PRIOR AUTHORIZATION MANUAL

FY2025

July 1, 2024

PRIOR AUTHORIZATION (PA) MANUAL REVISIONS

July 1, 2022

- **Removed references to:**
  - **Health Homes**
  - **TANF/CW**
  - **Prison-related services**

February 1, 2020

- Under the General Information section of the Manual:
  - Deleted Telemedicine Originating Site under Services Requiring No Prior Authorization, as that is no longer a billable service.
- Under the Prior Authorization Process – Behavioral Health Agencies section of the Manual:
  - Under Instant Prior Authorization, Pre-Admission Services revised language to allow for one pre-admission authorization per customer, per agency every 6 months - if it has been at least 3 months from customer's last billed service
  - Under Outpatient Request For Prior Authorization, Transitional Case Management- revised case management units to be congruent with rule changes
- Under Prior Authorization Process – Individual Providers
  - Deleted Exceptional Case under the PA Adjustment section as it no longer applies due to system limitations
  - Added language under Corrections PA Adjustment section regarding requests for additional Psychological Evaluation/Testing units
- Under the Medical Necessity Criteria section of the Manual:
  - Deleted Mental Necessity Criteria section for Exceptional Case as it no longer applies due to system limitations
  - Revised Amount of Service Allowable for Increased Case Management Units for OPBH Agencies to be congruent with rule changes
  - Revised Amount of Service Allowable for Transitional Case Management Units for OPBH Agencies to be congruent with rule changes
  - Revised language for Service/Reimbursement Limitation under Children's Partial Hospitalization Program to be more concise
- Under the Customer Data Core section of the Manual:
  - Section I
    - Added information on ACE Score
  - Section II & III
    - Military Status revised

GENERAL INFORMATION

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

- SoonerCare Choice,
- SoonerCare Traditional, and
- ODMHSAS contracted providers as specified by ODMHSAS

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

Outpatient Behavioral Health Agencies-

- Mental Health & Substance Abuse/Integrated Services
- Children's Day Treatment
- Children's Partial Hospitalization Program
- Automatic Step Down / After Care
- ICF/IID
- Additional Outpatient Services for Members in RBMS/TFC/Therapeutic Group Homes (Levels C&E)
- OJA Multi-Systemic Therapy
- ODMHSAS Specialty Programs

Individual Psychologists and Licensed Behavioral Health Professionals (LBHPs)-

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

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

SERVICES REQUIRING NO PRIOR AUTHORIZATION

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

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

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

Generic ID Services	E.g.,: consultation, training, outreach

Non-ID Crisis Services	Crisis when the customer can't be identified
Crisis Intervention Services	Outpatient Crisis Intervention
Community-Based Structured Crisis Care	Crisis stabilization
Disaster Services	Invoked for specific disasters
Competency Evaluation	Clinical evaluation to determine an individual's ability to defend themselves against criminal charges
Evaluation and Management Services	E.g,: pharmacologic management
Customer Follow-Up Services	Follow-up services that do not fall within the allowable functions under Case Management
Clinical Evaluation and Assessment for Children in Specialty Settings	Evaluation and Assessment services provided through Child Care Consulting contracts or Systems of Care
Medication Training and Support	Review/educational session conducted by a licensed registered nurse or PA focusing on consumer's response to medication
Screening and Referral	Evaluation of presenting problem(s) establishing the need for referral for clinical evaluation and assessment, and/or referral to relevant service resources.

GENERAL REQUEST INFORMATION

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

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

Things to note when completing and submitting PA requests:

- All electronically submitted PA requests will be completed within a five-business day timeframe.
- Most SoonerCare and ODMHSAS outpatient prior authorizations are issued for 1-6 months, depending on request type or level of care.
- Prior authorizations issued to privately contracted providers for treatment purposes are 6 months for SoonerCare members. Testing authorizations for this group of providers span 12 months.
- ODMHSAS will assign a client and provider specific PA number to each approved PA request. This client and provider specific PA number will be submitted to the MMIS on a batch basis each week night. Each PA number will be associated with from/through dates by service and month to indicate the length of time and the procedure group being authorized by ODMHSAS.

- **For any PA issues/questions**, providers may call the ODMHSAS PICIS Helpdesk at (405) 248-9326 or gethelp@odmhsas.org. This would include things like assistance with completing a request for authorization, PA adjustment, or other questions regarding the PA process.
- **For any billing issues/questions**, providers should contact the OHCA Provider Helpline at (800) 522-0114.

