PRIOR AUTHORIZATION MANUAL

FY 2015

Revised December 17, 2014

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PRIOR AUTHORIZATION MANUAL REVISIONS

July 1, 2014

- Under the General Information section of the Manual:
  - Revised information under the Services Requiring No Prior Authorization, for ODMHSAS: added Screening and Referral service
  - Revised information under Collaboration Between Outpatient Behavioral Health Providers:
    - Added language under Terminology, for Pended PA
    - Revised language under Exclusions From LOC/LOTs
    - Added a Note under Registering Staff for E-Mail Notification of LOC/LOT, under E-mail Notifications
- Under the Prior Authorization Process – Behavioral Health Agencies section of the Manual:
  - Revised information under Instant Prior Authorization
  - Under PA Adjustment, Behavioral Health Rehabilitation Services for Children Ages 4 & 5- added clarifying language with regard to the information required in the narrative section of the request
- In the Customer Data Core (CDC) section of the Manual:
  - Under Section I:
    - Revised information under Service Focus, Valid Entries- added a new service focus 32
    - Revised information under Screening- adding information regarding screening for Gambling

August 1, 2014

- Under the Prior Authorization Process – Behavioral Health Agencies section of the Manual:
  - Revised information under PA Adjustment, to include new requirements for Mental Health Psychosocial Rehabilitation
  - Revised information under Secondary Review, to include Mental Health Psychosocial Rehabilitation request for “At Risk” children
- Under the Medical Necessity Criteria section of the Manual:
  - Revised the criteria for Behavioral Health Rehabilitation Services for Children Ages 4 & 5 for OPBH Agencies to include new eligibility requirements for Mental Health Psychosocial Rehabilitation
  - Added new criteria for Behavioral Health Rehabilitation Services for “At Risk” Children for OPBH Agencies
- Added a new section for Frequently Asked Questions (FAQs) regarding changes in prior authorization for Mental Health Psychosocial Rehabilitation

December 17, 2014

- Throughout the Manual, ICF/MR has been changed to ICF/IID (Individuals with Intellectual Disabilities) to be congruent with recent rule changes
- Under the Prior Authorization Process – Behavioral Health Agencies section of the Manual:
  - Added a new information under Outpatient Requests for Prior Authorization, titled Continuation of Outpatient Services (Additional 6-Month PAs)
  - Provided clarification under the PA Adjustments section for Mental Health Psychosocial Rehabilitation:

        - Provided clarification regarding the testing requirements for the psychological evaluation for children At Risk
        - Provided clarification regarding the Submission Requirements for children At Risk
- Under the Prior Authorization Process – Individual Providers section of the Manual:
    - Added a new authorization type under Instant Prior Authorization regarding assessment for adults undergoing a medical operation
- Under the Medical Necessity Criteria (MNC) section of the Manual:
    - Revised the MNC for Children's Partial Hospitalization Program under service definitions and requirements, staffing requirements, and service limitations
    - Revised the MNC for Children's Day Treatment under service definitions and requirements, staffing requirements, and service limitations
    - Revised the MNC for Child Age 0 Through 36 Months
- Under the section for Frequently Asked Questions (FAQs) regarding changes in prior authorization for Mental Health Psychosocial Rehabilitation:
    - Revised/provided clarification regarding information to be provided from the school for At Risk requests.
- Under the CDC section of the Manual:
    - Added some language in the Transaction Types section under First Contact/Testing Only (Type 27)
    - Under Section I:
        - Changed the Inter-Related Fields response for Agency
        - Added a sentence to the Description for Service Focus & added a new service focus for Medical Operation Assessment under Valid Entries
        - Added additional information to the Inter-Related Fields response under Secondary Referral
    - Under Section II & III:
        - Added information under the Comments for Level of Care
    - Under Appendix: Codes and Definitions:
        - Added new referral types for RESTX under Referrals

GENERAL INFORMATION

Authorization for behavioral health services is required for the following benefit plans or ODMHSAS contractors:

- SoonerCare Choice,
- SoonerCare Traditional, and
- Insure Oklahoma – Individual Plan (PCP)
- ODMHSAS contracted providers as specified by ODMHSAS

The following outpatient behavioral health service areas require prior authorization by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS):

Outpatient Behavioral Health Agencies-

- Mental Health & Substance Abuse/Integrated Services
- Children's Day Treatment
- Children's Partial Hospitalization Program
- Automatic Step Down / After Care
- ICF/IID

- Additional Outpatient Services for Members in RBMS/TFC/Therapeutic Group Homes (Levels C&E)
- OJA Multi-Systemic Therapy
- ODMHSAS Specialty Programs

Individual Psychologists and Licensed Behavioral Health Professionals (LBHPs)-

- Psychological Testing
- Individual/Interactive, Family and Group Psychotherapy
- CALOCUS, Brief Intervention & Referral

*Inpatient Treatment will not be authorized by ODMHSAS. Authorization for these services will go through the Oklahoma Health Care Authority http://www.okhca.org

SERVICES REQUIRING NO PRIOR AUTHORIZATION

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

Medication Training & Support	2 units are allowed per month, per member, without prior authorization.
Crisis Intervention	All units allowed w/o PA, following OAC 317:30-5-241.4
Psychiatric Diagnostic Interview Exam/Assessment	1 Diagnostic Interview/Assessment per year per provider is allowed, unless there has been a break in services for six months.
Tobacco Cessation Counseling-Physician	Physician's service using the "5As" approach to tobacco cessation
Telemedicine Originating Site	Used when providing telemedicine services

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

Generic ID Services	Ex: consultation, training, outreach
Non-ID Crisis Services	Crisis when the customer can't be identified
Crisis Intervention Services	Outpatient Crisis Intervention
Disaster Services	Invoked for specific disasters
Competency Evaluation	Clinical evaluation to determine an individual's ability to defend themselves against criminal charges
Evaluation and Management Services	ex: pharmacologic management
Telemedicine Originating Site	Used when providing telemedicine services
Customer Follow-Up Services	Follow-up services that do not fall within the allowable functions under Case Management
Clinical Evaluation and Assessment for Children in Specialty Settings	Evaluation and Assessment services provided through Child Care Consulting

	contracts or Systems of Care
Tobacco Cessation Counseling-Physician	Physician's service using the "5As" approach to tobacco cessation
Medication Training and Support	Review/educational session conducted by a licensed registered nurse or PA focusing on consumer's response to medication
Screening and Referral	Evaluation of presenting problem(s) establishing the need for referral for clinical evaluation and assessment, and/or referral to relevant service resources.

GENERAL REQUEST INFORMATION

Providers can submit prior authorization (PA) requests and other information in one of the following ways:

- PICIS – available through http://ok.gov/odmhsas [click on the CDC Data Entry System (PICIS) link on the homepage] or at https://ww4.odmhsas.org/cdc.
- EDI (electronic data interface) – Some local software vendors have developed systems to allow agencies to use their own management information system and "upload" the required elements to PICIS.
- WebServices – Local software vendors can submit data from their system to ODMHSAS in real time. This allows providers to work denials and errors instantly instead of waiting on a file to process.

Things to note when completing and submitting PA requests:

- All electronically submitted PA requests will be completed within a five-business day timeframe.
- Most SoonerCare and ODMHSAS outpatient prior authorizations are issued for 1-6 months, depending on request type or level of care.
- Prior authorizations issued to privately contracted providers for treatment purposes are 6 months for SoonerCare members, and 12 months for Insure Oklahoma members. Testing authorizations for this group of providers span 12 months.
- ODMHSAS will assign a client and provider specific PA number to each approved PA request. This client and provider specific PA number will be submitted to the MMIS on a batch basis each week 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 ODMHSAS.
- **For any PA issues/questions**, providers may call the ODMHSAS PICIS Helpdesk at (405) 521-6444. This would include things like assistance with completing a request for authorization, PA adjustment or other questions regarding the PA process.
- **For any billing issues/questions**, providers should contact the OHCA Provider Helpline at (800) 522-0114.

ODMHSAS PICIS HELP DESK

ODMHSAS PICIS Help Desk hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except state holidays. The PICIS Help Desk can be contacted by phone at (405) 521-6444, toll free at (855) 521-6444, or by e-mail at gethelp@odmhsas.org.

Please do not send PA requests, or any other HIPAA Protected Health Information, by e-mail.

INFORMATIONAL WEB SITE FOR PROVIDERS

Forms and Manuals are located at www.odmhsas.org/arc.htm.

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 http://www.odmhsas.org/updates.asp.

EDUCATIONAL OPPORTUNITIES

ODMHSAS offers individualized training for the CDC/PA via webinars. If you would like to schedule a training, please contact the PICIS help desk.

SOONERCARE ELIGIBILITY

PICIS verifies client eligibility for SoonerCare against the Medicaid Management Information System (MMIS) eligibility file. Providers may check the OHCA Recipient Eligibility Verification System (REVS) at (800) 522-0310. For instructions on using REVS, call (800) 767-3949. Providers can also check eligibility through Medicaid on the Web/SoonerCare Secure Site with their 8-digit pin number, or call the OHCA Provider Helpline at (800) 522-0114 for assistance.

PROVIDER ELIGIBILITY

Each site must be clearly affiliated with and under the direct supervision and control of the contracting facility/individual provider. Each site operated by an outpatient behavioral health facility or individual provider 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/INDIVIDUAL PROVIDERS

Facilities/individual providers need to contact the PICIS Help Desk when a new provider number has been acquired. It is the provider's responsibility to notify ODMHSAS immediately, by phone or email. Once the provider number has been verified and entered into the PICIS database, PA numbers can be issued to the facility.

MEMBER NAME AND/OR SOONERCARE ID NUMBER CHANGES

Whenever OHCA links member IDs, those updates are sent to ODMHSAS in a nightly file. Once a week ODMHSAS will update the information in their system with this information. This process will

take any CDCs that are under deactivated IDs and move them to the active IDs. There is a report in PICIS that allows providers to see what customers have been linked and what the outcome was. This report is available under “Data Management” and is called “Customer Linking History Report.” Prior Authorizations for deactivated IDs will be recreated under the new ID. Whenever two IDs have been linked in the ODMHSAS system, an e-mail will be generated and sent to the e-mail address for the PICIS contact.

COLLABORATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS

Purpose

The purpose of collaboration between providers is to coordinate clinical care to prevent duplication of services, and to provide services that are complimentary and result in good treatment outcomes for the member. Note that “An eligible SoonerCare member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.” [OAC 317:30-5-596] It is a contractual requirement that providers will collaborate on behalf of the member’s best interests and choice of facility and/or provider. It is expected that these same requirements will be followed for ODMHSAS service recipients as well.

Letters of Collaboration (LOC) and Terminations (LOT) are required when one provider agency has a Level 1/2/3/4 authorization and another provider requests a Level 1/2/3/4 authorization. Either the two provider agencies must collaborate or one of the providers must terminate its relationship with the client. The process for both are described under individual sections below.

LOC/LOTs will not be required on open authorizations submitted prior to 2/6/2014. However, at the next request for authorization (CDC 42), a LOC/LOT will be required.

Terminology

Letter of Collaboration (LOC): This will allow providers to share the authorization cap for each member. Each provider will deliver specific, agreed upon services. These services will be decided based on the wishes of the member, and on communication between the responsible LBHPs at each provider agency to determine a service array that is complimentary and targeted to meet optimal treatment outcomes.

Letter of Termination (LOT): This document will end the member’s open Outpatient Level 1/2/3/4 authorization at other providers. The decision to terminate services will be based on the member’s wishes, after the member has been informed of the option to receive collaborative services between agencies, and informed how the termination of services will impact their treatment.

Courtesy Termination: When a provider has an open Level 1/2/3/4 authorization for a member and chooses to end the open authorization for the member at their agency (for example, the member has not been coming in for treatment for some time). This is done so that another provider does not need to do a LOC/LOT. A discharge CDC would have the same effect.

Pending PA: When a provider requests an Outpatient Level 1/2/3/4 authorization, but another provider already has an open Outpatient Level 1/2/3/4 on the same member, the second provider’s

request for a PA will be pended. This requires an LOC\LOT before authorization is approved and submitted to OHCA. Once an LOC/LOT is completed, the start of the authorization will be based on request date, not the date the LOC/LOT is completed. If a provider fails to complete a LOC/LOT within 30 days, their pended PA will be removed and they will have to start over.

Contest Termination: When a provider has had their open authorization terminated for one of their members and the member and the terminated provider would like ODMHSAS to work with the other provider and member to see if that was the appropriate action.

Who must Participate in Letters of Collaboration (LOC) and Letters of Termination (LOT)

All Medicaid and ODMHSAS outpatient behavioral health provider agencies who request Outpatient Level 1/2/3/4 authorizations for the following authorization groups:

Adult and Children 6+: PG042/PG043/PG044/PG045

Children Under 6: PG046/PG047/PG048/PG049

TANF/Child Welfare: PG034/PG035/PG036/PG037

Systems of Care: PG015

Exclusions from LOC/LOTs

All other Agency Prior Authorization types not listed under the "Who must Participate in Letters of Collaboration (LOC) and Letters of Termination (LOT)" section above, are excluded.

Individually contracted LBHPs/Psychologists do NOT participate in LOT/LOCs. When an individually contracted LBHP/Psychologist and an outpatient agency are providing services, the authorization does not need to be divided and an LOC is not required. However, documentation of the coordination of clinical care between the individually contracted provider and the outpatient agency needs to be noted in the member record.

Letters of Collaboration

Providers should note that a Letter of Collaboration is an administrative function to document the actual coordination of clinical care that should take place in a conversation between the designated LBHPs responsible for the member's care at each agency involved, in accordance with the member's wishes. LBHPs must do the collaboration for each agency.

A Letter of Collaboration may only exist between two agencies. If a member requests services at a third agency, an exception must be requested. This process can be initiated by calling the PICIS Helpdesk at 405-521-6444.

The LOC form does not have to be sent to ODMHSAS, just the split of the cap and who does which services. However, providers should have the member sign the LOC form and insert the information into the member record.

Please Note: Although the rules for LOC/LOT apply for all agencies, the following instructions are for providers that use PICIS to directly enter CDC/PA data. **If you have a vendor system, you may need to refer to their training documentation.**

Once the two LBHPs have communicated with each other regarding member clinical care and have come to agreement on the collaboration in conjunction with the member, click on the LOC/LOT link in the PICIS Home Page. Choose the 'Collaboration' tab.

Step One: Enter the individual to be contacted in case of questions and who should receive the response from the other provider.

Step Two: Review the information about the current authorization to ensure you are working on the correct authorization.

Step Three: Enter the amount of the monthly authorization cap each provider will have and the NPI of the responsible LHBP at your provider agency. Check the boxes of the services each provider will render. If you are the first to enter the proposal, click on 'Propose.' If you are responding to the other provider's proposal and find it acceptable, click on 'Accept.' If you are reviewing the other provider's proposal and make a change to the dollar amount and/or services to be provided, you will have to click on 'Propose,' so that the other provider can review your new proposal.

Modifying the Authorization Amount between Participating Providers

Providers are not required to agree upon the same Level. Together, the two providers cannot exceed the dollars of the highest level cap and each provider cannot exceed their level cap. If you have an active authorization and the amount goes down, then all months after the current one will be modified. If you have an active authorization and the amount goes up, then all months including the current one, are modified.

Ongoing Collaboration

If neither provider requests a change to the collaboration, the cap amount will continue at the same division until one of the providers request a change.

Prior to submitting a request to change the collaboration, it is expected that the LBHPs form both agencies will discuss possible changes with the member and communicate with each other regarding optimal client care. When a mutually acceptable arrangement has been reached, one of the providers must submit a new collaboration request to PICIS. The new proposal must be accepted by the other provider.

<u>Letters of Termination</u>

The LBHP is expected to meet with customer/guardian face-to-face to explain the LOT to a degree they can make an informed choice. Both the PBHP and the customer/guardian must sign the LOT.

Please Note: Although the rules for LOC/LOT apply for all agencies, the following instructions are for providers that use PICIS to directly enter CDC/PA data. **If you have a vendor system, you may need to refer to their training documentation.**

The LOT will not be available in PICIS until after a PG038 is requested. Each LOT has a unique identifier which is specific to the member. Each LOT will need to be printed individually. An LOT cannot be submitted until Outpatient Level 1/2/3/4 request is made. Once an LOT is received by ODMHSAS, most should be processed within 5 working days. The start of the authorization will be based on request date, not the date the other provider's authorization is terminated.

To access the LOT form, click on the LOC/LOT link in the PICIS Home Page and choose the 'Reports/LOT' tab. As a courtesy to other provider, the LBHP should ask the customer/guardian to check the boxes on the form regarding the reason for ending services.

Options for Submitting an LOT

You may submit an LOT via fax to the number listed on the LOT or via a vendor system. Paper and email submissions will NOT be accepted. Multiple LOTs can be submitted in single fax transmission.

If your authorization is terminated, you will receive a notification. Your authorization will be ended on the date the LOT is processed ODMHSAS, not on the date the LOT was signed by the member. You will receive a notification within 24 hours of processing, but in most cases, it will be fewer hours.

Contesting Terminations

When a provider has had their open authorization terminated for one of their members and the member and the terminated provider feel the appropriate action should have been a collaboration, the provider may contest the termination.

Please Note: Although the rules for LOC/LOT apply for all agencies, the following instructions are for providers that use PICIS to directly enter CDC/PA data. **If you have a vendor system, you may need to refer to their training documentation.**

To contest a termination, click on the LOC/LOT link in the PICIS Home Page and choose the 'Reports/LOT' tab. Open the 'Contest Termination' report, locate the terminated the authorization, click the green check next to the desired member and follow the instruction on the screen. You will be instructed to send a justification for the contest to the PICIS Helpdesk (gethelp@odmhsas.org) within 30 days of receiving the termination notification and a review will be initiated. Do not contact the PICIS helpdesk before submitting the contest form first. If PICIS Helpdesk staff identify the explanation as reasonable, the helpdesk will contact the ODMHSAS staff member responsible for arbitration to begin the mediation process.

Courtesy Termination

If you receive a notification that another provider has submitted a request for a PG038 or an Outpatient Level 1/2/3/4 on a client for which you have an open Outpatient Level 1/2/3/4 authorization and your services are no longer needed by the client, you may do a Courtesy Termination.

Please Note: Although the rules for LOC/LOT apply for all agencies, the following instructions are for providers that use PICIS to directly enter CDC/PA data. **If you have a vendor system, you may need to refer to their training documentation.**

In the PICIS Home Page, click on the LOC/LOT link and choose the 'Reports/LOT' tab. Locate the report showing a list of members for which another provider has submitted an authorization request. Click on the red 'X' next to the member's name and follow the instructions on the screen. The member's authorization will end with today's date. The other provider will be notified a collaboration or termination will be not required for that member. You are still required to submit a discharge CDC, one will not be submitted by ODMHSAS.

Note: If you submit a discharge transaction, this will terminate an open authorization too.

Registering Staff for E-mail Notification of LOC/LOT

In order to execute a LOC/LOT, staff must be registered for email notification. In the PICIS Home Page, click on the LOC/LOT link. Choose the 'Email Notification' tab to open the enrollment page. Complete each field and choose either Default, Primary or Secondary status.

- Default Contact will be used when ODMHSAS is unable to contact the Primary or Secondary Contact. This may be the PICIS Contact. Providers may change this at any point, but there must always be one Default Contact. Providers may choose to have multiple Default Contacts.
- Primary Contact is the individual who will receive email notifications for all of the locations they are associated with. Providers may choose to have multiple Primary Contacts. Each will receive the email notifications. Primary Contact is assigned by location. Providers may choose for the Primary Contact to be assigned to multiple locations. Primary and Default Contact can the same. If no Primary Contact is assigned to a location, the Default Contact will receive the email notifications.
- Secondary Contact is the individual who will receive email notification for all of the locations they are associated with and will be expected to act upon the notifications if the primary contact is unavailable. The Primary and Secondary Contact cannot be the same, however, Secondary and Default Contact maybe the same, unless the Primary and Default Contact are already the same. If no Secondary Contact is assigned to a location, the Default Contact will act as Secondary Contact.

Click on the Add button to add new contacts. If a staff member is no longer employed at the location or responsibilities have changed, please add new staff and delete the old staff. These individuals do not necessarily need PICIS access, but they may find it helpful to access reports available in PICIS.

Email Notifications

Email notifications will be sent on a daily basis:

- If you have an open Outpatient Level 1/2/3/4 authorization and another provider requests a PG038 or an Outpatient Level 1/2/3/4.
- If you submit a PG038 or an Outpatient Level 1/2/3/4 request and an Outpatient Level 1/2/3/4 authorization is open at another provider.

- If you have an open Outpatient Level 1/2/3/4 authorization and a Letter of Termination is accepted to close your authorization.
- If you have an open collaboration and the other provider terminates their authorization.
- Once a faxed termination has been reviewed, you will be notified that your pended authorization has been approved.
- If another provider contests the termination of the member's Outpatient Level 1/2/3/4 authorization, you will be notified of the dispute.

Email notifications will be sent as they occur:

- If another provider proposes or accepts a collaboration.
- If collaboration is changed by either provider and the other provider needs to review.
- If another provider terminates a proposed or open collaboration.
- If provider B deletes their pended PA.
- If you request a PG038 or an Outpatient Level 1/2/3/4 and another provider has an open outpatient Level 1/2/3/4 authorization and the other provide chooses to do a Courtesy Termination.

Other notification may be added as necessary.

Note: These notifications are also sent to your vendor system. If at any point you would like to stop receiving the e-mail notifications as an agency, and just receive them through your vendor system, please contact the PICIS Helpdesk and let them know.

Need Help?

- PICIS Helpdesk: 405-521-6444
- Webinar Training Document: http://www.odmhsas.org/LOCLOT_training.pdf

APPEALS PROCESS

SoonerCare : If the SoonerCare 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) 522-7082. The SoonerCare member will be further instructed on filing appeals through the Oklahoma Health Care Authority and the appropriate forms necessary for completion.

ODMHSAS: If the client (or parent/guardian of a minor) wishes to appeal a decision, they may contact Jacki Millspaugh, Clinical Support Manager, at (405) 522-3863.

PRIOR AUTHORIZATION PROCESS – BEHAVIORAL HEALTH AGENCIES

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

- Instant Prior Authorization
- Outpatient Request for Prior Authorization

INSTANT PRIOR AUTHORIZATION

For an Instant Prior Authorization, services are authorized automatically with the submission of a Customer Data Core (CDC).

The Instant PA process applies to the following:

- Both SoonerCare and ODMHSAS clients:
  - Preadmission Services – Transaction Type 21 (excluding service focus 32)
  - Urgent Recovery Center – Transaction Type 27, service focus 32
- The following services for ODMHSAS clients:
  - Detox- level of care SN
  - Halfway house- level of care CL
  - Residential Treatment (Substance Abuse and Mental Health)- level of care CI
  - Community Based Structured Crisis Care (CBSCC)- level of care SC
  - Mental Health Housing and Residential Care Services- service focus 11, level of care CL
  - Mental Health Inpatient- level of care HA
  - Community Support Services- service focus 11, level of care OO
  - Day School- service focus 23
  - Prison-related Services- service focus 09
  - TANF Reassessment- primary referral 49
  - Mobile Crisis – service focus 26

Pre-Admission Services

Providers are encouraged to utilize the Pre-admission Services prior to submitting an Outpatient Request for Prior Authorization. Information about Pre-admission Services is as follows:

- Once the CDC Transaction Type 21 has been submitted in PICIS 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 PICIS after the date of the first appointment (transaction) with the client.
- The length of the authorization for PG038 is 90 days. The end date of PG038 can be extended on-line in PICIS if needed, unless an admission has occurred.
- PG038 *includes* the initial assessment code (H0031) and Service Plan Development code (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.

- Once a prior authorization request for outpatient treatment has been approved in PICIS, the PG038 will be end dated. The PG038 will end date the day prior to the start of the initial prior authorization request.
- The PG038 is limited to one per client, 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.
- If a client has discharged and needs to be readmitted, but the criteria to request a new PG038 has not been met, the agency should do a Behavioral Health Service Plan Development Low Complexity service (which includes completion of the CAR or ASI and development of a service plan) and coordinate the dates of completion with the start date for the request for a new 6-month outpatient PA. The Behavioral Health Service Plan Development Low Complexity will be billed under the new outpatient authorization.

