SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services

OKLAHOMA HEALTH CARE AUTHORITY

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PURPOSE OF MANUAL

This manual contains the medical necessity criteria for Oklahoma Health Care Authority contracted behavioral medicine providers for inpatient services. All behavioral medicine services must be medically necessary. The medical record needs to reflect that medical necessity requirements/criteria are being followed.

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

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

The staff of the Oklahoma Health Care Authority (OHCA) thanks all of the physicians/practitioners who provide behavioral medicine services to ***SoonerCare*** members. Your feedback and input is valuable to the OHCA behavioral medicine program. Please send any comments, suggestions, or questions you have regarding this manual to the attention of: ProvServicesAdmins@okhca.org

INPATIENT ACUTE, RTC, CBT AND TFC MEDICAL NECESSITY CRITIERIA

Inpatient psychiatric (24/7 care) services (including TFC) for SoonerCare members under the age of 21 must be prior authorized before the service is provided. Telephonic initial and concurrent reviews to determine medical necessity criteria are required for the following services:

- Acute Care
- Psychiatric Residential Treatment Facility (PRTF)
- Crisis Stabilization
- TFC services

OHCA INPATIENT REVIEW REQUEST LINE

(800) 522-0114 and have your Provider ID number ready. Select:

- Option 1 for Provider,
- Option 6 for Prior Authorizations, and
- Option 2 for Behavioral Health

Authorization of services is not a guarantee of payment. The provider is responsible for insuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met.

All billing/claims inquiries should be directed to the OHCA Provider Helpline at 1-800-522-0114, option 2 and for Provider Enrollment (contract) questions, select option 5 on the call tree.

TELEPHONIC REQUEST REVIEW STEPS

1. Complete the required templates located on the OHCA Behavioral Health web page: http://www.okhca.org/providers.aspx?id=406
2. Fax the completed template to (405) 530-7260
3. Before transferring you to a reviewer, the Behavioral Health Unit staff will locate the faxed template in the fax queue and a case will be created in the system.
4. Telephonic reviews are conducted during business hours from 8:00am-5:00pm, Monday through Friday.
5. RTC requests will only be processed during business hours.
6. If an emergency psychiatric admission (acute care) occurs after regular business hours, the acute initial template needs to be faxed by 10:00 a.m. on the next business day.

All requests will be reviewed according to the medical necessity criteria as listed in the OAC 317:30-5-95.24 – 317:30-5-95.31 for inpatient and 317:30-5-740 – 317:30-5-746 for TFC.

OHCA INPATIENT POLICY

http://www.okhca.org/xPolicyPart.aspx?id=547&chapter=30&subchapter=5&part=6&title=INPATIENT%20PSYCHIATRIC%20HOSPITALS.

OHCA THERAPEUTIC FOSTER CARE POLICY

http://www.okhca.org/xPolicyPart.aspx?id=597&chapter=30&subchapter=5&part=83&title=RESIDENTIAL%20BEHAVIOR%20MANAGEMENT%20SERVICES

A face-to-face admission assessment by a Licensed Behavioral Health Practitioner is required prior to initiating the telephonic review. Less restrictive levels of care should be implemented and appropriately utilized before submitting a request for residential treatment.

AFTER HOURS PROCEDURES – ACUTE ADMISSIONS ONLY

Only acute care admissions are allowed after regular business hours for retroactive review. The acute care facility is to perform a telephonic review of medical necessity for the admission on the next business day. If the admission meets medical necessity criteria for acute care, the date of the admission will be authorized.

The acute initial template needs to be faxed by 10:00 a.m. on the next business day. Acute initial requests received after 10:00 a.m. will receive a technical denial.

Residential Treatment and TFC are not considered to be emergent levels of care. The telephonic reviews for these levels of care are conducted during regular business hours.

INPATIENT SERVICES FOR CHILDREN UNDER 5 YEARS OF AGE

Under certain circumstances, inpatient services may be determined to be appropriate for children less than 5 years of age. Inpatient services for this age group are very difficult to locate and will only be approved in extraordinary cases. Reviewers will care manage these cases in an attempt to meet the child's needs at the least restrictive level of care. The physician consultant will review all the inpatient referrals for children under the age of 5. **Please Note: Psychotherapy is not covered for children under the age of 3 for inpatient behavioral health services.**

OUT-OF-STATE PLACEMENT FOR ACUTE AND RTC CARE

Out-of-state placements will only be authorized when it is determined that the needed services are not available in the state of Oklahoma or if it is considered general practice for recipients in a particular locality to use SoonerCare contracted resources in a bordering state due to proximity.

BORDER PLACEMENTS

If the facility is in another state, but is as close as or closer than the nearest treatment facilities in Oklahoma, then it is not necessary to consider the placement an out-of-state placement.

Placement of a child in an out-of-state hospital in an adjoining border locality requires prior authorization when all of the following conditions are met:

- The border hospital must have an Oklahoma SoonerCare provider number for the level of care.
- The placement is chosen due to the close proximity to the family/guardian to facilitate participation in active treatment including discharge and reintegration planning.
- The client meets the Acute or RTC criteria.
- The use of the border hospital is usual and customary within the community or there are no available beds for that level of care in state.
- This designation has been approved by OHCA.

