND CONTINUED STAY IN PARTIAL HOSPITALIZATION PROGRAM:

1. The member needs to meet CALOCUS Level 4. You may photocopy and use this instrument in the original form. The manual for the CALOCUS is available as a PDF: http://www.wpic.pitt.edu/aacp/finds/CALOCUSv15.pdf. (CALOCUS is not required for step downs from an inpatient level of care: acute or RTC.)

2. The CAR will be reported on the CDC.
3. Current DSM IV Axis I Diagnosis (in ICD-9 format) that is consistent with symptoms
4. Individual's condition can be expected to be stabilized at this level of care.
5. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.

B. ADMISSION CRITERIA SEVERITY OF ILLNESS

Clinical Findings – *Must have either 1 or 2 to qualify:*

1. The member's condition is severe enough to require a higher intensity of services than is allowed by the Medical Necessity Criteria in the other outpatient Level(s) of Care. PHP is allowed for cases in which the child's condition may meet an inpatient level of care such as residential criteria, but there is evidence of a stable and safe living environment and the member's safety can be maintained during non-treatment hours. The goal is for the member to be treated at the least intensive setting able to meet the individual's medical needs. The partial hospitalization program can safely substitute for or shorten a hospital stay to prevent deterioration that would lead to a re-hospitalization
2. The member has been discharged from a higher level of care and continues to require intensive, structured treatment program to maintain progress and stability during a period of transition to a lower level of care. A CALOCUS is not required if the member is stepping down from a higher level of care (e.g., Acute or RTC).

C. CONTINUED STAY CRITERIA

Must continue to have all of the following to qualify in addition to the general requirements (Part A) listed above:

1. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident, documented, and can be described in objective terms, but goals of treatment have not been achieved.
2. Family system (caretaker, significant others) compliance with treatment is occurring. Active involvement and responsiveness to treatment recommendations of the Individual, family, caretakers, or significant others involved in the Individual's treatment is required.
3. Documentation must indicate continued risk and must address lack of and/or insufficient response to the treatment plan.
4. Clinical attempts at therapeutic re-entry into a less restrictive level of care have, or would, result in exacerbation of the mental disorder to the degree that would warrant the continued need for partial hospitalization services.
5. There is documented active planning for transition to a less intensive level of care.
6. Coordination with the school system is required and should be on-going from the time of admission.

D. AMOUNT OF ALLOWABLE SERVICE

- Initial requests for this level of service will be covered for a period of (1) to three (3) months.
- Extension requests are based on continued MNC documentation; be covered for a period of (1) to three (3) months; and family system is actively involved and responsive to treatment recommendations.

Children's Day Treatment

Service Definition and Requirements

- The program is available: At least four days per week. At least 3 hours per day.
- Treatment activities to include the following every week:
  - FT - *at least one hour per week* (Additional hours of FT may be substituted for other day treatment services. A strong family treatment focus is strongly encouraged and supported. It is seen as an integral part of day treatment.)
  - GT - *at least two hours per week*
  - IT - *at least one hour per week*
- And at least one of the following per day:
  - Medication training and support (nursing) - *once monthly if on medications*
  - BHRS to include alcohol and other drug education if clinically necessary and appropriate - *utilize Individual and Group Rehab to meet the additional hours per day requirement for day treatment.*
  - Case Management - *as needed and part of weekly hours for the member*
  - Occupational therapy - *as needed and part of weekly hours for the member*
  - Expressive therapy - *as needed and part of weekly hours for the member*.
- On-call crisis intervention services 24 hours a day, 7 days a week. (When persons served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but is available at all times.)
- The program provides: Assessment and diagnostic services and/or medication monitoring, when necessary.
- Making all of the necessary provisions and/or linkage with educational activities/vocational activities is a requirement.
- Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.

Target Population

- SoonerCare eligibility and MNC.
- 20 and younger (only)

Documentation Requirements

- Service Plan updates are required every 3 months.

Staffing Requirements

- Directed by an LBHP
- Multi-disciplinary team, Per OAC 317:30-5-240.
- Psychiatric services are available to persons served, including crisis intervention services 24 hours a day, 7 days a week

Service/Reimbursement Limitations

- Accreditation required (CARF, JCAHO, COA)

Service Code Modifiers

HE – Mental Health
HF – Substance Abuse or Integrated

Intensive Outpatient Program (Under Development)
Service Definition and Requirements
• Minimum of 9 direct contact hours per week (Minimum of 2 hours per week by LBHP) (CARF: In an intensive outpatient treatment, the person served and/or family members are provided with at least nine direct contact hours per week.) • LBHP conducts assessment to determine appropriateness of program admission • Treatment must include a minimum of IT, FT, GT, and PSR • 24, 7 crisis intervention services • Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.
Target Population
• SoonerCare eligibility and MNC.
Documentation Requirements
• Service Plan updates are required every 3 months.
Staffing Requirements
• Per OAC 317:30-5-240.
Service/Reimbursement Limitations
• Accreditation required (CARF, JCAHO, COA)
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated

Adult SMI and Older Adult Day Treatment (Under Development)
Service Definition and Requirements

• Minimum of 5 days per week, minimum 5-6 hours per day
• Assessment and diagnostic services
• Directed by a LBHP
• Treatment activities include:
  o Service Planning
  o BHRS
  o IT
  o GT
  o MT&S
  o CM
• Medication monitoring
• Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.

Target Population
• SoonerCare eligibility and MNC.
Documentation Requirements
• Service Plan updates are required every 3 months.
Staffing Requirements
• Multi-disciplinary team • Per OAC 317:30-5-240.
Service/Reimbursement Limitations
• Accreditation required (CARF, JCAHO, COA)
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated

ODMHSAS Instant Prior Authorization Criteria

Prison-related Services (DH502):
1. For prison-related contracts 2. Service focus = 09 3. Age ≥ 16
Recovery Services (DH503):
1. For ICCD Clubhouse, Consumer to Consumer and Day Center programs 2. Service focus = 11 3. SMI = 1
Non-ODMHSAS / Non-OHCA Funded Services (DH504):
1. For customers whose funding source is not ODMHSAS or SoonerCare 2. Used for reporting purposes only
Detox (DH505):
1. For substance abuse detoxification programs 2. Level of Care = SN
Halfway House (DH506):
1. For substance abuse halfway house programs 2. Level of Care = CL and Service Focus not equal 11
Residential Treatment (DH507):
1. For mental health and substance abuse residential treatment programs 2. Level of Care = CI
Day School (DH508):
1. For day school contracts 2. Service Focus = 23
Community-based Structured Crisis Care (DH509):
1. For community-based structured crisis care programs 2. Level of Care = SC
Mental Health Housing and Residential Care Services (DH510):
1. For mental health housing programs and residential care facilities 2. Level of Care = CL and Service Focus = 11 3. SMI = 1
Mental Health Inpatient (DH511):
1. For mental health inpatient program 2. Level of Care = HA
Mobile Crisis (DH514):
1. For specialized mobile crisis contracts 2. Service Focus = 26
Long-Term Inpatient (DH516):
1. For long-term care provided at Griffin Memorial Hospital and the Oklahoma Forensic Center 2. Level of Care = HA and Service Focus = 27
Med Clinic Only (DH517):
1. For customers who only require pharmacological services 2. Service Focus = 24
Family Support Contacts (DH518):
1. For providing services to family members on behalf of the admitted customer 2. Transaction type = 25

CRITERIA REFERENCE FORM FOR LEVELS OF CARE AND SPECIALIZED SERVICES

LEVEL OF CARE	CAR SCORES
Prevention and Recovery Maintenance	CAR or ASI/T-ASI scores must be documented.
Child (0-36 months)	Complete all domains (1-11)
Mental Health- Child Level 1	20 - 29 in 4 domains (1 - 9); OR 30 - 39 in 2 domains (1 - 9); OR 20 - 29 in 3 domains AND 30 - 39 in 1 or more domains (1 - 9)
Mental Health - Child Level 2	30 - 39 in 3 domains (1 - 9); OR 40 - 49 in 1 domain (1 - 9)
Mental Health -Child Level 3	30 – 39 in 4 domains, w/ 2 in 1, 6, 7 or 9; OR 40 – 49 in 2 domains, w/ 1in 1, 6, 7 or 9; OR 30 - 39 in 2 domains AND 40 - 49 in 1 domain, w/ 1-40 OR 2-30s in 1, 6, 7 or 9
Mental Health - Child Level 4	40 - 49 in 3 domains, with 1 in 1, 6, 7 or 9
Substance Abuse/Integrated - Child Level 1	CAR: Level 1 AND domain 3 with a score of 20 or higher; OR T-ASI: 2 or above in 3 areas; AND at least a 2 in Chemical Use Problem Area; OR ASI: 4 or above in 2 areas; AND at least a 4 in Alcohol and Drug Problem Area
Substance Abuse/Integrated - Child Level 2	CAR: Level 2 AND domain 3 with a score of 20 or higher; OR T-ASI: 3 or above in 2 areas; OR 4 in 1 area; AND at least a 4 in Chemical Use Problem Area; OR ASI: 5 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
Substance Abuse/Integrated - Child Level 3	CAR: Level 3 AND domain 3 with a score of 20 or higher; OR T-ASI: 3 or above in 3 areas; OR 4 in 2 areas; AND at least a 4 in Chemical Use Problem Area; OR ASI: 6 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
Substance Abuse/Integrated - Child Level 4	CAR: Level 4 AND domain 3 with a score of 20 or higher; OR T-ASI: 4 in 3 areas; AND at least a 4 in Chemical Use Problem Area; OR ASI: 7 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
Child RBMS .	30 - 39 in 4 domains, with 2 in 1, 6, 7 or 9; OR 40 - 49 in 2 domains, with 1 in 1, 6, 7 or 9; OR 30 - 39 in 2 domains AND 40 - 49 in 1 domain, with 1-40 or 2-30s in 1, 6, 7 or 9; OR T-ASI 3or above in 3 areas; OR 4 in 2 areas; AND at least a 2 in Chemical Use Problem Area
Mental Health - Adult Level 1	20 - 29 in 4 domains (1 - 9); OR 30 - 39 in 2 domains (1 - 9); OR 20 - 29 in 3 domains (1 - 9) AND 30 - 39 in 1 or more domains (1-9)
Mental Health - Adult Level 2	30 - 39 in 3 domains (1 - 9); OR 40 - 49 in 1 domain (1 - 9)
Mental Health - Adult Level 3	30 – 39 in 4 domains, with 2 in 1, 6, 7 or 9; OR 40 – 49 in 2 domains, with 1in 1, 6, 7 or 9; OR 30 - 39 in 2 domains AND 40 - 49 in 1 domain, with EITHER 1-40 OR 2-30s in 1, 6, 7 or 9
Mental Health Adult Level 4	40 - 49 in 4 domains (1 - 9), with 1 in 1, 6, 7 or 9
Substance Abuse/Integrated- Adult Level 1	CAR: Level 1 AND domain 3 with a score of 20 or higher; OR ASI: 4 or above in 2 areas; AND at least 4 in Alcohol or Drug Problem Area
Substance Abuse/Integrated- Adult Level 2	CAR: Level 2 AND domain 3 with a score 20 or higher; OR ASI: 5 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
Substance Abuse/Integrated - Adult Level 3	CAR: Level 3 AND domain 3 with a score 20 or higher; OR ASI: 6 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
Substance Abuse/Integrated - Adult Level 4	CAR: Level 4 AND domain 3 with a score 20 or higher; OR ASI: 7 or above in 3 areas; AND at least a 4 in Alcohol or Drug Problem Area
ICF/MR	Complete all domains

HOW TO IMPROVE CHANCES FOR AUTO-AUTHORIZATION OF OUTPATIENT REQUESTS SUBMITTED ON CARECONNECTION ®

1. These statuses will exist in CareConnection® when a request executes the auto authorization rules:
    a. Request status = Final-Approved or CR-Approved; service status = CM_AUTH. The request has passed all auto auth rules and is approved.

    b. Request status = Submitted, service status = CM_REV. The request will not auto auth and is forced to manual review.

    c. Request status = Hold_Submit, service status = FAIL_AUTH. The request has failed one or more checks and is NOT forced to manual review. The user will have the opportunity to correct errors and resubmit, both thru the web application AND thru EDI re-submission.

2. Any CDC meeting qualifications defined by DMHSAS will automatically generate a PA request in the background. This request will immediately be approved (PA number assigned) and exported to MMIS that evening. The term for this is "instant authorization". These are limited to transaction 21 (generates PG038 for initial services), and some DMH only codes.

3. The requested start date cannot be earlier than the date the request is submitted to APS Healthcare:

    a. On the web, the submit date is when the "Submit" button is pressed and no errors are generated.

    b. For EDI files, the submit date is the <CreateDate> in the header record of the file.

4. If this is an extension request, be sure that the new requested start date does not overlap the end date of the old authorization. The only exception is if a request for initial services (PG038) is the only historical record. The issues discussed above still apply.

5. The only review types subject to auto authorization are:
    - Mental Health - OP
    - Substance Abuse - OP
    - Integrated - OP
    - Prevention and Recovery
    - Admit to Outpatient

6. The requesting facility must be the treating provider.

7. Axis I must be completed. Deferred (799.9) and None (V71.09 or V65.5) are not acceptable for a primary Axis I diagnosis.

    For substance abuse/integrated requests, a substance abuse diagnosis is required in Axis I (301…301.9).

8. Axis II must be completed. The "None" codes above are allowed (v65.5, v71.09 or 799.9), as are MR diagnoses (317, 318, 318.1, 318.2, 319), borderline intellectual functioning (v62.89), and personality disorders (301....301.9).

    If a personality disorder diagnosis is for a minor consumer, the request will be forced to manual review. This is not true for an adult.

9. Axis III is a free field text that must be completed. Report medical issues only.

10. Axis IV – at least one psychosocial stressor must be something other than None/NA.
    - Level 1 - At least one stressor should be mild or moderate. Does not allow severe

- Level 2 - At least one stressor should be moderate. Does not allow severe
- Level 3 - At least one stressor should be moderate or severe
- Level 4 - At least one stressor should be severe

When you are rating these areas, think of them as you would the CAR score ranges for the related CAR domains. If the CAR score is 20-29, that would be mild; 30-39 moderate; 40-49 severe.

For example:
If you score the CAR family domain a 34, then the rating for the Primary Support in the Axis IV would be Moderate.

11. Axis V must be completed. This is the GAF score outlined in the DSM-TR. If this is an initial request, unknown or 0 (zero) are acceptable values for the past score.

12. The first item in the Services Requested section of the request is "Level" with a drop-down of I, II, III, IV, etc. To improve your auto-auth chances, be sure to indicate the CAR or ASI/T-ASI level as supported by the scores in this section. If you have questions, please refer to the Provider Manual on SoonerPro (http://www.soonerpro.com/Resources/Manuals.aspx).

13. The procedure group (PG) code requested must not exceed the level as indicated and must be supported by the CAR or ASI/T-ASI scores. It can be a lower level PG code if that is the frequency of services being provided, but it cannot be higher.

10. PG033 should ONLY be requested if there is a gap between the end date of a previous PA period and the start date of the current request. Adding this service to an initial or extension request will stop the request from auto-authorizing, so it should only be added when needed and explanation supplied for why it is requested.

(R 03-26-10)

GENERAL CARECONNECTION® TIPS

1. CareConnection® is going to default for the majority of requests to 6 months. If you are requesting a shorter PA, enter the number of months in the Length of Service and when you **tab** to the end date, it will automatically calculate the correct end date.

2. The Current section of the request is not a required field in CareConnection® for outpatient services; the Interpretive Summary is required and that is where the *current critical clinical information* supporting the need for the member to receive services or continue in services with your agency is to be documented.