ODMHSAS Instant Prior Authorization Criteria

Prison-related Services (DH502):
1. For prison-related contracts 2. Service focus = 09 3. Age ≥ 16
Community Support Services (DH503):
1. For ICCD Clubhouse, Consumer to Consumer and Day Center programs 2. Service focus = 11
ODMHSAS State Operated Facilities Only (DH504):
1. For customers whose funding source is not ODMHSAS or SoonerCare 2. Used for reporting purposes only 3. State-operated facilities 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
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
TANF Reassessment (DH519)
1. For TANF customers who have already used PG038 and have not been admitted for outpatient services, but are required by TANF to be reassessed 2. Primary Referral = 49

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

For an Outpatient Request for Prior Authorization, services are authorized with the submission of a CDC with additional PA related data elements (including diagnostic information), which both must meet medical necessity criteria. A few things to note about the Outpatient Request for Prior Authorization are as follows:

- The start date of the requests can be no more than fifteen (15) calendar days in the future.
- ODMHSAS will not retroactively authorize or back date any Outpatient Behavioral Health Services, unless so specified (Ex: the Pre-Admission Services PA and the Admit to Outpatient/Step-Down PA). Services may be back dated up to five calendar days.
- The responsible Licensed Behavioral Health Professional (LBHP) must ensure the accuracy and the appropriateness of the PA request.
- If during a PA period, a client's symptoms increase to the degree that another level of care is required, a new Outpatient Request for Prior Authorization should be submitted (CDC 42). The old PA will be end-dated, and a new PA (based on the new request) will be authorized.

Extra Unit BH Service Plan Development Low Complexity

This procedure code group (PG033) is available when a customer does not keep their scheduled appointment to update their Service Plan, and when they return for service the authorization has expired (and the time requirements to complete another behavioral health service plan development, moderate complexity are not met). Under this authorization a provider may provide some additional outpatient services along with the BH Service Plan Development Low Complexity, if needed (not to exceed the dollar cap for this PG group).

Providers will be required to complete an entire CDC 42, with additional PA related data elements. Diagnostic information is optional for this PA request. Data from the previous request may be utilized to populate this request.

Gambling

- For a request for gambling services only (service focus 19) or a request of Mental Health (MH) and gambling (service focus 20), the client must meet medical necessity criteria requirements for Mental Health.
- For a request for Substance Abuse (SA) and gambling (service focus 21), the client must meet medical necessity criteria requirements for Substance Abuse/Integrated.

OJA Multi-Systemic Therapy

- A request for OJA Multi-Systemic Therapy will only be authorized for designated OJA agencies. Requests for this service will be for PG016. The client must be age 20 or younger, and in OJA custody (reflected on the CDC).

RBMS/TFC/Therapeutic Group Homes (Levels C&E)

- This request is for additional outpatient behavioral health services for members in RBMS/TFC/Therapeutic Group Homes (Levels C&E). For this type of request, a PA request for standard outpatient services should be made. There is no unique PG group for this level of care, however, any agency providing services under this level of care must meet the Medical Necessity Criteria requirements for RBMS/TFC/Therapeutic Group Homes (Levels C&E) located in the Medical Necessity Criteria section of this Manual.

Continuation of Outpatient Services (Additional 6-Month PAs)

When nearing the end of the current 6 month Service Plan/PA period, the following should be followed for continuation of service for another 6 month period:

Process

A new/updated Assessment (CAR/ASI/TASI) should be completed, and a new/updated Service Plan should be developed based on the information collected during the Assessment. The completion of both of these items is considered a function under the billable service- Behavioral Health Service Plan Development, Low Complexity. The new/updated Service Plan can be completed up to 30 days prior to the end of the current Service Plan period (this is to allow time to help get the client in to complete the Service Plan, and to get the PA entered prior to expiration of existing Service Plan/PA period). The completion date of the Service Plan, and the start date of the Service Plan can be two different dates. Please note that a service plan is not complete until it has the signatures of the responsible LBHP and the client/guardian.

Example:

> *The last day of the current Service Plan is November 30, 2013. The new/updated Service Plan is completed with the client on November 2, 2013, and the plan is given a start date of December 1, 2013 to begin directly following the expiration of the current plan. A PA request is submitted on November 17, 2013 with a requested start date of December 1, 2013; coordinating the start date of the Service Plan with the start date of the PA (the start date of PA requests can be dated up to 15 calendar days in the future).*

Billing

The Service Plan should have a billing date of the day it is completed (not the start date). Based on the process above, Service Plans will be completed prior to the start date of the new/extension PA, and should be billed under the 6th month of the current outpatient authorization (out of the monthly cap).

Expired Plan/PA

When every effort has been made to try to schedule and complete the new/updated Service Plan/PA, and due to reasons outside of the agency's control it is not completed before the current Plan/PA expires, there are two options:

1) When contact is made and the client returns to the agency (as long as they have not been discharged), a PG033 can be requested. The PG033 allows for a set $ cap to be used to both complete the Behavioral Health Service Plan Development, Low Complexity, and to provide some services prior to its development (ex: the client has an immediate Case Management (CM) need prior to when the Service Plan can be developed). It is important to note that Administrative Rules require that services provided relate back to problems/goals/objectives on the client's active Service Plan: PG033 and PG038 are the only exceptions where outpatient (non-crisis) services can be billed without an active Service Plan in place.

   Example:
   A Service Plan development appointment is scheduled with the client 30 days prior to expiration of the current plan, but the client no shows. The provider cannot reach or find the client to reschedule and the plan/PA expires. The client comes in to the agency a couple of weeks later, and needs CM assistance with a housing eviction. A PG033 authorization is requested and received, the CM assistance/service is provided, and an appointment is scheduled for Service Plan development.

2) When contact is made and the client returns to the agency, the Behavioral Health Service Plan Development, Low Complexity is completed and the a new/extension PA request is completed and coordinated to start the same date. The Service Plan Development can be billed under the 1st month of the new outpatient authorization (out of the monthly cap). Note: This is also the process to follow for when someone has been discharged from the agency, returns for services, and the requirements for doing a new comprehensive assessment have not been met.

   Example:

   Expiration of the current PA and Service Plan is November 30, 2013. A Service Plan update is completed with the client (and signed/dated by client and responsible LBHP) on November 27th with a start date of November 27th. A PA request is submitted on December 1st with a start date backdated to November 27th (as PA requests can be backdated up to 5 calendar days).

PA ADJUSTMENT

Once a PA for outpatient services has been obtained, depending on the circumstance, a PA Adjustment may occur automatically or it may be requested. If a PA Adjustment requires that a request be submitted, providers will be able to request the PA Adjustment through PICIS (this is not available through EDI or WebServices). Questions regarding PA Adjustments should be directed to the PICIS help desk.

There are three (3) categories of PA Adjustment: Correction, Exceptional Case, & Mental Health Psychosocial Rehabilitation. Both Correction and Exceptional Case PA Adjustments require that a request be submitted by the provider. Mental Health Psychosocial Rehabilitation PA Adjustments are

based on eligibility type and may involve an automatic system adjustment, or a provider submitted request. The guidelines for each PA Adjustment category are as follows:

Correction

A request for PA Adjustment may 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, and some instant authorization edits) regardless of who made the error.

Exceptional Case

A request for PA Adjustment may be submitted when a client's condition is severe enough to require an intensity of outpatient services higher than Level Four Medical Necessity Criteria, and all Medical Necessity Criteria for Exceptional Case (located in the Medical Necessity Criteria section of this Manual) are met.

When submitting a PA Adjustment request for Exceptional Case, the following information is required:

Submission Requirements-

A narrative justification summary is required in the text field on the electronic request in PICIS. The narrative summary response should address the following elements:

- Documented support for the need for a 30-day period of increased services beyond what is supported by a Level 4 authorization; and
- Any other documentation needed to clarify that the client meets requirements for the Medical Necessity Criteria for Exceptional Case.

The following documents are required to be uploaded and attached to the electronic PA Adjustment Request:

- Clinical Assessment including:
    - Bio-psychosocial assessment, including a narrative of any updates if the assessment was not completed in the last 30 days (the updated information provided in the descriptors for the current CAR or ASI assessment may provide sufficient update);
    - Current CAR or ASI, including descriptors or narrative that supports the scores (The CAR/ASI must be no more than 30 days old);
- Current Service Plan (must be no more than 30 days old).

Failure to provide all of the information requested will result in an automatic denial and a new, complete request will need to be submitted.

Mental Health Psychosocial Rehabilitation

ODMHSAS will maintain lists of individuals who have been predetermined to meet criteria for rehabilitation services. Providers will be able to access this information for their clients through PICIS.

If the client is on the list as meeting criteria, providers will submit their initial PA Request with Rehab and the PA will be approved. If the PA request is not approved, the provider should request a level PA without rehab. After getting that approval, the provider will need to request a PA adjustment to add rehab services. Follow the instructions below for submitting a request for this type of PA adjustment.

Length of Authorization

The length of authorization for most PA Requests will continue to be for 6 months (except for Rehab for Ages 4 & 5, which is for a 3 month period). However, the duration of a PA Adjustment Request will be based on the type of request (see below). Example: For "At Risk", Providers would submit a new PA request every 6 months, but the initial PA Adjustment will extend across a 12 month period.

- History of Psychiatric Hospitalization or Admission to Crisis Centers: On-going/permanent
- Disability Determination for Mental Health Reasons: On-going/permanent
- Resident of Residential Care Facility: As long as they are a resident of that facility
- Receiving Services through Specialty Court Program: As long as they are a participant in a Mental Health Court or Drug Court program
- Current Individual Education Plan (IEP) or 504 Plan for Emotional Disturbance: 12 months
- At Risk: 12 months
- Ages 4 & 5: 3 months

Submitting a Request for PA Adjustment

ADULTS (Ages 21 and over)

For Adults ages 21 and over, one or more of the following criteria shall be met:

- History of Psychiatric Hospitalization or Admissions to Crisis Centers –
  An adult has been admitted to an inpatient psychiatric facility or crisis center (collectively referred to as "facility") in their lifetime.

  Provider must upload and attach to the electronic PA Adjustment Request one of the following:
  (1) Discharge summary from the facility; or
  (2) Admission note from facility.

- Disability Determination for Mental Health Reasons -
  An adult has been determined disabled by the Social Security Administration because of a mental health disorder. This includes individuals who qualify for SSDI or SSI due to a mental health disability.

  Provider must upload and attach to the electronic PA adjustment Request, the member's Benefit Verification Letter from SSA. Benefit Verification Letters can be obtained online instantly through my Social Security account which can be accessed through www.socialsecurity.gov/myaccount. For members unable to go online, they can call SSA's toll-free number, 1-800-772-1213 (TTY 1-800-325-0778).

- Resident of Residential Care Facility –
  An adult currently residing in a residential care facility designed to support individuals with mental health disorders.

Provider must upload and attach to the electronic PA Adjustment Request a letter from the residential care administrator stating that the member is a current resident and that their facility is designed to support individuals with mental health disorders.

- Receiving Services through Specialty Court Program -
  An adult currently receiving services through a Mental Health Court Program or Drug Court Program.

  If ODMHSAS is unable to identify that the individual is participating in one of these programs, the request will be denied.

CHILDREN (Ages 6 through 20)

For Children ages 6 through 20, one or more of the following criteria shall be met:

- History of Psychiatric Hospitalization or Admissions to Crisis Centers -
  A child who has been admitted to an inpatient psychiatric facility or crisis center (collectively referred to as "facility") in their lifetime.

  Provider must upload and attach to the electronic PA Adjustment Request one of the following:
  (1) Discharge summary from the facility; or
  (2) Admission note from facility.

- Disability Determination for Mental Health Reasons –
  A child who has been determined disabled by the Social Security Administration because of a mental health disorder. This includes individuals who qualify for SSDI or SSI due to a mental health disability

  Provider must upload and attach to the electronic PA adjustment Request, the member's Benefit Verification Letter from SSA. Benefit Verification Letters can be obtained online instantly through my Social Security account which can be accessed through www.socialsecurity.gov/myaccount. For members unable to go online, they can call SSA's toll-free number, 1-800-772-1213 (TTY 1-800-325-0778).

- Current Individual Education Plan (IEP) or 504 Plan for Emotional Disturbance -
  A child who has a current Individual Education Plan (IEP) or 504 Plan for Emotional Disturbance through the school system.

  Provider must upload and attach to the electronic PA Adjustment Request an attestation from a school official on school letter head indicating that the member has a current IEP or 504 Plan for Emotional Disturbance (if the adjustment request is made during a time that school is not in regular session, an IEP or 504 is considered current if it was in effect on the last day that school was in session). A sample IEP/504 Attestation can be located at www.odmhsas.org/arc.htm. Do NOT submit the actual IEP or 504 Plan.

- At Risk -
  A child who meets one of the following criteria, and who is determined by ODMHSAS to meet all Medical Necessity Criteria for this level of service (located in the Medical Necessity Criteria

section of this Manual) upon review of all required documentation submitted with the PA Adjustment Request:

(1) Referred by a school to a school psychologist, fully licensed psychologist or psychiatrist, for a full psychological evaluation based on the child's inability to function in the classroom because of mental illness and/or severe behavioral problems; OR
(2) Transitioning out of a Therapeutic Foster Care (TFC) home or OKDHS Level E Group Home, and has been referred to a school psychologist, fully licensed psychologist or psychiatrist, for a full psychological evaluation.

The Psychological Evaluation- At a minimum must include:

• A review of all available records, including academic records, and records of periods of observation or treatment (e.g., psychiatrist, psychologist, social worker, counselor, or neuropsychologist treatment notes). Records must be in sufficient detail to permit a clear evaluation of the nature and extent of any previous mental disorders.

• A thorough clinical interview to include a detailed history regarding: psychosocial or developmental problems; academic performance; legal issues; substance use/abuse (including treatment and quality of recovery); medical conditions, and all medication use; and behavioral observations during the interview.

• A mental status examination.

• Interpretation or review of interpretation of a full battery of psychological tests including but not limited to the following testing domains:
  - Intellectual/Neurocognitive; and
  - Personality (as appropriate for age and/or developmental stage of the child)

If testing has been performed within the previous 24 months, the provider must use a review of the interpretation from the previous tests.

• An integrated summary of findings with an explicit diagnostic statement, and the psychologist’s/psychiatrist's opinion(s) and recommendation(s) for treatment (including medication, therapy, rehabilitation) or monitoring should be explicitly stated. The integrated summary should also include the source for findings, including the battery of tests conducted.

When submitting a PA Adjustment request for rehabilitation services for "At Risk" Children, the following information is required.

Submission Requirements-

PA adjustment requests for "at risk" children can be submitted at any time during the authorization period. If the PA Adjustment is approved, the start date of the adjustment will be aligned with the start date authorized for the PA Request, and the PA request will be end-dated to the 6 month authorization period. If the PA Adjustment is denied, the PA Request will continue with the 6 month authorization period (without rehab services).

A narrative justification summary is required in the text field on the electronic request in PICIS. The narrative summary response should address the following elements:

• Documented support for the need for rehabilitation services in the treatment of the designated child (why it is needed in addition to psychotherapy);
• Information regarding the educational curriculum to be used to address the rehabilitation Service Plan objectives– the title of the curriculum and name of the author, or a web address where the curriculum can be viewed to determine if developmentally appropriate. If the web address is to a site with a variety of curriculum, the names of the specific curriculum to be used to address the rehabilitation Service Plan objectives should be provided. If using an educational curriculum created by the provider, it will need to be uploaded as an attachment to the request for review.

The following documents are required to be uploaded and attached to the electronic PA Adjustment Request:

• Clinical Assessment including:
  - Bio-psychosocial assessment (usually completed at intake by the outpatient agency), including a narrative of any updates if the assessment was not completed in the last 30 days (the updated information provided in the descriptors for the current CAR assessment may provide sufficient update);
  - Current CAR/ASI/TASI, including descriptors or narrative that is used to support the scores (The CAR/ASI/TASI must be no more than 30 days old).
  - The client's complete Service Plan- including the proposed rehabilitation objectives (The Service Plan must be no more than 30 days old).
  - The educational curriculum to be used, if created by the provider.
  - Interpretive Summary from the Psychological Evaluation (inclusive of all the required information stated previously in this section of the manual).

In addition to the above documentation requirements, children determined to be "at risk" through the school referral as described in (1) above will need to submit the following from the school:

• A copy of the child's adjusted school schedule, provided by the school, clearly reflecting the adjustments that have been made due to behavioral problems at school; or
• A signed letter from the principal or vice principal of the child's school expressing intent to adjust the child's schedule due to behavioral problems in the classroom.

PLEASE NOTE- The PA Adjustment Request can accommodate up to three (3) documents when uploading in PICIS. You are permitted to combine several documents together, or all documents as one, to help ensure that all required information is included.

- Ages 4 & 5
  A child age 4 or 5 who is being seen by the provider for psychotherapy services, has a defined need for behavioral health rehabilitation services to complement these more intensive therapies, and who is determined by ODMHSAS to meet all Medical Necessity Criteria for this level of service (located in the Medical Necessity Criteria section of this Manual) upon review of all required documentation submitted with the PA Adjustment Request:

  When submitting a PA Adjustment request for Behavioral Health Rehabilitation Services for Children Ages 4 & 5, the following information is required:

  Submission Requirements-

  A request for PA Adjustment for Rehab for 4 & 5 year olds must be requested no later than 5 days from the start date of the PA Request. If it has been over 5 days since the start date of PA

Request, a new PA Request will need to be submitted prior to submitting for PA Adjustment. If the PA Adjustment is approved, the start date of the adjustment will be aligned with the start date authorized for the PA Request, and the PA request will be end-dated to the 3 month authorization period allowed for Rehab for 4 & 5 year olds. If the PA Adjustment is denied, the PA Request will continue with the 6 month authorization period (without rehab services).

A narrative justification summary is required in the text field on the electronic request in PICIS. The narrative summary response should address the following elements:

• Documented support for the need for rehabilitation services in the treatment of the designated child (why it is needed in addition to psychotherapy);
• Documented support that the child has the ability to benefit from curriculum based education, including a description of the child's development as it relates to developmental expectations for age and stage particularly in the areas of cognition and language (if the request is for an additional 3 month period, beyond the initial 3 month authorization, documentation will also need to support specific ways in which the client is demonstrating progress in treatment with the addition of the rehabilitation service);
• Information regarding the educational curriculum to be used- the title of the curriculum and name of the author, or a web address where the curriculum can be viewed to determine if developmentally appropriate. If using an educational curriculum created by the provider, it will need to be uploaded as an attachment to the request for review.

The following documents are required to be uploaded and attached to the electronic PA Adjustment Request:

• Clinical Assessment including:
  - Bio-psychosocial assessment, including a narrative of any updates if the assessment was not completed in the last 30 days (the updated information provided in the descriptors for the current CAR assessment may provide sufficient update);
  - Current CAR, including descriptors or narrative that supports the scores (The CAR must be no more than 30 days old); and
  - Developmental assessment, including a narrative or any updates since the assessment was completed (a new developmental assessment must be conducted a minimum of annually). In lieu of attaching the developmental assessment, the name of the developmental assessment tool used, the date it was conducted, and the results (along with any updates since the assessment was completed) may be included in the text field of the PA Adjustment Request.

• The client's complete Service Plan- including the proposed rehabilitation objectives (The Service Plan must be no more than 30 days old).
• The educational curriculum to be used, if created by the provider.
• Documents necessary to support that the child meets one of the following criteria: History of Psychiatric Hospitalization or Admissions to Crisis Centers, Disability Determination for Mental Health Reasons, Current Individual Education Plan (IEP) or 504 Plan for Emotional Disturbance, or At Risk (criteria is explained in detail earlier in the PA Adjustment Request for Children ages 6 through 20).

Failure to provide all of the required PA Adjustment Request information will result in an automatic denial and a new, complete request will need to be submitted.

Response to Request

Once a decision has been made regarding the PA Adjustment request, an e-mail notification will be sent to the e-mail address listed in the contact information section of the PA Adjustment request.

Secondary Review

If a PA Adjustment request for Exceptional Case, or Mental Health Psychosocial Rehabilitation “At Risk” or Children Ages 4 & 5 is initially denied (for a reason other than insufficient information), the client (or parent/guardian of a minor) may appeal and request referral to a Board Certified Psychiatrist for a secondary review. This request must be submitted within ten (10) business days of receipt of the initial denial decision. Contact Jacki Millspaugh, ODMHSAS Clinical Support Manager, at (405) 522-3863 for instructions on submitting the request for secondary review.

PRIOR AUTHORIZATION PROCESS – INDIVIDUAL PROVIDERS
(Psychologists and Licensed Behavioral Health Professionals)

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

- Instant Prior Authorization
- Outpatient Request for Prior Authorization

INSTANT PRIOR AUTHORIZATION

For an Instant Prior Authorization, services are authorized automatically with the submission of a Customer Data Core (CDC).

The Instant PA process applies to the following:

- Testing for privately contracted individuals when there is no existing PA for treatment, CDC 27
- CALOCUS when there is no existing PA for treatment, CDC 27, Service Focus 31
- Assessment for adults undergoing a medical operation, CDC 27, Service Focus 33

When a Provider has an existing PA for treatment, and it is determined that either testing or CALOCUS are needed, the Provider must complete a CDC 42, and additional PA related data elements (including diagnostic information), which both must meet medical necessity criteria. Data from the previous request may be utilized to populate this request.

When an adult with SoonerCare is referred for a biopsychosocial assessment because they are undergoing a medical operation, a 27 CDC with a Service Focus of 33 will create a PG058 Authorization which will allow the provider to bill the 90791. For children, no CDC is necessary due to the 90971 being a non-PA service for children.

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

For an Outpatient Request for Prior Authorization, services are authorized with the submission of a CDC with additional PA related data elements (including diagnostic information), which both must meet applicable medical necessity criteria. A few things to note about the Outpatient Request for Prior Authorization are as follows:

- The start date of the requests can be no more than fifteen (15) calendar days in the future.
- ODMHSAS will not back date any Outpatient Behavioral Health Services beyond 30 days.
- The responsible Psychologist or Licensed Behavioral Health Professional (LBHP) must ensure the accuracy and the appropriateness of the PA request.

TYPES OF AUTHORIZATION REQUESTS

Initial Request for Treatment, CDC 23

- An Initial Request for Treatment is submitted when an individual has not received outpatient behavioral health services within the last six (6) months.
- Authorization numbers are not issued until submission of a completed CDC, and additional PA related data elements (including diagnostic information), which both must meet applicable medical necessity criteria.

Extension Request, CDC 42

- The client has been receiving outpatient behavioral health services with the provider within the last six (6) months, and the client meets medical necessity criteria for continued treatment.
- Updated CDC and additional PA related data elements are required.

PA ADJUSTMENT

Once a PA for outpatient services has been obtained, a PA Adjustment may be requested. Providers will be able to request PA Adjustments through PICIS (this is not available through EDI or WebServices). Questions regarding PA Adjustments should be directed to the PICIS help desk.

A PA Adjustment may be requested for the following:

<u>Correction</u>

A request for PA Adjustment may 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, and some instant authorization edits) regardless of who made the error.

Response to Request

Once a decision has been made regarding the PA Adjustment request, an e-mail notification will be sent to the e-mail address listed in the contact information section of the PA Adjustment request.

SOONERCARE LIMITATIONS AND EXCLUSIONS

Nursing Home Residents or Residents of a Skilled Nursing Facility: Payment is not made directly from SoonerCare (Oklahoma Health Care Authority) to outpatient behavioral agencies or individually contracted behavioral health providers for SoonerCare members who are residents of nursing facilities. The behavioral health provider may contract with the nursing facility and seek reimbursement directly from the facility. The OHCA is not a party to these relationships and is not liable for payment. Nursing home services are paid as an all-inclusive rate which includes behavioral health services if determined to be medically necessary by the resident's attending physician. ODMHSAS will not authorize prior authorizations for these individuals. If you receive an error stating the customer is in a nursing facility and you feel it is an error, you can contact the PICIS help desk for instructions on how to fix it.

ICF/IID Residents: ICF/IID residents are eligible for SoonerCare reimbursement of OPBH services. The procedure code group to request in an authorization is PG019. For additional authorization requirements, refer to the medical necessity criteria for ICF/IID. ODMHSAS will only allow the PG019 for individuals identified as ICF/IID. If you feel the ICF/IID identification was done in error you can contact the PICIS help desk for instructions on how to fix it.

Individual Education Plan Students (IEP): 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.

