
POLICY TRANSMITTAL NO. 08-55	DATE: NOVEMBER 7, 2008
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-22; 30-5-22.1; 30-5-231; 30-5-233 through 30-5-234;
30-5-241; 35-5-45 through 35-5-46; 35-17-11 through 35-17-12; and
35-17-15 through 35-17-16.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Physician rules are revised to: (1) allow reimbursement of one non stress test and/or one biophysical profile to a Maternal Fetal Medicine (MFM) specialist without requiring a prior authorization; and (2) remove the OB signature requirement from the high risk OB treatment plan form unless he or she wishes to request authorization of the ante partum management fee.

Rules are revised to allow reimbursement to International Board Certified Lactation Consultants (IBCLCs) who are licensed by the state as either a nurse or as a dietician.

Outpatient Behavioral Health rules are revised to remove language referring to the reimbursement methodology for PACT services. PACT services are currently reimbursed using a per diem rate inclusive of all services provided by the PACT team. The revised methodology is needed to comply with the Centers for Medicare and Medicaid Services and would reimburse PACT services using fee for service rates that correlate with each individual service.

SoonerCare eligibility rules are revised to remove language regarding the consideration of resources when determining financial eligibility for individuals categorically related to Aid to Families with Dependent Children (AFDC) and pregnancy-related services. Revisions are needed to remove incorrect language that inadvertently remained in rules after the asset test was eliminated.

ADvantage eligibility rules are revised to require the State to redetermine level of care annually for members participating in the ADvantage program.

Original signed on 11-5-08

Mary Stalaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 08-AA (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
317:30-5-22	317:30-5-22, pages 1-3, revised 8-1-08
317:30-5-22.1	317:30-5-22.1, 1 page only, revised 8-1-08
317:30-5-231	317:30-5-231, 1 page only, revised 7-25-08
317:30-5-233	317:30-5-233, 1 page only, revised 7-25-08
317:30-5-234	317:30-5-234, 1 page only, revised 7-25-08
317:30-5-241	317:30-5-241, pages 1-24, revised 10-1-08
317:35-5-45	317:35-5-45, pages 1-2, revised 10-1-08
317:35-5-46	317:35-5-46, 1 page only, revised 10-1-08
317:35-17-11	317:35-17-11, pages 1-6, revised 7-25-08
317:35-17-12	317:35-17-12, 1 page only, revised 7-25-08
317:35-17-15	317:35-17-15, 1 page only, revised 7-25-08
317:35-17-16	317:35-17-16, pages 1-2, revised 7-25-08

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetrical care are listed in (1) - (7) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

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OAC 317:30-5-22 (p2)

(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies, must be performed by an active candidate or Board Certified diplomate in Maternal-Fetal Medicine.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.

(1) Additional non stress tests, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

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(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA may receive prior authorization for medically necessary enhanced benefits which include:

- (1) prenatal at risk ante partum management;
- (2) a combined maximum of 12 fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses); and
- (3) a maximum of 6 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

- (1) ACOG or other comparable comprehensive prenatal assessment;
- (2) chart note identifying and detailing the qualifying high risk condition; and
- (3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Maternal Fetal Medicine (MFM) specialist.

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

- (1) Ante partum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ante partum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ante partum management is not made during an in-patient hospital stay.
- (2) Non stress tests, biophysical profiles and ultrasounds (in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C) are reimbursed when prior authorized.
- (3) Reimbursement for enhanced at risk ante partum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

**MEDICAL PROVIDERS-FEE FOR SERVICE
LACTATION CONSULTANTS SPECIFIC**

OAC 317:30-5-231

317:30-5-231. Eligible providers

Eligible providers must be licensed by the state as a nurse or dietician and be an International Board Certified Lactation Consultants (IBCLCs). Providers must have a current contract on file with the Oklahoma Health Care Authority.

317:30-5-233. Limitations

(a) Services billed by a contracted IBCLC are only covered when performed in the IBCLC's office setting, patient's home, or other confidential outpatient setting. Payment for inpatient services provided by a Lactation Consultant is included in the hospital's per diem rate.

(b) No separate reimbursement will be made to a facility.