DENIED REQUESTS AND RECONSIDERATION TIME LINE

All prior authorization requests go through a two level review process when a denial decision is issued. The final denial for an inpatient or TFC authorization request is issued by a Physician Consultant who is a Board Certified Child and Adolescent Psychiatrist.
Once the facility is notified of a denial for an initial or extension prior authorization request, the provider is allowed 24 business hours to submit additional information for reconsideration.

a. Example: If a review is denied on Wednesday 5/21/2014 then the reconsideration would need to be received by Thursday 5/22/2014.
b. Example: If a review is denied on Friday 5/23/2014 then the reconsideration would need to be received by Monday 5/26/2014.

If the denial is upheld after the additional information is reviewed, the provider has another 24 business hours to schedule a physician to physician review.
When services have been denied, further extension requests CANNOT be considered. If a review is given partial days after review from the Psychiatric Consult then a physician to physician review can't be requested. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient prior authorization process. The clinical information must include **current**, **relevant information**. If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

INITIAL ACUTE REQUESTS

Based on the Medical Necessity Criteria, the length of stay is authorized by the reviewer utilizing the following guidelines:

- The reviewer will determine the number of days authorized based on the clinical information submitted by the treating facility.
- The initial authorization for payment for acute care admission or upgrade to Acute may be up to **five (5) days**.
- In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.
- If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

Medical necessity criteria for acute psychiatric admissions for children (OAC 317:30-5-95.25)				
Acute psychiatric admissions for children must meet the terms or conditions contained in (1), (2),(3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.				
1.	**Yes**	**No**		A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-21 years of age may have any sequential personality disorders.
2.	**Yes**	**No**		Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary to the primary diagnosis.
3.	**Yes**	**No**		It has been determined by the reviewer that the current disabling symptoms could not have been managed, or have not been manageable, in a less intensive treatment program.
4.	**Yes**	**No**		Child must be medically stable.
5.	**Yes**	**No**		**Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:**
	A.	**Yes**	**No**	Specifically described suicide attempts, suicide intent, or serious threat by the patient.
	B.	**Yes**	**No**	Specifically described patterns of escalating incidents of self-mutilating behaviors.
	C.	**Yes**	**No**	Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
	D.	**Yes**	**No**	Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
6.	**Yes**	**No**		**Requires secure 24-hour nursing/medical supervision as evidenced by:**
	A.	**Yes**	**No**	Stabilization of acute psychiatric symptoms.
	B.	**Yes**	**No**	Needs extensive treatment under physician direction.
	C.	**Yes**	**No**	Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

ACUTE EXTENSION REQUESTS

Acute concurrent reviews are to be made on the *last* business day of the current authorization *before 3 p.m.* Failure to follow this time frame will result in loss of day(s). If an authorization expires on a weekend or holiday, the provider may request a concurrent review the last business day *prior* to the weekend or holiday before 3 p.m. OHCA will conduct the review the first business day following the expiration.

Based on the OHCA Medical Necessity Criteria, acute extensions may be authorized **up to five (5) days,** based upon the documented need for the extended care. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

Medical necessity criteria for continued stay – acute psychiatric admission for children (OAC 317:30-5-95.26)			
For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4).			
1.	Yes	No	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-21 years of age may have any sequential personality disorders.
2.	Yes	No	Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting. Documentation of regression is measured in behavioral terms. If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.
3.	Yes	No	Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).
4.	Yes	No	Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

RTC LEVEL OF CARE

INITIAL RTC REQUESTS

RTC admissions are not considered emergent. RTC admissions should be arranged during regular business hours between the hours of 8 a.m. and 5 p.m. Monday - Friday. The RTC request needs to be submitted by 3 p.m.

After the treatment facility has completed a face to face assessment of the child, the facility should fax the completed prior authorization request. To expedite the review, facilities are encouraged to call the reviewer to discuss the assessment findings, current mental status, and the medical necessity criteria for the requested level of care. Downgrades to RTC should be submitted on the Acute and RTC Initial Admission template.

The number of days authorized is based on the clinical information submitted by the treating facility. The initial authorization for RTC admission or downgrade to RTC *may* be **up to seven (7) days**. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

From the time of the initial review, a child must admit to an RTC facility within three business days. After three business days, a new review will be required to determine if the child still meets Medical Necessity Criteria for RTC admission. An exception may be made for out of state placements that require a more complex plan for travel arrangements.

Medical necessity criteria for admission - Psychiatric Residential Treatment for children (OAC 317:30-5-95.29)			
Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) through (5) (D) of this subsection.			
1	**Yes**	**No**	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	**Yes**	**No**	Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).
3	**Yes**	**No**	Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.
4	**Yes**	**No**	Child must be medically stable.

5	**Within the past 14 days the patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by:**			
	A	**Yes**	**No**	Suicidal ideation and/or threat.
	B	**Yes**	**No**	Current self-injurious behavior.
	C	**Yes**	**No**	Serious threats or evidence of physical aggression.
	D	**Yes**	**No**	Current incapacitating psychosis or depression.

6.	**Requires 24-hour observation and treatment as evidenced by:**
	❑ Intensive behavioral management. ❑ Intensive treatment with the family/guardian and child in a structured milieu. ❑ Intensive treatment in preparation for re-entry into community.