Correctional Facility Inmates: In accordance with 42 CFR 435.1009, correctional institutions do not qualify for BH services. 42 CFR 435.1009 states that FFP is not available in expenditures for services provided to: (1) Individuals who are inmates of public institutions as defined in 435.1010. In part, Inmate of a public institution means a person who is living in a public institution. Per the CMS Guidance: "It is important to note that the exception to inmate status based on 'while other living arrangements appropriate to the individual's needs are being made' does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations.

Treatment of Minors: SoonerCare providers are to follow state statutory regulations regarding the treatment of minors: 43A O.S. § 5-501 and 5-521. If you need further clarification regarding these state statutes, please consult with your legal counsel for guidance.

SoonerCare covers children who receive hospice services: When a child is in hospice he/she can only receive continued BH services and medication training/support if these services were initiated prior to the Hospice admission, or when other BH issues outside of their terminal illness diagnosis and treatment exist.

Medicaid Fraud Exclusion Program: The office of Inspector General, U.S. Department of Health and Human Services (OIG) has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded

Individuals and Entities (LEIE). Exclusions are imposed for a number of reasons. The exclusions fall into two categories: Mandatory or Permissive. To avoid civil monetary penalties (CMP) liability, health care entities need to routinely check the LEIE to ensure that new hires and current employees are not on the excluded list (see http://oig.hhs.gov/exclusions/index.asp).

Group Home and Therapeutic Foster Care Residents: Payment is not made for outpatient behavioral health services for children who are receiving Residential Behavioral Management Services (RBMS) in a Group Home or Therapeutic Foster Care unless authorized by the OHCA or its designated agent. In addition, the member record must include documentation to support that Medical Necessity Criteria for RBMS/TFC/Therapeutic Group Home (Level C&E) has been met. Adults and children in Facility Based Crisis Intervention Services cannot receive additional outpatient behavioral health services while in these facilities.

LEVELS OF CARE AND SPECIALIZED SERVICES

Levels/Services	OHCA & ODMHSAS	OHCA Only	ODMHSAS Only
Pre-admission	X		
Prevention and Recovery Maintenance, I, II, III, & IV	X		
0-36 months levels of care	X		
ICF/IID		X	
LBHP Testing		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
Community Support Services			X
ODMHSAS State Operated Facilities Only			X
Substance Abuse Detox			X
Substance Abuse Halfway House			X
Residential Treatment			X
Day School			X
Community-Based Structured Crisis Care			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 Mental Health Inpatient			X
Med Clinic Only			X
TANF Reassessment			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, the list of services for each group and any service specific caps, and the length of the PA, go to http://www.odmhsas.org/arc.htm and click on "PA Groups Spreadsheet."

MEDICAL NECESSITY CRITERIA

The Medical Necessity Criteria for the identified severity of illness and the corresponding level of care must be followed, and the client's medical/health record should reflect that the criteria have been met for the level of care identified and utilized.

CRITERIA REFERENCE FORM FOR LEVELS OF CARE AND SPECIALIZED SERVICES OUTPATIENT BEHAVIORAL HEALTH AGENCY	
LEVEL OF CARE	**SCORES/RATINGS**
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 2 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 2 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 2 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 1 in 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/IID	Complete all domains

ADULT MENTAL HEALTH CRITERIA FOR OPBH AGENCIES (OHCA- 21 and older; ODMHSAS- 18 and older)
Level One – Adult General Requirements (PG042):
Experiencing ***slight to moderate*** functional impairment.
DSM IV-TR (in ICD 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
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 (PG043):
Experiencing ***moderate*** functional impairment.
DSM IV-TR (in ICD 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
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 (PG044):
Experiencing ***moderate to severe*** functional impairment.
DSM IV-TR (in ICD 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
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 30s being in domains 1,6,7 or 9
Level Four – Adult General Requirements (PG045):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
DSM IV-TR (in ICD 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
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 (PG001):
Experiencing ***slight*** functional impairment.
DSM IV-TR (in ICD 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
CAR Scores must be listed in the client's chart.

CHILD MENTAL HEALTH CRITERIA FOR OPBH AGENCIES (Younger than 21)
Level One – Child MH General Requirements (PG042 and PG046):
Experiencing ***slight to moderate*** functional impairment.
DSM-IV-TR (in ICD 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.)
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 (PG043 and PG047):
Experiencing ***moderate*** functional impairment.
DSM IV-TR (in ICD 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.)
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 (PG044 and PG048):
Experiencing ***moderate to severe*** functional impairment.
DSM IV-TR (in ICD 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.)
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 30s being in domains 1,6,7 or 9
Level Four – Child MH General Requirements (PG045 and PG049):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
DSM IV-TR (in ICD 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.)
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 (PG001):
Experiencing ***slight*** functional impairment
DSM IV-TR (in ICD 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.)
CAR Scores must be listed in the client's chart.

SUBSTANCE ABUSE/INTEGRATED ADULT CRITERIA FOR OPBH AGENCIES (OHCA- 21 and older; ODMHSAS 18 and older)
Level One – Adult SA/Integrated General Requirements (PG042):
Experiencing ***slight to moderate*** functional impairment.
DSM IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR or ASI*): 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) ASI Scores: 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 (PG043):
Experiencing ***moderate*** impairments in functioning.
DSM IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR or ASI*) 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, 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 ASI Scores: 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 (PG044):
Experiencing ***moderate to severe*** functional impairment.
DSM IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR or ASI*): 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 OR ASI Scores: 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 (PG045):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for 24-hour inpatient type care without intensive outpatient services.
DSM IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR or ASI*): CAR Scores (Substance Abuse and Integrated Requests using the CAR assessment must have a score of 20 or higher in domain 3): 40-49 in 4 domains, with 1 domain being in 1, 6, 7, or 9 ASI Scores: 7 or above in 3 areas, must include a 4 in alcohol or drug problem area.
Prevention and Recovery Maintenance Level Criteria – Adult SA/Integrated (PG001):
Experiencing ***slight*** functional impairment
DSM IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
CAR Scores, T-ASI, and/ or ASI Scores must be listed in the client's chart.

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

SUBSTANCE ABUSE/INTEGRATED CRITERIA CHILD FOR OPBH AGENCIES (Younger than 21)
Level One – Child SA/Integrated General Requirements (PG042 and PG046):
Experiencing ***slight to moderate*** functional impairment.
DSM-IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR, T-ASI or ASI*): 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) T-ASI Scores: 2 or above in 3 areas, must include at least a 2 in Chemical Use Problem Area ASI Score: 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 (PG043 and PG047):
Experiencing ***moderate*** functional impairment.
DSM-IV-TR (in ICD Format) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR, T-ASI or ASI*): 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) 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 ASI Scores: 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 (PG044 and PG048):
Experiencing ***moderate to severe*** functional impairment.
DSM-IV-TR (IN ICD FORMAT) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR, T-ASI or ASI*): 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 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 ASI Scores: 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 (PG045 and PG049):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
SM-IV-TR (IN ICD FORMAT) Diagnosis: Axis I Substance-Related Disorder
Assessment Results (Use the CAR, T-ASI or ASI*): Substance Abuse and Integrated Requests using the CAR assessment must have a score of 40 or higher in domain 3: 40 - 49 in 3 domains, with 1 domain being in 1, 6, 7, or 9 T-ASI Scores: 4 in 3 areas; must include a 2 in the Chemical Use Problem Area ASI Scores: 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 (PG001):
Experiencing ***sligh***t functional impairment
DSM-IV-TR (IN ICD FORMAT) Diagnosis: Axis I Substance-Related Disorder
CAR Scores, T-ASI and/or ASI Scores must be listed in the client's chart.

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

EXCEPTIONAL CASE CRITERIA FOR OPBH AGENCIES (PG025)	
General Requirements (Must meet all of the following conditions)	
1. It is recognized that there may be periods in which the client's condition is severe enough to require a higher intensity of outpatient services than is allowed by the Medical Necessity Criteria in the outpatient Level(s) of Care. In this circumstance, providers may request additional services beyond the maximum allowed when the following criteria are met: a. The client is medically stable; b. Documentation clearly supports that the client meets Level four medical necessity criteria, and one or more of the items listed as "Appropriate" in the next section; and c. Documentation clearly supports the need for additional exceptional case services above and beyond Level four medical necessity criteria. 2. This therapeutic service includes a reassessment of the diagnosis; an update to the biopsychosocial; a functional assessment utilizing the required tool listed in the medical necessity criteria and an update to the service plan if the initial assessment/plan has already been completed. OAC 317:30-5-241.1 governs the requirement for this service. 3. All other procedure code group will be discontinued during utilization of the Exceptional Case Criteria procedure code group services and benefits. 4. The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.	
Appropriate (Any/or all of the following)	
1. Experiencing extreme functional impairment, but does not meet medical necessity criteria for acute inpatient hospitalization; 2. Stepping down from a higher level of care (acute/RTC/Inpatient.); 3. 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	These cases are considered "Exceptional" and will not be maintained at this level of intensity each PA period. Authorizations for this level are granted on a monthly basis and will not be granted for more than three consecutive months.

BEHAVIORAL HEALTH REHABILITATION SERVICES FOR CHILDREN AGES 4 & 5 FOR OPBH AGENCIES	
General Requirements (Must meet all of the following conditions)	
1. The child is currently receiving psychotherapy services, and there is a defined need for behavioral health rehabilitation services to compliment these more intensive therapies. **2.** The child meets one of the following criteria: History of Psychiatric Hospitalization or Admissions to Crisis Centers, Disability Determination for Mental Health Reasons, Current Individual Education Plan (IEP) or 504 Plan for Emotional Disturbance, or At Risk, pursuant to the PA Manual. **3.** The developmental level of the child has been assessed, and there is clear evidence that the child has the cognitive and language capacity to engage in curriculum based education. **4.** The service plan goals and objectives, and the educational curriculum used must be age and developmentally appropriate. **5.** The child meets criteria for Outpatient Level 1, 2, 3 or 4 mental health services **6.** The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.	
Amount of Service Allowable	Requests for this level of service will be covered for a period of three (3) months. Prior authorization will be required every 3 months.

BEHAVIORAL HEALTH REHABILITATION SERVICES FOR "AT RISK" CHILDREN FOR OPBH AGENCIES	
General Requirements (Must meet all of the following conditions)	
1. The child has been determined to be At Risk, pursuant to the PA Manual 2. The child is currently receiving psychotherapy services, and there is a defined need for behavioral health rehabilitation services to compliment these more intensive therapies. **3.** The service plan goals and objectives, and the educational curriculum used must be age and developmentally appropriate. **4.** The child meets criteria for Outpatient Level 1, 2, 3 or 4 mental health or substance abuse services **5.** The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.	
Amount of Service Allowable	Requests for this level of service will be covered for a period of six (6) months. Prior authorization will be required every 6 months.

AUTOMATIC STEP DOWN / AFTER CARE CRITERIA FOR OPBH AGENCIES (PG014)

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

1. The OHCA State Plan targets those clients 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 client's discharge from that facility. This will serve as the treatment guide for the outpatient provider/agency in the first month of outpatient care.
3. If a pre-existing outpatient provider utilizes the Automatic Step-Down (PG014), the procedure code group that was being utilized must be discontinued and ended. Documentation in the medical record needs to reflect and support these changes in level of care.
4. Following the automatic step down utilization time period of one month, the appropriate level of care services (procedure code group) will need to be instituted based on the current clinical need of the client utilizing the medical necessity criteria for levels of care.
5. After the expiration or discontinuation of the automatic step down benefit/services, a valid service plan development moderate or low complexity is required and should be completed (valid with required signatures) in the medical record before the pre-determined/alternate level of care (procedure code group) services are provided.
6. The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.

Target Group/ Amount of Service Allowable	• For those clients preparing to discharge or who have been denied admission to acute, RTC, crisis stabilization, group home or TFC, PHP/Day Tx/IOP, a 30 day utilization period for services is available at the time the provider accepts the initial referral. • The designated level of care and corresponding clinical information that supports the level of care needs to be clearly noted in the medical record.

Recommended Protocol for Automatic Authorization Period	Time Frame Requirement	Provider
• First outpatient appointment with the OPBH Agency	No more than 7 days	Agency
• Continuing face to face visits	One or more per week	LBHP/Case Manager
• For new clients, the assessment and service plan	Within 30 days	LBHP
• For established clients, service plan	Within 30 days	LBHP
• Continued counseling services: Appointments must be kept. Follow up efforts by the assigned case manager must be documented if appointments are missed.	On going	Case Manager
• 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 days of missed appointments, if the client/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 Van Rhodes at ODMHSAS. Information can be provided by phone at (405) 522-8876, or by fax at (405) 522-3867.

CHILD AGE 0 THROUGH 36 MONTHS (Infant Mental Health)
OPBH AGENCIES, PSYCHOLOGISTS AND LBHPS

Service Definition and Requirements

Definition: Infant Mental Health (IMH) Treatment Services Target infants and young children (birth to three) in distress or with clear symptoms indicating a mental health disorder. IMH Treatment Services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship. IMH Treatment Services are grounded in attachment theory, are relationship focused, developmentally appropriate and trauma informed, and address the interplay between the infant and parent or other significant caregivers. IMH Treatment Services focus on the parent-child dyad and are designed to improve infant and family functioning in order to reduce the risk for more severe behavioral, social, emotional and relationship disturbances as the infant gets older.

Required Therapeutic Services:

1. Before engaging in IMH treatment services, the infant/young child must receive:
   - A diagnostic evaluation that has resulted in a diagnosis (see DC: 0-3R guidelines for infant mental health comprehensive evaluation); and
   - An individualized Service Plan that includes IMH treatment as an intervention.
2. IMH treatment services shall include the following:
   - Family Psychotherapy with and without the child present. A minimum of 70% of the services must be Family Psychotherapy with the child present
   - Service delivery is focused on infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child
   - Each IMH provider must address, at a minimum:
     - Increasing parents/caregivers' ability to consistently and appropriately provide for the child's basic emotional needs for comfort, stimulation, affection and safety;
     - Increase infant's/young child's ability to initiate and respond to most social interactions in a developmentally appropriate way;
     - Increase infant's/child's ability to socially discriminate and be selective in choice of attachment figures;
     - Provide parent/infant interaction in order to encourage language and play, interpretation of an infant's behavior and reinforcement of a parent's/caregiver's appropriate actions and interactions; and
     - Provider must also provide crisis intervention services as appropriate. See DC: 0-3R for related therapeutic issues.

OPBH Agency providers are required to follow all of the requirements listed in OAC: 317:30-5-240 - 317:30-5-249.
Individually contracted Psychologists are required to follow all of the requirements listed in OAC 317:30-5-275 - 317:30-5-279.8.
Individually contracted LBHPs are required to follow all of the requirements listed in OAC 317:30-5-280 - 317:30-5-283.

Target Population

- Infants and young children birth through 36 months with SoonerCare eligibility , and at least one of the following:
  - Have had a comprehensive assessment by a LBHP identifying the need for this service; or
  - Are diagnosed with, or at risk of, a behavioral/emotional disorder; or
  - Have been referred by the child welfare system.
- If diagnosed with a behavioral/emotional disorder, contributing factors may include:
  - Substance abuse or co-occurring disorder in the home of the infant/young child
  - Primary parent/caregiver is diagnosed with a mental illness
  - Infant/young child or parent/caregiver has a developmental disability
  - Substantiated or suspected abuse or neglect of the infant/young child
  - Exposure to or experiencing trauma
  - Incarceration of primary parent/caregiver

Documentation Requirements
The provider must provide the standard documentation in the individual client files in addition to the following: • Diagnostic evaluation, including diagnosis • Individualized Service Plan • Progress notes that reflect the array of services provided • Discharge or transition plan that documents the need for any continuation or support services.   ▪ NOTE: All of the above documents need to legible, have timespans of provided services stated and contain the signature and licensure of the practitioner rendering the service. • CAR domains 1 - 9 must meet the level of care being requested.
Staffing Requirements

Qualified professionals: The treating professional is required to meet all of following specifications:
• Master's level licensed therapist or under supervision for licensure, or licensed psychologist.
• The services being provided to this population must be within the scope of practice of the therapist.
• Must be providing IMH services directly to infants, toddlers and their families/primary caregivers.
• Competency in the following areas is required. Supporting documentation should be available in the personnel file and available upon request for pre and/or post payment review:
  a. Early childhood development, diagnosis and treatment
  b. Infant mental health, diagnosis and treatment.
  c. Clinical experience with this age group.
  d. Service plan goals and objectives must be age and developmentally appropriate.
  e. DC: 0-3 R (IN ICD FORMAT) diagnosis for the client/child. Diagnosis is for the child, not the parent.

Services NOT allowed for Children Ages 0 through 36 Months
• Individual/Interactive Psychotherapy • Group Psychotherapy • Psychosocial Rehabilitation (Individual or Group) • Psychological Testing

PSYCHOLOGICAL EVALUATION/TESTING CRITERIA FOR OPBH AGENCIES, PSYCHOLOGISTS, AND LBHPS	
General Requirements	Assessment Results and Documentation Requirements:
1. Appropriate (Must meet ALL of the following conditions): a. Client is experiencing difficulty in functioning with origins not clearly determined; AND b. An evaluation has been recommended and/or requested by a physician, psychiatrist, psychologist, or a licensed mental health professional; AND c. Results of evaluation will directly impact current treatment strategies. d. If client 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 or diagnosis of a learning disorder *only*	DSM-IV-TR (in ICD Format) Diagnosis – all five axes must be completed: Axis I primary **diagnosis** (INCLUDING V and 900 codes, Deferred, and Provisional Diagnosis). Documentation Requirements must include ALL of the following information: Service 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 client? Notes: 1. A psychological technician for a Psychologist is defined by the State Board of Examiners of Psychologists as being "under the direct and continuing supervision of the licensed psychologist" [OAC 575:10-1-7]. 2. Qualified professionals for accredited outpatient behavioral health agency providers. Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP.

CHILDREN'S PARTIAL HOSPITALIZATION PROGRAM (PG012)

Service Definition and Requirements

Definition: Partial hospitalization is an intermediary, stabilizing step for youth who have had inpatient psychiatric hospitalization prior to returning to school and community supports or as a less restrictive alternative for children, adolescents, and their families when inpatient treatment may not be indicated. Treatment is time limited and therapeutically intensive clinical services are provided. The length of participation in the program is based on the individual's needs and medical necessity. The program needs to focus strongly on family involvement in treatment and be at least 5 days per week, (minimum of 3 hours per day) up to 4 hours therapeutic services per day. Closed on legal holidays. An hour of service constitutes 60 minutes. The treating provider is required to follow all of the requirements listed in the OAC: 317:30-5-240 – 317:30-5-249.

Required Therapeutic Services:

1. Psychiatrist face to face/visit 2 times per month (Physician services are billed separately and not included in the PHP rate.)
2. Crisis management services are available 24 hours a day, 7 days a week
3. Psychotherapies– Minimum of 4 hours per week:
   - Individual therapy and/or family therapy, minimum of 2 sessions (a session needs to be a minimum of one hour) per week.
   - Group Therapy, minimum of 2 sessions per week (a session needs to be a minimum of one hour).
4. Interchangeable Therapeutic Services to include the following:
   - Behavioral Health Rehabilitation Services (BHRS) *for children ages 6 and older, unless authorized for children ages 4 &5 through a PA Adjustment request*
   - Substance abuse education
   - Case management (face to face)
   - Medication Training & Support
   - Expressive Therapy
5. Occupational Therapy/Physical Therapy/Speech Therapy should be provided by the ISD (Independent School District).
6. Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.
7. Therapeutic holds are strongly discouraged, but if necessary for the welfare of the child, MUST follow accreditation requirements**.**
8. Trauma-Informed Care (TIC) recommended.(See NCTIC@abtassoc.com. www.mentalhealth.samhsa.gov/nctic)
9. Comprehensive psychological testing by a licensed psychologist is billed separately. Physician services are billed separately.
10. Active involvement of the client's family, caretakers or significant others involved in the individual's treatment is required

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.
- Service Plan updates are required every 3 months or more frequently based on clinical need. See also 317:30-5-248 regarding: of records.
- Documentation needs to specify active involvement of the client's family, caretakers, or significant others involved in the individual's treatment.
- The CALOCUS scores should include the composite score and CALOCUS level.

Staffing Requirements

- **Qualified professionals:** All services in the PHP program are provided by a team, the following configuration: physician, registered nurse, licensed behavioral health professionals (LBHPs), case managers, or other Mental Health/Substance Abuse paraprofessional staff. The service plan is directed under the supervision of a physician. Behavioral Health Rehabilitation Services are provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC) or LBHP who meets the professional requirements listed in 317:30-5-240.3.
- **Qualified Providers:** Provider agencies for PHP must be accredited by one of the national accrediting bodies. (The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA)) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of enrolled agency.
- 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 makes restraint assessments.
- Medical Director is a psychiatrist.
- A psychiatrist/physician is available 24 hours a day, 7 days a week
- Requirements at OAC 317:30-5-240.

Service/Reimbursement Limitations
Limitations: Services are limited to children 0 - 20 only. Behavioral Health Rehabilitation Services are not reimbursable for children ages 0-3, and are only reimbursable for children ages 4-5 if authorized through a PA Adjustment request. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be authorized. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered; those services are separately billable. Academic instruction, meals, and transportation are not covered. Fractional/partial units are allowable. Monthly cap (Benefit Limit): • 3 hours x $42.80 = $128.40 x 5 days = $642.00 per week x 4.33, with a $2779.86 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 / Medical Necessity Criteria
A. GENERAL REQUIREMENTS FOR ADMISSION AND CONTINUED STAY IN PARTIAL HOSPITALIZATION PROGRAM: **1.** Partial hospitalization services are services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition. Partial hospitalization services are reasonably expected to improve the individual's condition, functional level and to prevent relapse or hospitalization. **2.** The client 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://communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/CALOCUSv15.pdf **3.** CALOCUS is not required for step downs from an inpatient level of care (acute or RTC). **4.** The data fields for the CAR on the CDC and the PA request are not required. Enter 99 in the CAR domain fields. **5.** Current DSM IV Axis I Diagnosis (in ICD format) that is consistent with symptoms. **6.** Individual's condition can be expected to be stabilized at this level of care. **7.** 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 client'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 client's safety can be maintained during non-treatment hours. The goal is for the client 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 re-hospitalization. **2.** The client has been discharged from a higher level of care and continues to require an 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 client is stepping down from a higher level of care (e.g., acute psychiatric care 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 service 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 (PG007 and PG011)

Service Definition and Requirements

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

The program is available at least four days per week and 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*
- Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless prior authorization has been granted for children ages 4 and 5)
- Case Management - *as needed and part of weekly hours for the client*
- Occupational therapy - *as needed and part of weekly hours for the client*
- Expressive therapy - *as needed and part of weekly hours for the client*

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. The treating provider is required to follow all of the requirements listed in the OAC 317:30-5-240 – 317:30-5-249.

Staffing Requirements

Qualified professionals: All services in the Day Treatment are provided by a team, which *may* have the following configuration: physician, registered nurse, licensed behavioral health professionals (LBHPs), case managers, or other Mental Health/Substance Abuse paraprofessional staff. Services are directed by a LBHP. Psychiatric services are available to persons served, including crisis intervention services 24 hours a day, 7 days a week.

Behavioral Health Rehabilitation Services are provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC) or LBHP who meets the professional requirements listed in 317:30-5-240.3.

Service/Reimbursement Limitations

Limitations: Services are limited to children 0 - 20 only. Behavioral Health Rehabilitation Services are only reimbursable for children who meet the criteria established in 317:30-5-241.3; are not reimbursable for children ages 0-3; and are only reimbursable for children ages 4-5 if authorized through a PA Adjustment request.

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

Service Code Modifiers

Follow the modifier code combination and order listed on the fee schedule.

LBHP CALOCUS®, BRIEF INTERVENTION AND REFERRAL PROCEDURE (PG013)
Unit Length: Event

Service Requirement

Definition: The service code modifier combination (H0031 TG) is being used for the LBHP Child Adolescent Level of Care Utilization System (CALOCUS®), Brief Intervention and Referral procedure which is an event code. This is a procedure for children who are in crisis and at risk of needing 24-hour observation and out of home treatment.

One of the goals of the CALOCUS® process is for the assessor to use early interventions, including crisis interventions, to assist with maintaining the client in the community when clinically appropriate.