3. The Current section of the request is a good place to place comments for the reviewers that you want to stand out from the rest of the request. This is where you will:

   a. Clearly state the reason for submitting a Correction or Modification. If this is a Modification or Correction, do not request all the services again; only request the services that need modification or correction.

   b. Document that you have a letter of termination on file. Include the date the member/guardian signed the letter.

   c. Document that you have a letter of collaboration on file. Include the name of all collaborating agencies, date the letter was signed, the level of care agreed upon by the agencies, and amount of money to be allotted to each agency.

4. If you upload your requests via EDI and the Current section is not part of your EDI program, the above items in #3 are to be placed in the first line of the interpretive summary.

5. If you are submitting a Substance Abuse/Integrated Request, you do not have to complete both the CAR and the ASI/T-ASI*. If you choose to complete the ASI/T-ASI, you will enter 0 (zero) for the CAR scores and complete the ASI/T-ASI

scores. *For ODMHSAS requests, you will need to complete the ASI for Substance Abuse Requests, and both the ASI and the CAR for integrated requests.

6. If the member has an Axis II diagnosis of Mental Retardation, the IQ score is still required. This is usually documented in the Thinking/Mental Process section of the CAR, but is accepted in the interpretive summary as well.

7. If the request is an extension request, progress must be included and is acceptable either in the objectives section or in the interpretive summary.

COMMON ACRONYMS

ABD = Aid to Blind or Disabled
AODTP = Alcohol and Other Drug Treatment Professional
APS = APS Healthcare, Inc.
ARC = Area Resource Coordinator
ASI = Addiction Severity Index
BHP = Behavioral Health Professional
CAR = Client Assessment Record
CCPS = Consolidated Claims Processing System
CDC = Customer Data Core
CMHC = Community Mental Health Center
CW = Child Welfare Division of OKDHS
OKDHS = Oklahoma Department of Human Services
DMHSAS (DMH) = Oklahoma Department of Mental Health and Substance Abuse Services
EDOD = Estimated Date of Discharge
FFS = Fee-for-Service
HMO = Health Maintenance Organization
ICF/MR = Intermediate Care Facility for the Mentally Retarded
ICPC = Interstate Compact on Placement of Children
IHS = Indian Health Service
IMD = Institution for Mental Diseases
INT = In Need of Treatment
LOC = Level of Care
MMIS = Medicaid Management Information System
OAC = Oklahoma Administrative Code
OEPIC-IP = Oklahoma Employee/Employer Partnership for Insurance Coverage – Individual Plan aka Insure Oklahoma
OHCA = Oklahoma Health Care Authority
OJA = Office of Juvenile Affairs
PA = Prior Authorization
PCP = Primary Care Physician
PRTF = Psychiatric Residential Treatment Facility
RBMS = Residential Behavior Management Setting
RID = Recipient Identification Number
RTC = Residential Treatment Center
RVU = Relative Value Unit
SSN = Social Security Number
TANF = Temporary Aid to Needy Families
T-ASI = Teen Addiction Severity Index

Section III:

Service Descriptions for Outpatient Behavioral Health Agencies

SoonerCare Daily and/or Other Applicable Limits	
Individual/Interactive Psychotherapy	There is a maximum of 6, 15 minute, units of either Individual or Interactive Psychotherapy per day. Only one individual therapy session per day is allowed.
Group Psychotherapy	A maximum of 12 units per day are allowed.
Family Psychotherapy	A maximum of 12 units of Family Psychotherapy are allowed per day.
Individual Rehab	6 units
Group Rehab - Adults	24 units
Group Rehab - Children	16 units
Case Management	1141 hrs / annum / provider.
Case Management, Systems of Care	812 hrs / annum / provider.
Case Management, Intensive, CMHC	812 hrs / annum / provider.
Crisis Intervention	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. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. The maximum is **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. Prior authorization for CIS is not required.

Behavioral Health Assessment by Non-Physician (Moderate or Low Complexity)

Code: H0031
Unit Length: Completed Assessment Process

Service Requirement

Definition. Gathering and assessment of historical and current biopsychosocial information which includes face-to-face contact with the person and the LBHP. If appropriate, it can also include the person's family or other informants, or group of persons. The assessment findings will result in a written summary report and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

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

Target Population

OPBH Agency: Adults (21 years or older)
OPBH Agency: Child (younger than 21 years)

Documentation Requirements

The assessment must include all elements and tools required by the OHCA. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. For Behavioral Health Assessments, a progress note is not required.

The assessment must contain but is not limited to the following:
(A) Date, to include month, day and year of the assessment sessions(s),;
(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) BioPsychoSocial information, which must include:
(i) Identification of the member's strengths, needs, abilities, and preferences
(ii) History of the presenting problem;
(iii) Previous treatment history, include MH and/or SA/addictions;
(iv) Health history and current biomedical conditions and complications;
(v) Alcohol, Drug, and/or other addictions history;
(vi) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;
(vii) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(viii) Educational attainment, difficulties and history;
(ix) Cultural and religious orientation;
(x) Vocational, occupational and military history;
(xi) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(xii) Marital or significant other relationship history;
(xiii) Recreation and leisure history;
(xiv) Legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc.;
(xv) Present living arrangement;
(xvi) Economic resources;
(xvii) Current support system including peer and other recovery supports;
(M) Mental status and Level of Functioning information, including questions regarding:
(i) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(ii) Affective process, such as mood, affect, manner and attitude, etc., 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) Pharmaceutical information to include the following for both current and past medications:
(i) name of medication;
(ii) strength and dosage of medication;
(iii) length of time on the medication; and
(iv) benefit(s) and side effects of medication.
(O) LBHP's interpretation of findings and diagnosis;
(P) Signature and credentials of LBHP.
(Q) Client Data Core Elements reported into designated OHCA representative.

Staffing Requirements

Qualified professional. This service is performed by an LBHP.

Service/Reimbursement Limitations

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 service of more than six months and it has been more than one year since the previous assessment.

The annual (calendar year) maximum allotted is one Assessment per member, per provider without prior authorization.

Bill the “date of service” as the date when the assessment is fully completed and it has been signed by the LBHP.

A BioPsychoSocial assessment, re-evaluation of diagnosis and Treatment Plan updates are required every 6 months, and are reimbursed under the BH Services Plan, Low Complexity procedure code and rate.

Adults and children in Facility Based Crisis Intervention Services or who are residents of nursing facilities cannot receive additional Outpatient Behavioral Health Services outside of the admission and discharge dates.

Optional: Use the State of Oklahoma Screening/Assessment form.

Service Code Modifiers

TF – Low Complexity (1.5 hrs)
HE – Mental Health
HF – Substance Abuse or Integrated
HL – Psych Intern is service provider (OU/OSU only)

Behavioral Health Services Plan Development by a Non-Physician

Moderate Complexity or Low Complexity

Code: H0032
Unit Length: Completed Plan

Service Requirement

Definition. The Behavioral Health Service Plan is developed based on information obtained in an assessment or reassessment (conducted by the LBHP) and includes the evaluation of all pertinent information provided by the other practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the members strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children younger than 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.
Time requirements. Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

Target Population

OPBH Agency: Adults (21 years or older)
OPBH Agency: Child (younger than 21 years)

Documentation Requirements

Comprehensive and integrated service plan content shall address the following:
(i) member strengths, needs, abilities, and preferences (SNAP);
(ii) identified presenting challenges, problems, needs, and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for services;
(viii) specific 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 (signatures are required from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP); and
(xi) 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).

Service plan updates shall 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 practitioner(s) who will be responsible for providing services on the plan;
(vi) change in discharge criteria;
(vii) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and
(viii) Service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP.

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. **Optional: Use the State of Oklahoma Treatment Plan form.**
Staffing Requirements
Qualified professional. This service is performed by an LBHP. Other treatment team members may draft their portion of the plan.
Service/Reimbursement Limitations
Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member. One unit of the BH Service Plan Development Moderate Complexity 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. The "date of service" is when the Treatment Plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate. Extra Unit BH Service Plan Development, Low Complexity is available when needed. The extra unit is available as a procedure code group (PG033) and requires prior authorization when it is clinically appropriate to update a member's treatment plan outside of a current PA period.
Service Code Modifiers
TF – Low Complexity HE – Mental Health HF – Substance Abuse or Integrated HL – Psych Intern is service provider (OU/OSU only)

Psychological, Neuropsychological, Developmental, Neurobehavioral, or Substance Abuse Testing

Code: 96101, 96110, 96111, and 96118
Unit Length: Per Hour (96111 event)

Service Requirement
Psychological, Developmental, Neuropsychological, Neurobehavioral Testing is clinically utilized when an accurate diagnosis and determination of treatment needs cannot be made otherwise.
Target Population
Psychiatrists: Younger than 21 and 21 and older Psychologists/LBHPs with an individual contract: Child (younger than 21 years) OPBH Agency: Younger than 21 and 21 and older LBHP (IO-IP): 21 and older
Documentation Requirements
All psychological services must be reflected by documentation in the patient records. (1) All assessment, testing, and treatment services/units billed must include the following: (A) date; (B) start and stop time for each session/unit billed; (C) signature of the provider; (D) credentials of provider; (E) specific problem(s), goals and/or objectives addressed; (F) methods used to address problem(s), goals and objectives; (G) progress made toward goals and objectives; (H) patient response to the session or intervention; and (I) any new problem(s), goals and/or objectives identified during the session. Fax (800-762-1639) or Mail a copy of the Psychological Testing results to OHCA designated agent (APS Healthcare) for review and possible Care Coordination assistance.
Staffing Requirements
Physician, Psychologist and/or LBHP with an individual contract, LBHP in OPBH agency or IO-IP. **OPBH Agency Qualified professionals.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrician, psychological technician of a psychologist or a LBHP. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

Service/Reimbursement Limitations
Psychologists: There is no coverage for adults for services by a psychologist. Any testing performed for a child younger than three must be prior authorized. Four hours/units of testing per patient (over the age of two), per provider is allowed without prior authorization (PA) every 12 months. In circumstances where it is determined that further testing is medically necessary, additional hours/units may be prior authorized (up to 8 total per set of testing) by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can be authorized. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing services per day per provider are allowed. A child who is being treated in an acute inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either an RTC inpatient unit, therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed thru prior authorization by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians or psychologists with a license to practice in the state where the service is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed. Each physician and psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA). Home and Community-Based Waiver Services for the Mentally Retarded: All providers participating in the Home and Community-Based Waiver Services for the mentally retarded program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated HL – Psych Intern is service provider (OU/OSU only)

Psychological Testing by Technician, Code: 96102
Unit Length: Per Hour

Psychological Testing by Computer, Code: 96103
Unit Length: Session (only 1 allowable)

Neuropsychological Testing by Technician, Code: 96119
Unit Length: Per Hour

Neuropsychological Testing Administration with Computer, Code: 96120
Unit Length: Session (only 1 allowable)

Service Requirement

Psychological testing with qualified health care professional interpretation and report, administered by a technician.

PSYCHOLOGISTS: Psychological, Developmental, Neuropsychological, Neurobehavioral Testing is clinically utilized when an accurate diagnosis and determination of treatment needs cannot be made otherwise.

Four hours/units of testing per patient (over the age of two), per provider is allowed without prior authorization every 12 months.

In circumstances where it is determined that further testing is medically necessary, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can be authorized.

Any testing performed for a child younger than three must be prior authorized.

Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed.

OUTPATIENT BEHAVIORAL HEALTH SERVICES:
(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 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 psychometrician, 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.

Target Population

Psychiatrists: Younger than 21 and 21 and older
Psychologists/LBHPs with an individual contract: Child (younger than 21 years)
OPBH Agency: Younger than 21 and 21 and older
LBHP (IO-IP): 21 and older

Documentation Requirements

All psychological services must be reflected by documentation in the patient records.
(1) All assessment, testing, and treatment services/units billed must include the following:
- (A) date;
- (B) start and stop time for each session/unit billed;
- (C) signature of the provider;
- (D) credentials of provider;
- (E) specific problem(s), goals and/or objectives addressed;
- (F) methods used to address problem(s), goals and objectives;
- (G) progress made toward goals and objectives;
- (H) patient response to the session or intervention; and
- (I) any new problem(s), goals and/or objectives identified during the session.

A copy of the Psychological Testing results **must** be sent (fax or mail) to OHCA for review and possible Care Coordination assistance.
Service/Reimbursement Limitations
▪ Psychological technicians must provide no more than 140 billable hours (560 units) of service per month to members. ▪ The psychologist must maintain a record of all billable services provided by a psychological technician and done by computer. ▪ There is no coverage for adults for services by a psychologist, unless provided within a contracted OPBH agency or under IO-IP program.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated HL – Psych Intern is service provider (OU/OSU only)

Medication Training and Support Code: H0034
Unit Length: 15 minutes

Service Requirement
Definition. 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, medical or clinical records. 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.
Target Population
OPBH Agency: Adults (21 years or older) OPBH Agency: Child (younger than 21 years)
Documentation Requirements
Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on: (1) a member's response to medication; (2) compliance with the medication regimen; (3) medication benefits and side effects; (4) vital signs, which include pulse, blood pressure and respiration; and (5) Documented within the progress notes/medication record. Per OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.
Service/Reimbursement Limitations
Limitations. • Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities. • One unit is allowed per month per patient without prior authorization. • MT&S is not allowed to be billed on the same day as Pharmacological Mgmt 90862.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated

Onsite and Mobile Crisis Intervention Services (CIS) Code: H2011 **Unit Length: 15 minutes**
Service Requirement
Definition. Crisis Intervention Services are face to face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse.
Target Population
OPBH Agency: Adults (21 years or older) OPBH Agency: Child (younger than 21 years)
Documentation Requirements
OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. Services must be provided by a LBHP.
Service/Reimbursement Limitations
▪ 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. ▪ CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. ▪ The maximum is eight units per month, and 40 units per 12 months per member. ▪ Established mobile crisis response teams can bill a maximum of sixteen units per month. ▪ Prior authorization is not required.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated HL – Psych Intern is service provider (OU/OSU only)

Crisis Intervention Services (Facility Based Crisis Stabilization) Code: S9484
Unit Length: Hour

Service Requirement
Definition. FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.
Target Population
OPBH Agency: Adults (21 years or older) OPBH Agency: Child (younger than 21 years)
Documentation Requirements
OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs for the provision of group and individual treatments. A physician must be available.
Service/Reimbursement Limitations
▪ 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. ▪ Providers of this service must meet the requirements delineated in the OAC 450:23. ▪ Children's facility based stabilization (0-18 years of age) requires prior authorization.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated HL – Psych Intern (OU/OSU only)

Psychotherapy (Individual, Interactive, Family and Group) Code: H0004
Unit Length: 15 minutes

Service Requirement

Individual/Interactive Psychotherapy: With the exception of a qualified interpreter if needed, only the member and the LBPH or CADC 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.

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.

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 device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for kids or adults who are hearing impaired and require the use of language interpreter.

Group Psychotherapy: Group Psychotherapy must take place in a confidential setting limited to the LBHP or the CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP when treating mental illness or the CADC 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 Behavioral Health Rehabilitation Services.

Maximum Group sizes:
- Adults – 8 (18 and over)
- Children – 6 (younger than 18)
- ICF/MR - 6

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

Family Psychotherapy: Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or a CADC 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 Psycho-education.

Target Population

OPBH Agency: Adults (21 years or older)
OPBH Agency: Child (younger than 21 years)

Documentation Requirements

The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in face-to-face direct contact.

OAC 317:30-5, Section 248.