RTC SPECIALTY PROGRAMS
MEDICAL NECESSITY CRITERIA

Admissions will be restricted to children that meet the medical necessity criteria for RTC as well as at least 2 or more of the following description:

1. Children under the age of 21.
2. Child has failed at other levels of care or has not been accepted at other levels of care.
3. Behavioral, emotional and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the patient being a danger to him or herself and others for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but they do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least 2 or more of the following:
   a) Marked impairments in the use of multiple nonverbal behaviors such as eye-to- eye gaze, facial expression, body postures, and gestures to regulate social

interaction.

b) Inability to regulate their impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly.

c) Failure to develop peer relationships appropriate to developmental level.

d) A lack of spontaneous seeking to share enjoyment, interests or achievements with other people.

e) Lack of social or emotional reciprocity.

f) Lack of attachments to caretakers.

g) Requires a high level of assistance with activities of daily living requiring multiple verbal cues 50% of the time to complete these tasks.

h) Delay in, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communications such as gesture or mime.

i) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others.

j) Stereotyped and repetitive use of language or idiosyncratic language.

k) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

l) Encompassing preoccupation with one or more stereotyped and restricted pattern interest that is abnormal in intensity of focus.

m) Inflexible adherence to specific, nonfunctional routines or rituals.

n) Stereotyped and repetitive motor mannerisms (e.g. hand, finger flapping or twisting or complex whole-body movements).

o) Persistent preoccupation with parts of objects.

4. The patient is medically stable, but has co-morbid medical conditions which require specialized care during treatment.
5. Full scale IQ below 40 (profound mental retardation)
6. **1:1** Authorizations will be given to children in **specialty programs** who meet criteria for such request. This should be submitted in the template with presenting criteria to be assessed by the clinical reviewer.

RTC EXTENSION REQUESTS

RTC concurrent reviews should be made no earlier than 2 business days prior to the last day of the current authorization *before 3 p.m.* Failure to follow this time frame will result in loss of day(s). If an authorization expires on a weekend or holiday, the provider may request a concurrent review the last business day prior to the weekend or holiday before 3 p.m. OHCA will conduct the review the first business day following the expiration.

Based on the OHCA Medical Necessity Criteria, RTC extensions may be authorized **up to ten (10) days** for standard RTC programs or up to **twenty-one (21) days** for specialized programs.

In some instances, the reviewer may choose to refer to a physician consultant before making a determination.

The number of days issued is determined by the reviewer. The length is based on the level of

impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient authorization process. The clinical information must include current, relevant information.

Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

Medical necessity criteria for continued stay – psychiatric residential treatment center for children (OAC 317:30-5-95.30)			
For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).			
1	**Yes**	**No**	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	**Yes**	**No**	Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).
3	**Yes**	**No**	**Patient is making measurable progress toward the treatment objectives specified in the treatment plan:** ❑ Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans. ❑ Patient has made gains toward social responsibility and independence. ❑ There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge. ❑ There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.
OR			
4.	**Yes**	**No**	**Child's condition has remained unchanged or worsened:** ❑ Documentation of regression is measured in behavioral terms. ❑ If condition is unchanged, there is evidence of reevaluation of the treatment objectives and therapeutic interventions.
5	**Yes**	**No**	**There is documented continuing need for 24-hour observation and treatment as evidenced by:** ❑ Intensive behavioral management ❑ Intensive treatment with family/guardian and child in a structured milieu ❑ Intensive treatment in preparation for re-entry into the community
6	**Yes**	**No**	Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

COMMUNITY BASED TRANSITIONAL RESIDENTIAL TREATMENT (CBT)

INITIAL CBT REQUEST

CBT admissions are not considered emergent. CBT admissions should be arranged during regular business hours between the hours of 8 a.m. and 5 p.m. Monday-Friday. The CBT request needs to be submitted by 3 p.m.

After the treatment facility has completed a face to face assessment of the child, the facility should fax the completed prior authorization request. To expedite the review, facilities are encouraged to call the reviewer to discuss the assessment findings, current mental status, and the medical necessity criteria for the requested level of care. CBT request should be submitted on the Acute and RTC Initial Admission template.

The number of days authorized is based on the clinical information submitted by the treating facility. The initial authorization for CBT admissions may be **up to seven (7) days**. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

From the time of the initial review, a child must admit to a CBT facility within three business days. After three business days, a new review will be required to determine if the child still meets Medical Necessity Criteria for CBT admissions. An exception may be made for out of state placements that require a more complex plan for travel arrangements.

Medical necessity criteria for admission - Community Based Transitional Residential Treatment for children (OAC 317:30-5-95.29)			
Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) through (5) (D) of this subsection.			
1	**Yes**	**No**	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	**Yes**	**No**	Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).

3	**Yes**	**No**	Patient has received treatment in an acute, RTC, or children's crisis unit or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program. (A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care. (B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, or intensive outpatient services (C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care. (i) Personal safety (ii) Cognitive functioning (iii) Family relations (iv) Interpersonal relations (v) Educational/vocational performance
4	**Yes**	**No**	Child must be medically stable and not require 24 hour on-site nursing or medical care.

5	**Patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by:**			
	A	**Yes**	**No**	Suicidal ideation and/or threat.
	B	**Yes**	**No**	Current self-injurious behavior.
	C	**Yes**	**No**	Serious threats or evidence of physical aggression.
	D	**Yes**	**No**	Current incapacitating psychosis or depression.