The Child Adolescent Level of Care Utilization System (CALOCUS®) was developed by the American Association of Community Psychiatrists (AACP). The CALOCUS® instrument is a method of quantifying the clinical severity and service needs of children and adolescents.

You may photocopy and use the CALOCUS® instrument in the original form. The manual for the CALOCUS® is available as a PDF: **http://communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/CALOCUSv15.pdf**

Target Population

Child (under the age of 21)

Documentation Requirements

The treating provider is required to follow all of the requirements listed in the OAC 317:30-5-240 – 317:30-5-249. Additional requirements: Documentation should include the CALOCUS® scores, the composite score, and recommended CALOCUS® level, clinical summary, and all care management recommendations and activities.

Staffing Requirements

Qualified professionals**:** LBHPs that are individually contracted with OHCA, and have completed the CALOCUS® training. A copy of the CALOCUS® training certificate needs to be placed in the personnel file**.**

Service/Reimbursement Limitations

Procedure code clinical requirements:

1. **Crisis Intervention Services are included as a part of the procedure:** There needs to be documented efforts in the client's record to divert from a higher level of care by providing a crisis intervention services when medically necessary.
2. **CALOCUS®:** Documented completion of the CALOCUS® assessment tool. The CAR, ASI or TASI is *not* required for this procedure.
3. **Care Management:** Documented completion of all care management activities. This includes referrals as needed and appropriate; monitoring of care; and follow up to ensure that the service recommendations have been successfully accessed by the client and guardian.

Crisis intervention services (CIS) procedure code (H2011):

- The LBHP is *not* allowed to bill the crisis intervention code (H2011) on the same day as the CALOCUS® Brief Intervention and Referral procedure code (H0031 TG). Billing both on the same day is considered a duplication of service because the CALOCUS® procedure code is an event code which also includes crisis intervention services if medically necessary.
- H0211: The CIS code does not require a prior authorization. The maximum for the CIS code is eight units per month and 40 units each 12 months per client.

Documentation Requirements:

1. The medical record needs to include CALOCUS® scores, the composite score, and recommended CALOCUS® level, clinical summary, and all care management recommendations and activities.
2. Documentation of telephonic review within **48 hours** of the face to face assessment or next business day after the 48 hour time frame. The LBHP performing the assessment must be the person calling to discuss the case. If the reviewer and the assessor decide hospitalization is needed, the reviewer will assist in locating an available inpatient bed and notify the hospital that the CALOCUS® assessor will be contacting them with the clinical information which was obtained from the CALOCUS® assessment. The assessor will make arrangements to fax or send the CALOCUS® assessment information with the guardian to the hospital.

3. If the reviewer and assessor disagree on a level of care, the reviewer will staff the case with a physician for determination of the final disposition. 4. Documentation of care coordination: The assessor is required to provide referral and follow up care as a part of the CALOCUS® care coordination service which includes ensuring that the client has accessed the appropriate level of care that was recommended. Once the care coordination/follow up is completed, the CALOCUS® assessor needs to notify the reviewer of the outcome.
Service Code Modifiers
Follow the modifier code combination and order listed on the fee schedule.

RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES (RBMS),
THERAPEUTIC FOSTER CARE (TFC) AND
THERAPEUTIC GROUP HOMES (Levels C and E)
WHO NEED ADDITIONAL OPBH SERVICES
OUTPATIENT BEHAVIORAL AGENCIES

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

- 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.
- Inappropriate: Imminent danger to self and/or others (medically unstable); AND/OR Extreme level of functional impairment, meeting medical necessity criteria for acute inpatient hospitalization.
- The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.

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

1. DSM-IV-TR (IN ICD 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. Assessment Results (Use the CAR or T-ASI*):
   - 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.

OP BH Agency Services NOT allowed for SoonerCare members receiving RBMS:

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

ICF/IID Criteria (PG019)	
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 Diagnosis in BOTH a AND b (using the most recent version of the DSM, and ICD format): a. Axis I primary diagnosis on initials and extensions: any diagnosis is allowable including V codes and 900 codes except Deferred Diagnosis 799.9, and No Diagnosis V71.09 b. Axis II diagnosis on initials and extensions, including one of the following: Mild Mental Retardation 317, Moderate Mental Retardation 318.0, Sever Mental Retardation 318.1, Profound Mental Retardation 318.2 **2.** The following items need to be present in the member record to support that Medical Necessity Criteria has been met: **a.** A letter from the ICF/IID facility indicating the multi-axial diagnoses (using the most recent version of the DSM, and ICD format), specific behavioral concerns, reason for referral, and signed by an ICF/IID representative. **b.** 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. **c.** Major discrepancies between information obtained from the ICF-IID and providers documentation are to be resolved by the provider. It must be clear the member can benefit from outpatient therapy services. **d.** Psychological Testing documenting IQ Score, Vineland Adaptive Scale, and any additional clinical assessment reports that support the requested services. **e.** Communication domain at the end of the CAR must be completed; AND **f.** 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 fee-for-service SoonerCare members in a 24-hr setting	
1. Case Management 2. Psychosocial Rehabilitation (Individual or Group) 3. Medication Training and Support	

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 by 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 be 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 disabled, intellectually, mentally or physically, the client 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/herself 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, the disabled and elderly 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 (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 identified.
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 (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 (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 (Incapacitating): Disabled 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 (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 client 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 (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: Client 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 (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. Client 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 (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: Client not employable. Is unable to comply with rules and regulations or fulfill ANY of the expectations of the client'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 (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 (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 TRAINING

Web-based training on the Client Assessment Record (CAR) is available at http://www.ok.gov/odmhsas/ under E-Learning.

ADDICTION SEVERITY INDEX (ASI)
AND
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 above 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 client 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 client 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).

FREQUENTLY ASKED QUESTIONS:
CHANGES IN PRIOR AUTHORIZATION FOR MENTAL HEALTH PSYCHOSOCIAL REHABILITATION

How do we get to rehab service reports in PICIS?
On the PICIS home page, go to Reports, under Financial Reports there is a new section titled Rehabilitation. All related rehab service reports will be in this section.

On the No-Rehab list that PICIS has published, can you clarify that the people that are NOT on that list DO qualify for rehab?
For clients with current PAs that end after August 31, 2014, and the PAs include rehab services, if they are not on the No-Rehab list, then we have determined that they meet criteria for rehab services and they will remain with the PA groups that allow rehab services.

Why would PICIS not publish the list of approved clients for rehab services and make this easier for everyone?
We want you to focus on the clients that we do not have documentation for that would meet criteria if the documentation was sent to us. We will be providing a report of your current clients that have been determined by ODMHSAS to meet criteria in the future. However, we will only show the current clients at your agency, we are not allowed to show all clients eligible due to client confidentiality concerns.

When will we receive information that our existing clients are eligible?
The list will be made available before August 1.

When we submit the CDC 21, will we be alerted at that time if they meet the criteria?
We will not notify you, but will have a report that shows whether the client is eligible after you have submitted a 21.

If a client has an IEP, will PICIS have a list or do we send in the documentation?
PICIS does not have this information, the provider must send in the attestation form provided on the arc website (www.odmhsas.org/arc.htm). Do NOT submit the IEP document, only the provided attestation form.

Will all clients need a new assessment or transaction type 23?
No, they will not need a new assessment or a transaction type 23.

For clients currently receiving rehab services, will these services now become case management services?
No, rehab services and case management are two completely different services. For ODMHSAS clients, please refer to the ODMHSAS Services Manual for service definitions. For Medicaid members, please refer to Medicaid rules, Part 21 for rehab services and Part 67 for case management for service definitions. ODMHSAS will be monitoring utilization data for clients who were receiving rehab services and now are no longer eligible and begin receiving a lot of case management services that were not provided before the rehab services limits were in place. As a reminder, the system automatically limits the number of case management services allowed to be billed for each client per day and month.

Can the time spent on getting verification from SSA, getting verification from the school, or getting any other verification to meet rehabilitation requirements be billed under Case Management?
No, Case Management is used to connect clients to resources outside of the agency serving the client. These functions would not be connecting folks with external resources, but rather collecting information to support services/treatment within the agency. This would be like the collection of previous treatment records or financial documents that might be needed to ensure they meet service criteria within the exiting agency, which is not reimbursable.

What does the letter need to say from SSA?
Documentation needs to be the benefits letter from SSA.

When we send SSI/SSDI award letter, will you be able to verify if they have been determined disable due to mental health reasons?
No, at this time we cannot. We are working with SSA to automatically receive the information so that the providers are not required to submit benefit letters. It is the provider's responsibility to only request eligibility for clients with a mental health disability.

What happens when PICIS shows the client as being eligible for rehab services per the list and I don't think that they would meet the requirements? If rehab is performed and they are deemed not eligible do these services have to be repaid?
If the provider believes that the client does not meet the new rehab requirements and has been placed on the list by ODMHSAS in error, the provider is responsible for notifying ODMHSAS of the discrepancy by contacting the PICIS Helpdesk. Pursuant to OAC 317:30-5-241, "authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met." In order to facilitate the authorization process for providers, ODMHSAS is identifying clients that can be classified through claims data as meeting the new criteria. This however, does not absolve the provider of the requirements in 317:30-5-241.

If the provider submits documentation declaring the client as eligible and it is determined at a later date that the client was not eligible, then those payments can be recouped. For example, if an SSA benefits letter is submitted and it is later determined that the client's disability is not due to mental health reasons, the payments can be recouped. Another example is a client who is eligible because of s/he reside in a residential care facility. If during the authorization period, the client leaves the residential care facility, s/he is no longer eligible for rehab services and any rehab payments for rehab services after the discharge date from the residential care facility can be recouped.

For clients who are eligible under PG001 or PG038, will they automatically be switched to the new PA groups with rehab or do PA adjustments need to be done?
No, clients will remain in these PA groups and rehab services are not allowed with these PA groups.

If the client is already approved for rehab services, is an adjustment required?
No, current clients will remain in the PA groups that allow rehab services and in the future you should request the Rehab PA groups for these clients as long as they remain eligible.

Once required documentation is sent in, how long will it take ODMHSAS to verify rehab eligibility for a new client?
Initially, it may take up to 2-3 weeks. After the initial back log is completed, it is believed the timeframe will be within five business days.

On the IEP/504 attestation letter form, what does ED & OHI stand for?
Emotional Disturbance (ED) and Other Health Impairment (OHI). For OHI, mental health impairments must be identified somewhere in the Plan.

If they are level 4 and had rehab but are no longer eligible when the rehab shuts off will it change the PA cap?
No, the PA caps will remain the same.

Will providers be given a fax or transmittal number for submission of the necessary proof?
No, all of the documentation will be submitted through the PICIS system via PA adjustments.

How do letters of collaboration apply to rehab services?
If the client is eligible for rehab services for reasons other than being in a specialty court, the same collaboration rules apply. If the client qualifies due to being in a specialty court, only the specialty court provider can provide rehab services.

Do treatment plans need to be modified if the client is currently receiving rehab services and is no longer eligible and how quickly do these updates need to be made?
Providers can wait until the scheduled update to modify the plan. It is recommended that they write an informational progress note stating that the client will no longer be receiving rehabilitation services, as they are no longer eligible for the service, and that the client/guardian has been informed of the change.

If a client qualifies with more than one of the criteria, do I need to submit documentation for each criterion?
No, documentation showing the client meets one criterion is sufficient.

How do we determine if a consumer is admitted to a residential care facility (RFC) for mental health?
The provider must talk to the RCF and ask if facility is designed to serve clients with mental health disorders. Further, the provider must upload and attach to the electronic PA Adjustment Request a letter from the residential care administrator stating that the member is a current resident and that their facility is designated to support individuals with mental health issues.

Will autism qualify for mental health under the SSI?
Yes, autism does but intellectual disabilities do not.

If a client is currently receiving rehab services, will they be able to receive these services through the end of the authorization period?
No, ODMHSAS will be changing the PAs but only PA lines that start on/after 8/1 (please see example below). However, prior authorizations are not guarantees of payment (*see OAC 317:30-5-241).* Even though a PA line might be active with rehab up to 8/14 as in the example below, the rule goes into effect 8/1/2014. That means that if you know the customer does not meet criteria, rehab must not be provided after 8/1/2014. Any paid claims for rehab provided after 8/1/14 to clients that are known to the provider as not meeting the new criteria are subject to recoupment.

The authorization period is broken up into six lines. For all lines ending on or after August 1, 2014, rehab services will no longer be allowed. For example:

A PG044 in effect from 7/15/2014 to 1/14/2015 would have six lines:

- 7/15/2014 to 8/14/2014
- 8/15/2014 to 9/14/2014
- 9/15/2014 to 10/14/2014
- 10/15/2014 to 11/14/2014
- 11/15/2014 to 12/15/2014
- 12/15/2014 to 1/14/2015

The line starting 8/15 and the following lines would be changed to PG048. The line for the time period of 7/15/2014 to 8/14/2014 would stay the same.

If a client is referred from OJA or DHS or has been removed from the home, will they meet the "at risk" criteria?
If they are transitioning out of therapeutic foster care (TFC) or an OKDHS Level E group home, the client can be referred by OKDHS to a school psychologist, fully licensed psychologist or psychiatrist for a full psychological evaluation. This information from the psychological evaluation, along with other required information, will be submitted in a PA Adjustment Request for "at risk" children. ODMHSAS will review all of the information and determine if the child meets Medical Necessity for "at risk." Being in OJA or DHS custody or having been removed from the home does not necessarily indicate that children meet "at risk" criteria.

Do clients currently in therapeutic foster care (TFC) automatically qualify for rehab services?
No, TFC clients do not receive payments through the PICIS system. Rehab services should not be requested through the PICIS system for these children. For information regarding authorization of TFC services, visit www.okhca.org/behavioral-health.

Does Department of Corrections (DOC) Community Sentencing apply like Drug Court?
No, this is not considered a specialty court setting.

Does the history of psychiatric hospitalization include inpatient placement for drugs or alcohol?
No, it must be psychiatric hospitalization. That means detox, residential treatment for substance use disorders, battered women shelters, shelters, halfway houses, etc. are ***not*** settings that would qualify a client for rehab services.

Can you identify mental health disorders that qualify for rehab criteria and what documentation is needed?
We do not have a set list of disorders that meet SSI/SSDI disability determination. Please refer to the Rehab Eligibility Changes Guidance at www.odmhsas.org/arc.htm for documentation requirements.

What if the consumer is 17 and a dropout? Can a psychiatrist that is prescribing meds to them determine them "at risk" or does it have to originate from a "school psychologist"?
No, consumers who are not in school do not meet the criteria of inability to function in the classroom because of mental illness and/or severe behavioral problems. Additionally, it is ODMHSAS (acting as the designated SoonerCare behavioral health utilization manager for OHCA) that makes the "at risk" determination based on the results of the evaluations by one of the qualified providers listed above.

What if the psychiatric hospital does not exist anymore, like Children's Medical Center in Tulsa, or an adult facility that had inpatient in the 80s and the hospital does not have records for them?
If the hospital was publically funded, ODMHSAS should have the records. If there are not records of the inpatient stay, the client does not meet criteria. ODMHSAS will not accept client attestations in order to meet rehab eligibility criteria.

What exactly do the school/principal need to provide to CM/Therapist/Agencies that will be deemed appropriate for "at risk" determination?
The following documents are required to be uploaded and attached to the electronic PA Adjustment Request submitted by the behavioral health provider:

Clinical Assessment including:

- Bio-psychosocial assessment, including a narrative of any updates if the assessment was not completed in the last 30 days (the updated information provided in the descriptors for the current CAR assessment may provide sufficient update);
- Current CAR/ASI/TASI, including descriptors or narrative that supports the scores (The CAR/ASI/TASI must be no more than 30 days old).
- Current Service Plan (no more than 30 days old)
- The educational curriculum to be used, if created by the provider.
- Interpretive Summary from the Psychological Evaluation.

In addition to the above documentation requirements, children determined to be "at risk" through the school referral as described in (1) above will need to submit the following from the school:

- A copy of the child's adjusted school schedule, provided by the school, clearly reflecting the adjustments that have been made due to behavioral problems at school; or
  Or

- A signed letter from the principal or vice principal of the child's school expressing intent to adjust the child's schedule due to behavioral problems in the classroom.

For children 'at risk,' do they have to be referred to the psychologist/school psychologist/psychiatrist BY the school, or can they be referred by the provider or parent?
The child must be referred by school. These referrals are based on the child's inability to function in the classroom because of mental illness and/or severe behavioral problems.

For scheduling for a psychiatrist to determine conduct the evaluation, who does the responsibility fall on - the agency or the school?
The school must make the referral for a full psychological evaluation. Who actually schedules the appointment is irrelevant as long as the referral is from the school. Further, ODMHSAS is the final determiner of "at risk" based on the information presented in the PA Adjustment Request, which includes summary information from the evaluation/testing done by a psychologist/psychiatrist.

CUSTOMER DATA CORE (CDC)

Customer Data Core (CDC) FY2015

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CDC QUESTIONS? WHO TO CALL?

For questions, please call the ODMHSAS PICIS Provider Assistance Line at 855-521-6444 or you may send an email to the gethelp@odmhsas.org.

CUSTOMER DATA CORE

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 data are utilized for a multitude of purposes, e.g., linkage of services throughout providers statewide, identification of target groups being served, identification of emerging drug use trends, or determination of the prevalence of persons with serious mental illness being served.

The information collected through the CDC is used at many different levels and is used for performance improvement, reporting requirement to funding entities, funding allocations and system development.

TRANSACTION TYPES

There are six groups of transactions, which use twenty-one different transaction types. They are:

1. Preadmission/Contact (Types 21 and 27)
2. Admission (Type 23)
3. Level of Care Change (Type 40)
4. Information Update (Type 41)
5. Treatment Extension/Outcome Update (Type 42)
6. Discharge (Types 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72 and 92)

The date for each transaction is when the type of event occurred, not when the information was entered into the system. The date may be backdated to indicate the date the event occurred.

The transaction type and specific service focus will determine what type of prior authorization (PA) is given. For example, if an ODMHSAS-contracted substance abuse treatment agency reports an admission, a substance abuse service focus and a halfway house level of care, the PA created will be an instant PA for six months for halfway house services. If the service focus had been reported as mental health, an instant PA for community living would have been created.

An ‘open admission’ refers to a customer who has an admission (transaction type 23) in the system, but has not had a discharge (transaction types 60-72) reported.

Transactions must be entered into the system in a specific order. Transaction types 21, 23, and 27 can only be entered if a customer does not have an open admission. Transaction types 40 through 72 can only be entered if a customer does have an open admission.

CONTACTS (TRANSACTION TYPES 21 AND 27)

Contact transaction types (21 and 27) signify that an admission was not appropriate at that time or was unattainable for this individual at the time of contact. Mostly commonly, a transaction type 21 is reported to obtain a prior authorization for initial service payment for the customer. This allows the provider to provide some services before formally admitting the customer. Other examples for using a transaction 21 include: (1) an individual who was seen by a staff member, but an admission to the provider did not occur due to an emergency situation; (2) the customer was ambivalent regarding the initiation of treatment services; (3) a referral to a different provider for treatment was deemed appropriate; or (4) the customer refused treatment.

Contacts (transaction types 21 and 27) require the completion of Section I of the Customer Data Core (CDC), name, and address.

PRE-ADMISSION CONTACT (TYPE 21)

Pre-Admission Contacts request a Pre-Admission Services PA group. In order to submit a Pre-Admission contact, complete Section I, Name, and Address on the CDC and report the service with the Member ID.

FIRST CONTACT/TESTING ONLY (TYPE 27)

The purpose of the contact 27 is to allow individual psychologists or LBHPs to obtain a prior authorization to provide testing. Agencies can also use the 27 for TANF reassessments and for those in Urgent Recovery.

ADMISSION (TYPE 23)

Admission (transaction type 23) reflects the beginning of an episode of treatment for the customer. Admission information includes who referred the customer for services; treatment program type or level of care to which the customer is admitted; and social and financial information regarding the customer. A treatment episode will remain open until a discharge transaction is reported. An admission (transaction type 23) requires the completion of the customer data core (CDC) form.

Regardless of the different program structures, diversity of services provided, or location of services within an agency, only one admission transaction needs to be reported until all services have been terminated. Should a customer no longer need the structured services offered in a residential program and begin to receive services in an outpatient program at the same agency, the customer is still active and the original admission is intact. In the previous example given, a provider would complete a transaction code 40 indicating a level of care change on the CDC. A change in treatment modality does not affect the admission episode.

LEVEL OF CARE CHANGE (TYPE 40)

A level of care change (transaction type 40) reflects a significant change in the treatment activities a customer will be receiving. For example, a customer admitted to a residential program may be transferred to a halfway house program sponsored by the same agency. In this case, the customer would have a level of care change from Residential Treatment (CI) to Community Living (CL). **A customer is not discharged due to a change in program or treatment focus or because of a change in service delivery within the facility.**

The changes in levels of care allow the tracking of customer movement, treatment history, and the array of services delivered and received within a specific facility. Level of care changes can only be reported using this transaction type.

Levels of care are Outpatient (OO), Community Living (CL), Residential Treatment (CI), Detoxification (SN), Community-Based Structured Crisis Care (SC), and Hospitalization (HA).

An active customer of a provider, who suddenly requires hospitalization (in a non-affiliated facility) for psychiatric stabilization, medical emergency, or chemical withdrawal, should <u>not</u> be discharged if the anticipated hospital stay is short term and the provider is aware that the customer will be returning for continued services or treatment.

INFORMATION UPDATE (TYPE 41)

Information updates (41) allow agencies to report significant changes in a customer's demographics during a treatment episode. Information update is used to indicate customer information has changed since the last transaction was reported for the customer. This CDC transaction is for data information purposes only. This CDC is not connected to any prior authorization.

Only the fields that have changed since the last transaction on file are to be updated.

An information update (transaction type 41) cannot be reported in lieu of a Treatment Extension/Outcome Update (transaction type 42). Nor does the reporting of an information update modify or change the date a Treatment Extension/Outcome Update (transaction type 42) is due.

An information update (transaction type 41) is NOT reported to correct information on a prior transaction. For example, if a customer reported no drug use, but it is later determined that there was drug use at admission, six-month update, etc., the previous record should be **corrected** in the data system.

Level of care cannot be changed with an information update (transaction type 41).

TREATMENT EXTENSION/OUTCOME UPDATE (TYPE 42)

Treatment Extension/Outcome updates (transaction type 42) allows providers a way to regularly report a customer's progress throughout treatment.

As part of the National Outcome Measures (NOMs), states are required to report specific measures or outcomes. These measures will eventually be used to determine the amount of federal block grant funding states receive and will be used to demonstrate the effectiveness of treatment to state legislators and other funding sources. To gather and report this information, current and accurate data are required for every person receiving services. While all data elements should be updated, there are specific variables required to respond to the NOMS. These are required to be updated for individuals in treatment every six months and with every PA extension request. The assessments to be updated (CAR, ASI, and T-ASI) are conditional, dependent upon service focus and age.

The NOMs fields required at Treatment Extension/Outcome Updates include:

1. Level of Functioning (GAF)
2. Frequency of Drug Use (up to 3 fields)
3. Employment
4. Type of Employment
5. In School?
6. Number of Arrests in Past 30 Days
7. Number of Arrests in Past 12 Months
8. Residence
9. Number of Times Attending Self-Help in Past 30 days
10. If child, Section IV

Level of care cannot be changed with a Treatment Extension/Outcome Update (Type 42).

DISCHARGES (TYPES 60 – 72, 92)

All fields are assumed to be updated on all transaction types. To allow agencies to receive credit for all changes which occurred during treatment, all fields are allowed and assumed to be updated, regardless of transaction type.

Discharge transactions (60-72) signify that all services for the customer have been terminated, which ends the treatment episode. Once a customer is discharged, any future encounter with the individual will necessitate reporting an admission, or, if appropriate, a contact transaction.

A discharge may occur because the customer discontinues contact with the provider; staff and customer decide services are no longer necessary; the customer moves out of the service area or state; or the customer is deceased. The discharge indicates that no future encounters with that customer are anticipated.

A customer in a residential shelter program who moves to the community, and continues to come to the provider for outpatient services, is considered an active customer. The customer is not discharged from the residential shelter program and then re-admitted to the outpatient program. Since both programs are provided under the same organizational structure, the continuity of service would not be terminated. Facilities operating offices in different counties, cities, or other separate locations do not discharge a customer because of a change in service location. As long as a customer is receiving services under the same organizational authority, regardless of a change in service focus, treatment is considered ongoing.