Staffing Requirements
Qualified professionals: ▪ Licensed Behavioral Health Professional. ▪ CADC for AOD.
Service/Reimbursement Limitations
▪ Per CMS 8-minute rule: Partial billing is not allowed. When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. ▪ Daily Maximums: o Individual/Interactive: 6 units per day per member. o Group, Multi-family/Conjoint Family Therapy: 12 units per day per member/family unit. o Family Therapy: 12 units per day per member/family unit.
Service Code Modifiers
No Modifier - Individual Therapy HE - Mental Health HF - Substance Abuse or Integrated HV - Gambling HR - Family Therapy with the patient HS - Family Therapy without the patient HQ - Group Therapy HL - Psychologist Intern (OU/OSU only)

Multi-Systemic Therapy Code: H2023 **Unit Length: 15 minutes**
Service Requirement
MST intensive outpatient program services are limited to children within an OJA MST treatment program which provides intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.
Target Population
OPBH Agency: Child (younger than 21 years)
Documentation Requirements
OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. Masters level who work on a team established by OJA which may include Bachelor level staff.
Service/Reimbursement Limitations
▪ Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes (CMS 8 minute rule).
Service Code Modifiers
HO – Master's level HN – Bachelor's level HQ - Group

Behavioral Health Rehabilitation Services (BHRS) aka, Psychiatric Social Rehabilitation Services (PSRS) Code: H2017
Unit Length: 15 minutes

Service Requirement

Definition. BHRS/PSRS are behavioral health remedial services which are necessary to improve the member's ability to function in the community. This service may include the Evidence Based Practice of Illness, Management, and Recovery.

Clinical restrictions.
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.

These services 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.

Target Population

OPBH Agency: Adults (21 years or older)
OPBH Agency: Child (younger than 21 years)

Documentation Requirements

OAC 317:30-5, Section 248.

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.

Progress notes for intensive outpatient mental health, substance abuse, or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:
(A) Curriculum sessions attended each day and/or dates attended during the week;
(B) Start and stop times for each day attended;
(C) Specific goal(s) and objectives addressed during the week;
(D) Type of Skills Training provided each day and/or during the week;
(E) Member satisfaction with staff intervention(s);
(F) Progress, or barriers to, made toward goals, objectives;
(G) New goal(s) or objective(s) identified;
(H) Signature of the lead BHRS; and
(I) Credentials of the lead BHRS.

A list of participants for each Group rehabilitative session and facilitating BHRS, LBHP, or CADC must be maintained.

Staffing Requirements

Qualified providers. A BHRS, CADC, or LBHP may perform BHRS/PSRS, following a treatment curriculum approved by a LBHP or CADC for AOD. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT, CAPE, trauma informed, or other methodology.

Behavioral Health Rehabilitation Specialists (BHRS) are defined as follows:

On or After 7/01/10:
(1) Bachelor degree earned from a regionally accredited college or university recognized by the United States Department of Education and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or
(2) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential.

(3) Certification as an Alcohol and Drug Counselor.

Service/Reimbursement Limitations

- Group PSR services do not qualify for the OHCA transportation program, but they will arrange for

transportation for those who require specialized transportation equipment.

- 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.

Group sizes**:**

- Adults: (18 and over): 14 members to 1 staff.
- Children: (younger than 18) 8 members to 1 staff.

Limitations:

(A) **Transportation**. Travel time to and from BHR treatment is not compensable.

(B) **Time**. Breaks, lunch time and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location**. 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 BHRS, CADC, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Billing**. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home do not qualify for this service, unless prior approved by OHCA or its designated agent.

(E) **Group Daily Maximums:**

- Adults (age 18 and older) - 24 units per day.
- Children (younger than 18) - 16 units per day.

(F) **Individual**: The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

Service Code Modifiers
HE - Mental Health HF - Substance Abuse or Integrated HV - Gambling HQ - Group

Family Support and Training Code: T1027 **Unit Length: 15 minutes**
Service Requirement
Definition. 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. 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.
Target Population
▪ Child (younger than 21 years) ▪ Family Support and Training is designed to benefit the SoonerCare member experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community-based treatment program. ▪ Diagnosed with a pervasive developmental disorder. ▪ Under OKDHS or OJA custody residing within a RBMS level of care and who without these services would require psychiatric hospitalization.
Documentation Requirements
OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. Family Support Providers (FSP) must be certified through ODMHSAS.
Service/Reimbursement Limitations
The FSP cannot bill for more than one individual during the same time period.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated

Recovery Support Specialist (RSS) Code: H2015
Unit Length: 15 minutes

Service Requirement

Definition. Community Recovery Support (CRS) services are an EBP model of care which consists of a qualified recovery support provider who assists individuals with their recovery from behavioral health disorders. 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 members who 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.

CRS/RSS staff 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.

CRS/RSS staff 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.

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

Target Population

Adults 18 and older with SMI and/or AOD disorder(s).

Documentation Requirements

OAC 317:30-5, Section 248.

Staffing Requirements

Qualified professionals. Peer Recovery Support Specialist (RSS) who is certified through ODMHSAS.

Service/Reimbursement Limitations

- This service can be an individual or group service.
- Groups – No limit on size

Service Code Modifiers

HE – Mental Health
HF – Substance Abuse or Integrated
HQ - Group

Behavioral Health Aide Code: H2014 **Unit Length: 15 minutes**
Service Requirement
Definition. 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.
Target Population
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.
Documentation Requirements
OAC 317:30-5, Section 248.
Staffing Requirements
Qualified professionals. Behavioral Health Aides must be certified through ODMHSAS.
Service/Reimbursement Limitations
The Behavioral Health Aide cannot bill for more than one individual during the same time period.
Service Code Modifiers
HE – Mental Health HF – Substance Abuse or Integrated

Program of Assertive Community Treatment (PACT) Services Code: H0039
Unit Length: 15 minutes

Service Requirement

Definition. PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

Target Population

Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders.

Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team.

The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

Documentation Requirements

OAC 317:30-5, Section 248.

Staffing Requirements

Qualified professionals. Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55.

The team leader is required to be a LBHP.

Service/Reimbursement Limitations

A maximum of 105 hours per member per year in the aggregate. SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for FBCS and CM.

PACT services include the following: PACT assessments (initial, and comprehensive); behavioral health service plan (moderate and low complexity); treatment team meetings (team conferences with the member present is a billable service); individual and family psychotherapy; individual rehabilitation; recovery support services; group rehabilitation; group psychotherapy; crisis intervention; medication training and support services, blood draws and/or other lab sample collection services performed by the nurse.

All PACT compensable SoonerCare services are required to be face to face.

- Initial Assessment is the initial evaluation of the consumer based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Consumer assessment information for admitted consumers shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

- Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the consumer and his/her recovery planning team in pursuing goals. Bill only the face to face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

▪ Service Plan Development by a Non-Physician (Treatment Planning and Review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the consumer, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the consumer. The start and stop times for this service should be recorded in the chart. ▪ Treatment Team Meetings (Team Conferences): This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450-55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual consumer and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop should be recorded in the consumer's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill one treatment team meeting per member as medically necessary.
Service Code Modifiers
Group – HQ

Targeted Case Management Code: T1017
Unit Length: 15 minutes

Service Requirement

Behavioral health case management services are provided to assist members in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides linkage, advocacy, referral, and monitoring on behalf of members, to help members access appropriate community resources and support.

Case management is designed to assist individuals in accessing services for his or herself. The member has the right to refuse case management and cannot be restricted from other services because of a refusal of case management services. However, in referring a member for medical services, the case manager should be aware that the SoonerCare program is limited in scope.

The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services by following the case management guidelines established by the ODMHSAS.

In order to be compensable, the service must be performed utilizing the ODMHSAS Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Helping activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

The community-based behavioral health case management agency will coordinate with the member by phone or face-to-face, to identify immediate needs. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month.

<u>SoonerCare reimbursable behavioral health case management services include the following:</u>
(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.
(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.
(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.
(IV) Supportive activities such as non face-to-face communication with the member.
(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.
(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.
(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

Types of Case management:

- Standard case management with caseloads of 30-35 members.
- Intensive case management that focuses on the treatment of adults who are chronically or severely mental ill and who are also identified as high utilizers of mental health services and need extra assistance in accessing services and developing the skills necessary to remain in the community. The primary functions of intensive case management services are to assure an adequate and appropriate range of services are being provided to individuals to include: linkage with the mental health system, linkage with needed support system, and coordination of the various system components in order to achieve a successful outcome; aggressive outreach; and member education and resource skills development. Intensive case management caseloads are smaller, between 10 and 15 and the consumer typically has access 24 hours per day, 7 days per week.
- Wraparound facilitation service process that has been demonstrated as an effective way to support children and youth with severe emotional disturbance to live successfully in the community with their families. The wraparound service process identifies and builds on the strengths and culture of the child, family, and support system to create integrated and individualized plans to address the needs of the child and family that put the child at risk of long-term residential placement. Typically, to produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families and is available 24 hours per day, 7 days per week.

Target Population

Behavioral Health Adults (21 years or older)
Behavioral l Health Child (younger than 21 years)

Documentation Requirements

The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.

All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service plan documentation of each session must include, but is not limited to:
(1) date;
(2) person(s) to whom services are rendered;
(3) start and stop times for each service;
(4) original signature of the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
(5) credentials of the service provider;
(6) specific service plan needs, goals and/or objectives addressed;
(7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals
and/or objectives;
(8) progress or barriers made towards goals and/or objectives;
(9) member (family when applicable) response to the service;
(10) any new service plan needs, goals, and/or objectives identified during the service; and
(11) member satisfaction with staff intervention.

Staffing Requirements

Classifications:	Annual Hours/Provider:
▪ Case Manager III, Wraparound Facilitator	▪ 812
▪ Case Manager II, Wraparound Facilitator	▪ 812
▪ Case Manager III, Intensive	▪ 812
▪ Case Manager II, Intensive	▪ 812
▪ Case Manager III	▪ 1141
▪ Case Manager II	▪ 1141
▪ Case Manager I	▪ 1141

A case manager performing the service must have and maintain a current behavioral health case manager certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), pass the ODMHSAS web-based Case Management (CM) Competency Exam and meet one of the following requirements:

(1) Case Manager III - meets the agency's definition of a Licensed Behavioral Health Professional as defined below:
   (a) Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or current resident in psychiatry;
   (b) Practitioner with a license to practice in the state in which services are provided or one who is actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following boards: Psychology, Social Work (clinical specialty only), Professional Counselor, Marriage and Family Therapist, Behavioral Practitioner, or Alcohol and Drug Counselor;
   (c) 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 services are provided; or

(2) Case Manager II - meets the following requirements:
   (a) A bachelor's or master's degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes but is not limited to psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, and/or criminal justice;
   (b) A current license as a registered nurse in Oklahoma with experience in behavioral health care; or
   (c) a current certification as an alcohol and drug counselor in Oklahoma, and complete 7 hours of ODMHSAS specified CM training; or

(3) Case Manager I - has a high school diploma and:
   (a) 60 college credit hours; or
   (b) 36 total months of experience working with persons who have a mental illness (documentation of experience must be on file with ODMHSAS); and
   (c) Completed 14 hours of ODMHSAS specified CM training.

(4) Wraparound Facilitator Case Manager - meets the qualifications for CM II or CM III and has the following::
   (a) Successful completion of the DMHSAS training for wraparound facilitation within six months of employment; and
   (b) Participate in ongoing coaching provided by DMHSAS and employing agency; and
   (c) Successfully complete wraparound credentialing process within nine months of beginning process; and
   (d) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by DMHSAS;

(5) Intensive Case Manager - meets the provider qualifications of a Case Manager II or III and has the following:
   (a) A minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, and
   (b) must have attended the ODMHSAS 6 hour Intensive case management training.

Service/Reimbursement Limitations

<u>Reimbursable case management does not include:</u>
(I) physically escorting or transporting a member to scheduled appointments or staying with the member during an appointment; or

(II) monitoring financial goals; or
(III) providing specific services such as shopping or paying bills; or
(IV) delivering bus tickets, food stamps, money, etc.; or
(V) services to nursing home residents; or
(VI) psychotherapeutic or rehabilitative services,
psychiatric assessment, or discharge; or
(VII) filling out forms, applications, etc., on
behalf of the member when the member is not present; or
(VIII) filling out SoonerCare forms, applications, etc., or;
(IX) Services to members residing in ICF/MR facilities.
(X) Non face to face time that case manager's spend preparing the assessment document and the service plan paperwork.

Case Manager Travel Time:
With regard to travel time, when the rate was re-calculated, travel time was built into the average length of face to face time spent with a member (i.e. the rate assumes that the case manager will spend some amount of time traveling to the member for the face to face service). The case manager should only bill for the actual face to face time that they spend with the member and not bill for "windshield time". This would be considered duplicative billing since the rate assumes the travel component already.

SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes or ICF/MRs may not receive SoonerCare compensable case management services.

For information about ODMHSAS Case Management Certification, please visit their website: www.ok.gov.odmhsas

				Age	Daily Limits	Monthly Limit	Contract Type
Targeted Case Management, CM III, SOC, LBHP level	T1016	HE/HF/HV	TF	0-20	16	56	111 - CMHC
Targeted Case Management, CM II, SOC, MA/BA level	T1017	HE/HF/HV	TF	0-20	16	56	111 - CMHC
Targeted Case Management, CM III, Intensive, CMHC, MA level	T1016	HE/HF/HV	TG	18 - 999	16	25	111 – CMHC
Targeted Case Management, CM II, Intensive, CMHC, BA level	T1017	HE/HF/HV	TG	18 - 999	16	25	111 - CMHC
Targeted Case Management, CM III, LBHP/MA level	T1017	HE/HF/HV	HO	0 - 999	16	25	110 - OPBH 111 - CMHC
Targeted Case Management, CM II, MA/BA level	T1017	HE/HF/HV	HN	0 - 999	16	25	110 - OPBH 111 - CMHC
Targeted Case Management, CM I, less than BA	T1017	HE/HF/HV	HM	0 - 999	16	25	110 - OPBH 111 - CMHC
Targeted Case Management, PACT	T1017	HE/HF/HV		18 - 999	16	56	114 - PACT

Service Code Modifiers

HE – Mental Health
HF – Substance Abuse
HV – Gambling
HO – CM III
HN – CM II
HM – CM I

Section IV:

Client Assessment Record (CAR) for Outpatient Behavioral Health Providers

CLIENT ASSESSMENT RECORD (CAR)

GENERAL INFORMATION

The purpose of the Client Assessment Record (CAR) is to give clinicians a tool to evaluate the functioning level of their customers.

The clinician must have knowledge of the customer's behavior and adjustment to his/her community-based on the assessment, and other information. The knowledge must be gained through direct contact (face-to-face interview). It can also include systematic review of the customer's functioning with individuals who have observed and are acquainted with the customer.

The CAR levels of functioning have been structured within a "normal curve" format, ranging from Above Average Functioning (1-10) to Extreme Psychopathology (50). Pathology begins in the 20-29 range. The CAR format provides a broad spectrum of functioning and permits a range within which customers can be described.

The clinician's rating in each domain needs to based on assessment information: 1) the frequency of the behavior (How often does the behavior occur?); 2) the intensity of the behavior (How severe is the behavior?); 3) duration of the behavior (How long does the behavior last?); and 4) the impact the symptoms/behaviors have on daily functioning, to establish the severity of the customer's current condition.

Only current information is to be rated, not historical information.