(c) Services are not to duplicate any basic breastfeeding education/training a member may have received through another program such as WIC or the Children's First Program and services must be problem focused.

(d) Services provided by a contracted IBCLC must be provided face-to-face and in an individual setting.

(e) Reimbursement is limited to not more than 6 sessions per pregnancy and must be objectively documented as medically necessary.

317:30-5-234. Reimbursement

IBCLCs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

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OUTPATIENT BEHAVIORAL HEALTH
SERVICES SPECIFIC**

OAC 317:30-5-241 p(1)

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

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

(1) **Mental Health Assessment by a Non-Physician.** All agencies must assess the medical necessity of each individual to determine the appropriate level of care. The assessment must contain but is not limited to the following:

- (A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;
- (B) Source of information;
- (C) Member's first name, middle initial and last name;

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- (D) Gender;
- (E) Birth date;
- (F) Home address;
- (G) Telephone number;
- (H) Referral source;
- (I) Reason for referral;
- (J) Person to be notified in case of emergency;
- (K) Presenting reason for seeking services;
- (L) Psychiatric social information, which includes: personal history, including; family B social; educational; cultural and religious orientation; occupational B military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; financial; clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations; legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate; substance abuse and dependence, both current and historical; gambling abuse and dependence, both current and historical; and present life situation.
- (M) Mental status information, including questions regarding:
 - (i) physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
 - (ii) affective process, such as mood, affect, manner and attitude, etc., and
 - (iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and
 - (iv) Full Five Axes DSM diagnosis.
- (N) A section on health history and pharmaceutical information, with pharmaceutical information to include the following for both current and past medications:
 - (i) name of medication;
 - (ii) strength and dosage of medication;
 - (iii) length of time on the medication;
 - (iv) benefit(s) and side effects of medication; and
 - (v) level of functionality.
- (O) Identification of the member's strengths, needs, abilities, and preferences:
 - (i) LBHP's interpretation of findings;
 - (ii) signature and credentials of LBHP.
- (P) The assessment includes all elements and tools required

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OAC 317:30-5-241 p(3)

by the OHCA. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the member. For children under the age of 16, it includes an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an LBHP. The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment.

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

- (A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;
- (B) Source of information;
- (C) Member's first name, middle initial and last name;
- (D) Gender;
- (E) Birth date;
- (F) Home address;
- (G) Telephone number;
- (H) Referral source;
- (I) Reason for referral;
- (J) Person to be notified in case of emergency;
- (K) Presenting reason for seeking services; and
- (L) Psychiatric social information, which must include:
 - (i) personal history, including: family B social; educational; cultural and religious orientation; occupational B military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; and financial;
 - (ii) clinical treatment history including past and current

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

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one-half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. The service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment.

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

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

(B) The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment and determined diagnosis by the practitioners and the member of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited.

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

(D) Comprehensive and integrated service plan content addresses the following:

- (i) member strengths, needs, abilities, and preferences;
- (ii) identified presenting challenges, problems, needs, and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, measurable, attainable, realistic, and time-limited (unless the individual is on a

recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed);

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

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

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

(viii) any needed referrals for services;

(ix) specific discharge criteria;

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

(xi) service plans are not valid until all signatures are present (signatures are required from the member, the parent/guardian when applicable, and the primary LBHP); and

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

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

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

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

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

(C) Service plan updates must address the following:

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

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

(iii) change in goals and/or objectives (including target

dates) based upon member's progress or identification of new need, challenges and problems;

(iv) change in frequency and/or type of services provided;
(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;

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

(vii) additional referrals for needed services;

(viii) change in discharge criteria;

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

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

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

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

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

(B) The service is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited.

(C) For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals

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for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assist the family in caring for the child in the least restrictive level of care.

(D) Comprehensive and integrated service plan contents must address the following:

- (i) member strengths, needs, abilities, and preferences;
- (ii) identified presenting challenges and problems, needs, and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, measurable, attainable, realistic and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed);
- (v) each type of service and estimated frequency to be received;
- (vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;
- (vii) the practitioner(s) name and credentials who will be providing and responsible for each service;
- (viii) any needed referrals for services;
- (ix) specific discharge criteria;
- (x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
- (xi) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age 16 or otherwise applicable), and the primary LBHP; and
- (xii) changes in service plans can be documented in a Service Plan Update (low complexity) or in the progress notes until time for the Update (low complexity).