Level of care cannot be changed at discharge. Whatever the last level of care the customer received at the facility, should be the level of care on the discharge. This is true even if a customer is leaving the provider and going to a different provider and a different level of care.

COMPLETED TREATMENT (TRANSACTION TYPE 60)

Transaction type 60 is reported when the customer and the clinician agree that the treatment plan has been completed and services are no longer necessary at this provider.

COMPLETED COURT TREATMENT (TRANSACTION TYPE 61)

Transaction type 61 is reported when the customer has completed the court treatment under which he/she was admitted and is no longer legally required to remain in treatment.

LEFT AGAINST COUNSELOR'S ADVICE (ACA) – (TRANSACTION TYPE 62)

Transaction type 62 is reported when the customer leaves treatment against the advice of the clinician. If the customer wishes to stop services prior to completing treatment as outlined by their clinician OR there is no anticipation that the customer will return, use transaction type 62.

MOVED (TRANSACTION TYPE 63)

Transaction type 63 is reported when the customer moves his/her residence to a different geographical location and it is no longer feasible to receive services from the present provider. If a DOC inmate receiving services at a Special Population Treatment Unit is transferred to another correctional facility, use transaction type 63.

TRANSFERRED TO ANOTHER TREATMENT FACILITY (TRANSACTION TYPE 64)

Transaction type 64 is reported when the customer transfers to another treatment provider regardless of whether it is funded by ODMHSAS or OHCA and is not expected to return. A discharge is not submitted if the customer is expected to return, e.g., from a hospital back to a CMHC, and continuity of care needs to be maintained.

INCARCERATED (TRANSACTION TYPE 65)

Transaction type 65 is reported when the customer's treatment is terminated due to entering a correctional facility, such as jail or prison.

BROKE RULES (TRANSACTION TYPE 66)

Transaction type 66 is reported when the customer was discharged due to breaking the rules of the provider. Customer must have broken a written rule, e.g., showed up intoxicated, not just treatment non-compliant.

ABSENT WITHOUT LEAVE (AWOL) (TRANSACTION TYPE 67)

Transaction type 67 is reported when the customer leaves an **inpatient** mental health facility before the length of time determined by a court or before the prescribed period of time indicated by the program criteria has been completed. This transaction type can only be used with a court commitment legal status (03, 05, 07, 09, 12, 13, 17, 20, and 21).

DEATH (TRANSACTION TYPE 68)

Transaction type 68 is reported when the provider learns the customer is deceased. If the date of death is known, report that date as the date of discharge. If not, report the date the provider received news of the death.

FAILED TO BEGIN TREATMENT (TRANSACTION TYPE 69)

Transaction type 69 is reported when a Customer Data Core admission record has been submitted but the treatment plan was not initiated.

TREATMENT INCOMPATIBILITY (TRANSACTION TYPE 70)

Transaction type 70 is reported when treatment is not complete but the staff **and the customer** feel the episode should be terminated since continued stay will not be therapeutic for the customer. This discharge is marked by repeated failure to meet treatment goals, stagnation in progress toward recovery and/or a belief that continued treatment at this provider will not achieve a successful treatment outcome for the customer. This should only occur after the treatment staff has attempted to engage or re-engage the customer in treatment and determined the treatment goals are appropriate for the customer even though they cannot be attained. All attempts to correct the treatment plan and engage the customer should be well documented in the treatment chart before discharge.

MEDICAL (TRANSACTION TYPE 71)

Transaction type 71 is reported when a customer is discharged prior to treatment completion, necessitated by a need for medical treatment that cannot be managed concurrently with treatment.

DEPENDENT CHILD LEFT DUE TO PARENTAL DISCHARGE (TRANSACTION TYPE 72)

Transaction type 72 is for residential treatment and halfway house only, and is to be used as the discharge code for dependent children. The children are in substance abuse treatment **WITH** their parents. This discharge is not to be used for the discharge of adolescents in treatment without their parents.

NO SERVICE 180 DAYS – ADMINISTRATIVE DISCHARGE (TRANSACTION TYPE 92)

Transaction type 92 is created when a customer has not received services in 180 days and the provider has not submitted a discharge transaction for the customer.

These customers will be automatically discharged by the data system, on the 15th of every month. Due to the negative impact a 92 discharge may have on a provider's performance reports, it is important that a provider discharges all customers at the appropriate time.

If you have a customer you wish to keep in the data system past the 180 days, you may do so by reporting a transaction type 42 every six months.

SECTION I

The following are instructions for completing each field of the Customer Data Core.

AGENCY

DESCRIPTION: Identifies the provider reporting the CDC. This is the OHCA Provider ID plus the single letter location identifier.

VALID ENTRIES: **A 10 character number assigned by OHCA (e.g., 123456789A)**.

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Service Focus.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

DATE OF TRANSACTION

DESCRIPTION: The date of transaction refers to the date of the event, not the date the transaction is entered into the system.

Enter the date the transaction occurred in **MMDDYYYY** format using leading zeroes as needed.

Transaction date must be before or on the current date.

VALID ENTRIES: **MMDDYYYY**

COMMENTS: Refer to section describing the specific transaction type that is being used.

FEDERALLY REQUIRED FIELD: Yes

INTER-RELATED FIELDS: Military time.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Format for EDI is YYYYMMDD.

TRANSACTION TIME

DESCRIPTION: The time reported is the time the transaction occurred.

Report the time in military format.

VALID ENTRIES: **0000 – 2359**

COMMENTS: Midnight is 0000.

FEDERALLY REQUIRED FIELD: No

INTER-RELATED FIELDS: Date of Transaction.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

TRANSACTION TYPE

DESCRIPTION: The Transaction Type is a two-digit code that indicates the nature of this particular event. Please refer to "Transaction Types" section for definitions.

VALID ENTRIES:

21	**Pre-admission**
23	**Admission**
27	**First Contact/Testing Only**
40	**Level of Care Change**
41	**Information Update**
42	**Treatment Extension/Outcome Update**
60	**Completed Treatment**
61	**Completed Court Treatment**
62	**Left Against Counselor's Advice**
63	**Moved**
64	**Transferred to Another Treatment Facility**
65	**Incarcerated**
66	**Broke Rules**
67	**AWOL (mental health inpatient only)**
68	**Death**
69	**Failed to Begin Treatment**
70	**Treatment Incompatibility**
71	**Medical**
72	**Dependent Child Left Due to Parental Discharge**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Transaction type determines which fields must be completed on the CDC.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

MEMBER ID

DESCRIPTION: It is critical for the Member ID to be correct because it will be the means by which this, historical and subsequent entries for this individual will be linked to each other. In addition, if the Member ID is incorrect, payments will not be made for these individuals.

This is a 9 character identification number assigned through MMIS. This is also known as the customer's Medicaid ID. This ID is compared to the date of birth, name, and social security number given on the CDC to make sure the record being submitted matches the customer in the Medicaid system.

VALID ENTRIES: **A 9 character identifier assigned by OHCA.**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Date of Birth, Name, and Social Security Number.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

DATE OF BIRTH

DESCRIPTION: Enter the eight-digit month/day/year that represents the customer's date of birth (e.g., 01031960).

VALID ENTRIES: **MMDDYYYY**

COMMENTS: Date of birth must be before or on the transaction date.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: All age-related fields, and Member ID.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Format for EDI is YYYYMMDD.

SERVICE FOCUS

DESCRIPTION:

The Service Focus is a combination of the presenting problem(s) of the customer and the type of treatment the provider is able to provide to the customer. Many facilities provide several types of treatment (e.g., mental health and substance abuse).

The fields required for transaction types will depend on the service focus for the customer. For instance, if the service focus is Mental Health, CAR is required, but ASI/TASI are optional.

Specific edits are in place to ensure the appropriate information is completed for each service focus. In some case, the service focus will effect which type of prior authorization (PA) is allowed, or whether an instant PA is created.

The type of contract an agency has with OHCA will determine which service focus will be allowed to be reported.

VALID ENTRIES:

01 **Mental Health: CAR required, ASI or TASI optional**
This service focus would be used if the provider is treating a consumer for only mental health problems.

02 **Substance Abuse: ASI or TASI required, CAR Optional**
This service focus would be used if the provider is treating a consumer for only substance abuse problems.

03 **Drug Court: ASI required, CAR Optional**
This service focus is used if the provider has a qualified drug court substance abuse treatment program and the consumer has been remanded to drug court treatment. If used, a Drug Court number is required on the CDC. Must be 18 years or older.

06 **Mental Health and Substance Abuse: CAR required, ASI or TASI required**
This service focus is used for consumers in programs that are providing EITHER Mental Health OR Substance Abuse services and referring consumers on to the other type of services that is not being treated at that provider.

09 **Special Populations Treatment Unit: ASI Required, TASI not reportable, CAR Optional**
SPTU is for offenders who are incarcerated or have been released from prison and are on probation/parole. If used, a DOC number is required on the CDC. Must be 16 years or older.

11 **Other (Residential Care, Homeless and Housing Services,**

Employment Services, ICCD Clubhouses, Divorce Visitation Arbitration): CAR optional, ASI/TASI not reportable.

12 **PACT: CAR Required, ASI required within 6 weeks of Admission or if CAR substance abuse domain >= 30, otherwise ASI is optional**
The Program of Assertive Community Treatment (PACT) is an effective, evidenced-based, outreach-oriented, service delivery model using a 24-hour-per-day, seven-days-per-week approach to community based mental health services. Must be 18 years or older.

13 **Co-Occurring (Mental Health and Substance Abuse): CAR required, ASI/TASI required**
This service focus is used for consumers in programs that are providing BOTH Mental Health AND Substance Abuse service at the same time (fully integrated programs). Also, no gambling problems are present.

14 **SOC (Systems of Care): CAR required, ASI/TASI optional**
This service focus is used for customer in the Systems of Care program only.

15 **Mental Health Court: CAR required, ASI optional**
This service focus is used if the provider has a qualified mental health court substance abuse treatment program and the consumer has been remanded to mental health court treatment. Must be 18 years or older.

16 **ICC (Intensive Care Coordination): CAR required, ASI optional**
Intensive Care Coordination Teams are designed to transition individuals with serious mental illness from Griffin Memorial hospital or the Oklahoma County Crisis Center to community mental health centers.

17 **Mental Health Court/PACT: CAR Required, ASI required if CAR substance abuse domain >= 30, otherwise ASI is optional**
Must be 18 years or older.

18 **ICC/Mental Health Court: CAR required, ASI optional**
Must be 18 years or older.

19 **Gambling Addiction: CAR and SOGS required, ASI/TASI optional**
This service focus would be used if the provider is treating a customer with only gambling problems. No other mental health or substance abuse problems are present.

20 **Gambling/Mental Health: CAR and SOGS required, ASI/TASI optional**
This service focus would be used if the provider is treating a customer with gambling and mental health problems. No substance abuse problems are present.

21 **Gambling/Substance Abuse: CAR optional, ASI/TASI and SOGS required**
This service focus would be used if the provider is treating a customer with gambling and substance abuse problems. No mental health problems are present.

22 **Reentry Intensive Care Coordination Team (RICCT) Mental Health: CAR required, ASI optional**

23 **Day School: CAR optional, ASI or TASI required**

24 **Medication Clinic Only Customer: CAR required, ASI/TASI optional**

26 **Mobile Crisis: CAR/ASI/TASI not allowed**

27 **Long-term Inpatient: CAR required, ASI/TASI optional**

30 **ODMHSAS State-Operated Facilities Only: CAR/ASI/TASI optional**

31 **CALOCUS**

32 **Urgent Recovery: CAR optional, ASI/TASI optional**

33 **Medical Operation Assessment**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: LOF, Drug Court ID, DOC Number, CAR, ASI, TASI, Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

RACE

DESCRIPTION: The codes, based on U.S. Census Bureau definitions, are as follows:

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Black/African American: A person having origins in any of the black racial groups of Africa.

American Indian: A person having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent. This area includes, for example, China, India, Japan, Korea, and the Philippine Islands.

VALID ENTRIES: **Mark all applicable races.**

COMMENTS: At least one race must be selected, but multiple races are allowed.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Race is a loop within the EDI. The codes for race in EDI are: 1 for American Indian or Alaskan Native, 2 for Asian, 3 for Black or African American, 4 for Native Hawaiian or Other Pacific Islander, 6 for White.

SOCIAL SECURITY NUMBER (SSN)

DESCRIPTION: All agencies are required to collect and report SSN. The SSN reported on the CDC should be the SSN that is on the Medicaid file for the customer. If the SSN is incorrect you can contact the PICIS help desk for instructions on how to fix it.

VALID ENTRIES: **Any valid Social Security Number**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

ETHNICITY

DESCRIPTION: Hispanic/Latino: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish origin or descent. If only Hispanic/Latino then Race is White.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: If Hispanic/Latino is yes or no, you still must choose a race.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Race.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

GENDER

DESCRIPTION: Identifies the customer's gender.

VALID ENTRIES: **F** Female

M Male

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Pregnant and Maiden Name fields.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Female = 01, Male = 02.

ALERT INFORMATION

DESCRIPTION: Should an item of concern need to be identified, staff can briefly identify the nature of the concern. This is **not** a required field.

VALID ENTRIES: **Any 50-character response.**

COMMENTS: In the past, this field has allowed ODMHSAS to collect new information without having to change the CDC. After the Murrah Building Bombing, this field was used to identify the different groups of individuals receiving treatment. For example, using the words survivor, relative, rescue worker, and the like helped us determine who was seeking services and what populations might not be accessing care.

Frequently, agencies use this field to help them identify a certain population. At one provider, this field is used to report allergies. At another provider, the field identifies individuals at risk of suicide or individuals with depression. At another provider, it identifies individuals with possible contagious health-related conditions.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Optional.

SCREENING

DESCRIPTION: Screening is a formal process to determine the likelihood that an individual may be experiencing mental health, substance abuse, trauma or gambling related disorders. The purpose is not to establish the presence or specific type of such disorder but to establish the need for more in-depth assessment.

List of **possible** screening tools to utilize:

1. Integrated Screens
    a. OK COD Screen
    b. AC-COD Screen
2. Mental Health Screens
    a. Mental Status Exam (MSE)
    b. Mini-Mental Status Exam (MMES)
    c. Brief Symptom Inventory (BSI)
    d. Brief Psychiatric Rating Scale (BPRS)
    e. Mental Health Screening Form III
    f. BASC-2
3. Substance Use Screens
    a. Brown Two-Item
    b. CAGE/CAGE-AID
    c. TWEAK
    d. T-ACE
    e. Alcohol Dependence Scale (ADS)
    f. MAST (including brief and short variations)
    g. DAST (including 10, 20, and 28 item variations)
    h. DALI
    i. AUDIT and variations
    j. ASSIST
    k. UNCOPE
    l. CRAFFT
    m. CIWA-Ar
    n. SASSI
4. Trauma Screens
    a. LSC-R
    b. PCLC
    c. Trauma Questionnaire from START
5. Gambling Screens
    a. BBGS
    b. SOGS

Enter 1 for ‘Positive’ (Need for further assessment), 2 for ‘Negative’ (No need for further assessment), and 3 for ‘Not Administered’ in the box next to each screen type

Valid Entries:	**1**	Positive
	2	Negative
	3	Not administered

COMMENTS: 1, 2 or 3 must be selected for each of the four screens (Mental Health, Substance Abuse, Trauma and Gambling).

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Screening is a loop in EDI.

PRIMARY REFERRAL

DESCRIPTION: At admission (transaction type 23) or pre-admission/contact (transaction type 21 or 27), enter the referral code that best indicates FROM whom\where the individual was referred for services. Using the referral code list on the back of the CDC or in the Appendix, enter the two-digit code that corresponds to the referral source.

At discharge (transaction type 60-72), Primary Referral should indicate TO where the customer is being referred.

Referral does not need to be changed on information updates (41), level of care changes (40), or treatment extension/outcome updates (42).

VALID ENTRIES: **2 characters - see code list in appendix.**

COMMENTS: It is common for agencies to over report "01 – Self." While it may be common for customers to report self-referral, in many situations they have been 'encouraged' to seek treatment from an external source. It is important to identify these external sources to determine the number of customers involved in other systems such as the criminal justice or social services system.

Another common error is not updating the referral source at discharge. This is especially true for agencies that have data systems that copy the admission referral to the discharge screen. It is extremely important that agencies indicate where the customer has been referred for continuing services after discharge, if they are being returned to the criminal justice system, or if no further services are indicated. If a provider is recommending customers should continue to attend self-help groups, it is particularly important that this referral be reported.

If referral is 40, then a referral provider NPI number must be reported in the next field. Referral type 36 can only be used with transaction type 68. Referral type 28 can only be used with transaction types 62 and 67. Primary and Secondary referral cannot be the same, except for referral type 40. Referral type "06-Employer/Union" and "26-Reachout Hotline/Advertising Media" cannot be used at discharge. Referral type "31-Additional Service Recommend, Referral not Attainable" can only be used at discharge (transaction types 60-72). Referral type 39 can only be used with a transaction type 64.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Transaction Type, Referral Agency, and DHS Case Number.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Referral and Referral Agency are a loop in EDI.

PRIMARY REFERRAL AGENCY NUMBER

DESCRIPTION: If the primary referral is from an ODMHSAS/OHCA Funded Provider (referral code 40), the ten-character NPI for that provider must be entered. If the provider has several NPIs, only one is needed. If the primary referral is from an organization that is not funded by ODMHSAS/OHCA, leave this field blank.

VALID ENTRIES: **A 10 character NPI**

COMMENTS: Primary Referral Agency cannot be the same as Secondary Referral Agency. Providers cannot refer to themselves. The referral provider must have a current contract with OHCA or ODMHSAS.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Primary Referral.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if primary referral is 40.

EDI ISSUES: Referral and Referral Agency are a loop in EDI.

SECONDARY REFERRAL

DESCRIPTION: Should there be a secondary referral, enter the appropriate referral code of the additional referral. At admission (transaction type 23) or pre-admission/contact (transaction type 21 or 27), enter the referral code that best indicates FROM whom\where the individual was referred for services. Using the referral code list on the back of the CDC or in the Appendix, enter the two-digit code that corresponds to the referral source.

At discharge (transaction type 60-72), Primary Referral should indicate TO where the customer is being referred.

Referral does not need to be changed on information updates (41), level of care changes (40), or treatment extension/outcome updates (42).

VALID ENTRIES: **2 characters - see code list in appendix.**

COMMENTS: It is common for agencies to over report "01 – Self". While it may be common for customers to report self-referral, in many situations they have been 'encouraged' to seek treatment from an external source. It is important to identify these external sources to determine the number of customers involved in other systems such as the criminal justice or social services system.

Another common error is not updating the referral source at discharge. This is especially true for agencies that have data systems that copy the admission referral to the discharge screen. It is extremely important that agencies indicate where the customer has been referred for continuing services after discharge, if they are being returned to the criminal justice system, or if no further services are indicated. If a provider is recommending customers should continue to attend self-help groups, it is particularly important that this referral be reported.

If referral is 40, then a referral provider NPI number must be reported in the next field. Referral type 36 can only be used with transaction type 68. Referral type 28 can only be used with transaction types 62 and 67. Primary and Secondary referral cannot be the same, except for referral type 40. Referral type "06-Employer/Union" and "26-Reachout Hotline/Advertising Media" cannot be used at discharge. Referral type "31-Additional Service Recommend, Referral not Attainable" can only be used at discharge (transaction types 60-72). Referral type 39 can only be used with a transaction type 64.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Some referral codes are required for certain discharges and some can only be used with particular transaction types. If the secondary referral code is 40, then a

secondary provider code must be reported. There are six additional referrals that are open for the secondary referrals, but those are only for the customers regarding residential treatment. For these additional codes, inter-related fields are the agency, transtype, gender, level of care, pregnancy, and due date.

REQUIRED, CONDITIONAL OR OPTIONAL: Optional.

EDI ISSUES: Referral and Referral Agency are a loop in EDI.

SECONDARY REFERRAL AGENCY NUMBER

DESCRIPTION: If the secondary referral is from an ODMHSAS/OHCA Funded Provider (referral code 40), the ten-character NPI for that provider must be entered. If the provider has several NPIs, only one is needed. If the secondary referral is from an organization that is not funded by ODMHSAS/OHCA, leave this field blank.

VALID ENTRIES: **A 10-character NPI**

COMMENTS: Primary Referral Agency cannot be the same as Secondary Referral Agency. Providers cannot refer to themselves. The referral provider must have a current contract with OHCA or ODMHSAS.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Secondary Referral.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if secondary referral is 40.

EDI ISSUES: Referral and Referral Agency are a loop in EDI.

COUNTY OF RESIDENCE

DESCRIPTION: This is the county where the individual is residing at the time of transaction. Each county in Oklahoma has a two-digit numerical code.

If the individual is an Oklahoma resident, enter the county code that corresponds to his/her county of residence. If the individual is a resident of another state, then enter the two-character alpha code that corresponds to that state. If the individual is homeless, report the county in which the individual spent the previous evening. If the individual is in an institution or in prison, report the county where the provider is located.

VALID ENTRIES: **See appendix for code list.**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

ZIP CODE

DESCRIPTION: The five-digit zip code associated with the individual's address must be completed. In addition, the "Zip Plus Four" can be reported if known. If determined that the individual is "Homeless-Streets," with no legal address, enter 99999. If all nines are entered, then the current residence must equal "Homeless-Streets" (J). If customer's residence is "Homeless-Shelter" (I), report the zip code of the shelter.

VALID ENTRIES: **5 or 9 characters**

COMMENTS: To find a zip code for an address, you may use this link: http://zip4.usps.com/zip4/welcome.jsp (dated 2/3/2010).

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Residence.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

SECTION II & III

RESIDENCE

DESCRIPTION: For inpatient settings (hospitalization, residential treatment, halfway house, crisis unit, etc.) at admission, the residence is based on where the customer residence was before entering treatment. For these settings at discharge, report to where the customer is going. For outpatient treatment, the residence is based on where the customer currently is living.

VALID ENTRIES:

A **Permanent Housing -** Permanent housing is integrated in the community (house, duplex, mobile home, apartment, retirement living center, school dormitory, fraternity/sorority, etc.). Housing either is owned by the person or includes the full rights of tenancy; including a lease, a key, privacy, and the choice of a roommate, where relevant. Specialized housing support services are not provided (although the person may be receiving general outpatient mental health/addiction services). This also includes all facets of foster care.

B **Permanent Supported Housing - Non-Congregate -** Permanent housing integrated in the community (house, duplex, mobile home, apartment). Typically housing will be scattered in the community, however, if housing unit is in a complex (such as apartments), no more than half of the total number of apartment units would have people with mental illness and/or addiction disorders living in them. Housing either is owned by the person or includes the full rights of tenancy; including a lease, a key, privacy, and the choice of a roommate, where relevant. Specialized housing support services (on-going and regular) are being provided in the home/community targeted to assist people with mental illness and/or addiction disorders with maintaining safe and affordable permanent housing (e.g., evaluation of housing support needs; assistance with accessing and maintaining income/benefits; assistance with other home management activities such as housekeeping, paying bills, budgeting, grocery shopping and food preparation; and assistance with building relationships/natural supports (including landlord, neighbors, family, friends, and cultural and social networks). Although the person may be receiving general outpatient mental health/addiction services that may periodically or indirectly address housing needs (such as general case management), this residence designation can only be used if the person is receiving specialized housing support services.

C **Permanent Supported Housing - Congregate -** Permanent housing in a setting typically with multiple housing units (such as apartments), where more than half of the total number of housing units have people with mental illness and/or addiction disorders living in them. This also includes housing with single room occupancy (SRO) units, where a person has a one-room apartment and shares common living areas (such as living room, kitchen and in some cases a bathroom). All housing includes the full rights of tenancy, including a lease, a key, privacy, and the choice of a roommate, where relevant. Ongoing and regular, specialized housing support services are being provided in the home/community targeted to assist people with mental illness and/or addiction disorders with maintaining safe and affordable permanent housing (e.g., evaluation of housing support needs; assistance with accessing and maintaining income/benefits; assistance with other home management activities such as housekeeping, paying bills, budgeting, grocery shopping and food preparation; and assistance with building relationships/natural supports (including landlord, neighbors, family, friends, and cultural and social networks). Although the person may be receiving general outpatient mental health/addiction services that may periodically or indirectly address housing needs (such as general case management), this residence designation can only be used if the person is receiving specialized housing support services.