CAR DOMAIN DEFINITIONS

1. FEELING/MOOD/AFFECT: Measures the extent to which the person's emotional life is well moderated or out of control.
2. THINKING/MENTAL PROCESS: Measures the extent to which the person is capable of and actually uses clear, well-oriented thought processes. Adequacy of memory and overall intellectual functioning are also to be considered in this scale.
3. SUBSTANCE USE: Measures the extent to which a person's current use of synthetic or natural substances is controlled and adaptive for general well-being and functioning. Although alcohol and illegal drugs are obvious substances of concern, any substance can be subjected to maladaptive use or abuse, especially if compounded by special medical or social situations.
4. MEDICAL/PHYSICAL: Measures the extent to which a person is subject to illness, injury and/or disabling physical conditions, regardless of causation. Demonstrable physical effects of psychological processes are included, but not the effects of prescribed psychotropic medications. Physical problems resulting from assault, rape, or abuse are included.
5. FAMILY: Measures the adequacy with which the customer functions within his/her family and current living situation. Relationship issues with family members are included as well as the adequacy of the family constellation to function as a unit.
6. INTERPERSONAL: Measures the adequacy with which the person is able to establish and maintain interpersonal relationships. Relationships involving persons other than family members should be compared to similar relationships by others of the same age, gender, culture, and life circumstances.
7. ROLE PERFORMANCE**:** Measures the effectiveness with which the person manages the role most relevant to his or her contribution to society. The choice of whether job, school, or home management (or some combination) is most relevant for the person being rated depends on that person's age, gender, culture and life circumstances. If the member has an intellectual, mental or physical disability, the member would be

scored relative to others with the same disability and in the same situation. Whichever role is chosen as most relevant, the scale is used to indicate the effectiveness of functioning within the role at the present time.

8. SOCIO-LEGAL**:** Measures the extent and ease with which the person is able to maintain conduct within the limits prescribed by societal rules and social mores. It may be helpful to consider this scale as a continuum extending from pro-social to anti-social functioning. *****Other Behavioral Non-Chemical Addictions would be rated here: gambling, internet, pornography, sexual, etc.**

9. SELF CARE/BASIC NEEDS: Measures the adequacy with which the person is able to care for him/her self and provide his/her own needs such as food, clothing, shelter and transportation. If the customer lives in a supportive or dependent situation for reasons other than lack of ability (e.g. confined on criminal sentence), estimate the ability to make arrangements independently and freely. Children, people with disabilities, and aged persons who are cared for by others should also be rated on their own ability to make arrangements compared to others their age.

LEVEL OF FUNCTIONING RATING SCALE

- **1 - 9 (Above Average):** Functioning in the particular domain is consistently better than that which is typical for age, gender, and subculture, or consistently average with occasional prominent episodes of superior, excellent functioning. Functioning is never below typical expectations for the average person.
- **10 - 19 (Average):** Functioning in the particular domain as well as most people of same age, gender, and subculture. Given the same environmental forces is able to meet usual expectations consistently. Has the ability to manage life circumstances.
- **20 - 29 (Mild to Moderate):** Functioning in the particular domain falls short of average expectation most of the time, but is not usually seen as seriously disrupted. Dysfunction may not be evident in brief or casual observation and usually does not clearly influence other areas of functioning. Problems require assistance and/or interfere with normal functioning.
- **30 - 39 (Moderate to Severe):** Functioning in the particular domain is clearly marginal or inadequate, not meeting the usual expectations of current life circumstances. The dysfunction is often disruptive and self-defeating with respect to other areas of functioning. Moderate dysfunction may be apparent in brief or casual interview or observation. Serious dysfunction is evident.
- **40 - 49 (Very Severe / Incapacitating):** Any attempts to function in the particular domain are marked by obvious failures, usually disrupting the efforts of others or of the social context. Severe dysfunction in any area usually involves some impairment in other areas. Hospitalization or other external control may be required to avoid life-threatening consequences of the dysfunction. Out of control all or most of the time.
- **50 (EXTREME):** The extreme rating for each scale, suggests behavior or situations totally out of control, unacceptable, and potentially life threatening. This score indicates issues that are so severe it would not be generally used with someone seeking outpatient care.

CAR DOMAIN SCORING EXAMPLES

FEELING / MOOD AFFECT

- **1 – 9 (ABOVE AVERAGE):** Anxiety, depression, or disturbance of mood is absent or rare. The person's emotional life is characterized by appropriate cheer and optimism given a realistic assessment of his/her situation. Emotional control is flexible, with both positive and negative feelings clearly recognized and viewed as within his/her control. Reactions to stressful situations are clearly adaptive and time limited.
- **10 – 19 (AVERAGE):** No disruption of daily life due to anxiety, depression or disturbance of mood. Emotional control shows consistency and flexibility. A variety of feelings and moods occur, but generally the person is comfortable, with some degree of pleasant or warm affect. When strong or persistent emotions occur, the object and approximate causes are readily indentified.

- ADULT: Able to cope, either alone or with the help of others, with stressful situations. Not overwhelmed when circumstances seem to go against him/her. Doesn't dwell on worries; tries to work out problems. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Considers self a worthy person.
- CHILD: Not overwhelmed when circumstances seem to go against him/her. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Reactions to stressful events are age appropriate.

- **20 – 29 (Mild to Moderate):** Occasional disruption due to intense feelings. Emotional life is occasionally characterized by volatile moods or persistent intense feelings that tend not to respond to changes in situations. Activity levels may occasionally be inappropriate or there may be disturbance in sleep patterns.
- ADULT: Tends to worry or be slightly depressed most of the time. Feels responsible for circumstances but helpless about changing them. Feels guilty, worthless and unloved, causing irritability, frustration and anger.
- CHILD: Frustration, anger, loneliness', and boredom persist beyond the precipitating situation. May be slightly depressed and/or anxious MOST OF THE TIME.

- **30 – 39 (Moderate to Severe):** Occasional major (severe) or frequent moderate disruptions of daily life due to emotional state. Uncontrolled emotions are clearly disruptive, affecting other aspects of the person's life. Person does not feel capable of exerting consistent an effective control on own emotional life.
- ADULT: The level of anxiety and tension (intense feelings) is frequently high. There are marked frequent, volatile changes in mood. Depression is out of proportion to the situation, frequently incapacitation. Feels worthless and rejected most of the time. Becomes easily frustrated and angry.
- CHILD: Symptoms of distress are pervasive and do not respond to encouragement or reassurance. May be moderately depressed and/or anxious most of the time or severely anxious/depressed occasionally.

- **40 – 49 (Very severe / incapacitating):** Severe disruption or incapacitation by feelings of distress. Unable to control one's emotions, which affects all of the person's behavior and communication. Lack of emotional control renders communication difficult even if the person is intellectually intact.
- ADULT: Emotional responses are highly inappropriate most of the time. Changes from high to low moods make a person incapable of functioning. Constantly feels worthless with extreme guilt and anger. Depression and/or anxiety incapacitate person to a significant degree most of the time.
- CHILD: Emotional responses are highly inappropriate most of the time. Reactions display extreme guilt and anger that is incapacitating.

- **50 (EXTREME):** Emotional reactions or their absence appears wholly controlled by forces outside the individual and bears no relationship to the situation.

Scoring Tips:

- When determining if a person scores in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Unable to control one's emotions, which affects all of the person's behavior and communication."

THINKING/MENTAL PROCESS

This domain refers to the person's intellectual functioning and thought processes only. If there is a lowering of functioning level in either one, please rate the more severe of the two.

- **1 – 9 (ABOVE AVERAGE):** Superior intellectual capacity and functioning. Thinking seems consistently clear, well organized, rational and realistic. The person may indulge in irrational or unrealistic thinking, or fantasy, but is always able to identify it as such, clearly distinguishing it from more rational realistic thought.

- **10 – 19 (AVERAGE):** No evidence of disruption of daily life due to thought and thinking difficulties. Person has at least average intellectual capacity. Thinking is generally accurate and realistic. Judgment is characteristically adequate. Thinking is rarely distorted by beliefs with no objective basis.
- ADULT: Capable of rational thinking and logical thought processes. Oriented in all spheres. No memory loss.
- CHILD: Intellectual capacity and logical thinking are developed appropriately for age.

- **20 – 29 (Mild to Moderate):** Occasional disruption of daily life due to impaired thought and thinking processes. Intellectual capacity slightly below average ("Dull Normal" to Borderline) and/or thinking occasionally distorted by

defensive, emotional factors and other personal features. Poor judgment may occur often, but is not characteristic of the person. Communications may involve misunderstandings due to mild thought disorders. Includes specific impairments of learning or attention and the ability to generalize from acquired knowledge.

- ADULT: Borderline retardation; but can function well in many areas. Peculiar beliefs or perceptions may occasionally impair functioning. Occasionally forgetful, but is able to compensate.
- CHILD: Bordering retardation or developmentally delayed, but can function well in many areas. Inability to distinguish between fantasy and reality may, on occasion, impair functioning.

- **30 – 39 (Moderate to Severe):** Frequent or consistent interference with daily life due to impaired thinking. Mild to moderate mental retardation and/or frequent distortion of thinking due to emotional and/or other personal factors may occur. Frequent substitution of fantasy for reality, isolated delusions, or infrequent hallucinations may be present. Poor judgment is characteristic at this level.
- ADULT: Mild to moderate retardation, but can function with supervision. Delusions and/or hallucinations interfere with normal daily functioning. Frequently disoriented as to time, place, or person. Person is unable to remember recent or past events.
- CHILD: Mild to moderate retardation. May be preoccupied by unusual thoughts of attachments.

- **40 – 49 (Very severe / incapacitating):** Incapacitated due to impaired thought and thinking processes. Severe to profound mental retardation and/or extreme disruption or absence of rational thinking may exist. Delusions or frequent hallucination that the person cannot distinguish from reality may occur. Communication is extremely difficult
- ADULT: Unable to function independently. Severely disoriented most of the time. Significant loss of memory.
- CHILD: Severely disoriented most of the time. Loss of memory. If speech is present, it may manifest itself in peculiar patterns.
- **50 (EXTREME):** Profound retardation, comatose, or vegetative. No process that would ordinarily be considered "thinking" can be detected, although person may appear to be conscious. Communication is virtually impossible. Extreme catatonia.

NOTE: A score of 40 or more in this domain must include a statement indication the customer's ability to participate in treatment planning and benefit from the OP services requested.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Severely disoriented most of the time"

SUBSTANCE USE

- **1 – 9 (ABOVE AVERAGE):** All substances are used adaptively with good control. Substances known to be harmful are used sparingly, if at all.

- **10 – 19 (AVERAGE):** No impairment of functioning due to substance use. Substance use is controlled so that it is not apparently detrimental to the person's over-all functioning or well-being. Substances used and amount of use are within commonly accepted range of the person's subculture. Infrequent excesses may occur in situations where such indulges have no serious consequences.
- ADULT: No functional impairment noted from any substance use. Reports occasional use of alcohol with no adverse effects.
- CHILD: No effects from intake of alcohol drugs, or tobacco other than possible one occurrence of experimentation.

- **20 – 29 (Mild to Moderate):** Occasional or mild difficulties in functioning due to substance use. Weak control with respect to one or more substances. May depend on maladaptive substance use to escape stress or avoid direct resolution of problems, occasionally resulting in increased impairment and/or financial problems.
- ADULT: Occasional apathy and/or hostility due to substance use. Occasional difficulty at work due to hangover or using on the job.

- CHILD: Occasional incidence of experimentation with alcohol, drugs or other substance with potential adverse effects.

- **30 – 39 (Moderate to Severe):** Frequent difficulties in functioning due to substance use. Has little control over substance use. Lifestyle revolves around acquisition and abuse of one or more substances. Has difficulty on the job, at home and /or in other situations.
- ADULT: Needs alcohol, drugs or other substances to cope much of the time, without them, feels upset and irritable. Frequent hangovers/highs or other effects of substance abuse that are causing difficulty on the job, at home and/or other situations.
- CHILD: Repeated use of alcohol, drugs, or other substances causing difficulty at home and/or school.

- **40 – 49 (Very severe / incapacitating):** People with disabilities or incapacitated due to substance use. Substance abuse dominates the person's life to the almost total exclusion of other aspects. Serious medical and/or social consequences are accepted as necessary inconveniences. Control is absent, except as necessary to avoid detection of an illegal substance.
- ADULT: Major focus on obtaining desired substance. Other functions ignored. Unable to hold job due to use of alcohol, drugs or other substances
- CHILD: Unable to function at home or in school due to substance use. Life revolves around obtaining desired substance.

- **50 (EXTREME):** Constantly high or intoxicated with no regard for basic needs or elemental personal safety. May include extreme vegetative existence.

NOTE: The use of substances by family members is recorded in domain #5, as it relates to the family's ability to operate as a functional unit.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Substance abuse dominated the person's life to the almost total exclusion of other aspects".
- In addition to scoring substance use in this domain, you can also score substance dependence for someone who is not using at this time. Example of this would be- how frequently is someone thinking of using and how does that impact their daily functioning (i.e. if someone is thinking of using all the time, and is participating in 5 AA meetings daily to keep from using- this may be impacting their ability to hold down a job, etc.).

MEDICAL/PHYSICAL

- **1 – 9 (ABOVE AVERAGE):** Consistently enjoys excellent health. Infrequent minor ills cause little discomfort, and are marked by rapid recovery. Physical injury is rare and healing is rapid. Not ill or injured at this time of rating and in good physical condition.

- **10 – 19 (AVERAGE):** No physical problems that interfere with daily life. Generally good health without undue distress or disruption due to common ailments and minor injuries. Any chronic medical/physical condition is sufficiently controlled or compensated for as to cause no more discomfort or inconvenience than is typical for the age. No life-threatening conditions are present.
- ADULT: Occasional common colds, fatigue, headaches, gastrointestinal upsets, and common ailments that is endemic in the community. No sensory aids required. No medications.
- CHILD: Occasional common ailments. Rapid recovery with no long-term effects. No sensory aids required. No medications.

- **20 – 29 (Mild to Moderate):** Occasional or mild physical problems that interfere with daily living. Physical condition worse than what is typical of age, sex, and culture and life circumstances; manifested by mild chronic disability, illness or injury, or common illness more frequent than most. Includes most persons without specific disability, but frequent undiagnosed physical complaints. Disorders in this range could become life threatening only with protracted lack of care.

- ADULT: Controlled allergies. Needs glasses, hearing aid, or other prostheses, but can function without them. Needs medication on a regular basis to control chronic medical problem.
- CHILD: Illnesses more frequent than average. Controlled allergies. Needs glasses, hearing aid, or other prostheses, etc.

- **30 – 39 (Moderate to Severe):** Frequent and/or chronic problems with health. Person suffers from serious injury, illness or other physical condition that definitely limits physical functioning (though it may not impair psychological functioning or productivity in appropriately selected roles). Includes conditions that would be life threatening without appropriate daily care. Cases requiring hospitalization or daily nursing care should be rated 30 or above, but many less critical cases may be in this range also.
- ADULT: Diabetes, asthma, moderate over/underweight or other evidence of eating disorder. Cannot function without function without glasses, hearing aid or other prostheses. Heavy dependence on medications to alleviate symptoms of chronic illness.
- CHILD: Diabetes, asthma, moderate over/underweight or other evidence of eating disorder. Cannot function without glasses, hearing aid, or other prostheses. Physical problems secondary to abuse. Heavy dependence on medication.

- **40 – 49 (Very severe / incapacitating):** Incapacitated due to medical/physical health. The person is physically incapacitated by injury, illness, or other physical co9ndition. Condition may be temporary, permanent or progressive, but all cases in this range require at least regular nursing-type care.
- ADULT: Medical/physical problems are irreversible and incapacitating. Must have special medication in order to survive.
- CHILD: Medical/physical problems are irreversible and incapacitating.

- **50 (EXTREME):** Critical medical/physical condition requiring constant professional attention to maintain life. Include all persons in a general hospital intensive care unit.

NOTE: Include how the medical condition limits the customer's day-to-day function for score of 20 and above.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "but all cases in this range require at least regular nursing-type care".
- When determining if a person scored in the 30-39 range, please note that just having Diabetes, Asthma, etc. does not automatically equate a score in this range. In addition, symptoms/condition "definitely limits physical functioning".