ODMHSAS PICIS HELP DESK

ODMHSAS PICIS Help Desk hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except state holidays. The PICIS Help Desk can be contacted by phone at (405) 248-9326 or by e-mail at gethelp@odmhsas.org.

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

INFORMATIONAL WEB SITE FOR PROVIDERS

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

In order to ensure that you will receive regular updates on system changes (changes in requirements, process, etc.) be sure to subscribe to e-mail updates on http://www.odmhsas.org/updates.asp.

EDUCATIONAL OPPORTUNITIES

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

SOONERCARE ELIGIBILITY

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

PROVIDER ELIGIBILITY

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

NEWLY CERTIFIED FACILITIES/INDIVIDUAL PROVIDERS

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

MEMBER NAME AND/OR SOONERCARE ID NUMBER CHANGES

Whenever OHCA links member IDs, those updates are sent to ODMHSAS in a nightly file. Once a week ODMHSAS will update the information in their system with this information. This process will take any CDCs that are under deactivated IDs and move them to the active IDs. There is a report in PICIS that allows providers to see what customers have been linked and what the outcome was. This report is available under "Data Management" and is called "Customer Linking History Report." Prior Authorizations for deactivated IDs will be recreated under the new ID. Whenever two IDs have been linked in the ODMHSAS system, an e-mail will be generated and sent to the e-mail address for the PICIS contact.

COLLABORATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS

Purpose

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

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

Terminology

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

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

Courtesy Termination: This document is used when a provider has an open Level 1/2/3/4 authorization for a member and chooses to end the open authorization for the member at their agency

(for example, the member has not been coming in for treatment for some time). This is done so that another provider does not need to do a LOC/LOT. A discharge CDC would have the same effect.

Pending PA: When a provider requests an Outpatient Level 1/2/3/4 authorization, but another provider already has an open Outpatient Level 1/2/3/4 on the same member, the second provider's request for a PA will be pended. This requires an LOC\LOT before authorization is approved and submitted to OHCA. Once an LOC/LOT is completed, the start of the authorization will be based on request date, not the date the LOC/LOT is completed. If a provider fails to complete a LOC/LOT within 30 days, their pended PA will be removed and they will have to start over.

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

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

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

Outpatient Levels 1-4, with Rehab: PG042/PG043/PG044/PG045

Outpatient Levels 1-4, without Rehab: PG046/PG047/PG048/PG049

Systems of Care: PG015 and PG055

Exclusions from LOC/LOTs

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

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

Letters of Collaboration

Providers should note that a Letter of Collaboration is an administrative function to document the actual coordination of clinical care that should take place in a conversation between designated clinician's responsible for the member's care at each agency involved, in accordance with the member's wishes. LBHPs (or Licensure Candidates) are responsible for the collaboration. Certified Behavioral Health Case Managers may assist the LBHP/Licensure Candidate with the collaboration process, but the LHBP/Licensure Candidate must approve/sign off on the LOC, and be available to consult with the case manager and/or communicate with the collaborating agency as needed.

A Letter of Collaboration may only exist between two agencies. If a member requests services at a third agency, an exception must be requested. This process can be initiated by calling the PICIS Helpdesk at 405- 248-9326.

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

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

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

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

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

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

Modifying the Authorization Amount between Participating Providers

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

Letters of Termination

A designated clinician is expected to meet with member/guardian face-to-face to explain the LOT to a degree they can make an informed choice. LBHPs (or Licensure Candidates) are responsible for the LOT. Certified Behavioral Health Case Managers may assist the LBHP/Licensure Candidate with the LOT process, but the LHBP/Licensure Candidate must approve/sign off on the LOT, and be available to consult with the case manage as needed. Both the LBHP and the customer/guardian must sign the LOT.

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

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

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

Options for Submitting an LOT

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

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

Contesting Terminations

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

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

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

Courtesy Termination

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

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

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

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

Registering Staff for E-mail Notification of LOC/LOT

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

- Default Contact will be used when ODMHSAS is unable to contact the Primary or Secondary Contact. This may be the PICIS Contact. Providers may change this at any point, but there must always be one Default Contact. Providers may choose to have multiple Default Contacts.

- Primary Contact is the individual who will receive email notifications for all of the locations they are associated with. Providers may choose to have multiple Primary Contacts. Each will receive the email notifications. Primary Contact is assigned by location. Providers may choose for the Primary Contact to be assigned to multiple locations. Primary and Default Contact can the same. If no Primary Contact is assigned to a location, the Default Contact will receive the email notifications.