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

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

(B) Alcohol and/or Substance Abuse Treatment Plan Development

(low complexity) are provided by the treatment team members.

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

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

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

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

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

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

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

(vii) additional referrals for needed services;

(viii) change in discharge criteria;

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

(x) service plans are not valid until all signatures are present. The required signatures are the:

(I) member (if over age 14),

(II) parent/guardian (if under age 16 or otherwise applicable), and

(III) primary LBHP.

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

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

(7) Individual/Interactive Psychotherapy.

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

cognitive discussion of reality, or any combination of these items to provide therapeutic change.

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

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the member and the LBPH or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

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

(8) Group Psychotherapy.

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan.

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This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

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

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

(9) Family Psychotherapy.

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or an AODTP and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(B) A maximum of three units of Family Psychotherapy are allowed per day per member/family. Family Psychotherapy must be provided by a LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) Psychiatric Social Rehabilitation Services (group).

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

- (i) date;
- (ii) start and stop time(s) for each day of service;
- (iii) signature of the primary rehabilitation clinician;
- (iv) credentials of the primary rehabilitation clinician;
- (v) specific goal(s) and/or objectives addressed (these must be identified on service plan);
- (vi) type of skills training provided;
- (vii) progress made toward goals and objectives;
- (viii) member's report of satisfaction with staff intervention; and
- (ix) any new needed supports identified during service.

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

(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time. The minimum staffing ratio is fourteen members for each PSRS, AODTP, or LBHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention

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program such as MANDT or CAPE or trauma informed methodology.

In order to develop and improve the member's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the outpatient behavioral health agency site. When this occurs, the PSRS, AODTP, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.

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

(11) Psychiatric Social Rehabilitation Services (individual).

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

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

(12) Assessment/Evaluation testing.

(A) Assessment/Evaluation testing is provided by a clinician

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

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

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

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

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time. The minimum staffing ratio is fourteen members for each PSRS, LBHP, or AODTP for adults and eight to one for children under the age of eighteen. This service may be performed by an AODTP, LBHP, or a PSRS. In order to develop and improve the member's community and interpersonal functioning and self care abilities, services may take place in settings away from the agency site. When this occurs, the AODTP, LBHP, or PSRS must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a

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fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.

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

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

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

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

(15) Medication Training and Support.

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and

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Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for SoonerCare member who reside in ICF/MR facilities. One unit is allowed per month per patient without prior authorization.

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

(16) Crisis Intervention Services.

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

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

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

in the Oklahoma Administrative Code. Children's facility based stabilization (0-18 years of age) requires prior authorization.

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

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

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

- (i) Assessment and evaluation;
- (ii) Treatment planning;
- (iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;
- (iv) Symptom assessment, management, and individual supportive psychotherapy;
- (v) Medication evaluation and management, administration, monitoring and documentation;
- (vi) Rehabilitation services;
- (vii) Substance abuse treatment services;
- (viii) Activities of daily living training and supports;
- (ix) Social, interpersonal relationship, and related skills training; and,
- (x) Case management services.

(C) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for Crisis Intervention Services (facility based stabilization).

(19) Behavioral Health Aide. This service is limited to

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

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

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

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

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

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

(20) **Family Support and Training.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody residing within a RBMS level of care and who without these services would require psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family

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members to increase their ability to provide a safe and supportive environment in the home and community for the child.

This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements, such as the crisis plan and plan of care process; training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. Parent Support ensures the engagement and active participation of the family in the treatment planning process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management. Services are goal directed as identified in the child's individualized plan of care and provided under the direction of a child and family treatment team and are intended to support the family with maintaining the child in the home and community.

For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the member.