6.	**Requires 24-hour observation and treatment as evidenced by:**
	❑ Intensive behavioral management. ❑ Intensive treatment with the family/guardian and child in a structured milieu. ❑ Intensive treatment in preparation for re-entry into community.

CBT EXTENSION REQUEST

CBT concurrent reviews should be made no earlier than 2 business days prior to the last day of the current authorization before 3 p.m. Failure to follow this time frame will result in loss of day(s). If an authorization expires on a weekend or holiday, the provider may request a concurrent review the last business day prior to the weekend or holiday before 3 p.m. This is not mandatory. OHCA will conduct the review the first business day following the expiration.

Based on the OHCA Medical Necessity Criteria, CBT extensions may be authorized **up to twenty-one (21) days**.

In some instances, the reviewer may choose to refer to a physician consultant before making a determination.

The number of days issued is determined by the reviewer. The length is based on the level of the impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to

whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient authorization process. The clinical information must include current, relevant information.

Facilities may provide additional documentation to support acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

Medical necessity criteria for continued stay – Community Based Transitional Residential Treatment for children (OAC 317:30-5-95.30)			
For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).			
1	**Yes**	**No**	A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders.
2	**Yes**	**No**	Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).
3	**Yes**	**No**	**There is documented continued need for 24 hour observation and treatment as evidenced by:** ❑ Patient making measurable progress toward the treatment objectives specified in the treatment plan. ❑ Clinical documentation clearly indicates continued significant functional impairment in tow of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors: (i) Personal Safety (ii) Cognitive functioning (iii) Family relations (iv) Interpersonal relations (v) Educational/vocational performance
4.	**Yes**	**No**	**Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.**
5	**Yes**	**No**	**Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment at this level of care.**

SUBSTANCE ABUSE DETOXIFICATION

An initial maximum of five (5) days for substance abuse detoxification (detox) is allowable based on medical necessity. If serious physiological evidence of detoxification persists after the initial authorization, up to three (3) additional days may be issued based on a case-by-case review of medical necessity criteria. An inpatient review is not necessary for detox if a medical emergency exists and the detox takes place on a medical unit. Substance Abuse detoxification will not be authorized for SoonerCare reimbursement for caffeine, nicotine or cannabis substances.

Medical necessity criteria for admission - inpatient chemical dependency detoxification for children (OAC 317:30-5-95.27)					
Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.					
1	**Yes**	**No**	Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.		
2	**Yes**	**No**	Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses).		
3	**Yes**	**No**	It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.		
4	**Yes**	**No**	Requires secure 24-hour nursing/medical supervision as evidenced by:		
		A	**Yes**	**No**	Need for active and aggressive pharmacological interventions.
		B	**Yes**	**No**	Need for stabilization of acute psychiatric symptoms.
		C	**Yes**	**No**	Need extensive treatment under physician direction.
		D	**Yes**	**No**	Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to seven to eight days based on a case-by-case review, per medical necessity criteria as identified in the OHCA Behavioral Health Provider Manual as described in OAC 317:30-5-95.27.

THERAPEUTIC FOSTER CARE (TFC)

INITIAL TFC REQUESTS

All initial Therapeutic Foster Care requests will be conducted telephonically with a reviewer. TFC admissions are not considered emergent. TFC admissions should be arranged to occur during regular business hours.

After a DHS/OJA custody child has received a Medical Necessity Criteria review, the reviewer will fax a notice indicating that the child appears appropriate for TFC assessment to the Placement Office at OJA, (405) 530-2892 and the local OJA worker, or to the identified DHS

Area Resource Coordinator (ARC).

The clinical information will be on-hold until the admitting TFC provider has completed a face to face assessment and calls for the prior authorization for SoonerCare payment.

The TFC provider is responsible for notifying when the TFC admission is later than the date of the call for the initial admission authorization. Clinical information may be held for forty-five (45) days while the child is awaiting TFC placement, unless they have admitted to a n inpatient psychiatric facility. At forty-five (45) days, the clinical information is no longer considered current. If forty-five (45) days have passed and the child is NOT placed, a new admission request must be completed. The time frame for TFC will be counted in calendar days.

The treating TFC facility must call with the clinical information derived from their face to face assessment of the child. The length of stay authorized for SoonerCare payment may be **up to three (3) months (90 days.).**

If client is being readmitted to a TFC provider following discharge from an Acute or RTC facility, refer to section titled "TFC Clients That Are Placed in Acute or RTC" for length of stay guidelines. If a client is discharged to a lower level of care and later re-admitted, the initial authorization process must be repeated.

In cases where the face to face assessment may occur (or is not completed until) after regular business hours, the TFC agency will call the next business day to notify of the admission. If the child meets TFC criteria, the authorization will be backdated to the date of admission.

All denials will be reviewed by a physician consultant during working hours within one (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria.
The clinical information must include current, relevant information.

TFC agency staff should provide crisis management for all clients. For crisis situations, the therapist is to see the child face-to-face before calling for an inpatient authorization, except in situations where the need for hospitalization does not allow for this to occur.

If a child is out of the TFC placement due to being either AWOL or placed in a shelter for behavioral issues more than five (5) days, the child is discharged from the agency and the authorization will end. If the child returns to the TFC home (or another home within the same agency) within five (5) days, the authorization will remain active. The agency will document the time and behaviors leading to the AWOL or placement in a shelter and the time out of the TFC home.