- Secondary Contact is the individual who will receive email notification for all of the locations they are associated with and will be expected to act upon the notifications if the primary contact is unavailable. The Primary and Secondary Contact cannot be the same, however, Secondary and Default Contact maybe the same, unless the Primary and Default Contact are already the same. If no Secondary Contact is assigned to a location, the Default Contact will act as Secondary Contact.

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

Email Notifications

Email notifications will be sent on a daily basis:

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

- If you submit a PG038 or an Outpatient Level 1/2/3/4 request and an Outpatient Level 1/2/3/4 authorization is open at another provider.
- If you have an open Outpatient Level 1/2/3/4 authorization and a Letter of Termination is accepted to close your authorization.
- If you have an open collaboration and the other provider terminates their authorization.
- Once a faxed termination has been reviewed, you will be notified that your pended authorization has been approved.
- If another provider contests the termination of the member's Outpatient Level 1/2/3/4 authorization, you will be notified of the dispute.

Email notifications will be sent as they occur:

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

Other notification may be added as necessary.

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

Need Help?

- PICIS Helpdesk: (405) 248-9326
- Webinar Training Document: http://www.odmhsas.org/LOCLOT_training.pdf

APPEALS PROCESS

SoonerCare: If the SoonerCare member (or parent/guardian of a minor) wishes to appeal a decision, a hearing with OHCA may be requested. This request must be filed within twenty (20) days of receipt of the denial decision. Contact the Docket Clerk, OHCA, (405) 522-7082. The SoonerCare member will be further instructed on filing appeals through the Oklahoma Health Care Authority and the appropriate forms necessary for completion.

ODMHSAS: If the client (or parent/guardian of a minor) wishes to appeal a decision, DMHcommunications@odmhsas.org.

PRIOR AUTHORIZATION PROCESS – BEHAVIORAL HEALTH AGENCIES

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

- Instant Prior Authorization
- Outpatient Request for Prior Authorization

INSTANT PRIOR AUTHORIZATION

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

The Instant PA process applies to the following:

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

Pre-Admission Services

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

- Once the CDC Transaction Type 21 has been submitted in PICIS an instant authorization number for the Pre-admission Services (PG038) will be issued. The start date of the authorization will be the Transaction Date listed on the CDC.
- The CDC Section One (Transaction Type 21) can be submitted in PICIS after the date of the first appointment (transaction) with the client.
- The length of the authorization for PG038 is 90 days. The end date of PG038 can be extended on-line in PICIS if needed, unless an admission has occurred.
- PG038 *includes* the initial assessment code (H0031) and Service Plan Development code (H0032).
- The Pre-admission Services, Procedure Code Group PG038, has a listing of procedure codes which can be used as clinically appropriate and medically necessary. Daily limits still apply. The procedure codes in the Pre-admission Services can be utilized in any order and frequency.
- Once a prior authorization request for outpatient treatment has been approved in PICIS, the PG038 will be end dated. The PG038 will end date the day prior to the start of the initial prior authorization request.

- The PG038 is limited to one per customer, per agency every 6 months and it must be at least 3 months from the customer's last billed service.
- If a client has discharged and needs to be readmitted, but the criteria to request a new PG038 has not been met, the agency should do a Behavioral Health Service Plan Development Low Complexity service (which includes completion of the CAR or ASI and development of a service plan) and coordinate the dates of completion with the start date for the request for a new 6-month outpatient PA. The Behavioral Health Service Plan Development Low Complexity will be billed under the new outpatient authorization.

ODMHSAS Instant Prior Authorization Criteria

Community Support Services (DH503):
1. For ICCD Clubhouse, Consumer to Consumer and Day Center programs 2. Service focus = 11
ODMHSAS State Operated Facilities Only (DH504):
1. For customers whose funding source is not ODMHSAS or SoonerCare 2. Used for reporting purposes only 3. State-operated facilities only
Detox (DH505):
1. For substance abuse detoxification programs 2. Level of Care = SN
Halfway House (DH506):
1. For substance abuse halfway house programs 2. Level of Care = CL and Service Focus not equal 11
Residential Treatment (DH507):
1. For mental health and substance abuse residential treatment programs 2. Adults: Level of Care = CI 3. Dependent Children 0 – 3 years: 4. Level of Care = CI 5. At least one presenting problem in 747 – 747 range
Day School (DH508):
1. For day school contracts 2. Service Focus = 23
Community-based Structured Crisis Care (DH509):
1. For community-based structured crisis care programs 2. Level of Care = SC
Mental Health Housing and Residential Care Services (DH510):
1. For mental health housing programs and residential care facilities 2. Level of Care = CL and Service Focus = 11
Mental Health Inpatient (DH511):
1. For mental health inpatient program 2. Level of Care = HA
Mobile Crisis (DH514):
1. For specialized mobile crisis contracts 2. Service Focus = 26
Long-Term Inpatient (DH516):
1. For long-term care provided at Griffin Memorial Hospital and the Oklahoma Forensic Center 2. Level of Care = HA and Service Focus = 27
Med Clinic Only (DH517):
1. For customers who only require pharmacological services Service Focus = 24
Residential Treatment or Halfway House for Dependent Children Ages 4 – 17 (DH521)
1. For substance abuse residential treatment programs and substance abuse halfway houses programs 2. Level of Care = CI or SC 3. Ages 4-17 4. At least one presenting problem in 747 – 747 range