D **Transitional Housing -** Transitional residence for people with mental illness and/or addiction disorders needing on-site supports (includes transitional living facilities). This type of housing is intended to assist residents with stabilization and acquisition of skills necessary to transition to permanent supported or permanent housing.

E **Temporary Housing -** Housing in the community in which the person's stay in the residence is considered temporary and time-limited in nature. Includes hotels/motels and people who are sleeping on the sofa or floor of a friend or family member (no permanent residence). Also includes OJA/DHS shelters.

F **Residential Care Facility/Group Home -** A group living environment (shared living spaces) specifically for the room, board, and care of people with mental illness (including youth with a serious emotional disturbance) and physical disabilities. Medical staff is not required for this setting.

G **Nursing Home -** A group living environment specifically for the care of older people and people with mental illness and physical disabilities. Medical staff is required for this setting.

H **Institutional Setting -** includes psychiatric institutions, schools for people with mental and physical disabilities, and correctional facilities. If institutional setting is selected, then living situation for the customer must equal 1 (alone).

I **Homeless - Shelter -** includes a domestic violence shelter, shelter for displaced or homeless individuals (like Salvation Army, Jesus House, etc.). The zip code and address of the shelter should be reported when residence = "Homeless-Shelter."

J **Homeless - on the street -** should be reported for anyone living on the street, in their car, or in any place not meant for human habitation. The zip code should be '99999' and address can either be the word "Homeless" or the address of the provider. City, county, and state should be where they slept last night.

COMMENTS:

A homeless person under CDC criteria is a person who: (a) lacks a fixed, regular and adequate night time residence AND (b) has a primary night time residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations including welfare hotels, congregate shelters, halfway houses, and transitional housing for the mentally ill; or an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, not limited to people living on the streets. Individuals are considered homeless if they have lost their permanent residence, and are temporarily living in a shelter to avoid being on the street.

Customers can self-report that they are homeless. If they lose their housing and they have to sleep in a shelter or on the streets as identified above, then they would count as homeless. Only one night meets the conditions to be homeless. If they are in a hospital they are not counted as homeless. Prisoners being released or in the custody of a correctional facility are not considered homeless at the time of admission for treatment. The definition also excludes persons in a hospital, residential care facility, commercial hotel/motel, supervised apartment, or living with parent/other relative (even if only temporarily). The definition does include domestic violence and sexual assault shelters, as the persons have fled a residence that is not adequate (i.e., not safe).

If an individual selects 'H-Institutional Setting' then '1-Alone' must be selected for Living Situation.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Living Situation, Zip Code and In Prison or Jail.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

IS CUSTOMER IN PRISON OR JAIL?

DESCRIPTION: This field is used to identify individuals in prison or jail.

VALID ENTRIES:

1 Prison - indicates the customer is incarcerated in a state or federal correctional facility.

2 No

3 Jail – indicates the customer is incarcerated in local law enforcement facility (county, city, township, etc.)

COMMENTS: If customer is in '1 – Prison' or '3 – Jail,' then residence must be 'H - Institutional Setting' and living situation is '1 – Alone.' For Prison, customer must be greater than 12 years of age.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Living Situation, Residence.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

LIVING SITUATION

DESCRIPTION: Living situation relates to the residence reported in previous field and indicates with whom the customer is residing.

VALID ENTRIES:

1 **Alone** - indicates the customer is living with no one; or living in an institutional or communal setting. In other words, the customer resides alone or in a setting with individuals in which interaction may only occur because of residing in the same building.

2 **With Family/Relatives** - indicates that the customer is living with a spouse, children, parents, siblings, grandparents, aunts, uncles, etc.

3 **With Non-Related Persons** - indicates friends or other non-related persons. In other words, the individuals living in the residence have agreed to share the same household, but are not related by blood or marriage. This should not be selected if the customer is living in a setting with individuals in which interaction may only occur because of residing in the same building (i.e., jail, residential care home, institutional setting).

COMMENTS: If Residence is 'H - Institutional Setting,' then Living Situation is '1 – Alone.' Even though a customer is financially independent of their family, if an adult customer is living with parents or family members, please report '2 – With Family/Relatives.'

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Residence.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

CHRONIC HOMELESSNESS

DESCRIPTION: An individual must have been on the streets or in an emergency shelter (i.e., not transitional housing), has been continuously homeless for a year or more OR has had at least 4 episodes of homelessness in the past 3 years and the individual must have a disabling condition.

A disabling condition is a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Chronic homelessness only includes single individuals, not families.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: This data element is collected to help identify individuals who are repeatedly or long-time homeless. Local authorities use this information for planning. In addition, reported data secures continued funding of homeless grants.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

EMPLOYMENT

DESCRIPTION: This field is used to identify the employment status of the customer.

VALID ENTRIES:

1 **Full time** represents gainful employment of 35 or more hours per week.

2 **Part time** represents gainful employment of less than 35 hours per week.

3 **Unemployed** represents an individual who has been laid off, fired, or is temporarily not working and has looked for work during the past 30 days. Unemployed is to be reported only when the individual is seeking gainful employment.

4 **Not in Labor Force** represents an individual not gainfully employed and not looking for employment in the past 30 days, or is incapable of seeking employment. Not in Labor Force may include homemakers, students, children, residents or inmates of an institution, persons retired or disabled, etc.

COMMENTS: Volunteers, if they have no other employment, should be reported in the full-time or part-time employment status depending on the number of hours they volunteer.

For residential treatment, halfway, detox and other inpatient treatment settings, employment status at admission of the customer prior to entering treatment should reported. For example, if a customer is employed full-time, then enrolls themselves in a substance abuse residential treatment program which doesn't allow them to leave the facility, at admission, their employment status would be 1 or 2. If they have lost their jobs prior to entering treatment, employment status would be 3.

At discharge from these same programs, the employment status they are going to should be reported. For example, if a customer has been in a substance abuse residential treatment program, has not been working, but does have a job to return to, their employment status would be 1 or 2.

For outpatient, report the current employment status at the time of the CDC.

If Employment is "4-Not in Labor force," you must select A-F for Type of Employment/Not In Labor Force. If Employment is "3-Unemployed," you must select "4-None" for Type of Employment/Not In Labor Force. If Employment is 1 or 2, then Type of Employment/Not In Labor Force must be 1-3, 5, or 6.

In the event that an individual has an employment status of full-time or part-time and falls into one of the Not In Labor Force categories, such as student, it is recommended that the full-time or part-time status be selected, and the matching Type of Employment be selected, although either would be accurate.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Type of Employment/Not in Labor Force.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

TYPE OF EMPLOYMENT/NOT IN LABOR FORCE

DESCRIPTION: If the customer is employed, choose one of the options which best describes the type of employment. If the customer is unemployed, mark 'none.' If customer is not in the labor force, choose one of the options from A - F.

VALID ENTRIES:

1 **Competitive -** Work performed on a full-time or part-time basis for which an individual is compensated in accordance with the Fair Labor Standards Act.

2 **Supported -** Work performed on a full-time or part-time basis for which an individual is compensated in accordance with the Fair Labor Standards Act, works in an integrated work setting, and receives ongoing support services in order to perform their job. Supported employment assists individuals with disabilities for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

3 **Volunteer -** Work performed in which an individual has a set time schedule and work responsibilities but does not receive a monetary salary. Employment should be marked either full or part-time.

4 **None -** If the customer is unemployed, you must check None for Type of Employment.

5 **Transitional -** Temporary work site placement. Job placement and training responsibility of the service provider (i.e., psychosocial clubhouse) rather than the employer. Worker is paid at least minimum wage, works in an integrated work site (primarily with persons without disabilities), and is paid wages from the employer.

6 **Sheltered Workshop -** Non-integrated work site comprised primarily of persons with disabilities. May be paid less than minimum wage.

A **Homemaker –** a person who manages a household.

B **Student –** a person who is in school.

C **Retired –** a person who has withdrawn from his or her occupation.

D **Disabled –** A person who has a physical or mental impairment seriously limiting one or more functional capacities (such as mobility, self-care, communication, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome.

E **Inmate –** Prison or institution that keeps a person, otherwise able, from entering the labor force.

F **Other**

COMMENTS: If type of employment is A-F, then Employment must equal "4-Not in Labor force." If type of employment is 4, then Employment must equal "3-Unemployed." If type of employment is 1, 2, 3, 5, or 6, then Employment must equal 1 or 2.

In the event that an individual has an employment status of full-time or part-time and falls into one of the Not In Labor Force categories, such as student, it is recommended that the full-time or part-time status be selected, and the matching Type of Employment be selected, although either would be accurate.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Employment.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDUCATION (HIGHEST GRADE COMPLETED)

DESCRIPTION: This represents the highest grade completed by the customer. Twenty-five is the maximum number that can be reported.

VALID ENTRIES:

00	No education
01-12	Completed grades 01-12
12	Completed GED
13	Completed freshman year of college
14	Completed sophomore year of college
15	Completed junior year of college
16	Completed senior year of college
17	Completed Master's Degree
18-25	Add 1 for each additional year after Masters, with a maximum of 25**.**

COMMENTS: This federal definition does not include career and vocational training. We have asked the federal government to consider modifying the definition, but they have yet to do so. Education must be '00' if age is less than 5. Education cannot be greater than customer's age.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

IS CUSTOMER CURRENTLY IN SCHOOL?

DESCRIPTION: The "In School" variable reflects the person's school attendance for the last month the school was **in session**. If the person attended school at least once in the last month the school was in session, then mark "Yes," else mark "No." School includes kindergarten through high school, college, vocational training and trade schools.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

MILITARY STATUS

DESCRIPTION: Describes the customer's current status or previous status in the military.

VALID ENTRIES:

1 **VETERAN -** A veteran is a person, 16 years or over, who has served (regardless of the amount of time, type of discharge, or eligibility status for VA benefits) but is not now serving on active duty in the U.S. Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service Commissioned Corps, or who served as a Merchant Marine seaman during World War II. Persons who served in the National Guard or Military Reserves are classified as veterans only if they were ever called or ordered to active duty not counting the 4-6 months for initial training or yearly summer camps.

2 **NO -** Not a veteran or on active duty.

3 **ACTIVE -** Individual is currently serving full time in the military. Members of a reserve are not considered active duty. Individual must be 16 years or older.

COMMENTS: This field was previously titled "Veteran Status." The field was changed on 7/1/2010 to include active military value, a value recommended by NASMHPD Research Institute and soon to be required by SAMHSA for block grant reporting.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

MARITAL STATUS

DESCRIPTION: This field describes the customer's marital status. The following categories are compatible with the U.S. Census.

VALID ENTRIES:

1 **NEVER MARRIED –** refers to individuals who have legally never married, reports that he/she has never entered into a marriage contract, or has had a marriage annulled.

2 **MARRIED -** refers to individuals who report that they are legally married.

3 **DIVORCED -** refers to individuals who have previously been legally married, but marriage was legally dissolved by a court.

4 **WIDOWED -** refers to an individual whose spouse is no longer living.

5 **LIVING AS MARRIED -** refers to individuals who are not legally married, but who report that they have a marital living arrangement.

6 **SEPARATED -** refers to legal separations and individuals who report they are no longer living with a spouse, but are not legally divorced.

COMMENTS: A common data collection error is to reverse 'never married' and 'married.' This happens because data collection staff are used to using the '1-yes; 2-no' questions. When they ask 'are you married' and the customer responds 'yes', many times they mark it as '1' for 'yes.' This is incorrect. A 'yes' response to that question should be '2 – married.'

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

IS CUSTOMER PREGNANT?

DESCRIPTION: Describes if the customer is pregnant.

VALID ENTRIES: **1** YES - Customer is pregnant

2 NO - Customer is not pregnant

COMMENTS: Prior to 7/1/2010, values for the field were 0 for not pregnant or male and 1-9 to indicate the number of months pregnant. Field was changed because of the large number of mistakes reported by providers. If customer is male, the field must remain blank. If female, the field is required. If response is "yes," customer age must be 12-55 years of age.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Expected date of birth and gender.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if customer is female.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

IF YES ENTER EXPECTED DOB, BLANK IF NO

DESCRIPTION: If customer is pregnant, report the anticipated date of birth. Date can be an estimate.

Leave blank if not pregnant.

VALID ENTRIES: **MMDDYYYY**

COMMENTS: Field was added 7/1/2010 to help minimize the number of mistakes in reporting for 'Is customer pregnant?'. Due date cannot be less than transaction date. Due date cannot be more than nine months from transaction date.

FEDERALLY REQUIRED FIELD: Expected due date is not required by federal government, but some indication of whether female customers is pregnant are required.

INTER-RELATED FIELDS: 'Is Customer Pregnant' and Gender.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if 'is customer pregnant' is yes.

ANNUAL INCOME

DESCRIPTION: Enter the dollar amount only (no cents), which represents the total combined annual income of the customer and any individuals with which the customer is financially interdependent. If annual income is unknown, multiply the estimated monthly income by 12.

As defined by the DMHSAS eligibility criteria, income includes total annual cash receipts before taxes from all sources, with the exceptions noted below:

Income includes money, wages, and salaries before any deductions; net receipts from non-farm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses); net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses); regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and non-federally-funded General Assistance or General Relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

Income does not include non-cash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied non-farm or farm housing, and such federal non-cash benefit programs as Medicare, Medicaid, food stamps, school lunches, loans, and housing assistance.

VALID ENTRIES: **000000 – 999999** **If there is no annual income, enter zeros.**

COMMENTS: In the case of adult customers living with their family, such as parents, aunts/uncles or brothers/sisters, only the income of the customer should be listed. The income of the parents or

family members providing a home to the adult customer should not be included in this total. A spouse or child living with the customer and providing income would be included in the income total. For children, report the income of the parents/legal guardian.

All children seventeen years of age or younger in need of behavioral health services funded by the ODMHSAS may be served regardless of income level. For children, report the income of the parents/legal guardian.

For children in OJA or DHS custody, income can be zero.

Income must be integers with no commas.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

NUMBER CONTRIBUTING TO AND/OR DEPENDENT UPON "ANNUAL INCOME"

DESCRIPTION: Enter the number (01-15) of individuals dependent upon or contributing to the income of the customer. This should reflect the customer, family members, or significant others who are interdependent financially. It should indicate the number of people who must live on the income reported in the annual income field. This field is used in conjunction with Annual Income to determine the eligibility of the customer for payment of services by DMHSAS.

NOTE: In the case of an adult customer living with his/her parents or other family, where only the income of the customer was listed, then the number contributing to and/or dependent upon the income should be listed as "1" to indicate the customer only and not the parents.

However, if the adult customer has dependents also living with him/her in the parents' household, then the dependents should be reported in the number while still excluding the parents of the adult customer.

When an adult customer is living with his/her parents or family (other than spouse) the living situation should be reported as "with family members" and the number reported here will still be "1."

VALID ENTRIES: **01-15**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

SUPPLEMENTAL SECURITY INCOME (SSI)

DESCRIPTION: SSI is a federal needs-based program (Title XVI of the Social Security Act) that provides monthly payments to aged, blind, and disabled persons who have little or no resources and income.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

DESCRIPTION: This federal program (Title II of the Social Security Act) provides cash benefits for those disabled workers (and their dependents) that have contributed to the Social Security Trust Fund through the withholding of FICA tax on their earnings or through direct payment of FICA tax by self-employed individuals. This is not a needs-based program.

VALID ENTRIES:

1 Yes

2 No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

MEDICARE

DESCRIPTION: These fields indicate whether the customer is currently Medicare eligible.

VALID ENTRIES: **1** Yes

2 No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

MEDICAID

DESCRIPTION: This field indicates whether the customer is currently Medicaid eligible.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

DOES CUSTOMER SPEAK ENGLISH WELL?

DESCRIPTION: A customer speaks English well if she/he is able to understand and convey information in English.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: If the answer is "2-No," then "If no, what language is preferred?" must be completed. If English proficiency is "1-Yes," then the preference and specification must be blank.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: 'If no, what language is preferred?' and 'If language 2 or 9, then specify.'

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

IF NO, WHAT LANGUAGE IS PREFERRED?

DESCRIPTION: If customer does not speak English well, what is the preferred language?

VALID ENTRIES:

1	Spanish
2	American Indian (specify)
3	German
4	French
5	Vietnamese
6	Chinese
7	Slavic (Russian, Polish, etc.)
8	Sign Language
9	Other (specify)

COMMENTS: If a child is not old enough to speak, report the language preference of the child's family. If the answer is 2 or 9, then "IF LANGUAGE 2 OR 9, THEN SPECIFY" must be reported. Otherwise, language specification must be blank.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: 'Does customer speak English well' and 'If language 2 or 9, then specify.'

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if customer does not speak English well.

IF LANGUAGE 2 OR 9, THEN SPECIFY

DESCRIPTION: If customer preferred language is American Indian or Other, report the language preference. Up to 50 characters are allowed.

VALID ENTRIES: **Any language (up to 50 characters).**

COMMENTS: If a child is not old enough to speak, report the language preference of the child's family.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: 'Does customer speak English well' and 'If no, what language is preferred?'

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if preferred language specified is Native North American or other.

DISABILITY

DESCRIPTION: If the customer has one or multiple disabilities, enter the appropriate codes. Disability refers to non-mental health disabilities. If the customer does not have a disability, enter 01 in the first field and leave the remaining fields blank. As with all fields, always fill-in the first field, before entering data into a later field. If the selection is "11 - Interpreter for the Deaf," a code of 09 or 10 is required.

VALID ENTRIES:

01 **NONE**

02 **SEMI-AMBULATORY:** Orthopedically impaired which affects the person's performance, either by congenital anomaly (e.g., club foot, absence of a member), disease (e.g., poliomyelitis), or other impairment (e.g., cerebral palsy, fractures, or burns).

03 **NON-AMBULATORY:** Severely orthopedically impaired which adversely affects the person's performance, either by congenital anomaly or other impairment. Impairment so severe as to completely restrict voluntary mobility.

04 **SEVERE SIGHT DISABILITY:** Visual impairment which, even with correction/prescription lenses, adversely affects performance.

05 **BLIND:** Not having the ability to see. Absence of perception of visual stimuli.

06 **ORGANIC BASED COMMUNICATION DISABILITY:** A communication disorder (e.g., language impairment or voice impairment) which adversely affects communication.

07 **CHRONIC HEALTH PROBLEM:** Limited strength and vitality or alertness due to a chronic health problem such as heart problems, tuberculosis, asthma, epilepsy, or diabetes.

08 **MENTAL RETARDATION/DEVELOPMENTAL DISABILITY:** Significantly sub-average general intellectual functioning existing concurrently with a deficit in adaptive behavior and manifested in the developmental period which adversely affects performance.

09 **HARD OF HEARING:** Only partial recognition of spoken language. Conversation must be in close proximity to the person and be unusually clear for understanding. The individual experiencing the hearing disorder should make the designation of

hard of hearing or deaf.

10 **DEAF:** Inability to recognize sounds or word combinations sufficiently to carry on normal oral communication, even when using amplification devices. The presence or absence of speech by the customer is not taken into consideration for this designation. The individual experiencing the hearing disorder should make the designation of hard of hearing or deaf.

11 **INTERPRETER FOR THE DEAF:** An interpreter for the deaf may be either a sign language interpreter or an oral interpreter for the deaf. If code 11 is reported, indicating the need for either a sign language interpreter or an oral interpreter to communicate with the customer, then code 09 or 10 must be reported as well.

COMMENTS: A provider can report up to four disability codes. If the first code is "01-none," then Disability fields 2, 3 and 4 must be blank.

FEDERALLY REQUIRED FIELD: No

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

EDI ISSUES: Disability is a loop in EDI.

LEGAL STATUS

DESCRIPTION: Enter the number that denotes the legal status of the customer at the time of transaction. There are three general categories of legal status: voluntary, court commitment, and court referred. Although there are 11 distinctive legal status codes, each of them fall into one of the previously mentioned categories. Outpatient providers typically report codes 01 and 15.

VALID ENTRIES:

01 **VOLUNTARY ADMISSION**: Individual who applies for admission voluntarily to the provider and is accepted as a patient. This applies to Mental Health and Substance Abuse facilities pursuant to Title 43A.

03 **CIVIL COMMITMENT:** A court order under the Mental Health Code requires the individual to receive services involuntarily from the agency. (Mental Health Law Title 43A). This was formerly identified as Court Commitment.

05 **NOT GUILTY BY REASON OF INSANITY (NGRI):** An individual who is acquitted of a criminal act on the ground that he/she was insane at the time of the act. An individual may then be court committed to the agency under the Mental Health Code. The court must be notified twenty days prior to proposed discharge. In some facilities this is categorized as a District Court commitment. (Criminal Statutes Titles 22, 1161). This is only reportable by the Oklahoma Forensic Center.

07 **JUVENILE COURT ORDER:** Requires a minor to be detained in a specified location for examination and/or treatment. (Juvenile Statutes Title 10). This legal status can include juveniles who are Adjudicated Deprived, Delinquent, In Need of Supervision, or In Need of Mental Health Treatment in accordance with Title 43A O.S.

09 **COURT ORDER FOR OBSERVATION AND EVALUATION:** The court requires the agency to examine the individual in a specified period of time <u>to determine if the individual is competent to stand trial.</u>

12 **EMERGENCY DETENTION:** Patient arrival at a facility from a point of emergency examination with three (3) required forms: a) Petition; b) Licensed Mental Health Professional's Statement; c) Peace Officer's Affidavit. An individual cannot be detained in a facility for more than 72 hours, excluding weekends and holidays,

pending court hearing. (Mental Health Law Title 43A)

13 **CONTINUED EMERGENCY DETENTION:** Patient has been evaluated at a facility. He/she has the three (3) required forms (listed above) and an order has been issued for additional detention. Time and place of hearing has been set. (Mental Health Law Title 43A)

15 **COURT REFERRED:** An individual who has been evaluated by a agency and referred for treatment by the court. Referrals for treatment should be accompanied by proper documentation indicating the need for treatment. This legal status includes but is not limited to mental health and drug court participants, DUI customers, individuals who are community sentenced, and DHS child custody cases. (Title 47)

17 **PROTECTIVE CUSTODY:** Status of an individual taken into protective custody and detention of a person pursuant to the provisions of Section 5-208 until such time as an emergency examination is completed and a determination is made as to whether or not emergency detention is warranted. (Mental Health Law Title 43A)

20 **CRIMINAL HOLD:** Adjudicated by the court to be incompetent, but capable of achieving competency (22 O.S. § 1175.6(2))

21 **COURT COMMIT WITH HOLD:** Adjudicated by the court to be incompetent and incapable of achieving competency within a reasonable time (22 O.S. § 1175.6(3))

COMMENTS:

Court Commitment is when a court action requires that the customer be evaluated, detained pending a court hearing, or receive services at a particular treatment facility. In most cases, court papers will accompany the customer or be submitted to the facility. This action is not only requiring the individual to receive services, it requires the particular facility to accept the customer for treatment. Court commitments general occur within an **inpatient mental health setting**. These are the ONLY legal statuses which qualify for the discharge status "67 – AWOL." Court Commitment legal status codes are 03, 05, 07, 09, 12, 13, 17, 20, and 21.

Court Referred is when a court may order an individual to seek and receive services in order to fulfill some part of their sentencing or in lieu of jail detention. However, this is NOT a court commitment. Examples of court referred individuals include, but are not limited to mental health and drug court participants, DUI offenders, individuals in a community sentencing program and DHS child custody cases. In all these instances, the legal status would be "15 – Court Referred." Frequently the papers accompanying the individual come from a judge and even contain the language "Court Referral or Court Order." However, this order is for the individual to seek and receive services, not for the

facility to accept the individual as a customer. If a customer leaves this facility setting prior to completing their treatment plan, it is **NOT** a discharge "67 – AWOL." You must choose the appropriate discharge code that indicates why the customer left prior to completing treatment. If a legal status of 01 or 17 is selected, county of commitment must be blank.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: County of Commitment.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: not required for customers less than 18 years of age.

COUNTY OF COMMITMENT

DESCRIPTION: If the customer has been remanded through the court or criminal justice system to a facility for treatment, the county in which the legal proceedings took place is to be reported in this field. The county of commitment may differ from the customer's county of residence.

VALID ENTRIES: **A 2 characters county code - see appendix for code list of counties**

COMMENTS: If the legal status code = 01 or 17, you must leave this field blank. Any other legal status code requires county of commitment to be completed. County of commitment must be from an Oklahoma county and cannot be from another state.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Legal Status.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required if legal status in (03, 05, 07, 09, 12, 13, 15, 20, 21); not required for customers less than 18 years of age.