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

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

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

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

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

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

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

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

(i) High School diploma or GED;

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

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

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

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

(C) Example of work performed:

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

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

- recovery experience;
 - (II) model effective coping techniques and self-help strategies;
 - (III) assist members in articulating personal goals for recovery; and
 - (IV) assist members in determining the objectives needed to reach his/her recovery goals.
- (ii) Utilizing ongoing training may:
- (I) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;
 - (II) facilitate peer support groups;
 - (III) assist in setting up and sustaining self-help (mutual support) groups;
 - (IV) support members in using a Wellness Recovery Action Plan (WRAP);
 - (V) assist in creating a crisis plan/Psychiatric Advanced Directive;
 - (VI) utilize and teach problem solving techniques with members;
 - (VII) teach members how to identify and combat negative self-talk and fears;
 - (VIII) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
 - (IX) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
 - (X) assist other staff in identifying program and service environments that are conducive to recovery; and
 - (XI) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.
- (iii) Possess knowledge about various mental health settings and ancillary services (i.e., Social Security, housing services, and advocacy organizations).
- (iv) Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.
- (I) attend continuing education assemblies when offered by or approved by the ODMHSAS's Office of Consumer Affairs; and
 - (II) develop and share recovery oriented material at

member specific continuing education trainings.

(v) Serve by:

(I) providing and advocating for effective recovery oriented services;

(II) assisting members in obtaining services that suit that individual's recovery needs;

(III) informing members about community and natural supports and how to utilize these in the recovery process; and

(IV) assisting members in developing empowerment skills through self-advocacy.

(vi) Develop specific competencies which will enhance their work skills and abilities. Identified tasks include, but are not limited to:

(I) becoming a trained facilitator of Double Trouble in Recovery (DTR);

(II) becoming a trained facilitator of Wellness Recovery Action Plan (WRAP);

(III) pursuing the USPRA credential of Certified Psychiatric Rehabilitation Practitioner (CPRP).

(b) Prior authorization and review of services requirements.

(1) General requirement. All SoonerCare providers who provide outpatient behavioral health services are required to have the services they provide prior authorized by the OHCA or its designated agent. Services that do not require prior authorization are as follows:

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

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

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

(D) Crisis Intervention Services; and

(E) Adult Facility Based Crisis Intervention.

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

(3) Prior authorization process.

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

authorization.

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

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

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

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

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

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

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

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

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

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

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

Services; and Adult Facility Based Crisis Intervention.

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

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

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

(IV) psychiatric and treatment history;

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

(VI) services requested.

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

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

(C) Authorization for services.

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

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

317:35-5-45. Determination of income and resources for categorical relationship to AFDC

Income is determined in accordance with OAC 317:35-10 for individuals categorically related to AFDC. ■ 1 Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. ■ 2 Individuals categorically related to AFDC are excluded from the AFDC resource test. Certain AFDC rules are specific to money payment cases and are not applicable when only SoonerCare services are requested. Exceptions to the AFDC rules are:

- (1) the deeming of the parent(s)' income to the minor parent;
- (2) the deeming of the sponsor's income to the sponsored alien;
- (3) the deeming of stepparent income to the stepchildren. The income of the stepparent who is not included for SoonerCare in a family case is not deemed according to the stepparent liability. Only the amount of the stepparent's contribution to the individual is considered as income. The amount of contribution is determined according to OAC 317:35-10-26(a)(8), Person acting in the role of a spouse;
- (4) the AFDC lump sum income rule. For purposes of SoonerCare eligibility, a period of ineligibility is not computed;
- (5) mandatory inclusion of minor blood-related siblings or minor dependent children. For SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children; ■ 3
- (6) the disregard of one half of the earned income;
- (7) dependent care expense. For SoonerCare only, dependent care expenses may be deducted for an in-home provider who, though not approved, would have qualified had the qualification process been followed;
- (8) AFDC trust rule. The availability of trusts for all SoonerCare only cases is determined according to OAC 317:35-5-41.6;
- (9) AFDC Striker rules. Striker status has no bearing on SoonerCare eligibility;
- (10) ET&E Sanction rule. The ET&E status has no bearing on SoonerCare eligibility. However, a new SoonerCare application is required.

INSTRUCTIONS TO STAFF

1. Workers must review data exchange screens on all Medicaid applications. If there appears to be conflicting information, the worker interviews the applicant to determine

if income verification is necessary.