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

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

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

Extra Unit BH Service Plan Development Low Complexity

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

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

Gambling

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

OJA Multi-Systemic Therapy

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

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

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

Transitional Case Management

This procedure code group (PG041) is to be used for children who meet medical necessity criteria for Transitional Case Management to assist them with transitioning from inpatient care to the community.

The PG041 is a one-day Prior Authorization (PA) that is requested after the child has been discharged from inpatient care. The requested date for the PA (not the date entered) must be within 7 days of the child discharging, since the PA is covering services provided while inpatient. Providers will be required to complete a CDC. CAR scores are not required for this PA request; 99 should be entered into the CAR score fields. The units authorized for transitional case management are separate from the case management units authorized under the PA for outpatient services.

After the PA has been issued, a provider can bill all units of transitional case management provided to the child within the last 30 days of their inpatient stay. All units of service provided should be billed for the date of the PA, not the actual dates that services were provided. For example: one hour of case management is provided on January 5, 2015, and two hours of case management is provided on January 10, 2015; the child discharges on January 11, 2015; the PA is requested for January 12, 2015; and a total of 3 hours (12 units) is billed for the PA request date of January 12, 2015. The service code/modifier combinations billed should be the ones specifically designated for transitional case management.

Please note that progress notes should be completed for each date actual services are provided, not on the PA bill date.

Mobile Crisis

This procedure code group (PG059) is to be used for the provision of mobile crisis services by those agencies with mobile crisis contracts. Mobile crisis authorizations can be acquired both prior to admission to outpatient behavioral health services, and after admission. CDC information must be entered correctly in order to generate an instant authorization. CDC information should include the following:

PA – PG059
CDC Transaction Types – 21, 40, or 42
Service Focus – 26
Level of Care: OO (only needed on transaction type 40 and 42)

Note: Any preadmission mobile crisis will be ended at admission, and any done during an outpatient behavioral health admission will only be ended by discharge. The mobile crisis PAs are separate and will not end other authorizations, however, if a new mobile crisis PA is entered before the last one has expired it will end it for the day before so that there are not overlapping PAs.

PATH

This Procedure Code Group (DH520) is to be used by agencies with an ODMHSAS contract for PATH, for the provision of designated services for all individuals served under the Federal PATH grant. It is a one-time 6-month authorization that is requested in addition to a standard outpatient authorization, to accommodate the more intensive service need during the first 6 months of the transitional 9-month PATH program. This is an instant authorization that will be created upon completion of a 23, 40, or 42 CDC with a service focus of 25 (PATH) and outpatient level of care. This request is totally separate from the standard outpatient PA request, and has a separate dollar cap. Valid CAR Scores are required, but they do not need to support a particular level to access the PATH PA.

PA ADJUSTMENT

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

There are Two (2) categories of PA Adjustment: Correction, & Mental Health Psychosocial Rehabilitation. Correction PA Adjustments require a manual review. Mental Health Psychosocial Rehabilitation PA Adjustments are based on eligibility type and may involve an automatic system approval, or require a manual review, depending on the type. The guidelines for each PA Adjustment category are as follows:

Correction

A request for PA Adjustment may be submitted when a provider finds any errors or discrepancies on a PA (e.g., typographical error, wrong provider number, wrong Recipient ID number, and some instant authorization edits) regardless of who made the error. This PA Adjustment type may also be submitted when client meets medical necessity criteria for Increased Case Management Units, but it is not identified in the PICIS or MMIS system as such. The PA Adjustment request must be accompanied by supporting documentation. The PICIS Helpdesk will either back date or delete the authorization so providers can resubmit with corrections.