TOBACCO USE

DESCRIPTION: Report the number of times tobacco is used on a typical day. A typical day refers to what the customer would normally use tobacco if there were no residency restrictions (e.g., admitted to inpatient). Any type of tobacco use is included.

VALID ENTRIES: **00-99**

COMMENTS: According to the Centers for Disease Control, "Tobacco use is the single most preventable cause of disease, disability, and death in the United States. Each year, an estimated 443,000 people die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million have a serious illness caused by smoking. For every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness. Despite these risks, approximately 43.4 million U.S. adults smoke cigarettes. Smokeless tobacco, cigars, and pipes also have deadly consequences, including lung, larynx, esophageal, and oral cancers." (http://www.cdc.gov/nccdphp/publications/aag/osh.htm)

This data element helps us identify and enumerate to our stakeholders the additional health challenges faced by our customers. In FY09, approximately 78% of all persons served by ODMHSAS used tobacco.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

PRESENTING PROBLEM

DESCRIPTION: At the time of admission, enter the problem codes representing the identified problems that appear to have caused the customer to seek service. The primary presenting problem **should always** indicate the problem for which the customer will receive services. Up to three presenting problems can be recorded whether or not the provider will provide services for the secondary or tertiary presenting problem.

For example, anxiety/panic and substance abuse may both be identified as presenting problems, but only substance abuse is within the scope of treatment delivered by the provider. Both problems should be listed as presenting problems. Substance abuse must be listed as primary since it will be treated and anxiety/panic should be indicated as secondary since it will not be in the treatment plan.

Refer to the presenting problem code list in the Appendix or back of the CDC form. At a minimum, a primary presenting problem must be reported. Secondary and tertiary presenting problems are not necessarily the problems requiring treatment.

VALID ENTRIES: **A 3 character field**

COMMENTS: If an alcohol presenting problem is indicated (710, 711, 741), you must indicate alcohol in one of the drugs of choice. If a drug presenting problem is indicated (720, 721, 742), you must indicate a drug in one of the drugs of choice. If presenting problems of alcohol and drugs are indicated (730, 731, 743), then drugs of choice must include 02 (alcohol) and a drug (03-21). Primary, secondary and tertiary presenting problems cannot be the same. At least one presenting problem must be selected for each individual, regardless of service focus or program. As with all fields, you must report the first one, before a second or third can be selected.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Service Focus, Drug of Choice.

REQUIRED, CONDITIONAL OR OPTIONAL: Required for Primary, optional for Secondary and Tertiary.

EDI ISSUES: Presenting Problems are a loop in EDI.

DRUGS OF CHOICE

DESCRIPTION: Enter the drug of choice code that identifies each substance for which the customer is seeking treatment or abusing. Up to three drugs of choice can be reported. If the customer is not abusing a substance or seeking treatment for a substance, enter 01-None in the first field and leave the rest blank. As with all fields, always fill-in the first field, before entering data into a later field.

When a substance abuse related problem (problem codes 710, 711, 720, 721, 730, 731, 741, 742, 743) is reported as a Primary, Secondary, or Tertiary presenting problem, the substance being abused must be identified in Drugs of Choice.

VALID ENTRIES:

01	None
02	Alcohol
03	Heroin
04	Non-Prescription Methadone
05	Other Opiates and Synthetics
06	Barbiturates
07	Other Sedatives and Hypnotics
08	Other Amphetamines
09	Cocaine
10	Marijuana/Hashish
11	Other Hallucinogens
12	Inhalants
13	Over-the-Counter
14	Other Tranquilizers
15	PCP
16	Other
17	Unknown
18	Methamphetamine
19	Benzodiazepine
20	Other Stimulants
21	Club Drugs (e.g., GHB, GBL, Ecstasy, Rohipnol)

COMMENTS: If one of the presenting problems is 710, 711, or 741, alcohol (02) must be reported. If one of the presenting problems is 720, 721, or 742, at least one substance (03-21) must be reported. The presenting problem codes 730, 731 and 743, require alcohol and at least one drug be reported. If "12-inhalants" is indicated as the drug of choice, then the route of administration must equal 3 (inhalation). If "02-alcohol" is indicated as the drug of choice, then the route of

administration must equal 1 (oral). If drug of choice is 01 or 17, then the corresponding route of administration, frequency of use, and age first used questions must be blank. No drugs of choice can be the same.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Primary/Secondary/Tertiary Presenting Problem, Route of Administration, Frequency of Use, Age of First Use.

REQUIRED, CONDITIONAL OR OPTIONAL: Required for Primary, optional for Secondary and Tertiary.

EDI ISSUES: Drug of Choice, Usual Route of Administration, Frequency of Use and Age First Used are a loop in EDI.

USUAL ROUTE OF ADMINISTRATION

DESCRIPTION: For each substance identified in Drug(s) of Choice, usual route of administration must be reported. **If no substance was reported (01) or drug of choice is unknown (17), leave this field blank.**

The usual route of administration reported must directly correspond with the drug of choice reported. For example, if Alcohol has been identified in the first field in Drugs of Choice, the first Route of Administration must indicate Oral (1).

VALID ENTRIES:

1	**Oral**
2	**Smoking**
3	**Inhalation**
4	**Injection**
5	**Other**

COMMENTS: If drug of choice is 12-Inhalants, then route of administration must be 3-Inhalation. If drug of choice is 02-Alcohol, then route of administration must be 1-Oral.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Drug(s) of Choice.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if primary drug of choice is **not** 01 or 17. Also required for secondary and tertiary if drugs of choice are reported.

EDI ISSUES: Drug of Choice, Usual Route of Administration, Frequency of Use and Age First Used are a loop in EDI.

FREQUENCY OF USE IN LAST 30 DAYS

DESCRIPTION: For each substance identified in Drugs of Choice, a code must be reported which indicates the frequency with which each substance is used in the last 30 days. **If no substance was reported in Drugs of Choice, leave this field blank.** The Frequency of Use reported must directly correspond with its drug of choice and route of administration that have been reported.

VALID ENTRIES:

1	**No Past Month use**
2	**1-3 Times a Month**
3	**1-2 Times a Week**
4	**3-6 Times a Week**
5	**Daily**

COMMENTS: Frequency of Use should not be reported if the drug of choice is 01-None or 17-Unknown. If secondary or tertiary drug of choice is blank, secondary and tertiary Frequency of Use are left blank. Otherwise, frequency of use is reported.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Drug(s) of Choice.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if primary drug of choice is **not** 01 or 17. Also required for secondary and tertiary if drugs of choice are reported in these fields.

EDI ISSUES: Drug of Choice, Usual Route of Administration, Frequency of Use and Age First Used are a loop in EDI.

AGE FIRST USED

DESCRIPTION: Enter the customer's age, in years, when the customer first used the substance(s) identified in Drugs of Choice. **If no substance was reported in Drugs of Choice, leave this field blank**. The age the drug of choice was first used must directly correspond to the substance abuse problem identified for treatment and the Drugs of Choice, Usual Route of Administration, and Frequency of Use reported.

VALID ENTRIES: **00 – 99**

COMMENTS: Age First Used cannot be greater than the age of the customer. An age should not be reported if the drug of choice is 01-None or 17-Unknown. If secondary or tertiary drug of choice is blank, secondary and tertiary Age First Used are left blank.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Drug(s) of Choice.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required if primary drug of choice is **not** 01 or 17. Also required for secondary and tertiary if drugs of choice are reported.

EDI ISSUES: Drug of Choice, Usual Route of Administration, Frequency of Use and Age First Used are a loop in EDI.

LEVEL OF CARE

DESCRIPTION: Level of care represent the various combinations of treatment programs and activities, staffing patterns, and settings through which services are provided by a provider.

VALID ENTRIES:

OO **Outpatient -** Outpatient level of care includes a range of treatment services provided on an individual or group basis to ambulatory customers residing in the community.

CL **Community Living Programs** include Community Housing Programs, Halfway House Programs, Residential Care, and Shelter Programs

CI **Residential Treatment** does not include residential care facilities.

SN **Detoxification**

SC **Community-based Structured Crisis**

HA **Hospitalization**

COMMENTS: Only report the levels of care for which the provider delivers. If the customer is discharging, indicate the last level of care they received, not the level of care they will be entering once they leave. Level of care directly relates to which prior authorization a customer receives. Incorrect level of care entries will prevent a provider from being able to properly bill services. Level of care cannot be the same as the previous level of care on transaction type 40 (level of care change). The level of care cannot be changed on transaction types 41, 42 or 60-72.

Additional edits look in the type of contract the agency has with OHCA and ODMHSAS and restricts the level of care based on that. For example, an agency that only has a regular mental health agency contract with OHCA, with no extra contract with ODMHSAS, can only report the OO level of care.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Agency.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

CLIENT ASSESSMENT RECORD (CAR)

DESCRIPTION: The CAR is an assessment tool to rate an individual's well-being in nine domains.

The CAR is not required on discharge types 62 (Left ACA), 63 (Moved), 67 (AWOL), 68 (Death), or 69 (Failed to begin treatment).

If the customer scores 30 or above on the substance use domain, he/she should be further assessed for substance use by the provider OR referred for a substance abuse assessment by an external provider. The CAR domains are to be re-administered at every treatment plan update.

VALID ENTRIES: **01-50, 99**

COMMENTS: The CAR is required to be completed on all customers with a service focus of mental health at admission. Record the two-digit (01-50) score for each of the nine subscales. When a CAR score is not available, but required, enter 99 into all fields.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Service Focus.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional – dependent upon service focus.

ADDICTION SEVERITY INDEX (ASI)

DESCRIPTION: The ASI is an assessment tool to rate an individual's well-being in seven domains.

The ASI must be reported on transaction types 23 and 42 for certain Service Focuses. The ASI or the ASI Lite must be reported on transaction types 60, 61, 63, 64 and 70, unless the discharge occurs within 30 days of admission. The ASI is optional on other discharge types.

Record the one-digit (0-9) severity scores for each of the seven subscales.

If the customer scores 4 or above on the psychiatric subscale, he/she should be further assessed for a mental health disorder by the provider OR referred for a mental health assessment by an external provider.

ASI scores are only reported for customers who are 18 years or older.

VALID ENTRIES: **0-9**

COMMENTS: When an ASI score is not available, but required, enter 9 into all fields.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Service Focus.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - dependent upon service focus for individuals 18 years and older. ASI or ASI Lite is required if discharge code is 60, 61, 63, 64, or 70.

TEEN ADDICTION SEVERITY INDEX (T-ASI)

DESCRIPTION: The T-ASI is an assessment tool to rate an adolescent's well-being in seven domains.

The T-ASI must be reported on transaction types 23 and 42 for certain Service Focuses. The T-ASI must be reported on transaction types 60, 61, 63, 64 and 70, unless the discharge occurs within 30 days of admission. The T-ASI is optional on other discharge types.

Record the one-digit (0-4) severity scores for each of the seven subscales.

T-ASI scores are only reported for customers who are between the age of 12 and 17 (under 18 years old).

VALID ENTRIES: **0-4, 9**

COMMENTS: When a TASI score is not available, but required, enter 9 into all fields.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional – dependent on service focus for individuals under 18 years of age. The T-ASI is also required if discharge code is 60, 61, 63, 64, 70.

CURRENT LOF (GAF SCALE)

DESCRIPTION: Current Level of Functioning is an assessment of the customer's level of functioning that should be done at each transaction except 41. Refer to the Global Assessment of Functioning Scale in the Appendix or the DSM-IV Manual.

VALID ENTRIES: **01-99**

COMMENTS: Level of functioning is optional for service focus 11 and 30.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional. Optional for service focus 11 and 30, required for all other service focuses.

SERIOUS MENTAL ILLNESS (SMI)

DESCRIPTION: For making this determination, refer to the Definition of Serious Mental Illness in the Appendix. The customer's illness and treatment history must meet this definition of SMI before a Yes (1) can be reported.

SMI is only reported for customers who are **18 and older**.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: SMI must be reported for all individuals 18 or older.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required for all customers 18 and older.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

SERIOUS EMOTIONAL DISTURBANCE (SED)

DESCRIPTION: For making this determination, refer to the Definition of Serious Emotional Disturbance in the Appendix. The customer's illness and treatment history must meet this definition of SED before a Yes (1) can be reported.

SED is only reported for customers who are **0 to 17 (under 18 years old).**

VALID ENTRIES:

1	Yes
2	No

COMMENTS: SED must be reported for all individuals under 18 years.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional - required for all customers less than 18 years old.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

ARRESTS IN PAST 30 DAYS

DESCRIPTION: Arrest information must be collected from all customers. Enter the number (**00-99**) of times the customer has been arrested in the past 30 days. Although there is only one admission question (transaction type 23), there are two questions, which may be asked at discharge (transaction types 60-72), level of care change (transaction type 40), or treatment extension/outcome update (transaction type 42).

YOU MUST CHOOSE which condition fits the scenario and use the appropriate questions.

Admission Question
How many ***times*** have you been arrested in the past 30 days?

Discharge/Level of Care Change/6-Month Update Questions
Based on the length of time the customer has been in treatment, there are two conditions, which require a slightly different question to be asked: (1) customer has been in treatment less than 30 days, ask question #1 OR (2) customer has been in treatment longer than 30 days, ask question #2. Read the "time" statement and find the one that is true.

1) If less than 30 days has passed since admission, then ask:
How many times have you been arrested since admission?

2) If more than 30 days has passed since admission, then ask:
How many times have you been arrested in the past 30 days?

Drug court sanctions do NOT count as an arrest.

VALID ENTRIES: 00-99

COMMENTS: Do not report "99" if arrest information is unavailable. You must collect the correct information before reporting data. Number of arrest in past 30 days must be less or equal to number of arrest in past 12 months. This data element is now required for all customers, regardless of service focus.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Arrests in Past 12 Months.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

ARRESTS IN PAST 12 MONTHS

DESCRIPTION: Arrest information must be collected from all customers. Enter the number (**00-99**) of times the customer has been arrested in the past twelve months.

The twelve-month total must be inclusive of the 30-day arrest information, which means that arrest in past 12 months must be greater than or equal to arrests in past 30 days.

Although there is only one admission question (transaction type 23), there are two questions, which may be asked at discharge (transaction types 60-72), level of care change (transaction type 40), or treatment extension/outcome update (transaction type 42). YOU MUST CHOOSE which condition fits the scenario and use the appropriate questions.

Admission Question
How many ***times*** have you been arrested in the past 12 months?

Discharge/Level of Care Change/6-Month Update Questions
Based on the length of time the customer has been in treatment, there are two conditions, which require a slightly different question to be asked: (1) customer has been in treatment less than 12 months, ask question #1 OR (2) customer has been in treatment longer than 12 months, ask question #2. Read the "time" statement and find the one that is true.

1) **If less than 12 months has passed since admission, then ask**: How many times have you been arrested since admission?

2) **If more than 12 months has passed since admission, then ask:** How many times have you been arrested in the past 12 months?

Drug court sanctions do NOT count as an arrest.

VALID ENTRIES: 00-99

COMMENTS: Do not report "99" if arrest information is unavailable. You must collect the correct information before reporting data. Number of arrest in past 12 months must be greater than or equal to number of arrest in past 30 days. This data element is now required for all customers, regardless of service focus.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: Arrest in Past 30 days.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

SELF-HELP GROUP ATTENDANCE IN PAST 30 DAYS

DESCRIPTION: The intent of this item is to measure whether customers have attended non-professional, peer-oriented self-help groups to assist in their recovery during the past 30 days. Participation in social support of recovery activities is defined as attending self-help group meetings, religious/faith affiliated recovery or self-help group meetings, meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery. Examples include Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous, and consumer drop-in centers. Although there is only one admission question, there are two questions, which may be asked at discharge (transaction types 60-72), level of care change (transaction type 40), or treatment extension/outcome update (transaction type 42).

YOU MUST CHOOSE which condition fits the scenario and use the appropriate questions.

Admission Question
How many ***times*** have you attended self-help/support groups in the past 30 days?

Discharge/Level of Care Change/6-Month Update Questions
Based on the length of time the customer has been in treatment, there are two conditions, which require a slightly different question to be asked: (1) customer has been in treatment less than 30 days, ask question #1 OR (2) customer has been in treatment longer than 30 days, ask question #2. Read the "time" statement and find the one that is true.

1) If less than 30 days has passed since admission, then ask:
How many times have you attended self-help/support groups since admission?

2) If more than 30 days has passed since admission, then ask:
How many times have you attended self-help/support groups in the past 30 days?

VALID ENTRIES: **00-99**

COMMENTS: This field is required for all individuals.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

FAMILY ID

DESCRIPTION: This field is used to report the family member's Member ID for individuals receiving services with their family, such as children who are in residential treatment or a parent who receives ancillary services while their child receives treatment. If both parents are in treatment, enter the mother's Member ID.

VALID ENTRIES: **A 9 character Member ID**

COMMENTS: This is commonly used for children in treatment with a parent in residential and halfway house substance abuse treatment, but may be used in other settings.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Presenting Problem.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required if presenting problem in (745, 746, or 747).

EDI ISSUES: Family ID, DOC Number and DHS Case Number are mutually exclusive fields. Only one of the fields would need to be reported, depending on the type of program the consumer was involved in. In the EDI documentation, the field is referred to as 'Family ID.'

DOC NUMBER

DESCRIPTION: If you are providing substance abuse services to a customer in the custody of or under the supervision (e.g., probation or parole) of the Department of Corrections, enter the customer's DOC number.

Enter the letters "DOC" in the first three boxes followed by the customer's DOC number. The last box in this field may or may not be blank depending on the length of the number. For example "DOC1234567."

VALID ENTRIES: **Up to 10 Characters**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Service Focus.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required if service focus = 09.

EDI ISSUES: Family ID, DOC Number and DHS Case Number are mutually exclusive fields. Only one of the fields would need to be reported, depending on the type of program the consumer was involved in. In the EDI documentation, the field is referred to as 'Family ID.'

DHS CASE NUMBER

DESCRIPTION: DHS case number is required for customers being treated under the TANF/Child Welfare contract. The primary referral source must be 49 –TANF/Child Welfare. C or H must be the first character of the seven-character TANF case number. Child Welfare number must be 10 characters beginning with KK.

VALID ENTRIES: **A 7 character identifier for TANF customers, starting with the letter "C" or "H." A 10 character identifier for Child Welfare customers start with "KK."**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Primary Referral.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required on any transaction if primary referral code = 49.

EDI ISSUES: Family ID, DOC Number and DHS Case Number are mutually exclusive fields. Only one of the fields would need to be reported, depending on the type of program the consumer was involved in. In the EDI documentation, the field is referred to as 'Family ID.'

CLINICIAN OF RECORD (NPI)

DESCRIPTION: Although ODMHSAS/OHCA will allow facilities to use their own definition of 'clinician of record', in general, this should identify who is primarily responsible for a consumer's care.

The intent of this field will allow clinicians to track the outcomes and demographics of their customers.

Recommendation for determining the Clinician of Record:

Admission (23): Report which individual is the primary clinician responsible for the customer's care at that time. If the clinician of record is not known at admission, enter the NPI of the person signing the treatment plan.

Treatment extension/outcome update (42): Report which clinician of record at the point the 6-month update was reported.

Discharge (60-72): Report which clinician of record at the point the discharge was reported.

Level of Care Change (40): Report which clinician will be responsible for the customer's care in the new level of care. For example, if a customer is leaving residential treatment unit and going to outpatient, the clinician of record should be from the outpatient treatment unit.

VALID ENTRIES: A **10 character NPI**

COMMENTS: This field was requested by providers. It will be used in reports to assist the provider in performance improvement.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Required.

SECTION IV

Only complete this section if customer is 0 – 17 years old (under 18).

Section IV is a new set of questions, initiated on 7/1/2010. Prior to that date, the design of the CDC was primarily modeled around adult outpatient care. To provide an opportunity to better understand and report the outcomes of children, providers across the state of Oklahoma met to determine a core set of outcomes. Instead of trying to collect every possible outcome, the group was tasked with focusing on the priority outcomes. Information from these fields will provide an understanding of the performance of providers, the outcomes of customers, and provide information to advocate for funding of children's programs.

OJA CUSTODY

DESCRIPTION: If the customer is a child in the custody or under the supervision of the Office of Juvenile Affairs, mark 1 for Yes, otherwise indicate No. A response must be reported if the customer is under 18 years of age.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

DHS CUSTODY

DESCRIPTION: If the customer is in the custody or under the supervision of the Department of Human Services, mark 1 for Yes, otherwise indicate No. A response must be reported if the customer is less than 18 years of age.

VALID ENTRIES:

1	Yes
2	No

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

EDI ISSUES: Format for EDI is 0 = No and 1 = Yes.

TYPE OF OUT-OF-HOME PLACEMENT

DESCRIPTION: In what type of out-of-home placement is the customer living? Select the number (**1- 6**) corresponding to the type of placement of the child. A response must be reported if the customer is under 18 years of age.

VALID ENTRIES:

1 **Not in Out-of-Home Placement** - If the child is not in out-of-home placement.

2 **Residential Treatment -** Treatment services are provided in a 24-hour structured environment. This would include a residential treatment center (RTC) that is associated with a hospital. It also includes placement of children or adolescents in a residential drug treatment facility, residential placements through OJA or DHS, such as Rader, Manitou, and Central Oklahoma Juvenile Treatment Center.

3 **Specialized Community Group Home -** This is a structured program for custody children operated by an individual in his/her own home. Each Specialized Community Group Home serves a specifically defined population. These homes are primarily used for developmentally disabled youth.

4 **Foster Care -** A child who is in the custody of the Department of Human Services or the Office of Juvenile Affairs and was placed in a family home where the child lives with the family and possibly other foster children. This can include kinship care and therapeutic foster care.

5 **Group Home -** Group homes can serve up to 16 children. There is 24-hour awake supervision and sometimes children attend school at the group home. There are Level C, D, and E group homes either operated or contracted through the Department of Human Services and the Office of Juvenile Affairs.

6 **Other** – All other types of out-of-home placement.

COMMENTS: This field is to indicate where the customer is current living, not past placement.

PLEASE NOTE: Out-of-home placement is not necessarily restrictive placement. Please read the comments on 'days on restrictive placement' for more about this issue.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

DAYS IN RESTRICTIVE PLACEMENT IN PAST 90 DAYS

DESCRIPTION: Restrictive placement includes jail, juvenile detention center, inpatient psychiatric hospital, drug/alcohol rehabilitation center, residential treatment, group home. This **does NOT** include medical hospital, foster care, therapeutic foster care, group or individual emergency shelter, supervised independent living, home of a family friend, adoptive home, home of a relative, school dormitory, biological parent(s), independent living with a friend or independent living alone.

If a child was in restrictive placement for any time during a day, the whole day is counted.

VALID ENTRIES: **00-90** **Number of days in past 90 days**

COMMENTS: This measure and 'out-of-home placement' are not necessarily related. Customers can be in an out-of-home placement and not be in restrictive placement. For example, a customer may be in foster care at the time the CDC is collected/reported, but those days in foster care will not be counted in this measure.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

INCIDENTS OF SELF-HARM IN PAST 90 DAYS

DESCRIPTION: Self-harm is defined as the intent to create pain as a coping mechanism. Incidents of self-harm include self-mutilation, suicide attempts (but not suicide ideation), and cutting. This **does NOT** include social trends such as tattooing and body piercing.

Self-harm can range from mild behaviors such as scratching the skin with a paper clip to suicide attempts.

VALID ENTRIES: **00-90** **Number of days in past 90 days**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

DAYS ABSENT FROM SCHOOL IN PAST 90 DAYS

DESCRIPTION: For school-aged children, report how many days the customer was absent from school in the past 90 days of the school year. School absences are the number of days the child/youth has been absent from school during the most recent 90 days of school. During the summer months or holidays, go back to the last 90 days school was in session. An absence indicates the child missed the full day of school.

If the child/youth was not enrolled in private or public school for the last 90 days, mark "99" for "not applicable."

The "not applicable" category includes children/youth that are home-schooled or have permanently dropped out of school.

Do NOT include days the child was suspended from school as absences.