FAMILY

- **1 – 9 (ABOVE AVERAGE):** Family unit functions cohesively with strong mutual support for its members. Individual differences are valued.

- **10 – 19 (AVERAGE):** Major conflicts are rare or resolved without great difficulty. Relationships with other family members are usually mutually satisfying.

- *****DEFAULT TO AVERAGE RATING IF ADULT HAS NO FAMILY OR LACK OF FAMILY CONTACT. Feelings about lack of contact would be noted in domain #1*****

- ADULT: Primary relationships are good with normal amount of difficulties. Feels good with family relationships and secure in parent role. Destructive behavior among family members is rare.
- CHILD: Conflicts with parents or siblings are transient; family is able to resolve most differences promptly. Parenting is supportive and family is stable.

- **20 – 29 (Mild to Moderate):** Relationships within the family are mildly unsatisfactory. May include evidence of occasional violence among family members. Family disruption is evident. Significant friction and turmoil evidenced, on some consistent basis, which is not easily resolved.
- ADULT: Family difficulties such that member occasionally thinks of leaving. Some strife with children.

- CHILD: Problems with parents or other family members are persistent, leading to generally unsatisfactory family life. Evidence of recurring conflict or even violence involving adults and children.

- **30 – 39 (Moderate to Severe):** Occasional major or frequent minor disruption of family relationships. Family does not function as a unit. Frequent turbulence and occasional violence involving adults and children.
- ADULT: Turbulent primary relationship or especially disturbing break-up. Adult rage and/or violence directed toward each other or children.
- CHILD: Family inadequately supportive of child. Constant turmoil and friction. Family unit is disintegrating.

- **40- 49 (Very severe / incapacitating):** Extensive disruption of family unit. Relationships within family are either extremely tenuous or extremely destructive.
- ADULT: Not capable of forming primary relationships. Unable to function in parenting role. Abusive or abused.
- CHILD: Isolated. Lacking family support. Abused or neglected.

- **50 (EXTREME):** Total breakdown in relationships within family. Relationships that exist are physically dangerous or psychologically devastating.

NOTE: For adults, note and score current, ACTIVE family problems only. For children report and score the behavior of the current family as it affects the child.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Abusive or abused" for adults, and "Abused or neglected" for children.
- Score only the current family system (in the last 30 days). Family system can include anyone that the person identifies as family (ex: common law husband/wife might be scored here). Please note that if someone is identified and scored as family, they should not be included and scored again under domain 6. Interpersonal.

INTERPERSONAL

- **1 – 9 (ABOVE AVERAGE):** Relationships are smooth and mutually satisfying. Conflicts that develop are easily resolved. Person is able to choose among response styles to capably fit into a variety of relationships. Social skills are highly developed.
- ADULT: Has wide variety of social relationships and is sought out by others.
- CHILD: Social skills highly developed for age.

- **10 – 19 (AVERAGE):** Interpersonal relationships are mostly fruitful and mutually satisfying. Major conflicts are rare or resolved without great difficulty. The person appears to be held in esteem within his or her culture.
- ADULT: Good relationship with friends. Forms good working relationships with co-worker.
- CHILD: Member is able to relate well to peers or adults without persistent difficulty.

- **20 – 29 (Mild to Moderate):** Occasional or mild disruption of relationships with others. Relationships are mildly unsatisfactory although generally adequate. May appear lonely or alienated although general functioning is mostly appropriate.
- ADULT: Some difficulty in developing or keeping friends. Problems with co-workers occasionally interfere with getting work done.
- CHILD: Some difficulty in forming or keeping friendships. May seem lonely or shy.

- **30 – 39 (Moderate to Severe):** Occasional major or frequent disruption of interpersonal relationships. May be actively disliked or virtually unknown by many with whom there is daily contact. Relationships are usually fraught with difficulty.
- ADULT: Has difficulty making and keeping friends such that the relationships are strained or tenuous. Generally rejects or is rejected by co-workers; tenuous job relationships.
- CHILD: Unable to attract friendships. Persistent quarreling or social withdrawal. Has not developed age social skills.

- **40 – 49 (Very severe / incapacitating):** Serious disruption of interpersonal relationships or incapacitation of ability to form relationships. No close relationships; few, if any, casual associations which are satisfying.
- ADULT: Socially extremely isolated. Argumentative style or extremely dependent style makes work relationships virtually impossible.
- CHILD: Socially extremely isolated. Rejected, unable to attach to peers appropriately.

- **50 (EXTEME):** Relationship formation does not appear possible at the time of the rating.

NOTE: Relationships with family members are reported in domain #5.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "No close relationships".
- This domain scores only the person's ability to make and maintain relationships outside of the family system- not the type of people they choose to have relationships with. If they are maintaining relationships with people who are getting them into trouble/putting them at risk, this may be a consideration for poor judgment when scoring in domain #2.

ROLE PERFORMANCE

- **1 – 9 (ABOVE AVERAGE):** The relevant role is managed in a superior manner. All tasks are done effectively at or before the time expected. The efficiency of function is such that most of the tasks appear easier than for others of the same age, sex, culture, and role choice.

- **10 – 19 (AVERAGE):** Reasonably comfortable and competent in relevant roles. The necessary tasks are accomplished adequately and usually within the expected time. There are occasional problems, but these are resolved and satisfaction is derived from the chosen role.
- ADULT: Holds a job for several years, without major difficulty. Student maintains acceptable grades with minimum of difficulty. Shares responsibility in childcare. Home chores accomplished.
- CHILD: Maintains acceptable grades and attendance. No evidence of behavior problems.

- **20 – 29 (Mild to Moderate):** Occasional or mild disruption of role performance. Dysfunction may take the form of chronic, mild overall inadequacy or sporadic failures of a more dramatic sort. In any case, performance often falls short of expectation because of lack of ability or appropriate motivation.
- ADULT: Unstable work history. Home chores frequently left undone; bills paid late.
- CHILD: Poor grades in school. Frequent absences. Occasional disruptive behavior at school.

- **30 – 39 (Moderate to Severe):** Occasional major or frequent disruption of role performance. Contribution in the most relevant role is clearly marginal. Member seldom meets usual expectations and there is a high frequency of significant consequences, i.e. firing, suspension.
- ADULT: Frequently in trouble at work, or frequently fired. Home chores ignored; some bills defaulted.
- CHILD: Expelled from school. Constantly disruptive and unable to function in school.

- **40 – 49 (Very severe / incapacitating):** Severe disruption of role performance due to serious incapacity or absent motivation. Attempts, if any, at productive functioning are ineffective and marked by clear failure.
- ADULT: Member not employable. Is unable to comply with rules and regulations or fulfill ANY of the expectations of the member's current life circumstance.
- CHILD: Expelled from school. Constantly disruptive and unable to function in school.

- **50 (EXTREME):** Productive functioning of any kind is not only absent, but also inconceivable at the time of rating.

NOTE: Identify and assess only the customer's primary role. Family role would be described in domain #5. If residing in an RCF, RCF resident would be considered the primary role. Score functioning relative to others in the same life circumstance.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Attempts, if any, at productive functioning are ineffective and marked by clear failure"

SOCIO-LEGAL

- **1 – 9 (ABOVE AVERAGE):** Almost conforms to rules and laws with ease, abiding by the "spirit" as well as the "letter" of the law. Any rate deviations from rules or regulations are for altruistic purposes.
- **10 – 19 (AVERAGE):** No disruption of socio-legal functioning problems. Basically a law-abiding person. Not deliberately dishonest, conforms to most standards of relevant culture. Occasional breaking or bending of rules with no harm to others.
- ADULT: No encounters with the law, other than minor traffic violations.
- CHILD: Generally conforms to rules. Misbehavior is non-repetitive, exploratory or mischievous.
- **20- 29 (Mild to Moderate):** Occasional or mild disruption of socio-legal functioning. Occasionally bends or violates rules or laws for personal gain, or convenience, when detection is unlikely and personal harm to others is not obvious. Cannot always be relied on; may be in some trouble with the law or other authority more frequently than most peers; has no conscious desire to harm others.
- ADULT: Many traffic tickets. Creates hazard to others through disregard of normal safety practices.
- CHILD: Disregards rules. May cheat or deceive for own gain
- **30 – 39 (Moderate to Severe):** Occasional major or frequent disruption of socio-legal functioning. Conforms to rules only when more convenient or profitable than violation. Personal gain outweighs concern for others leading to frequent and/or serious violation of laws and other codes. May be seen as dangerous as well as unreliable.
- ADULT: Frequent contacts with the law, on probation, or paroled after being incarcerated for a felony. Criminal involvement. Disregard for safety of others.
- CHILD: Unable to consider rights of others at age appropriate level. Shows little concern for consequences of actions. Frequent contact with the law. Delinquent type behaviors.
- **40 – 49 (Very severe / incapacitating):** Serious disruption of socio-legal functioning. Actions are out of control without regard for rules and law. Seriously disruptive to society and/or pervasively dangerous to the safety of others.
- ADULT: In confinement or imminent risk of confinement due to illegal activities. Imminent danger to others or property.
- CHILD: In confinement or imminent risk of confinement due to delinquent acts.
- **50 (EXTREME):** Total uncontrolled or antisocial behavior. Socially destructive and personally dangerous to almost all unguarded persons.

NOTE: Since danger to others is a clear component of scores of 30 and over, a clear statement as to the customer's danger to others must be included in the request.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "In confinement or imminent risk of confinement" due to illegal activities/ delinquent acts.

SELF CARE/BASIC NEEDS

- **1 – 9 (ABOVE AVERAGE):** Due to the fundamental nature of this realm of behavior, "above average" may be rated only where needs can be adequately and independently obtained in spite of some serious obstacle such as extreme age, serious physical handicap, severe poverty or social ostracism.

- **10 – 19 (AVERAGE):** Customer is able to care for self and obtain or arrange for adequate meeting of all basic needs without undue effort.
- ADULT: Able to obtain or arrange for adequate housing, food, clothing and money without significant difficulty. Has arranged dependable transportation.
- CHILD: Able to care for self as well as most children of same age and developmental level.

- **20 – 29 (Mild to Moderate):** Occasional or mild disruption of ability to obtain or arrange for adequate basic needs. Disruption is not life threatening, even if continued indefinitely. Needs can be adequately met only with partial dependence on illegitimate means, such as stealing, begging, coercion or fraudulent manipulation.
- ADULT: Occasional assistance required in order to obtain housing, food and/or clothing. Frequently has difficulty securing own transportation. Frequently short of funds.
- CHILD: More dependent upon family or others for self care than would be developmentally appropriate for age.

- **30 – 39 (Moderate to Severe):** Occasional major or frequent disruption of ability to obtain or arrange for at least some basic needs. Include denial of need for assistance or support, meeting needs wholly through illegitimate means. Unable to maintain hygiene, diet, clothing and/or prepare food.
- ADULT: Considerable assistance required in order to obtain housing, food and/or clothing. Consistent difficulty in arranging for adequate finances. Usually depends on others for transportation. May need assistance in caring for self.
- CHILD: Ability to care for self considerably below age and developmental expectation.

- **40 – 49 (Very severe / incapacitating):** Severe disruption of ability to independently meet or arrange for the majority of basic needs by legitimate or illegitimate means. Unable to care for self in a safe and sanitary manner.
- ADULT: Housing, food and/or clothing must be provided or arranged for by others. Incapable of obtaining any means of financial support. Totally dependent on others for transportation.
- CHILD: Cannot care for self. Extremely dependent for age and developmental level.

- **50 (EXTREME):** Person totally unable to meet or arrange for any basic needs. Would soon die without complete supportive care.

NOTE: When rating a child in this domain, rate on child's functioning only, without regard to adequacy of parent's provisions for basic needs. The developmental level of the child must also be considered.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Severe disruption of ability to independently meet or arrange for the majority of basic needs by legitimate or illegitimate means".

CAR ASSESSMENT GUIDE

The CAR Assessment Guide provides examples of questions you can ask for each CAR domain to help collect the information you need to determine the most accurate score.

CAR 1 FEELING/MOOD/AFFFECT

- How have you been feeling (i.e., nervous, worried, depressed, angry)?
- What has your mood been like?
- How often do you feel this way and for how long?
- Has there been any change in your sleep habits over the past month?
- Has there been any change in your eating habits over the past month?
- Has there been anything bothering you over the past month? If yes, please explain.
- Have your feelings/mood been interfering with your relationships? If yes, please give specific examples and frequency of occurrence?
- Have your feelings/mood been interfering with your job? If yes, please give specific examples and frequency of occurrence?
- Have your feelings/mood been interfering with your ability to complete household responsibilities? If yes, please give specific examples and frequency of occurrence?

- Have you been told that you seem depressed, anxious, or overly sad during the last month?
- Have you felt like hurting yourself or others during the past month?

CAR 2 THINKING/MENTAL PROCESS

- Have you experienced any difficulties with your memory over the past month? If yes, please give specific examples and how difficulties have impacted daily functioning.
- Have you experienced any difficulties with concentration? If yes, please give specific examples and how difficulties have impacted daily functioning.
- Have you been told that you have a learning disability or do you think you have problems with learning or thinking? If yes, please give specific examples and how difficulties have impacted daily functioning during the past month.
- Have you had any recurring thoughts during the past month that bother you? If yes, please explain. Do these interfere with your daily functioning in any way? If yes, please give specific examples.
- Do you ever hear voices or see things that other people can't hear or see? If yes, please give specific examples. Has this occurred within the past month? If yes, how often has this occurred and for how long? Does this interfere with your daily functioning in any way? If yes, please give specific examples.
- Orientation questions:
  - Who am I?
  - Where are we?
  - Why are we here today?
  - What is today's date?
  - Who is the President of the United States?
- Have you had any thoughts that people are against you or are out to get you over the past month? If yes, please explain.
- Do you feel that you have used poor judgment in any of your decision making over the past month or has anyone told you that you were not using good judgment or making poor decisions? If yes, please explain. How is this impacting your life (give specific examples)?
- Does anyone ever tell you that they have problems understanding what you are trying to say? If yes, please explain. Has this occurred during the past month? If yes, how is this impacting your life (give specific examples)?

CAR 3 SUBSTANCE USE

- Have you used alcohol and/or other drugs during the last month? If yes,
  - What type(s) of substance was used?
  - How much have you used and how often?
  - What are some of the reasons you used?
  - How do you access the alcohol and/or other drugs (pay for them, trade favors, given to you, steal them)?
  - How has substance use impacted your daily functioning (relationships, work, household responsibilities, health)?
- Have you thought about using alcohol and/or other drugs during the past month? If yes,
  - What type(s) of substance have you thought about using?
  - How often do you think about using?
  - What do you do to keep from using (If attends AA/NA meetings how often)? How much time do you spend on these activities?
  - Do your thoughts of use and/or activities to avoid using negatively impact your daily functioning in any way (relationships, work, household responsibilities, and health)? If yes, please give specific examples.

CAR 4 MEDICAL/PHYSICAL

- Do you have any current medical/physical conditions? If yes,
  - What type of medical/physical conditions do you have?
  - Do your conditions require special care (medication, diet, nursing care)? If yes, please specify.
  - Do your conditions currently impact your daily functioning (relationships, work, household responsibilities, self care)? If yes, please give specific examples and frequency of occurrence.
- Are you currently taking medication for medical/physical condition(s) and/or for psychiatric reasons? If yes,

- What medication(s) are you taking?
- At what dosage is your medication prescribed?
- What condition/symptoms was your medication prescribed for?
- Does your medication help reduce/control your symptoms?