Children downgrading from acute or RTC levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified ARC or the OJA worker so an appropriate TFC placement and treatment can be arranged.

THERAPEUTIC FOSTER CARE ADMISSION MEDICAL NECESSITY CRITERIA (OAC 317:30-5-741)			
A child must meet ALL of the following conditions.			
1	**Yes**	**No**	A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-5-240.3(a) within the 30 day period resulting in a primary diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.
2	**Yes**	**No**	Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.
3	**Yes**	**No**	It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.
4	**Yes**	**No**	Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.
5	**Yes**	**No**	The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.
6	**Yes**	**No**	The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

TFC EXTENSION REQUESTS

Although reviews are conducted by phone, the faxed template is required. Extensions are reviewed by phone between the hours of 8 a.m. and 5 p.m. Monday - Friday. Calls should be made within 30 days from the expiration of the current authorization. Failure to follow this time frame will result in loss of day(s).

After the first TFC extension, authorizations may be **up to 90** days for subsequent extensions. The number of days allowed will be determined by the reviewer and based on the level of impairment, severity and chronicity of the symptoms that meet Medical Necessity Criteria, including the need for 24 hour crisis intervention.

All denials will be reviewed by a physician consultant during working hours within (1) business day. When services have been denied, further extension requests CANNOT be considered. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The clinical information must include current, relevant information.

The TFC Provider will be responsible for providing the reviewer with information regarding DHS/OJA participation in the child’s treatment needs and planning.

CONTINUED STAY THERAPEUTIC FOSTER CARE MEDICAL NECESSITY CRITERIA (OAC 317:30-5-741)

The criteria for continued stay in TFC are the same as the TFC admission criteria above. Utilize these same criteria when determining the need for continued stay in TFC.

TFC CLIENTS FIVE YEARS OF AGE AND YOUNGER

Under certain exceptional circumstances, TFC may be approved for children five years of age and younger. Special procedures are in place within the DHS system to ensure that the TFC provider is trained to work with children of this age. For children five years of age and younger, the length of stay authorized on all TFC placements will not exceed 90 days for initial or extension requests.

TFC CLIENTS THAT ARE PLACED IN ACUTE OR RTC

If a child is admitted to an acute care or RTC facility while authorized for TFC, the provider may utilize any of the remaining days of the TFC dates authorized on existing PA once the child is discharged from the higher level of care. The child must be admitted directly from the TFC home and return directly to a TFC home upon discharge from the higher level of care. If the authorization dates on the existing PA for TFC expire while the child is receiving inpatient care, a new prior authorization request must be submitted prior to discharge from the inpatient facility or the TFC provider runs the risk of losing days. The number of days authorized for the new admission after discharge will up to 90 days.

If a child is discharged from TFC level of care, *except to a higher level of care*, a new admission request must be submitted if the child returns to TFC.

TFC PG GROUPS WITH REHAB CHANGES (Effective September 12, 2014)

Psychosocial Rehabilitation (PSR) services for children below age 6 are disallowed unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) laws. Two additional PG groups have been added to accommodate this change. PG056 is a 30 day authorization for children ages 0-5 without Psychosocial Rehabilitation and PG057 is an extension authorization for children ages 0-5 without Psychosocial Rehabilitation.

The requirements to be approved for Psychosocial Rehabilitation are as follows:

- Psychosocial Assessment
- Developmental appropriateness (how can the child benefit from a curriculum based treatment intervention?)
- Please provide the name of the curriculum used to determine developmental appropriateness.

A denial for Psychosocial Rehabilitation will go through a two level review process:

- The initial request for Psychosocial Rehabilitation (PSR) will be given by the clinical reviewer.
- If the TFC agency request a reconsideration for PSR once the initial denial is given then it will go to the Psychiatric Consultant for final determination.

STEPDOWN FROM ACUTE OR RTC TO TFC

Children downgrading from acute or RTC levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified DHS ARC or the OJA Placement office (405-530-2892) and the local OJA/ DHS worker so an appropriate TFC placement and treatment could be arranged.

BEHAVIORAL HEALTH CARE MANAGEMENT AND COORDINATION

Reviewers will provide care coordination to improve treatment at all levels of care, which includes inpatient and outpatient providers, as well as the member's family/guardian. Reviewers will also inquire as to entitlements the child may have such as DDSD or SSI. In cases in which the member may be eligible but not currently receiving such, the reviewer will work with the provider to facilitate the steps that are taken to apply for the entitlements.

On every review, the reviewer will question progress in treatment or lack thereof, discuss plans for follow up care upon discharge including provider name, telephone number, appointment date and time. In addition, questions regarding the plans for placement upon discharge will be asked. If the plan is for the child to not return to his/her former home, the reviewer will work with the treating facility to assist the guardian/responsible party to arrange for alternative placements on an ongoing basis. All options including those not SoonerCare compensable will be explored. Every attempt will be made to refer each of these children to a local system of care program in their home community prior to discharge. This referral should be coordinated by the hospital and the reviewer to ensure a seamless transition to the lower level of care.