VALID ENTRIES:

00-66	**Number of days in past 90 days**
99	**Not applicable**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

DAYS SUSPENDED FROM SCHOOL IN PAST 90 DAYS

DESCRIPTION: For school-aged children, report how many days the customer was suspended from school in the past 90 days of the school year. School suspensions are the number of days the child/youth has been suspended from school during the most recent 90 days of school. During the summer months or holidays, go back to the last 90 days school was in session. Do not include 'in-school' suspension days. If they are expelled, count the days until they have another school placement or home school arrangements.

If the child/youth was not enrolled in private or public school for the last 90 days, mark "99" for "not applicable."

The "not applicable" category includes children/youth that are home-schooled or have permanently dropped out of school.

VALID ENTRIES: **00-66** **Number of days in past 90 days**

99 **Not applicable**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

DAYS NOT PERMITTED TO RETURN TO DAY CARE IN PAST 90 DAYS

DESCRIPTION: For children under school age, report how many days was the customer was not permitted to return to day care. Only include days which the child was not permitted due to their behavioral issues, not days related to child or parent's illness.

If the child was not in day care in the last 90 days, mark "99."

VALID ENTRIES: **00-66** **Number of days in past 90 days**

99 **Not applicable**

COMMENTS: None.

FEDERALLY REQUIRED FIELD: No.

INTER-RELATED FIELDS: Date of Birth.

REQUIRED, CONDITIONAL OR OPTIONAL: Conditional: required for all customers less than 18 years of age.

LEGAL NAME

DESCRIPTION: Enter the legal last name, the maiden name if applicable, the legal first name, and the middle name of the customer.

The name fields only accept letters, hyphens, apostrophe, and spaces. **Do not use parentheses, quotes or AKA. Do not use nicknames or aliases.**

Last Name: Up to 50 characters
Maiden Name: Up to 50 characters
First Name: Up to 50 characters
Middle Name: Up to 50 Characters
Suffix: Only report Jr., Sr., II, III, IV, V

COMMENTS: None.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL:

Last Name: Required.
Maiden Name: Conditional: required for all female customers.
First Name: Required.
Middle Name: Optional.
Suffix: Optional.

ADDRESS

DESCRIPTION: Enter the address of the customer's residence.

If the customer is 'homeless-on the streets,' you may use the address of the provider or use the word 'Homeless.' For 'homeless-shelter,' please use the zip code and address of the shelter.

For individuals in OJA/DHS/DOC custody, you may use the address of the provider.

Address 1: Up to 50 characters
Address 2: Up to 50 characters
City: Up to 20 characters (alpha characters only)
State: 2-character standard postal codes

COMMENTS: Zip code is reported in Section I.

FEDERALLY REQUIRED FIELD: Yes.

INTER-RELATED FIELDS: None.

REQUIRED, CONDITIONAL OR OPTIONAL:

Address 1: Required.
Address 2: Optional if additional street information is needed (not a second address).
City: Required.
State: Required.

APPENDIX: CODES AND DEFINITIONS

MILITARY TIME CHART

1 AM = 0100 HOURS
2 AM = 0200 HOURS
3 AM = 0300 HOURS
4 AM = 0400 HOURS
5 AM = 0500 HOURS
6 AM = 0600 HOURS
7 AM = 0700 HOURS
8 AM = 0800 HOURS
9 AM = 0900 HOURS
10 AM = 1000 HOURS
11 AM = 1100 HOURS
12 NOON = 1200 HOURS
1 PM = 1300 HOURS
2 PM = 1400 HOURS
3 PM = 1500 HOURS
4 PM = 1600 HOURS
5 PM = 1700 HOURS
6 PM = 1800 HOURS
7 PM = 1900 HOURS
8 PM = 2000 HOURS
9 PM = 2100 HOURS
10 PM = 2200 HOURS
11 PM = 2300 HOURS
12 MIDNIGHT=0000 HOURS

REFERRALS

01	Self
02	Significant Other
03	School
04	Church/Clergy
05	Group Home
06**	Employer, Union
08	Non-Psychiatric Hospital
09	Veterans Administration Hospital
10	Indian Health Service
11	Department of Health
12	Department of Corrections
14	Department of Human Services
18	Nursing Home
21	Private Psychiatrist/Mental Health Professional/General Physician
22	Social Security
23	Attorney/Legal Aid
25	Law Enforcement
26**	Reachout Hotline/Advertising Media
28*	Referral Due to Unscheduled Discharge (transaction type 62 or 67only)
30	Shelter for Homeless
31*	Additional Services Recommended, Referral Not Attainable
32	Court
33	Probation
34	Parole
35	Department of Public Safety
36*	Active Customer – Died (transaction type 68 only)
37	Private Physician
38	Health Maintenance Organization (HMO)/Managed Care Organization (MCO)
39*	Change in Pay Source (transaction type 64 only)
40	ODMHSAS-funded Facility (Needs OHCA Location #)
41	Non-ODMHSAS/OHCA funded Psychiatric Hospital
42	Non-ODMHSAS/OHCA funded Mental Health Center
43	Non-ODMHSAS/OHCA funded Community Agency
44	Non-ODMHSAS/OHCA funded Residential Care Home
45	Non-ODMHSAS/OHCA funded Alcohol/Drug Program
46	Non-ODMHSAS/OHCA funded Domestic Violence Facility
47	Non-ODMHSAS/OHCA funded Crisis/Stabilization Facility
48	Office of Juvenile Affairs
49	TANF/Child Welfare
50	Change in Eligibility Standards
51	Self Help Group
52	Parent/Guardian
91***	RESTX Referral: IV Drug User/Pregnant > 7 months
92***	RESTX Referral: IV Drug User/Pregnant < 7 months
93***	RESTX Referral: Pregnant > 7 months
94***	RESTX Referral: Pregnant < 7 months
95***	RESTX Referral: IV Drug User
96***	RESTX Referral: Adult/Adolescent

*These Referrals can only be reported at the time of discharge.
**These Referrals can only be reported at the time of admission.
***Only reportable on secondary referrals.

OKLAHOMA COUNTIES

Adair	01	LeFlore	40
Alfalfa	02	Lincoln	41
Atoka	03	Logan	42
Beaver	04	Love	43
Beckham	05	McClain	44
Blaine	06	McCurtain	45
Bryan	07	McIntosh	46
Caddo	08	Major	47
Canadian	09	Marshall	48
Carter	10	Mayes	49
Cherokee	11	Murray	50
Choctaw	12	Muskogee	51
Cimarron	13	Noble	52
Cleveland	14	Nowata	53
Coal	15	Okfuskee	54
Comanche	16	Oklahoma	55
Cotton	17	Okmulgee	56
Craig	18	Osage	57
Creek	19	Ottawa	58
Custer	20	Pawnee	59
Delaware	21	Payne	60
Dewey	22	Pittsburgh	61
Ellis	23	Pontotoc	62
Garfield	24	Pottawatomie	63
Garvin	25	Pushmataha	64
Grady	26	Roger Mills	65
Grant	27	Rogers	66
Greer	28	Seminole	67
Harmon	29	Sequoyah	68
Harper	30	Stephens	69
Haskell	31	Texas	70
Hughes	32	Tillman	71
Jackson	33	Tulsa	72
Jefferson	34	Wagoner	73
Johnston	35	Washington	74
Kay	36	Washita	75
Kingfisher	37	Woods	76
Kiowa	38	Woodward	77
Latimer	39		

*Customers having residence out of state will indicate the state with the alpha codes identified on the next page.

STATE CODES

ALABAMA	**AL**
ALASKA	**AK**
ARIZONA	**AZ**
ARKANSAS	**AR**
CALIFORNIA	**CA**
COLORADO	**CO**
CONNECTICUT	**CT**
DELAWARE	**DE**
DISTRICT OF COLUMBIA	**DC**
FLORIDA	**FL**
GEORGIA	**GA**
HAWAII	**HI**
IDAHO	**ID**
ILLINOIS	**IL**
INDIANA	**IN**
IOWA	**IA**
KANSAS	**KS**
KENTUCKY	**KY**
LOUISIANA	**LA**
MAINE	**ME**
MARYLAND	**MD**
MASSACHUSETTS	**MA**
MICHIGAN	**MI**
MINNESOTA	**MN**
MISSISSIPPI	**MS**
MISSOURI	**MO**
MONTANA	**MT**
NEBRASKA	**NE**
NEVADA	**NV**
NEW JERSEY	**NJ**
NEW HAMPSHIRE	**NH**
NEW MEXICO	**NM**
NEW YORK	**NY**
NORTH CAROLINA	**NC**
NORTH DAKOTA	**ND**
OHIO	**OH**
OREGON	**OR**
PENNSYLVANIA	**PA**
RHODE ISLAND	**RI**
SOUTH CAROLINA	**SC**
SOUTH DAKOTA	**SD**
TENNESSEE	**TN**
TEXAS	**TX**
UTAH	**UT**
VERMONT	**VT**
VIRGINIA	**VA**
WASHINGTON	**WA**
WEST VIRGINIA	**WV**
WISCONSIN	**WI**
WYOMING	**WY**

PRESENTING PROBLEMS

OTHER:

100 Other Non-Behavioral Health Problem

PHYSICAL:

110 Speech/Hearing
120 Physical
130 Medical/Somatic

DEVELOPMENTAL INADEQUACIES:

210 Intellectual
220 Emotional
230 Social
240 Physical

ABUSE VICTIM:

311 Sexual Incest - Received Medical Treatment
Sexual abuse by a family member, which had occurred in the past year. Family includes all blood-related persons, as well as stepparents, step-siblings and half siblings. The person must have received medical treatment for injuries, etc. that resulted from the abuse.

312 Sexual Incest - No Medical Treatment
Sexual abuse by a family member, which has occurred in the past year. Family includes all blood-related persons, as well as stepparents, step-siblings and half siblings. However, the customer did not receive any medical treatment.

314 History of Sexual Incest
Sexual abuse by a family member, which occurred at least one year ago. Family includes all blood-related persons, as well as stepparents, step-siblings and half siblings.

321 Exploitation/Neglect - Received Medical Treatment
322 Exploitation/Neglect - No Medical Treatment
331 Psychological Abuse - Received Medical Treatment
332 Psychological Abuse- No Medical Treatment
341 Physical Abuse- Received Medical Treatment
Abuse of an individual through physical contact, such as hitting, slapping, punching, shoving, choking, etc.

342 Physical Abuse- No Medical Treatment
Abuse of an individual through physical contact, such as hitting, slapping, punching, shoving, choking, etc.

344 History of Physical Abuse

Abuse which has occurred at least one year ago through physical contact, such as hitting, slapping, punching, shoving, choking, etc.

351 Family/Dependent of Abuse Victim - Received Medical Treatment

352 Family/Dependent of Abuse Victim - No Medical Treatment

361 Sexual Assault by Stranger - Received Medical Treatment
Any forced, coerced, or unwanted sexual contact by a stranger – received medical attention.

362 Sexual Assault by Stranger - No Medical Treatment
Any forced, coerced, or unwanted sexual contact by a stranger – did not receive any medical attention.

364 History of Sexual Abuse
Sexual abuse which has occurred at least one year ago. Example, adults molested or sexually abused as children.

371 Sexual Assault by Acquaintance/Intimate Partner - Received Medical Treatment
Any forced, coerced, or unwanted sexual contact by an acquaintance/intimate partner. Intimate partners include spouse, common law spouse, boyfriends, girlfriends, dates, etc). Received medical attention.

372 Sexual Assault by Acquaintance/Intimate Partner - No Medical Treatment
Any forced, coerced, or unwanted sexual contact by an acquaintance/intimate partner. Intimate partners include spouse, common law spouse, boyfriends, girlfriends, dates, etc). Did not receive medical attention.

SOCIAL RELATIONS DISTURBANCE:

410 With Family Members

420 Outside Immediate Family

SOCIAL PERFORMANCE DEFICIT:

450 Social Performance Deficit

EMOTIONAL MALADJUSTMENT/DISTURBANCE:

500 Emotional Maladjustment/Disturbance

501 Depression

502 Anxiety/Panic

503 Eating Disorder

THOUGHT DISORDER/DISTURBANCE:

510 Perceptual Problems

520 Disorientation

530 Other Psychotic Symptoms

BEHAVIORAL DISTURBANCE:

610 Homicidal
620 Assaultive
621 Domestic Abuse Perpetrator
A perpetrator of domestic abuse, who uses physical, emotional/psychological and sexual contact as a means to threaten, hurt or control a partner or family member.
630 Other
631 Involvement with Criminal Justice System
632 Runaway Behavior
633 Attention Deficit/Hyperactivity Disorder
634 Oppositional Defiant Disorder
635 Posttraumatic Stress Disorder

SUICIDAL/SELF-ABUSIVE:

650 Suicidal/Self-Abusive

SUBSTANCE ABUSE RELATED PROBLEMS:

710 Alcohol Abuse
711 Alcohol Dependency
720 Drug Abuse
721 Drug Dependency
730 Abuse of Both Alcohol and Drug(s)
731 Dependency on Both Alcohol and Drug(s)
741 At Risk for Relapse (Alcohol)
742 At Risk for Relapse (Drugs)
743 At Risk for Relapse (Both)
745 Dependent Child of an Alcohol Abuse Customer (Family ID Required)
746 Dependent Child of a Drug Abuse Customer (Family ID Required)
747 Dependent Child of Both Alcohol & Drug Abuse Customer (Family ID Required)
748 Co-Dependent of an Alcohol Abuse Customer
749 Co-Dependent of a Drug Abuse Customer
750 Co-Dependent of Both Alcohol and Drug Abuse Customer
751 Family Member or Significant Other of a Substance Abuse Customer

GAMBLING:
760 Pathological Gambling
761 Problem Gambling
762 Relative of person with Gambling Problem

GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

This is an assessment of the customer's level of functioning at the time of admission, change in level of care, discharge, and when clinically significant.

CODE

100 to 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90 to 81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80 to 71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).

70 to 61 Some mild symptoms (e.g., depressed mood and mild insomnia) **OR** some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful inter-personal relationships.

60 to 51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR** moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).

50 to 41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR** any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40 to 31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) **OR** major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 to 21 Behavior is considerably influenced by delusions or hallucinations, **OR** serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR** inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

20 to 11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR** occasionally fails to maintain minimal personal hygiene (e.g., smears feces) **OR** gross impairment in communication (e.g., largely incoherent or mute).

10 to 01 Persistent danger of severely hurting self or others (e.g., recurrent violence) **OR** persistent inability to maintain minimal personal hygiene **OR** serious suicidal act with clear expectation of death.

DEFINITION OF SERIOUS MENTAL ILLNESS (SMI) ADULTS

(18 and Older)

SMI History

In the early 1980s, the ODMHSAS began to place more emphasis on the treatment of individuals who suffer from a major mental illness. To begin to monitor the movement of these individuals through the system and to identify services provided to this population, the Department developed criteria to define this target population as individuals with a "chronic mental illness." This definition focused on diagnosis, functioning and duration of illness. The duration of the illness had to be at least two years to meet the target population definition.

Beginning in 1991, the definition was changed somewhat; less emphasis was placed on diagnosis and more emphasis placed on functional impairment. Many of the components of the federal definition were incorporated into the definition. As a result, the definition was broadened to include more individuals and the title was changed to "severe and persistent mental illness."

In 1995, with the advent of managed care, the ODMHSAS again revised the target population definition. The title was changed to "serious mental illness." There was little change in diagnostic criteria. Less emphasis was placed on duration of illness, and the functional impairment criteria were revised. In addition, a functional assessment tool was developed to make the identification of this target population more objective.

"Serious Mental Illness" means a condition experienced by persons age 18 and over that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.
(2) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.
(3) The adult must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(B) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(ii) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(v) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

DEFINITION OF SERIOUS EMOTIONAL DISTURBANCE (SED)

Children and Adolescents (Under 18 years of age)

"Serious Emotional Disturbance" (SED) means a condition experienced by persons from birth to 18 that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.
(2) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.
(3) The child must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
(B) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
(ii) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.
(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).
(v) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

CONDENSED CDC EDITS

Fields	Required/ Conditional/ Optional	Rules
Agency	**Required**	
Agency Site	**Required**	
Date of Transaction	**Required**	Transaction date must be equal to or less than the current date, and customer must have eligibility for date of transaction
Military Time	**Required**	
Transaction Type	**Required**	
Member ID	**Required**	Must be a valid Medicaid ID, and name, date of birth, and SSN must match what is on the Medicaid file for Member ID given
DOB	**Required**	Must be less than or equal to transaction date
Service Focus	**Required**	
Race	**Required**	At least one race must be selected
SSN	**Required**	
Ethnicity	**Required**	
Gender	**Required**	
Alert Information	Optional	
Mental Health Screen	**Required**	
Substance Abuse Screen	**Required**	
Trauma Screen	**Required**	
Primary/Secondary Referral	**Primary Required,** Secondary optional	Referral 31 can only be used with 60 - 72 transaction types Referral 28 can only be used with transaction types 62 OR 67 Referral 39 can only be used with a transaction type 64 Referral 36 can only be used with a transaction type 68 Referrals 06 and 26 cannot be used with 60 - 72 transaction types Primary and Secondary cannot be the same, except for referral 40
Primary/Secondary Referral Agency	Conditional	Required if Referral = 40 Primary and secondary referral agencies cannot be the same Referral provider cannot = admitting provider Referral provider must be active provider
County of Residence	**Required**	
Zip Code	**Required**	IF Zip code = 99999, then Residence = J (Homeless-Streets)

Fields	Required/ Conditional/ Optional	Rules
Residence	**Required**	If Residence = J (Homeless-Streets), then Zip Code must = 99999 If prison/jail = 1 (prison), then Residence = H (institutional setting);
Is customer in Prison/Jail	**Required**	If prison/jail = 1 (prison), customer age must be greater than 12
Living Situation	**Required**	If residence = H (institutional setting), then Living situation must = 1 (alone)
Chronic Homelessness	**Required**	
Employment	**Required**	
Type of Employment/Not in Labor Force (NILF)	**Required**	If Employment = 4 (NILF) then Type of Employment/NILF = A-F If Employment must = 3 (Unemployed), then Type of Employment/NILF = 4 (None) If Employment must = 1 or 2 , then Type of Employment/NILF = 1-3, 5 or 6
Education	**Required**	Education must = 00 if customer age is under age 5 Education cannot be greater than age of customer
Is customer currently in school	**Required**	
Military Status	**Required**	If Military Status = 1 or 3, then customer age must be 16 years of age or older
Marital Status	**Required**	
Is customer pregnant	Conditional	Required if female; blank if male If Pregnant = 1 (yes), then customer age must be between 12-55 years of age
If 1, enter expected DOB	Conditional	Required only if female and answered 1 (yes) on 'Is customer pregnant?'; Blank if male or answered 2 Expected DOB must be greater than, equal to, but not more than 9 months from today's date
Annual Income	**Required**	
Number contributing to and/or dependent	**Required**	
SSDI	**Required**	
Medicare	**Required**	
SSI	**Required**	
Medicaid	**Required**	
Does Customer speak English well?	**Required**	

Fields	Required/ Conditional/ Optional	Rules
If language"2" what language is preferred (1-9)	Conditional	If 'Does customer speak English well' = 1 (yes), then language preferred and specified must be blank If 'Does customer speak English well' = 2 (no), then language preferred must be completed
If 2 or 9, then specify	Conditional	Required if language preferred = 2 or 9
Disability 1, 2, 3, 4	**Required for 1;** Optional for 2, 3, 4	If Disability = 11 (interpreter for the deaf), then another code must include a 09 or 10 Disability 2, 3, AND 4 MUST BE BLANK IF Disability 1 = 01 Disability 1, 2, 3 and 4 cannot be the same
Legal Status	**Required**	
County of Commitment	Conditional	If legal status = 01 or 17, then county of commitment must be blank
Tobacco Use	**Required**	
Presenting Problem -- Primary/Secondary/Tertiary	**Required**	Presenting Problems cannot be the same At least one Presenting Problem must equal 710 - 743 if Service Focus = 02, 03, 06, 09, 21
Drugs of Choice - Primary/Secondary/Tertiary -	**Primary-- Required** Secondary-- Conditional Tertiary-- Conditional	Primary Drug of Choice required if any presenting problem = 710-743. If Presenting Problem = 710, 711 or 741, then a drug of choice must = 02 (alcohol) If Presenting Problem = 720, 721 or 742, then a drug of choice must = 03-21 (drug) If Presenting Problem = 730, 731 or 743, then drug of choice must include 02 (alcohol) and a 03-21 (drug) Primary Drug of Choice cannot be blank Secondary or tertiary drug of choice cannot be 01 (none) No drug of choice can be the same (NOTE: there is NO 1:1 connection between 'Presenting Problems' and 'Drugs of Choice')
Usual Route of Administration	Conditional	Required if any Drug of Choice does not = 01 or 17 If Drug of Choice = 12 (inhalants), then Route of Administration must = 3 (inhalation) If Drug of Choice = 02 (alcohol), then Route of Administration must = 1 (oral) If Drug of Choice = 01 or 17, then Route of Administration must be blank
Frequency of Use	Conditional	Required if any Drug of Choice does not = 01 or 17 If Drug of Choice = 01 or 17, then Frequency of Use must be blank
Age First Used	Conditional	Required if primary drug of choice does not = 01 or 17 If Drug of Choice = 01 or 17, then Age First Used must be blank Age cannot be greater than the customer's age

Fields	Required/ Conditional/ Optional	Rules
Level of Care	**Required**	Level of Care cannot be the same as previous Level of Care on Transaction Type 40 Level of care cannot be modified on a 41, 42, or discharge transaction
CAR	**Required**	CAR Optional on Service Focus 02, 03, 09, 11, 21, 23, 30
ASI	Conditional	ASI Required if 18 years old or above and Service Focus = 02, 03, 06, 09, 21 ASI Required if 18 years old or above, Service Focus = 02, 03, 06, 09, 21 and there was an ASI on last CDC for Transaction Types 60, 61, 62, 63, 64, 70 ASI Optional if 18 or older on Transaction Types 62, 65, 66, 67, 68, 69, 71, 72 Not Applicable for service focus 11
TASI	Conditional	TASI Required if age 12-17 and Service Focus = 02, 03, 06, 21, 23 Required if age 12-17, Service Focus = 02, 03, 06, 21, 23 and there was an TASI on previous CDC for Transaction Types 60, 61, 63, 64, 70 Optional if 17 or younger for Transaction Types 62, 65, 66, 67, 68, 69, 71, 72 Not Applicable for service focus 11
Current LOF	**Required**	Current LOF optional for Service Focus 11
SMI	Conditional	Required if customer 18 years or older Do not allow for under 18 years old
SED	Conditional	Required if customer is under 18 years old Do not allow for 18 years or older
In the past 30 days, how many times has the customer been arrested or since admission if less than 30 days ago?	**Required**	
In the past 12 months, how many times has the customer been arrested or since admission if less than 30 days ago?	**Required**	Arrests in Last 12 Months cannot be less than Arrests in Past 30 Days
In the past 30 days, how many times has the customer attended self-help/support groups or since admission if less than 30 days ago?	**Required**	

Fields	Required/ Conditional/ Optional	Rules
Family ID, Drug Court, DOC #, or DHS Case Number	Conditional	If Service Focus = 03, Drug Court number is required If Service Focus = 09, Department of Corrections (DOC) number is required If Referral = 49, then DHS case number Family ID required when Presenting Problem = 745, 746 or 747
Clinician of Record (NPI)	**Required**	
Is this customer in the custody of OJA	Conditional	Only required for under 18 years old
Is this customer in the custody of DHS	Conditional	Only required for under 18 years old
In what type of out of home placement is the customer living	Conditional	Only required for under 18 years old
In the past 90 days how many days was the customer in restrictive placement	Conditional	Only required for under 18 years old
In the past 90 days, on how many days did an incident of self-harm occur	Conditional	Only required for under 18 years old
In the past 90 days of the school year how many days was the customer absent from school	Conditional	Only required for under 18 years old
In the past 90 days how many days of the school year how many days was the customer suspended from school	Conditional	Only required for under 18 years old
In the past 90 days, how many days was the customer not permitted to return to day care	Conditional	Only required for under 18 years old
Last Name	**Required**	
Maiden Name	Conditional	Required if female; optional if male; ALPHA CHARACTER ONLY
First	**Required**	
Middle	Optional	

Fields	Required/ Conditional/ Optional	Rules
Suffix	Optional	
Address 1	**Required**	
City	**Required**	
State	**Required**	
Address 2	Optional	

REQUIRED (R), CONDITIONAL (C), OR OPTIONAL (O)

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