CAR 5 FAMILY

- Do you live with family members? If yes,
  - Which family member or family members do you live with (parents, siblings, husband, children, partner)?
  - Are there any current problems at home? If yes, please give specific examples and frequency of problems.
  - How do you get along with the family member(s) you live with? If the answer is not well, then give specific examples and frequency.
  - How do family members treat you? If the answer is not well, then give specific examples and frequency.
- If you do not live with family members, do you live with a foster family? If yes,
  - How do you get along with your foster family members (foster parents, foster siblings)? If the answer is not well, then give specific examples and frequency.
  - How do foster family members treat you? If the answer is not well, then give specific examples and frequency.
  - Are there any current problems at home? If yes, please give specific examples and frequency.
  - Do you have any visitation with your biological family? If yes, what type of contact (phone, supervised, etc.), frequency and duration of contact? Was the interaction positive? If no, please give specific examples of what made the interaction negative.
- If you do not live with family members, have you had contact with any family members during the past month? If yes,
  - What type of contact have you had (phone, in-person)?
  - How often was the contact and what was the duration of contact?
  - Was the interaction positive? If no, please give specific examples.

CAR 6 INTERPERSONAL

- Do you have any close friends? If yes,
  - How many close friends do you have?
  - What makes them a close friend?
  - How long have you been close friends? If not long, have you had many long-term friendships? If no, what do you think interferes with maintaining long-term friendships?
  - How much and what type of contact (phone, in person) have you had with your close friend(s) during the past month? Is this less or more contact than you usually have?
  - How have you been getting along with your close friends during the past month? If not well, please give specific examples and frequency.

  If no,
  - If you have no close friends, would you like some? If yes, what are some of the things that might be interfering with you achieving this?
- Do you find it easy to make friends? If no, what makes it hard?
- How are your relationships at Work/School/Day Care/ Day Program? Have you had any conflicts during the last month? If yes, please give specific examples and frequency.
- Do you find the friendships you have to be satisfying? If no, please explain.

CAR 7 ROLE PERFORMANCE

- Are you currently employed? If yes,
  - How long have you worked there?
  - How do you like your job?
  - Do you have any current problems at work? If yes, give specific examples of type of problem(s), and frequency of problems?
  - Are you currently at risk of losing your job?

- Are you currently a student? If yes,
  - Do you like school?
  - What kind of grades do you make? If poor grades, why?
  - How do you get along with your teachers?
  - Do you ever get in trouble at school? If yes, what for and how often?
  - Have you been suspended or expelled during the past month?
- Are you currently responsible for managing your home? If yes,
  - Have you paid your bills on time during the past month? If not, how late were/are bills, and have there been any consequences for paying late (utilities turned off or current cut-off notice, recent eviction or current eviction notice)?
  - Are you able to keep your house clean? If no, give specific example of how dirty, frequency, current obstacles to keeping a clean house, and any consequences that have occurred (poor health, letter from landlord, eviction notice).
  - Do you have any children living in your home? If yes, are you able to adequately care form them (prepare and serve nutritious meals, maintain a safe and sanitary living environment, meet their basic needs)?
- Do you have any other responsibilities? If yes,
  - What are your responsibilities in your family and/or at your house (this would also include Nursing Home, RCF, or ICFMR)?
  - Do you always fulfill all of your responsibilities? If no, please give specific examples of when you have not fulfilled your responsibilities, how often this occurs, any consequences that have occurred, and possible reasons for not fulfilling responsibilities.

CAR 8 SOCIO-LEGAL

- Would other people say you are an honest person? If no, please explain.
- Have you broken a law or been accused of breaking a law within the last month? If yes, please give specific examples and include frequency of occurrence and any consequence that may have occurred as a result.
- Have you broken any rules or been accused of breaking the rules during the last month (at home, work, school, treatment, etc.)? If yes, please give specific examples and include frequency of occurrence and any consequence that may have occurred as a result.
- Have you hurt anyone during the past month (family member, friend, stranger, animals, etc.)? If yes, please explain.
- Do you think of yourself, or do others see you, as dangerous?
- Are you currently on probation or parole? If yes, have you been meeting the requirements of your probation or parole during the past month?

CAR 9 SELF CARE/BASIC NEEDS

Age 18 or Over

- If you are age 18 or older, do you currently arrange for your own housing, food (purchasing and preparing), clothing (purchasing and maintaining/laundry), money, transportation without difficulty? If no,
  - What areas are you unable to arrange for or having difficulty with?
  - Please give some specific examples of the difficulties you are having?
  - How often do these difficulties occur?
  - Have you received any assistance from anyone to help arrange for these things within the last month? If yes, please explain the type and amount of assistance.
- If you are taking medication, are you taking it as prescribed? If no, please explain.
- If on a special diet (diabetes, etc.), are your following your dietary requirements? If no, please explain.
- *Observe for Hygiene maintenance*

Younger than age 18

For children younger than the age of 18, questions should be asked based on the developmental appropriateness for the age group of the child being assessed. It is recommended that the clinician have a resource available reflecting the appropriate developmental expectations for each age group, and that this information be utilized to help structure questions and assess member abilities based on age expectation.

Section V:

Addiction Severity Index (ASI)

Teen Addiction Severity Index (T-ASI)

Addiction Severity Index (ASI)

The Addiction Severity Index (ASI) was developed in 1980 by A. Thomas McLellan Ph.D. as an interview tool for substance-dependent patients. The ASI was originally created to evaluate outcomes for several different substance abuse programs. In hopes of being able to capture any possible outcome information the tool was designed to cover a broad range of potential areas that the treatment may have affected. For this reason the instrument measures seven different problem areas (listed below) and the clinician assigns a severity score to each problem area following the completion of the structured interview. Each problem area receives a severity score from 0 to 9 with 9 being the most severe.

Problem Areas

- Medical Status
- Employment/Support Status
- Alcohol
- Drugs
- Legal Status
- Family/Social Relationships
- Psychiatric Status

Prior to administering this instrument clinicians must complete the ASI training, which is offered by the Oklahoma Department of Mental Health and Substance Abuse Services. The ASI is designed for adults age eighteen (18) and older and is not to be used with adolescents.

Teen Addiction Severity Index (T-ASI)

The Teen Addiction Severity Index (T-ASI) was developed in 1992 by Yifrah Kaminer, M.D. The tool is designed as a brief structured interview to provide information about aspects of an adolescent's life that may contribute to his/her substance abuse issues. The T-ASI is a modified version of the ASI described in the above section. The questions and categories being assessed were changed to better fit with this population. This instrument may be administered separately to both the adolescent and their parent. The T-ASI was designed to be a first step in developing a member profile that can be used for both research and treatment. The instrument is also designed as a follow up to treatment to help measure the progress a member has made after completing treatment. The T-ASI has six problem areas that are rated from 0 to 4 with 4 being the most severe.

Problem Areas

- Chemical (Substance) Use
- School Status
- Employment/Support Status
- Family Relations
- Peer/Social Relationships
- Legal Status
- Psychiatric Status

Prior to administering this instrument clinicians must complete the T-ASI training, which is offered by the Oklahoma Department of Mental Health and Substance Abuse Services. The T-ASI is designed for children age twelve (12) through seventeen (17).

Section VI: Psychologists

Psychologist

OVERVIEW

In an effort to promote effective and efficient health care for Oklahoma SoonerCare Traditional/OEPIC recipients receiving behavioral health rehabilitative services, the Oklahoma Health Care Authority (OHCA) has contracted with the APS Healthcare, Inc. (APS) to conduct prior authorization (PA) of Outpatient Behavioral Health Rehabilitative Services. SoonerCare recipients enrolled in the SoonerCare Choice Primary Care Physician Case Manager (PCPCM) program, SoonerCare Traditional and Insure Oklahoma (Oklahoma Employee/Employer Partnership for Insurance Coverage-Individual Plan (O-EPIC (IP)) must be prior authorized for these services by APS. The PCPCM does not have responsibility for referring, approving or gate keeping these or any other behavioral health services.

OPERATIONS

APS office hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except national holidays. Requests must be submitted on APS CareConnection® available through www.SoonerPRO.com (Click on the APS CareConnection® link) or visit https://okcareconnection.apshealthcare.com. . All new requests that have complete documentation will be reviewed and responded to via APS CareConnection® or OHCA's SonerCare on the Web/SoonerCare Secured Site within 5 (five) business days. Incomplete requests will be returned to the provider for the needed corrections.

Oklahoma SoonerCare QIO Website
Forms and Manuals are located on the website.
www.SoonerPRO.com

The APS Help Desk can be reached at SoonerCareHelpDesk@apshealthcare.com.

Please! Do not send treatment plans or any other Protected Health Information by e-mail or through the SoonerPro website.

Providers can access the APS web page, http://www.apshealthcare.com, for more information about APS Healthcare, Inc. Providers may also call APS at 1-800-762-1560 for assistance in completing the request forms, or any other questions regarding the PA process.

TYPES OF SERVICES

The Therapies

- Psychiatric Diagnostic Interview Exam/Assessment — *only one Diagnostic Interview/Assessment for level of care per year per provider is allowed, unless there has been a break in services for six months.*
- Crisis Intervention
- Health and Behavior coded services for children with chronically and terminally ill children.
- Individual psychotherapy / Interactive psychotherapy (*one-to-one treatment with the member)*

- Group Therapy—*must consist of two or more unrelated patients over the age of 4 years. Maximum group size is six patients. No more than one group session is allowed per member per day.*
- Family Therapy (*face-to-face interaction with the family/patient).*
- Multi Family Groups *(no more than 8 family units per group)*

Each SoonerCare member may receive a combined total of five units (hours) per month of any combination of the above therapies after submission of the Customer Data Core (CDC) to APS. Beyond these 5 units, therapy services may be approved for 3 additional units per month after submission of a Psychologist Prior Authorization Request via APS CareConnection®.

No more than twelve hours per day may be billed for therapy/testing in any given day

Beginning July 1, 2010, Health and Behavior codes may be used only for chronically or terminally ill children.

Only Children's services (younger than 21) may be performed by Psychologists under your SoonerCare Provider contract.

PCP Behavioral health screening and referral

PCPs who are Medical Home providers have been encouraged to conduct a screening and brief intervention for their members for the purpose of identifying behavioral health problems, and to make referrals to Psychologists for a more thorough assessment and services, if needed. All providers are encouraged to make contact with the PCP/Medical Home offices in the areas they serve so that the physician can refer easily to psychologists for evaluation, it is expected that the member be seen within 72 hours after seeing the physician. The psychologist is expected to contact the referring physician with results of the assessment and plan of service, in order to work collaboratively with the member's Medical Home.

Therapy Services for Members in Residential Behavior Management Settings (RBMS)

All therapy services for patients who are in an RBMS (defined as a group home or a Therapeutic Foster Care placement) must be prior authorized. The request for services must clearly document why additional services beyond what the RBMS can provide are required. Additionally, documentation must indicate how the additional services are differentiated from the therapy provided by the RBMS to document that services are not being duplicated.

Psychological Testing

Eight hours of psychological testing are allowed with authorization through the CDC process per member per provider per year. If more than eight units are required, a Prior Authorization Request must be submitted to APS via APS CareConnection®. An additional 4 units may be authorized if the request meets medical necessity criteria based on a medical review. The reimbursement rate for psychological testing includes the time for writing and analyzing test results and providing feedback to the member on the testing results. The Customer Data Core will have to be sent into APS within 30 days of the testing date in order for the testing to have an authorization for payment.

All testing for children younger than the age of three years must be prior authorized.

All psychological testing for a member in an RBMS (group home or TFC) must be prior authorized. The request should clearly document that the member resides in the RBMS.

Effective October 1, 2006, inpatient RTC providers are reimbursed via an all-inclusive per diem. The per diem is to cover all services required by the SoonerCare/ OEPIC member during inpatient RTC treatment. Therefore, a prior authorization will not be provided if a SoonerCare/OEPIC member requires psychological testing while at the RTC level of care, unless the treating facility is considered a community-based RTC facility. Prior authorization for psychological testing can not be provided until the member is discharged from inpatient RTC treatment. A technical denial will be issued if prior authorization for testing is requested while a member is under inpatient RTC treatment. If testing is required while the member is at the RTC level of care, the psychologist should discuss reimbursement with the treating hospital regarding payment.

A child in inpatient acute care can receive psychological services separate from the acute facility.

OHCA is requesting that all test results be faxed to APS where they will be used only for care coordination purposes.

Psychology interns and post-doctoral fellows who are in APA accredited training programs may provide compensable psychological services under their supervisor's OHCA contract number. Refer to OHCA Behavioral Health Rules at www.okhca.org.

Psychologists under supervision for Licensure must provide all services under the Supervisor's OHCA contract and follow all rules pursuant to that contract, including the prior authorization process as described.

Procedures not covered:

- Sensitivity training
- Encounter groups
- Workshops
- Sexual Competency Training
- Marathons or Retreats for mental disorders
- Strictly educational training
- Psychotherapy to persons younger than three years of age unless specifically approved through the prior authorization process

Authorization Dates

The start date for authorization period for therapies begins when the first service was provided. Diagnostic Interviews and Crisis Intervention for the purpose of stabilization and hospital diversion do not require authorization. Starting on July 1, 2010 a Customer Data Core must be received by APS within 30 days of the first date of service, at which time an initial authorization will be provided for 5 additional units the first month and for 5 more months thereafter. The provider will, therefore, have an authorization for five units per month for 6 months. If the additional 3 sessions for the month are needed, they can be requested through the prior authorization process and for these the authorization begins the day the request is received.

Testing authorizations end twelve months from the start date of the authorization.

Additional Units for both therapies and for testing may be prior authorized in the process below:

Submit the Psychologist Request for Prior Authorization via CareConnection® along with any additional information required.

The request must include:

- The psychologist's name, provider number, fax and phone number.
- The member's full name, Recipient ID (SoonerCare) number, social security number, date of birth, age, sex, and placement if applicable.
- DSM-IV-TR (in ICD-09 format) diagnosis (including rule-out and provisional diagnoses).
- All five Axes must be completed
- Clinical behavioral health justification for additional testing and/or therapy.
- List of the testing instruments to be used if authorizing for testing.
- How the evaluation results may impact current treatment.
- Results of previous testing (most recent if known), or previous therapy.
- The total number of requested additional units for psychological testing and/or the total number of requested units of additional counseling.

APS will review for previous Prior Authorizations for testing within the current year. Only one testing per provider per member is allowed per year. It is always a good idea to check with APS to see if a member has received psychological testing twelve months prior to the member's request.

Recipient Eligibility:

APS CareConnection® verifies member eligibility against the Medicaid Management Information System (MMIS) eligibility file. If the eligibility file indicates that the member does not currently qualify, providers may submit a "Courtesy Review" request and APS will complete the review based on the information submitted. The review will remain in "Courtesy Review" status until benefits have been determined, at which time it is the provider's responsibility to notify APS by fax. Once APS has verified the eligibility, an authorization number will be assigned.

An Authorization number will not be assigned when the member does not qualify or their Health Program does not include behavioral health benefits.

The Authorization will date back to when the request was originally received by APS, subject to the eligibility dates contained in the MMIS system. No services can be prior authorized prior to the eligibility date.

Providers may check the OHCA Recipient Eligibility Verification System (REVS) at 1-800-522-0310. For instructions on using REVS, call 1-800-767-3949. Providers can also check eligibility through SoonerCare on the Web secure website with their 8-digit pin number, or call the OHCA Provider Helpline at 1-800-522-0114 for assistance.

Types of Responses

Clinical Correction Notice:

An APS Reviewer will assess each request for overall completeness of the required elements and all necessary supporting documentation. If the request is incomplete, or the reviewer needs additional information to determine the medical necessity of the requested services, the request will be returned for correction with a Note to Provider in the Services Requested section of the request stating what additional information is needed to

process the request. The facility has ten (10) calendar days from the date of the Note to Provider to respond. If there is no response within the required 10 days, the request will be technically denied.