NON-VERBAL PRIOR AUTHORIZATION REQUIREMENTS

Children must have a diagnosis of Autistic Spectrum Disorder and the following:

- Early Childhood onset before the age of 3.
- Have a diagnosis of intellectual disability that includes a social domain in the profound category in the DSM V.
- Pervasive since early childhood, the making of sounds that have no correlation to any known languages as the only form of communication.
- Pervasive early childhood, speaking one or two words repetitively with no correlation to any particular object, person, event or relationship as the only form of communication.
- Not able to communicate by use of sign language or other alternative communication forms or languages.

Non-Verbal Prior Authorizations are reviewed by OHCA supervisor(s) for approval. If a denial is given by the OHCA supervisor, a reconsideration can be requested with new clinical information. The reconsideration will then go to our Psychiatric Consults for review.

If the denial is upheld by the Psychiatric Consultant, further reviews will not be reconsidered unless a new request is submitted with additional information.

CASE MANAGEMENT

Case management is considered an integral part of discharge planning. Case management is to be offered to all non-state custody SoonerCare members under the age of 21. This includes those members admitted to inpatient services, both acute and RTC, or those deemed ineligible according to medical necessity criteria for reimbursement for care.

When a SoonerCare member is admitted to an inpatient facility, case management will be offered as a part of the discharge planning that begins at admission. A parent/guardian has the right to decline. If a parent/guardian accepts the case management referral, the treating facility will contact the appropriate case management agency and make the referral. The reviewer may be contacted to assist in the case management referral if necessary.

TRANSFERS

If a child is transferred from one treating facility to another for the same level of care, the reviewer is to be notified when the transfer occurs. The length of stay authorization will be the length of stay initially assigned, minus the days the child has already spent in treatment for that period. If a child transfers from one facility to another with five (5) days or less remaining on the authorization, the transferring facility must provide the next extension request for the new treating facility.

The same procedure applies to TFC clients transferring with less than 30 days remaining on the current authorization. Authorization is NOT required for a transfer. If an extension is not requested by the transferring facility prior to the expiration of the authorization, the new facility will lose days.

CHANGES IN LEVEL OF CARE

If a child is downgraded from acute care to RTC within the same facility, a new request must be made with the new provider number and the current prior authorization must be end dated.

The initial length of stay for RTC will be determined based on the clinical information received from the provider. If a child downgrades from acute to RTC prior to using all the acute days that were prior authorized, the provider will contact the reviewer to request the remainder of the acute days to be switched to RTC on the day of the downgrade. If the child is going to be downgraded at the time the acute care days expire, then the provider will need to do a phone review on the last business day of the acute authorization.

If a child is in need of a more restrictive level of care and is currently authorized for RTC, the reviewer is to be contacted by telephone. The provider must clinically justify how the acute level of care will benefit the client (i.e. the need for increased services). Children downgrading from acute or RTC levels of care directly to TFC will not require an initial face to face assessment by the TFC facility prior to admission. The guardian would request the clinical information be sent to the identified ARC or the OJA worker so an appropriate TFC placement and treatment can be arranged.

DISCHARGE REFERRAL INFORMATION

Discharge referral information should include information that would adequately prepare those providing follow up care. Information should include:

- Behaviors that can be expected upon discharge.
- Supports that need to be in place for the family & in the community.
- Educational needs.
- After school needs: daycare vs. to home after
- school. Recreational needs. Day to day activities:
    - Those that are good for the child
    - Those that should be avoided for the child.

Information about family dynamics and sibling relational issues:

- Safety plan.
- Specific recommendations:
    - If TFC, number of children in the home
    - Family setting vs. group setting
    - If child is better with groups or
    - individuals If child is better with males
    - or females Intimacy needs
    - Interactions with younger children in the home
    - Interactions with older children in the home

AUTOMATIC STEP DOWN SERVICES AFTER DISCHARGING

For those children preparing to discharge or who have discharged from a higher level of care, automatic step down outpatient services can be utilized for the first 30 (thirty) days. For continuity and expediency, the Individual Plan of Care and Assessment from the higher level of care facility should be sent to the outpatient provider. This will serve as the treatment guide for the outpatient provider/agency the first 30 days of outpatient care.

If during the first 30 days, the client/guardian does not respond to letters, phone calls or other attempts to engage them in initiating services or continuing in services, the outpatient provider/facility will provide this information to a Behavioral Health Review Coordinator either by fax or phone.

DISCHARGE FROM ACUTE, RTC, or CBT (Effective September 12, 2014)

Inpatient psychiatric programs must provide “Active Treatment”. Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend.

Discharge planning is the responsibility of the provider and should begin at the time of admission. Discharge planning requires active collaboration with the patient, family and all

involved outpatient practitioners, agencies, and should be ongoing throughout treatment so that effective connections remain intact. Discharge information should be documented in the patient record as soon as possible and no later than two weeks prior to discharge, including dates and times of the appointments. Needed services may consist of the Wraparound process through Systems of Care, counseling, case management, and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition. Appointments should be no later than 7 days after discharge. Reasons for outlier appointment times should be documented in the member's chart.