2. Income of self employed individuals must be verified with copies of income tax records or statements showing income and expenses for the previous year. If the individual has been self employed for less than a year, income and expense statements for the time period the individual has been self employed must be provided.
3. Refer to OAC 317:35-6-36(b).

317:35-5-46. Determination of income and resources for categorical relationship to pregnancy-related services

Countable income for an individual categorically related to pregnancy-related services is determined in the same manner as for an individual categorically related to AFDC. (See OAC 317:35-5-45). Eligibility is based on the income received in the first month of certification with changes in income not considered after certification. **■ 1** Individuals categorically related to pregnancy-related services are excluded from a resource test.

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1. See OKDHS Form 08AX001E (Appendix C-1), Schedule 1.A.

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program there is not a spenddown calculation as the member does not pay a vendor payment.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or**

over and in a mental health hospital. For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital.

The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program, there is no spenddown calculation as the member does not pay a vendor payment.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for care. If the

individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving ADvantage program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS Appendix C-1, Schedule XI. ■ 1 When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS Appendix C-1, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment.** There is not a spenddown calculation for individuals receiving ADvantage program services as the member does not pay a vendor payment.

(D) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

INSTRUCTIONS TO STAFF

1. The computation for the community spouse's share of resources is:
 - (1) Total Countable Resources
 - (2) Divided by 2 (Cannot exceed the maximum resource standard. If less than the minimum resource standard, deem from spouse up to the minimum standard).

317:35-17-12. Certification for ADvantage program services

(a) **Application date.** If the applicant is found eligible for Medicaid, certification may be effective the date of application. The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.

(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the computer form and the appropriate notice is computer generated to the member and the Administrative Agent (AA). Notice information is retained on the notice file for county use.

(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.

(b) **Financial certification period for ADvantage program services.**

The financial certification period for the ADvantage program services is 12 months. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical Certification period for ADvantage program services.**

The medical certification period for the ADvantage program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan by the case manager. In addition, an independent evaluation of medical eligibility is completed by the OKDHS Nurse at least every third year. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, the OKDHS Nurse does an independent evaluation of medical eligibility before the end of the current medical certification period.

**MEDICAL ASSISTANCE FOR ADULTS
AND CHILDREN-ELIGIBILITY**

OAC 317:35-17-15

317:35-17-15. Redetermination of eligibility for ADvantage services

(a) The worker must complete a redetermination of financial eligibility prior to the end of the certification period. ■ 1 A notice is generated only if there is a change which affects the member's financial responsibility.

(b) The ADvantage case manager or the OKDHS nurse must complete a redetermination of medical eligibility prior to the end of the certification period.

INSTRUCTIONS TO STAFF

1. All factors of eligibility must be reviewed and documented in FACS case notes.

317:35-17-16. Member annual level of care re-evaluation and annual re-authorization of service plan

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan to the AA for certification. Along with the service plan submitted for annual recertification, the case manager forwards to AA the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every 11 months, the ADvantage case manager makes a home visit to evaluate the ADvantage member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process. The OKDHS nurse evaluation substitutes for the case manager's fourth quarter assessment in the client's third year.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the AA evaluates whether the member continues to meet policy defined criteria for Nursing Facility level of care.

(3) Except for enrollment years in which the OKDHS nurse is scheduled to do an independent assessment for medical eligibility, the AA notifies OKDHS/ASD electronically of member medical assessment by providing the member's identifying information and the member's UCAT Part III including level of care criteria domain scores to justify member medical eligibility recertification for an additional 12 month period.

(4) OKDHS/ASD determines whether a member requires further assessment for annual medical eligibility determination. For a member requiring further assessment, and at least every third year, the OKDHS nurse schedules a home visit with the member to do a UCAT reassessment which will be used for redetermination of medical eligibility.

(5) The OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, for a determination of continued medical eligibility. The area nurse, or designee, makes the medical eligibility decision and recertifies medical eligibility prior to expiration date of current medical eligibility

certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the area nurse, or nurse designee, updates the system's "medical eligibility end date" and notifies the AA electronically. The AA communicates to the member's case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, helps the member to arrange alternate services in place of ADvantage.