Note: All requests with a Clinical Correction Notice generated will be dated from the date the original request was received if the provider responds within the 10 calendar days.

Provider Response to a Clinical Correction:

When a provider responds to an APS Clinical Correction all requested information must be addressed to avoid a Technical Denial.

Approval:

Issued when all required documentation is present, medical necessity is evident; the member qualifies in MMIS and, if testing has been requested, the member has had no equivalent previous testing within the past year.

Modification:

Based on the information provided, a reviewer may modify a provider's request by reducing the total units requested for an authorization period. Modifications are made based on the most appropriate array and frequency of services for each request, utilizing the guidelines established in the Outpatient Manual and Part 21 Administrative Code.
The type and amount of testing within the last year will also be considered when determining medical necessity.

Denial:

Issued when there has been (1) no response to the Clinical Correction within the required 10 calendar days, (2) guidelines for prior authorization are not met, or (3) when the requested testing/therapy does not meet Medical Necessity Criteria. Cases may be referred to an APS Clinical Consultant for final review as needed.

Courtesy Review:

If the MMIS file shows the member as not qualifying, the request will be reviewed based on the information provided in the request and a Courtesy Review decision will be issued. A PA number will not be assigned when the member does not qualify. The PA will date back to when the request was received by APS, subject to the eligibility dates contained in the MMIS system (e.g., PA request received 02/14/05 and eligibility determined from 03/01/05, no services will be prior authorized before 03/01/05).

It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/OEPIC.

Note: It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/OEPIC when a Courtesy Review decision has been issued.

Correction Request:

A Correction Request must be submitted when a provider finds any errors or discrepancies on a PA (i.e., typographical error, wrong provider number, wrong service code, wrong Recipient ID number, etc.) regardless of who made the error. APS processes these requests within 5 (five) business days.

Status Request:

If a response to a request is not received within 5 (five) business days and after verifying the Status on CareConnection®, a Status Request form may be submitted. This request documents your submitted request 5 (five) business days prior and reserves the original start date if the request is not on file at APS. This form can be located at www.SoonerPro.com, on the Resources tab click the Downloadable Forms link on the left side navigation bar and then select the Outpatient Forms folder.

Provider Response to Status Requests:

If the psychologist receives a response reflecting that the original request for services or the response to the Clinical Correction was not received at APS, then the psychologist has ten business days (from the date the Status Request Response was faxed from APS) to re-submit the request/ response. If the documentation is not re-submitted within the ten business days, the original submit date (as supported by the Status Request) will not be honored. If the documentation is received after the ten business days allowed (as supported by the submitted information), the start date of services assigned is the date the response is received at APS.

If the psychologist receives a response indicating the request for service has been processed and a Clinical Correction was issued requesting additional documentation or information, the psychologist has ten calendar days (from the date the Status Request Response was faxed from APS) to submit the required Clinical Correction. If the Clinical Correction response is not submitted within the allowed ten calendar days, a Technical Denial decision will be issued (i.e. due to no response within the time frame allowed).

Medical Necessity Criteria for Psychological Testing

Psychological Testing Requirements

A. Evaluation
   1. Appropriate (Must meet ALL of the following conditions)
      a) Member is experiencing behavioral health difficulty in functioning, origins not clearly determined; AND
      b) An evaluation has been recommended and/or requested; AND
      c) Results of evaluation may directly impact current treatment strategies.
      d) If member has been tested recently a different testing battery will be performed.

   2. Inappropriate
      a) Evaluation results will not directly impact current treatment; AND/OR
      b) Evaluation results will be utilized for academic placement/purposes only; AND/OR
      c) An equivalent psychological evaluation has been conducted by another provider (including private psychologists) within the current calendar year; AND/OR
      d) Patient resides in an inpatient residential facility.

B. Assessment Results
   1. DSM-IV-TR (in ICD-09 format) Diagnosis

a) Axis I primary diagnosis (INCLUDING V and 900 codes, Deferred, and Provisional Diagnosis).
b) All five Axes MUST be completed

C. Submission Requirements (must include ALL of the following information)
What tests will be used?
How many hours will the testing require?
Who will be performing the tests, and what are their credentials?
What is the reason for the testing?
How might the evaluation results specifically affect treatment for the member?
How will the test results be used to benefit the member?
Regimen
Amount/Array of Services
The maximum allotment is 8 hours/units per calendar year, unless a completely different set of psych tests are utilized or there is clear, clinically stated rationale for retesting using equivalent instruments.

General Prior Authorization Information

Turn Around Time from APS
:
Psychologist CDC based authorizations are processed within 5 (five) business days. The psychologist may view the authorization on SoonerCare on the OHCA Web secure website or on APS CareConnection®.

Authorization Period
The start date for the authorization period begins the date of the first service. An authorization will be rendered after the CDC is submitted to APS within 30 days of the first date or testing.
☑ Testing authorizations end twelve months from the start date of the PA.
☑ Therapy authorizations end after 30 sessions or six months from the start date of the PA, which ever comes first.

Authorization Numbers

APS will assign a member and provider site-specific authorization number to each approved request. This member and provider site-specific authorization number will be submitted to MMIS on a batch basis each night. Each number will be associated with from/through dates by service and month to indicate the length of time and the amount of service being authorized by APS. Once the facility has received an authorization number, the facility must utilize the EDS HCA-12A (formerly the MS-MA-5) form when filing a claim for the stated services covered. (Submit the PA number on the HCFA-1500, now CMS-1500 form, in Item 23, or on the electronic 837 format.) Facilities must follow the OHCA Provider Manual for submitting claims requiring authorization numbers, as specific procedure codes are to be utilized when filing claims for Outpatient Behavioral Health Rehabilitative Services.

Billing Issues

Any billing questions should be directed to the OHCA Provider Helpline at 1 (800) 522-0114.
Educational Opportunities
APS will announce training sessions on www.SoonerPro.com website. Providers are encouraged to recommend training topics to APS through SoonerPro. APS will also work with providers to develop specific training

programs and conduct on-site training sessions at the request of providers. APS will work with providers to identify locations and training topics. All training materials and requests must be approved by OHCA in advance.

☑ Find updated rates at SoonerCare on the Web
https://www.ohcaprovider.com/Oklahoma/Security/logon.xhtml

Service Name for Psychologists	CPT/HCPC Codes (Per Unit)
Psychiatric Diagnostic Interview Examination	90801
Interactive Psychiatric Diagnostic Interview Examination	90802
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, face-to-face with the patient. -or-	90804 (20-30 min.)
	90806 (45-50 min.)
	90808 (75-80 min.)
Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient.	90810 (20-30 min.)
	90812 (45-50 min.)
	90814 (75-80 min.)
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an Inpatient hospital, partial hospital or residential care setting, face-to-face wit the patient.	90816 (20-30 min.)
	90818 (45-50 min.)
	90821 (75-80 min.)
Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an Inpatient hospital, partial hospital or residential care setting, face-to-face with the patient.	90823 (20-30 min.)
	90826 (45-50 min.)
	90828 (75-80 min.)
Group Psychotherapy *	90853 (60 min.)
Family Psychotherapy without patient present *	90846 (60 min.)
Family Psychotherapy with patient present *	90847 (60 min.)
Hypnotherapy	90880
Psychological Testing, psychologist/physician only, face-to-face with the patient, time interpreting test results and preparation of the report	96101 (60 min.)
Psychological Testing per hour of technician time-with Qualified Health Care Provider (QHCP) (limited to certified psychometrist or psychological technician of a psychologist) interpretation and report, admin. by	96102 (60 min.)

a tech (face to face only)	
Psychological Testing by a computer with QHCP interpretation and report (flat rate, one per recipient per calendar year without PA)	96103 (flat rate, one per recipient per calendar year w/o PA)
Neuropsychological Testing per hour by a psychologist/physician *Indicates restriction to physician and psychologist only.	96118 (60 min.)
Neuropsychological Testing per hour of Technician time - w/ QHCP interpretation and report, administered by a Technician (face to face only)	96119 (60 min.)
Neuropsychological Testing by a computer w/QHCP interpretation and report (flat rate, one per recipient per calendar year without PA)	96120 (flat rate, one per recipient per calendar year w/o PA)
Neurobehavioral status exam by a psychologist/physician *Indicates restriction to physician and psychologist only.	96116 (60 min.)
Developmental testing, interpretation and report *Indicates restriction to physician and psychologist only.	96110
Developmental testing; extended *Indicates restriction to physician and psychologist only.	96111
Health and Behavior Assessment – 15 min	96150**
Health and Behavior Re-Assessment	96151**
Health and Behavior Intervention – 15 min	96152**
Health and Behavior Intervention, Group	96153**
Health and Behavior Intervention, Family with patient present	96154**
Health and Behavior Intervention, Family without patient present	96155**
Crisis Intervention Service – 15 min	H2011**
CALOCUS Assessment, Brief Intervention, and Referral	H0031 TG

*Note: the sessions for family therapy and group therapy must continue for at least 45 minutes.

*Note: only those officially trained in the CALOCUS can bill for this level of assessment

Section VII:

Licensed Behavioral Health Providers

FY'11 CHANGES FOR LICENSED BEHAVIORAL HEALTH PROVIDERS FOR SOONERCARE AND INSURE OKLAHOMA

1. **LBHPs**: As of July 1, 2010 all licensed Behavioral Health Providers will be able to contract directly with the Oklahoma Health Care Authority to serve children and their families. (Adults are not included in this benefit.) LBHPs currently contracted with Insure Oklahoma can also contract with OHCA to serve SoonerCare children and families. The provisions in this manual apply to those who already are Insure Oklahoma providers. These are the services that LBHPs may provide:
    a. Allows LBHPs to provide a limited benefit for children and their families.
    b. Services allowed include assessment, crisis intervention, individual, group, family, and multifamily therapy.
    c. Only one assessment per member per provider is allowed per year, unless there has been a break in services for six months, at which time another assessment may be performed.
    d. The maximum number of units/sessions allowable per month is eight units of psychotherapies and 8 units of psychological testing per year per patient.
    e. For CALOCUS trained LBHPs, there will be a reimbursable service code for performing a level of care assessment, brief intervention, referral, and case management process.

2. **Outpatient BH Agencies:** LBHPs working in OPBH agencies will be able to provide the level of care CALOCUS assessment, brief intervention, referral, and case management process and be reimbursed for it through the agency, separate from their current assessment practices. The agencies will still provide their full array of services under the levels 1-4 system.

Processes and Procedures

There are three authorization tracks available to clinicians wishing to utilize the provisions in the rule.

A. Outpatient Behavioral Health Assessment/Therapy Track

1. This track utilizes the processes for a clinician in private practice:
    a. 90801 assessment,
    b. crisis intervention,
    c. individual, family, group, and multifamily therapy
    d. The 90801 will not require a prior authorization, nor will crisis intervention.
    e. Providers submit the Customer Data Core (CDC) within 30 days of the first date of service in order for an authorization to be generated for billing purposes.
        i. Five units/sessions per month for six months will then be authorized.
        ii. Should the clinician require the additional three units per month allowed, the clinician will need to send the APS 2-page prior authorization request form to APS for approval.
    f. An update to the CDC is required every six months as part of your extensions requests and when you discharge a patient.
    g. Once a CDC is in Care Connection, then further CDC submissions will auto populate most fields, and you'll only be required to update the applicable fields, in order to save provider time.

B. LBHP Testing/Evaluation Track

1. If psychological testing is indicated, then 8 hours of testing is allowed without prior authorization. Additional units must be prior authorized by sending in the 2-page APS prior authorization request form.

The Customer Data Core must be sent into APS within 30 days of the date of testing so that an authorization can be approved for billing purposes.

2. Testing requests will be manually/clinically reviewed by APS for clinical need should more than 8 hours of testing be required.
3. All testing for children younger than the age of three years *must be prior authorized*
4. Psychological Testing for Members in Residential Behavior Management Settings: All psychological testing for a member in an RBMS (group home or TFC) must be prior authorized. The request should clearly document that the member resides in the RBMS.
5. Psychological Testing for Members in Inpatient Residential Treatment Center Level of Care: Effective October 1, 2006, inpatient RTC providers are reimbursed via an all-inclusive per diem. The per diem is to cover all services required by the SoonerCare/ OEPIC member during inpatient RTC treatment. Therefore, a prior authorization will not be provided if a SoonerCare/OEPIC member requires psychological testing while at the RTC level of care, unless the treating facility is considered a community-based RTC facility. Prior authorization for psychological testing can not
6. Psychological Testing in Inpatient Acute Settings: A child in inpatient acute care can receive psychological services separate from the acute facility
7. Sending Test Results to APS: OHCA is asking that all test results be faxed to APS for purposes of care coordination exclusively.
8. Psychological Testing in Inpatient Acute Settings:
9. A child in inpatient acute care can receive behavior health services separate from the acute facility.
10. Testing authorizations end twelve months from the start date of the PA.
11. APS will review for previous Prior Authorizations for testing within the current year.

- Psychological Testing Requirements: *Appropriate*
  (Must meet ALL of the following conditions)
  a) Member is experiencing behavioral health difficulty in functioning, origins not clearly determined; AND
  b) An evaluation has been recommended and/or requested; AND
  c) Results of evaluation may directly impact current treatment strategies.
  d) If member has been tested recently a different testing battery will be performed.

- Psychological Testing: *Inappropriate*
  a) Evaluation results will not directly impact current treatment; AND/OR
  b) Evaluation results will be utilized for academic placement/purposes only; AND/OR
  c) An equivalent psychological evaluation has been conducted by another provider(including private psychologists) within the current calendar year; AND/OR
  d) Patient resides in an inpatient residential facility.

- Psychological Testing: *Assessment Results*
  (DSM-IV-TR (in ICD-09 format) Diagnosis)
  a) Axis I primary diagnosis (INCLUDING V and 900 codes, Deferred, and Provisional Diagnosis).
  b) All five Axes MUST be completed

- Psychological Testing*: Submission Requirements* (must include ALL the following information)
  a) What tests will be used?
  b) How many hours will the testing require?
  c) Who will be performing the tests, and what are their credentials?
  d) What is the reason for the testing?
  e) How might the evaluation results specifically affect treatment for the member?
  f) How will the test results be used to benefit the member?

- Psychological Testing: Amount/Array of Services
  a) The maximum allotment is 8 hours/units per calendar year, unless a completely different set of psych tests are utilized or there is clear, clinically stated rationale for retesting using equivalent instruments.

