
POLICY TRANSMITTAL NO. 10-19	DATE: APRIL 20, 2010
FAMILY SUPPORT SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF INTERGOVERNMENTAL RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-3-62; 30-3-63; 30-5-95.33; 30-5-95.35; 30-5-585; 30-5-586; 30-5-595; 30-5-596; 30-5-596.1; 30-5-596.2; 30-5-972; and 30-5-992.

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

Rules are revised to broaden TCM to all BA/BS level degrees. Currently a Case Manager II and III bachelor's degree had to be in a behavioral health field, with the revisions any bachelor's degree earned from a regionally accredited college or university recognized by the United States Department of Education will be accepted. Additionally rules were revised to combine adult and children outpatient Behavioral Health TCM rules into one streamlined set. Revisions were also made to provide more consistency with Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) policy.

Children's inpatient psychiatric treatment rules are revised to add LADCs as a qualified LBHP's in inpatient settings for children. Currently LADCs are not one of the licensed behavioral health professionals that provide services in an inpatient setting for children, which limits access for specialized treatment in alcohol and drug addiction. The revisions will increase the specialty access to care for people with drug or alcohol addiction as well as expand the type of licensure children's inpatient psychiatric treatment centers staff can hold in order to provide services.

Agency rules are written to establish policy for hospital acquired conditions. Rules will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. Payment will be made as though the secondary diagnosis was not present. The selected conditions that OHCA will recognize are those conditions identified as non-payable

by Medicare. Rules will also include the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the recognized hospital acquired conditions.

Original signed on 4-16-10

Mary Stalnaker, Director
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WF # 10-G (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>
317:30-3-62	317:30-3-62, pages 1-2, revised 4-1-10
317:30-3-63	317:30-3-63, pages 1-2, revised 4-1-10
317:30-5-95.33	317:30-5-95.33, pages 1-2, revised 3-3-10
317:30-5-95.35	317:30-5-95.35, 1 page only, revised 3-3-10
317:30-5-585	-----
317:30-5-586	-----
317:30-5-595	317:30-5-595, pages 1-3, revised 3-3-10
317:30-5-596	317:30-5-596, pages 1-5, revised 3-3-10
317:30-5-596.1	317:30-5-596.1, 1 page only, revised 3-3-10
317:30-5-596.2	-----
317:30-5-972	317:30-5-972, 1 page only, revised 3-3-10

317:30-3-62. Serious reportable events B never events

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.

(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.

(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same

hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.

(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.

(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).

(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.

317:30-3-63. Hospital acquired conditions

(a) Coverage. The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

- (1) Foreign Object Retained After Surgery
- (2) Air Embolism
- (3) Blood Incompatibility
- (4) Pressure Ulcer Stages III & IV
- (5) Falls and Trauma
 - (A) Fracture
 - (B) Dislocation
 - (C) Intracranial Injury
 - (D) Crushing Injury
 - (E) Burn
 - (F) Electric Shock
- (6) Catheter-Associated Urinary Tract Infection
- (7) Vascular Catheter-Associated Infection
- (8) Manifestations of Poor Glycemic Control
 - (A) Diabetic Ketoacidosis
 - (B) Nonketotic Hyperosmolar Coma
 - (C) Hypoglycemic Coma
 - (D) Secondary Diabetes with Ketoacidosis
 - (E) Secondary Diabetes with Hyperosmolarity
- (9) Surgical Site Infection Following:
 - (A) Coronary Artery Bypass Graft- Mediastinitis
 - (B) Bariatric Surgery
 - (i) Laparoscopic Gastric Bypass
 - (ii) Gastroenterostomy
 - (iii) Laparoscopic Gastric Restrictive Surgery
 - (C) Orthopedic Procedures
 - (i) Spine
 - (ii) Neck
 - (iii) Shoulder
 - (iv) Elbow
- (10) Deep Vein Thrombosis and Pulmonary Embolism
 - (A) Total Knee Replacement
 - (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.

317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served

and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF and every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a mental health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner ; Licensed Alcohol and Drug Counselor (LADC), (or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not Medicaid compensable and can not be billed to the Medicaid recipient.

317:30-5-595. Eligible providers

Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) Agencies must hold current accreditation appropriate to outpatient behavioral health from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.

(B) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(C) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.

(D) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(E) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(F) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(G) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.

(2) **Provider Qualifications.**

(A) **Service provider education and experience requirements if certified before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the ODMHSAS. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:

(i) Associate degree in a related human service field, OR;

(ii) Two years of college education plus two years or more human service experience, OR;

(iii) Bachelors degree in a related human service field plus one year or more human service experience, OR;

(iv) Masters degree in a related human service field.

(B) Service provider education and experience requirements if certified after July 1, 2001 and before July 1, 2007. For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and have a:

- (i) Bachelors or masters degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR
- (ii) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR
- (iii) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; and
- (iv) Current case management certification from the ODMHSAS.

(C) Service provider education and experience requirements if certified after July 1, 2007. For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and meet either (i), (ii), or (iii) below, and (iv):

- (i) Certified Behavioral Health Case Manager III meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.
- (ii) Certified Behavioral Health Case Manager II a bachelors or masters degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, education and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours

of ODMHSAS specified CM training. (After July 1, 2010: Any bachelors or masters degree earned from a regionally accredited college or university recognized by the USDE).

(iii) Certified Behavioral Health Case Manager I meets the requirements in either (I) or (II), and (III):

(I) completed 60 college credit hours; or

(II) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(III) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.

(D) **Wraparound Facilitator Case Manager** - meets the qualifications for CM II or CM III and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(E) **Intensive Case Manager** - meets the provider qualifications of a Case Manager II or III and has the following:

(i) A minimum of 2 years Behavioral Health Case Management experience, crisis intervention experience, and

(ii) must have attended the ODMHSAS 6 hours Intensive case management training.

(F) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

(1) Payment is made for services rendered to SoonerCare member's as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more

appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from an higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member (and family's, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d).

(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(IV) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the individual plan of care.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public

institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

(i) Basic Case Management/Resource Coordination.

Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individuals strengths and meet needs in order to achieve stability in the community.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM).

Intensive Case Management is targeted to adults with serious and persistent mental illness (including member's in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including member's in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To ensure that these intense needs are met, case manager caseloads are limited to 25. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis intervention experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

(C) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

- (i) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or
- (ii) Managing finances; or
- (iii) Providing specific services such as shopping or paying bills; or
- (iv) Delivering bus tickets, food stamps, money, etc.; or
- (v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or
- (vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or
- (vii) Filling out SoonerCare forms, applications, etc., ;
- (viii) Mentoring or tutoring; or
- (ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies.

(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

- (i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
- (ii) Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
- (iii) Residents of ICF/MR and nursing facilities unless transitioning into the community;
- (iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.

(b) SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A SoonerCare member may be approved for a time frame of one to twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed individual plan of service is not required at the time of initial request. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240.

317:30-5-972. Reimbursement

Office of Juvenile Affairs Targeted Case Management (OJATCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

317:30-5-992. Reimbursement

Child Welfare Targeted Case Management (CWTCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.