Transition/Discharge Planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff. Examples of appropriate discharge planning are as follows:

- Appointment scheduling and sharing documentation by UR/case management.
- Phone attempts, messages, and contact with guardian regarding treatment and discharge planning.
- Contact and/or staffing with follow up treatment providers (ex: outpatient counseling agencies, Wraparound, medication management, etc.).
- Scheduling appointments for aftercare services.
- Sharing documentation (copying, scanning, faxing for follow-up care).
- Assist guardians with accessing DDSD, SSI/SSDI
- If a parent/or guardian takes the NAMI education class then it will satisfy the requirement for discharge planning.
- Discharge groups – specific curriculum focused on patient's discharge goals, what they need to do to achieve them and why follow up treatment is necessary (all issues with not wanting to do follow up care, etc.)
- Treatment plan staffing (only time discussing that patient) – the treatment plan staffing must be noted as a written document that states the discussion is related to transition/discharge planning.

If a member is discharged from an inpatient facility AMA, court ordered out of treatment, or discharge is unplanned, then it is still required that the discharge/stepdown plan is completed. When a member is discharged from the RTC level of care to outpatient services, the RTC provider must fax the discharge plan. Please place a copy of the discharge plan in the record showing that it was faxed.

CORRECTION REQUESTS

When a facility finds that a data entry error has been made (e.g., typographical error, wrong provider number, wrong procedure code, wrong SoonerCare member number, etc.), the facility will notify the reviewer by phone with the information to be corrected or may fax in a correction request form.

TRAVEL ASSISTANCE

Each inpatient facility must have a travel assistance policy/plan to assist those SoonerCare

families that need assistance with the expenses of traveling to attend family therapy while their child is receiving inpatient psychiatric care. The inpatient facility is responsible for notifying the families of this assistance and the procedure the family must follow.

FAMILY THERAPY 'In an Instance'/ Exception Request Procedures

1. Family therapy means interaction between a LBHP, member, and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.
2. Family therapy is a part of active treatment and this involves the member and their family/guardian from the time of an admission throughout the treatment and discharge process.
3. Family therapy must be provided one hour per week for acute and residential treatment for members under the age of 18.
4. One hour of individual therapy addressing relevant family issues may be substituted for a family session 'in an instance' in which the family is unable to attend a scheduled session by a LBHP (ex: family emergency, family illness, death, inclement weather, etc).
    - 'In an instance' is not an ongoing circumstance that will prevent the family from coming to family therapy.
    - 'In an instance' should be rare.
    - The therapist is required to document the 'in an instance' situation in the clinical template submitted when conducting individual therapy in lieu of family therapy.
5. An exception request is an on-going chronic significant illness or situation that will render the parent/guardian incapable of attending the weekly family therapy sessions (ex: ongoing illness, distance of guardian from facility,etc).
    - The exception to conducting weekly family therapy needs to be reported to the behavioral health specialist.
    - The inpatient reviewer will need to staff the 'exceptions' to family therapy with the OHCA Behavioral Health Supervisor. The exception designation 'needs to be approved' in the medical necessity review prior authorization process.
    - Reasons for exceptions to this requirement must be well documented in the member's treatment plan.
    - On the clinical template it should be outlined the specifics of the request for an exception and when it went into effect.

VIDEO CONFERENCING FOR FAMILY THERAPY WHEN AN EXCEPTION IS GRANTED

Video-conferencing has been approved for use effective Jan 15, 2014 in lieu of required face to face weekly family therapy sessions for members who are inpatient if there is a formal exception approved by OHCA.

- This must be done over a secure network.
- Guardians/parents can utilize the tele-conferencing equipment at the outpatient agencies or Community Mental Health Centers (CMHC). Guardians/parents may also

utilize the equipment from agencies in which they access outpatient services.

- There is no fee paid to the provider for the use of the equipment.
- There is no requirement that a staff member from the CMHC or outpatient agency be present with the family during the tele-conferencing session.
- This is not a billable service by the outpatient, inpatient, or CMHC but does fulfill the requirement for face to face family therapy on the part of the inpatient facility.
- At this time Apple's FaceTime system is the only software approved for use. This can only be used if the provider and/or guardians are using a desktop computer in a setting that ensures confidentiality, using a wired connection.

RECREATIONAL THERAPY (Effective September 12, 2014)

Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

PHYSICIAN SERVICES

Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed thirty (30) calendar days in a CBT, seven (7) calendar days in a specialty PRTF, and ten (10) calendar days in a regular PRTF. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs. Due to policy changes physician progress notes must be dated, signed, and time stamped in order for it to count towards the core hours for each specified level of treatment.

ACTIVE TREATMENT

Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services.

REIMBURSEMENT

Acute psychiatric units within general medical surgical hospitals and Critical Access hospitals will be paid utilizing a DRG methodology. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable and not included in the DRG.

Acute psychiatric units within freestanding psychiatric hospitals will be paid a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable.

Residential treatment in psychiatric hospitals or inpatient psychiatric programs will be reimbursed a pre-determined all-inclusive per diem for routine, ancillary and professional services.

Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at pre-determined per diem to private PRTFs with <u>16 beds or less</u> for routine services. All other services are separately billable.

Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at a pre-determined <u>all- inclusive</u> per diem to private PRTFs with <u>16 beds or more</u> for routine, ancillary and professional services.

OHCA APPROVAL OF OUT-OF-STATE PLACEMENTS

When a child is in parental, DHS or OJA custody and admission to an out-of-state facility that is not a border placement is requested, OHCA must approve the placement prior to the child admitting to a facility outside of Oklahoma. Many factors are considered by OHCA in approving a child for placement out-of-state. The primary issues to be considered are lack of appropriate treatment resources in Oklahoma or if the child has exhausted the resources currently available in Oklahoma.