C. Level of Care Assessment, Brief Intervention, Referral, and Case Management Process Track

1. Of particular importance to this track is the expectation that trained clinicians provide:
   a. A level of care assessment tool, chosen by OHCA and known as the CALOCUS, for children who might otherwise enter inpatient psychiatric hospital treatment, crisis intervention for those children and their families, provide case management to find an appropriate resource in their communities for those children and their families, and follow up to insure the member has made the appropriate contact with any referrals made.
   b. The totality of these services will be required in order to bill for this.
   c. In order for an authorization to be generated, the clinician will:
      1) Enter into the APS Care Connection the CALOCUS assessment scores, the Customer Data Core, which includes, the CAR scores, diagnosis, clinical summary information, if the member requires a referral, and follow up information.
      2) The clinician will call APS to discuss the assessment results and member's needs.
      3) APS will determine appropriate level of care and make appropriate referral(s).
      4) If you are the most appropriate provider for this child, then you will then receive an authorization from APS.
      5) If another provider is determined the most appropriate, then APS will coordinate with the accepting provider.
      6) After you have contacted the accepting provider for follow-up on whether the member made their first appointment, then you'll complete your "pending authorization," by calling APS to provide this information. APS will generate your authorization.
   d. Of note: crisis intervention services provided before, during, or after the level of care assessment will not require authorization.
   e. The clinician may choose to use a release form for the parent or guardian to sign in order to share information with other resources in the community. A sample release form will be made available on SoonerPro or you can use a release that you currently use to cover other potential providers who may be asked to serve the member.
   f. All LBHPs wishing to provide the level of care assessment, brief intervention, referral, and case management process must be trained in how to use the CALOCUS, either through an OHCA state-approved trainer or other training approved by OHCA.
   g. The CALOCUS is a nationally validated tool and is in the public domain (paper form, there is an electronic version available that does cost). Individuals from a variety of settings and parts of the state have become trainers through a "training of trainers" by CALOCUS and will be available to do trainings in areas of the state in which they currently practice. A list of trainers will be made available to you. In addition, some trainers are already committed to offering training at the conferences and workshops offered by the associations representing licensed providers (OCA, OKAMFT, OPA, NASW, ODAPCA, OSASA, NAMP, etc.)
   h. If an untrained clinician sees a member who requires a CALOCUS assessment and no trained clinician is available to provide this assessment quickly, the clinician can call the APS reviewer team, provide the clinical information to the available reviewer, and that reviewer can go through the CALOCUS questions with the clinician, score the tool, and collaborate with the clinician regarding the best resource for the member.

i. Should the level of care assessment indicate that the member can be seen in outpatient services in the community, the provider can proceed with treatment through the allowed therapies. The Customer Data Core, however, will need to be sent to APS in order for an authorization number to be generated which allows the provider to bill for all services.

Case Management:

Case management is a critical piece of the integrated assessment process. It is considered a specialized aspect of any assessment and therapeutic process. The case management component can be understood in the following sections.

A child may be referred to an LBHP to provide a level of care assessment through several avenues: 1) self-referral, 2) APS, 3) an OHCA care coordinator, 4) OKDHS/OJA, 5) another service provider in the community, or 6) a hospital which determines that the child does not require immediate inpatient care.

- The clinician doing the assessment is expected to be familiar with the resources in the community so that the appropriate level of care can be implemented within a community-based context. The clinician along with APS shall determine the appropriate services for the member. This collaboration is especially important if the clinician is not familiar with appropriate resources that might exist in a nearby community. Once a resource is determined, The LBHP or psychologist is responsible for arranging for those services and doing a follow up to make sure the member has connected with that service.

- If the member does not show up for his/her referral appointment, additional follow up for that member is no longer the responsibility of the clinician. APS will then complete the authorization for the level of care assessment and will take over the tracking of the member until follow up can be established.

- Should the CALOCUS indicate that inpatient treatment is the appropriate level of care for the child, the LBHP will need to contact APS and a coordinated effort by the APS reviewer team and the clinician will result in a decision regarding which inpatient level of care might be appropriate and any other pertinent information that would be helpful for the inpatient provider.

Hospitalization and Therapeutic Foster Care

- Hospital process: Should a child and guardian show up at the hospital for an assessment, the hospital will do their assessment.
- Should a hospital level of care not be deemed as necessary, the hospital will call APS to get a referral in the member's community for further evaluation and treatment.
- Should there be an automatic step down from a higher level of care to a lower level, the hospital will call APS to get a referral in the member's community for further evaluation and treatment.
- Therapeutic Foster Care has its own process and is handled by the Department of Human Services. If the child is in the custody of OKDHS or OJA, the custodial worker will take care of that child. If, however, the child has a social service specialist who is part of a prevention case, the clinician can do the CALOCUS and inform the social service specialist of the results, and the OKDHS social service specialist will do the case management of the case.

- Therapy Services for Members in a Residential Behavior Management Settings (RBMS): All therapy services for patients who are in an RBMS (defined as a group home or a Therapeutic Foster Care placement) must be prior authorized. The request for services must include the treatment plan from the group home or TFC and must clearly document why additional services beyond what the RBMS can provide are required. Additionally, documentation must indicate how the additional services

PCP Behavioral Health Screening and Referral

PCPs who are Medical Home providers have been encouraged to conduct a screening and brief intervention for their members for the purpose of identifying behavioral health problems, and to make referrals to LBHPs for a more thorough assessment and services, if needed. All providers are encouraged to make contact with the PCP/Medical Home offices in the areas they serve so that the physician can refer easily to psychologists for evaluation. It is expected that the member be seen within 72 hours after seeing the physician. The LBHP is expected to contact the referring physician with results of the assessment and plan of service, in order to work collaboratively with the member's Medical Home.

Authorization Requirements

The start date for prior authorization period begins the day the request is received. Requests cannot be back dated per OHCA guidelines. However, Diagnostic Interviews, Assessments for Level of Care, and Crisis Intervention for the purpose of stabilization and hospital diversion do not require prior authorization. Starting on July 1, 2010, after these services are provided, a Client Data Core must be received by APS within 30 days of the first date of service, at which time an initial authorization will be provided for five units per month for 6 months. If the additional 3 sessions for the month are needed, they can be requested through the prior authorization process and for these the authorization begins the day the request is received.

Requests cannot be back dated per OHCA guidelines. However, Diagnostic Interviews, Assessments for Level of Care, and Crisis Intervention for the purpose of stabilization and hospital diversion do not require prior authorization. Starting on July 1, 2010, after these services are provided, a Customer Data Core must be received by APS within 30 days of the first date of service, at which time an initial authorization will be provided for five units per month for 6 months. If the additional 3 sessions for the month are needed, the start date for prior authorization period begins the day the request is received. They can be requested through the prior authorization process and for these the authorization begins the day the request is received.

Submitting Requests for Additional Units

Submit the LBHP Request for Prior Authorization via CareConnection® along with any additional information required. The request must include:

- The provider's name, provider number, fax and phone number.
- The member's full name, Recipient ID (SoonerCare) number, social security number, date of birth, age, sex, and placement if applicable.
- DSM-IV-TR (in ICD-09 format) diagnosis (including rule-out and provisional diagnoses).
- All five Axes must be completed
- Clinical behavioral health justification for additional testing and/or therapy.
- List of the testing instruments to be used.
- How the evaluation results may impact current treatment.

- Results of previous testing (most recent if known).
- The total number of requested the total number of requested additional units for psychological testing and/or units of additional counseling.

Recipient Eligibility

APS CareConnection® verifies member eligibility against the Medicaid Management Information System (MMIS) eligibility file. If the eligibility file indicates that the member currently does not qualify, providers may submit a "Courtesy Review" request and APS will complete the review based on the information submitted. The review will remain in "Courtesy Review" status until benefits have been determined, at which time it is the provider's responsibility to notify APS by fax. Once APS has verified the eligibility, an authorization number will be assigned.

A PA number will not be assigned when the member does not qualify or who's Health Program does not include behavioral health benefits.

The PA will date back to when the request was originally received by APS, subject to the eligibility dates contained in the MMIS system. No services can be prior authorized prior to the eligibility date.

Providers *may* check the OHCA Recipient Eligibility Verification System (REVS) at 1-800-522-0310. For instructions on using REVS, call 1-800-767-3949. Providers can also check eligibility through SoonerCare on the Web secure website with their 8-digit pin number, or call the OHCA Provider Helpline at 1-800-522-0114 for assistance.

Types of Responses

Clinical Correction Notice:

An APS Reviewer will assess each request for overall completeness of the required elements and all necessary supporting documentation. If the request is incomplete, or the reviewer needs additional information to determine the medical necessity of the requested services, the request will be returned for correction with a Note to Provider in the Services Requested section of the request stating what additional information is needed to process the request. The facility has ten (10) calendar days from the date of the Note to Provider to respond. If there is no response within the required 10 days, the request will be technically denied.

Note: All requests with a Clinical Correction Notice generated will be dated from the date the original request was received if the provider responds within the 10 calendar days.

Provider Response to a Clinical Correction:

When a provider responds to an APS Clinical Correction all requested information must be addressed to avoid a Technical Denial.

Approval:

Issued when all required documentation is present, medical necessity is evident; the member qualifies as active in MMIS and, if testing has been requested, the member has had no equivalent previous testing within the past year.

Modification:

Based on the information provided, a reviewer may modify a provider's request by reducing the total units requested for an authorization period. Modifications are made based on the most appropriate array and frequency of services for each request, utilizing the guidelines established in the Outpatient Manual and Part 21 Administrative Code.
The type and amount of testing within the last year will also be considered when determining medical necessity.

Denial:

Issued when there has been (1) no response to the Clinical Correction within the required 10 calendar days, (2) guidelines for prior authorization are not met, or (3) when the requested testing/therapy does not meet Medical Necessity Criteria. Cases may be referred to an APS Clinical Consultant for final review as needed.

Courtesy Review:

If the MMIS file shows the member does not qualify for SoonerCare benefits, the request will be reviewed based on the information provided in the request and a Courtesy Review decision will be issued. A PA number will not be assigned when the member does not qualify for SoonerCare benefits. The PA will date back to when the request was received by APS, subject to the eligibility dates contained in the MMIS system (e.g., PA request received 02/14/05 and eligibility determined from 03/01/05, no services will be prior authorized before 03/01/05).

It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/OEPIC.

> Note: It is the provider's responsibility to notify APS when a member qualifies for SoonerCare/OEPIC when a Courtesy Review decision has been issued.

Correction Request:

A Correction Request must be submitted when a provider finds any errors or discrepancies on a PA (i.e., typographical error, wrong provider number, wrong service code, wrong Recipient ID number, etc.) regardless of who made the error. APS processes these requests within 5 (five) business days.

Status Request:

If a response to a request is not received within 5 (five) business days and after verifying the Status on CareConnection®, a Status Request form may be submitted. This request documents your submitted request 5 (five) business days prior and reserves the original start date if the request is not on file at APS.

Provider Response to Status Requests:

1) If the LBHP receives a response reflecting that the original request for services or the response to the Clinical Correction was not received at APS, then the LBHP has ten business days (from the date the Status Request Response was faxed from APS) to re-submit the request/ response. If the documentation is not re-submitted within the ten business days, the original submit date (as supported by the Status Request) will not be honored. If the documentation is received after the ten business days allowed (as supported by the submitted information), the start date of services assigned is the date the response is received at APS.

2) If the LBHP receives a response indicating the request for service has been processed and a Clinical Correction was issued requesting additional documentation or information, the psychologist has ten

calendar days (from the date the Status Request Response was faxed from APS) to submit the required Clinical Correction. If the Clinical Correction response is not submitted within the allowed ten calendar days, a Technical Denial decision will be issued (i.e. due to no response within the time frame allowed).

For forms and additional information, please visit:
http://www.soonerpro.com/Resources/Resources.aspx

Codes for Insure Oklahoma and LBHP Contractors. July 1, 2010

Service Name	CPT Codes (Per Unit)
Psychiatric Diagnostic Interview Examination	90801
CALOCUS assessment, brief intervention, referral and follow-up**	HOO31
Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, in an office or outpatient facility, face-to-face with the patient. -or-	90804 (20-30 min.)
	90806 (45-50 min.)
	90808 (75-80 min.)
Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient.	90810 (20-30 min.)
	90812 (45-50 min.)
	90814 (75-80 min.)
Group Psychotherapy *	90853 (60 min.)
Family Psychotherapy without patient present *	90846 (60 min.)
Family Psychotherapy with patient present *	90847 (60 min.)
Hypnotherapy	90880
Psychological Testing face-to-face with the patient, time interpreting test results and preparation of the report	96101 (60 min.)
Psychological Testing per hour of technician time- w/ qhcp (qualified health care professional; limited to certified psychometrist) interpretation and report, admin. by a tech (face to face only)	96102 (60 min.)
Psychological Testing by a computer w/ qhcp interpretation and report (*flat rate, one per recipient per calendar year without PA)*	96103 (flat rate, one per recipient per calendar year w/o PA)
Neuropsychological Testing per hour	96118 (60 min.)
Neuropsychological Testing per hour of Technician time - w/qhcp interpretation and report, administered by a Technician (face to face only)	96119 (60 min.)
Neuropsychological Testing by a computer w/qhcp interpretation and report (*flat rate, one per recipient per calendar year without PA)*	96120 (flat rate, one per recipient per calendar year w/o PA)
Interpretation of Testing Results (untimed event code)	90887
Developmental testing	96111
CALOCUS Assessment, Brief Intervention, and Referral	H0031 TG
Crisis Intervention	H2011

*Note: the sessions for family therapy and group therapy must continue for at least 45 minutes.

*Note: only those officially trained in the CALOCUS can bill for this level of assessment.

Section VIII:

Billing Procedures

A. OKMMIS Provider Billing and Procedure Manual
http://okhca.org/providers.aspx?id=100

B. SoonerCare Secure Site
https://www.ohcaprovider.com/Oklahoma/Security/logon.xhtml

SoonerCare on the Web is the OHCA's secure Web site, offering providers, both SoonerCare and ODMHSAS, a number of services from submitting claims on the Web to fast verification of claim status. New providers are assigned a PIN to access the Web site.

To access the page, go to www.okhca.org, click on the Provider tab and choose Secure Site from the drop-down menu. For more information on logging in for the first time and entering the secure site, look under the Help tab on the Web site. SoonerCare on the Web is available from 5 to 1 a.m.

C. Available Services on the OHCA Secure Web Site
The following services are available to SoonerCare on the Web users:

- Global messaging (can be specific to one or all providers).
- Claims submission.
- Claims inquiry.
- Prior authorization submission.
- Provider PA notices.
- Prior authorization inquiry.
- Procedure pricing.
- Financial warrant amount.
- Eligibility verification.
- Managed Care rosters.

D. HP Field Consultants

The Oklahoma Health Care Authority (OHCA) is the state agency responsible for the administration of the Oklahoma SoonerCare program. The OHCA has a contractual agreement with Electronic Data Systems (HP) to be the fiscal agent for the Oklahoma SoonerCare program.

HP has a team of regional field consultants with knowledge of Oklahoma SoonerCare and ODMHSAS billing requirements and claim-processing procedures. Training is offered on billing, eligibility verification system, Electronic Data Interchange (EDI) and SoonerCare Programs.

Field consultants provide training through on-site visits and workshops. They encourage providers to use electronic claim submission because it's fast, easy to use and saves money.

The focus of a field consultant is to:
1. Train newly enrolled providers;
2. Contact and visit high-volume providers; and
3. Conduct provider training workshops.

Providers may contact their field consultant by telephone to request a visit for training at the provider's location. Field consultants are responsible for arranging their own schedules. They are available Tuesday through

Thursday for onsite provider visits. Provider on-site visits are normally scheduled two weeks in advance. Since field consultants are often out of the office, please allow a minimum of 48 hours for telephone calls to be returned.

NOTE: For SoonerCare or ODMHSAS claim research, contact the OHCA (HP) Call Center at 800-522-0114 or 405-522-6205. Field consultants are the last resource for any claim inquiry questions.

E. Individual Rendering Provider Enrollment for Outpatient Behavioral Health Agencies

To be announced: All behavioral health providers who work in an outpatient behavioral agency setting will be required to have an individual contract; a SoonerCare provider number. When this requirement goes into effect, the agency will be required to list the individual provider number as the "rendering provider," and the agency provider number will be posted as the "pay to" on all SoonerCare claims.

F. Electronic provider enrollment (EPE)

OHCA is excited to announce a new electronic enrollment process through the OHCA Secure Site. The OHCA online electronic provider enrollment (EPE) is a web based contracting process.

In order to enroll, all providers will need to obtain the federally required National Provider Identifier (NPI). The NPI will be the number which will appear in the "rendering" provider field. You can apply for an NPI at this website:

https://nppes.cms.hhs.gov/NPPES/Welcome.do

If you have any questions about contracting, please call Provider Enrollment (800) 522-0114 option 5. Any provider enrollment representative should be able to assist you.