Mental Health Psychosocial Rehabilitation

ODMHSAS will maintain lists of individuals who have been predetermined to meet criteria for rehabilitation services. Providers will be able to access this information for their clients through PICIS. If the client is on the list as meeting criteria, providers will submit their initial PA Request with Rehab and the PA will be approved. If the PA request is not approved, the provider should request a level PA without rehab. After getting that approval, the provider will need to request a PA adjustment to add rehab services. Follow the instructions below for submitting a request for this type of PA adjustment.

Length of Authorization

The length of authorization for most PA Requests will continue to be for 6 months (except for Rehab for Ages 4 & 5, which is for a 3-month period). However, the duration of a PA Adjustment Request will

be based on the type of request (see below). For example: “At Risk”, Providers would submit a new PA request every 6 months, but the initial PA Adjustment will extend across a 12-month period.

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

Submitting a Request for PA Adjustment

ADULTS (Ages 21 and over)

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

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

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

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

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

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

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

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

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

CHILDREN (Ages 6 through 20)

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

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

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

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

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

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

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

- At Risk -
  A child who meets one of the following criteria, and who is determined by ODMHSAS to meet all Medical Necessity Criteria for this level of service (located in the Medical Necessity Criteria section of this Manual) upon review of all required documentation submitted with the PA Adjustment Request:

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

The Psychological Evaluation- At a minimum must include:

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

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

• A mental status examination.

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

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

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

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

Submission Requirements-

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

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

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

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

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

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

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

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

- Ages 4 & 5

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

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

  Submission Requirements-

  A request for PA Adjustment for Rehab for 4 & 5 year olds must be requested no later than 5 days from the start date of the PA Request. If it has been over 5 days since the start date of PA Request, a new PA Request will need to be submitted prior to submitting for PA Adjustment. If the PA Adjustment is approved, the start date of the adjustment will be aligned with the start date authorized for the PA request, and the PA request will be end-dated to the 3-month authorization period allowed for Rehab for 4 & 5 year olds. If the PA Adjustment is denied, the PA Request will continue with the 6-month authorization period (without rehab services).

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

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

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

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

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

Response to Request

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

Secondary Review

If a PA Adjustment request for Exceptional Case, or Mental Health Psychosocial Rehabilitation "At Risk" or Children Ages 4 & 5 is initially denied (for a reason other than insufficient information), the client (or

parent/guardian of a minor) may appeal and request referral to a Board Certified Psychiatrist for a secondary review. This request must be submitted within ten (10) business days of receipt of the initial denial decision. Contact DMHcommunications@odmhsas.orgfor instructions on submitting the request for secondary review.

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

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

- Instant Prior Authorization
- Outpatient Request for Prior Authorization

INSTANT PRIOR AUTHORIZATION

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

The Instant PA process applies to the following:

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

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

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

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

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

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

TYPES OF AUTHORIZATION REQUESTS

Initial Request for Treatment, CDC transaction type **23**

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

Extension Request, CDC transaction type **42**

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

PA ADJUSTMENT

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

A PA Adjustment may be requested for the following:

Correction

A request for PA Adjustment may be submitted when a provider finds any errors or discrepancies on a PA (e.g., typographical error, wrong provider number, wrong procedure group code, wrong Recipient ID number, and some instant authorization edits) regardless of who made the error.

A request for PA Adjustment may also be submitted to request additional Psychological Evaluation/Testing units, based on the established medical necessity criteria under the Medical Necessity Criteria (MNC) section of this manual (see General Requirements). Based on MNC, further testing may be appropriate when:

> A standard battery of tests has already been administered and scored, and it is concluded that there is **still** insufficient information to 1) clearly determine the origins of client's difficulty in functioning and 2) support recommendations for effective treatment strategies; AND
>
> There is clear justification for an extended (different) battery of testing to achieve 1) and 2) above.