Children who are placed out of state have a serious behavioral health disorder, along with a complicating medical disorder and/or handicap. Some examples might include children with severe autism, brain injury, hearing or vision impairment.

1. The parent/ guardian must contact the OHCA.
2. A face to face assessment referral will be facilitated. If there is a current LBHP (licensed practitioner), this provider needs to contact the OHCA with his/her clinical findings and recommendations for treatment.
3. Medical necessity criteria must be met.
4. The reviewer will request the following information:
    a. Complete treatment history of the client, including inpatient and outpatient treatment stays must be submitted. The current treating facility and/or guardian can submit this information.
    b. Medical records from the current treating facility and past treatment providers

may be requested.

c. A physician's referral letter recommending specialized treatment and noting the unavailability of treatment within the state of Oklahoma, including supportive clinical information such as diagnosis and symptomology must be submitted.
d. An Interstate Compact on Placement of Children (ICPC) must be in place between the sending and receiving states.
e. This information will be submitted *by fax.* The submitted information will be reviewed with OHCA for final approval.

DEPARTMENT OF HUMAN SERVICES CUSTODY CHILDREN

Prior to placing a DHS custody child in an out-of-state inpatient psychiatric facility, the Juvenile Judge who has jurisdiction and the child's attorney must agree with the placement. There must be prior approval between the sending and receiving states via Interstate Compact on Placement of Children (ICPC). The DHS Child Welfare worker must complete forms, which are submitted to the Oklahoma ICPC director (405-522-0672) and ICPC approval must be received from the state's ICPC director before the child can be transported to the out-of-state facility. This information will be submitted *by fax.* The submitted information will be reviewed with OHCA for final approval. Initial inquiries can be made by calling the OHCA.

RECONSIDERATION

Effective **July 1, 2006**, the behavioral health reconsideration process ended. The review decision issued is considered by the OHCA to be a final administrative determination and not appealable to the OHCA for any further administrative hearings.

SERVICE QUALITY REVIEW

1. All facilities contracted with the state of Oklahoma that provide acute, residential and TFC services to SoonerCare recipients under the age of 21 during the past contract year will be reviewed by the OHCA contractor.
2. Service Quality Reviews will be done as a combination of desktop or on-site audits.
3. Records can be submitted by using one of these 4 methods: fax, mail, CD-rom/DVD disk, or the provider can choose to upload the records through the provider portal.
4. Each facility will be reviewed one time within the contract period, but OHCA has the right to request the OHCA SQRS team to perform an additional ad hoc review at any time.
5. Local/in-state and boarder facilities and agencies may have a complete onsite review. The SQR team may also choose to conduct complete onsite reviews if the facility has special issues that the team believes are best monitored directly or could be missed when records are submitted by the facility or agency.
6. When a facility or agency is found by the review team to have issues that are considered unsafe, or fail to provider services that meet minimum treatment standards as determined by the entire team then a second review is conducted within 60 days. The facility or agency may also be referred to the OHCA Quality Assessment team.
7. Service Quality (SQ) reviews are performed as referenced in OAC317:30-5-95. 42 for inpatient providers and in OAC 317:30-5-743.1 for TFC providers.

8. The documentation reviewed during inpatient provider SQ reviews includes (but is not limited to):
   - DSM-V primary diagnosis;
   - Clinical information supporting medical necessity criteria and the need for requested level of care;
   - Medical, psychiatric and social evaluations were completed within the time frame specified by OAC 317: 30-5-95.37;
   - Parent(s)/ Guardian received copies of the information of behavioral management of patient, guidelines and conditions, grievance procedures, address and phone number for DHS Advocacy office, patient bill of rights, seclusion/ restraint policy and consent for case management;
   - Informed consent signed by parent/ guardian for use of psychotropic medications; Medical issues are identified and receiving appropriate care;
   - Individual Plan of Care (service plan) completed and addresses areas specified by OAC 317: 30-5-95.33, including dated signatures of treatment team members, collaboration of parent/ guardian, medications and dosages and discharge plan;
   - RN documentation every 24 hours for acute and every 7 days for RTC levels of care;
   - Services provided for SoonerCare member with developmental disabilities or any disability are rendered appropriately;
   - Use of Seclusion/ Restraint;
   - Frequency of active treatment components as specified in OAC 317: 30-5-95.34;
   - Facility accreditation and policies and procedures; and
   - Employee licensure, CPR, and crisis management competencies and background checks.

9. The documentation reviewed during TFC provider SQ reviews includes (but is not limited to):
   - DSM-V primary diagnosis;
   - Clinical information supporting the need for requested level of care;
   - Medical, psychiatric and social evaluations were completed within the time frame specified by OAC: 317-30-5-95.42;
   - Individual Plan of Care (service plan) completed and addresses areas specified by OAC:317-30-5-742.2, including dated signatures of treatment team members, collaboration of guardian, medications and dosages and discharge plan;
   - Frequency of active treatment components as specified in OAC: 317-30-5-742;
   - Involvement of biological parents, as clinically indicated;
   - Use of crisis intervention;
   - Facility accreditation and policies and procedures; and
   - Employee licensure and background checks.