Response to Request

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

SOONERCARE LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

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

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

LEVELS OF CARE AND SPECIALIZED SERVICES

Levels/Services	OHCA & ODMHSAS	OHCA Only	ODMHSAS Only
Pre-admission	X		
Prevention and Recovery Maintenance, I, II, III, & IV	X		
0-36 months levels of care	X		
ICF/IID		X	
LBHP Testing		X	
Automatic Step Down/After Care	X		
Children's Day Treatment		X	
Adult Drug Court Outpatient			X
Community Support Services			X
ODMHSAS State Operated Facilities Only	X		X
Substance Abuse Detox	X		X
Substance Abuse Halfway House	X		X
Residential Treatment	X		X
Day School			X
Community-Based Structured Crisis Care	X		X
Mental Health Housing and Residential Care Services			X
Mental Health Inpatient	X		X
Generic ID Services			X
Non ID Crisis Services			X
Disaster Services			X
Mobile Crisis	X		
Long-Term Mental Health Inpatient			X
Med Clinic Only			X

Levels of Care and Specialized Services can include other categories as determined by OHCA and ODMHSAS. For a list of current Levels of Care/Specialized Services Prior Authorization Groups, including the dollar cap allowed, the list of services for each group and any service specific caps, and the length of the PA, go to http://www.odmhsas.org/arc.htm and click on "PA Groups Spreadsheet."

MEDICAL NECESSITY CRITERIA

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

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

ADULT MENTAL HEALTH CRITERIA FOR OPBH AGENCIES (OHCA- 21 and older; ODMHSAS- 18 and older)
Level One – Adult General Requirements (PG042):
Experiencing ***slight to moderate*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder
CAR Scores (a minimum of the following): a. 20 – 29 in 4 domains (Domains 1 – 9) OR b. 30 – 39 in 2 domains (Domains 1 – 9) OR c. 20 – 29 in 3 domains and 30 – 39 in 1 or more domains (Domains 1 – 9)
Level Two – Adult General Requirements (PG043):
Experiencing ***moderate*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder
CAR Scores (a minimum of the following): a. 30 – 39 in 3 domains (Domains 1 – 9) OR b. 40 – 49 in 1 domains (Domains 1 – 9)
Level Three – Adult General Requirements (PG044):
Experiencing ***moderate to severe*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder
CAR Scores (a minimum of the following): a. 30 – 39 in 4 domains with 2 domains being in 1,6,7, or 9 OR b. 40 – 49 in 2 domains with 1 domain in 1,6,7 or 9 OR c. 30 – 39 in 2 domains AND 40 in 1 domain with EITHER the 40 or 2 of the 30s being in domains 1,6,7 or 9
Level Four – Adult General Requirements (PG045):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder
CAR Scores (a minimum of the following): 40 in 4 domains, with 1 being in 1, 6, 7 or 9
Prevention and Recovery Maintenance Level Criteria – Adult (PG001):
Experiencing ***slight*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed when the focus is Recovery Maintenance (a provisional diagnosis is allowed when the focus is Prevention). b. Personality disorder
CAR Scores must be listed in the client's chart.

CHILD MENTAL HEALTH CRITERIA FOR OPBH AGENCIES (Younger than 21)
Level One – Child MH General Requirements (PG042 and PG046):
Experiencing ***slight to moderate*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
CAR Scores (a minimum of the following): a. 20 – 29 in 4 domains (Domains 1 – 9) OR b. 30 – 39 in 2 domains (Domains 1 – 9) OR c. 20 – 29 in 3 domains and 30 – 39 in 1 or more domains (Domains 1 – 9)
Level Two – Child MH General Requirements (PG043 and PG047):
Experiencing ***moderate*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
CAR Scores (a minimum of the following): a. 30 – 39 in 3 domains (Domains 1 – 9) OR b. 40 – 49 in 1 domains (Domains 1 – 9)
Level Three – Child MH General Requirements (PG044 and PG048):
Experiencing ***moderate to severe*** functional impairment.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
CAR Scores (a minimum of the following): a. 30 – 39 in 4 domains with 2 domains being in 1,6,7, or 9 OR b. 40 – 49 in 2 domains with 1 domain in 1,6,7 or 9 OR c. 30 – 39 in 2 domains AND 40-49 in 1 domain with EITHER the 40 or 2 of the 30s being in domains 1,6,7 or 9
Level Four – Child MH General Requirements (PG045 and PG049):
Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed. b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
CAR Scores (a minimum of the following): 40-49 in 3 domains, with 1 being in 1, 6, 7 or 9
Prevention and Recovery Maintenance Level Criteria – MH Child (PG001):
Experiencing ***slight*** functional impairment
DSM 5 (in ICD Format) Diagnosis (a OR both a AND b): a. Principal (Reason for Visit) Mental Health disorder: diagnosis may include approved Z codes and T codes; a provisional diagnosis is not allowed when the focus is Recovery Maintenance (a provisional diagnosis is allowed when the focus is Prevention). b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
CAR Scores must be listed in the client's chart.

SUBSTANCE ABUSE/INTEGRATED ADULT CRITERIA FOR OPBH AGENCIES (OHCA- 21 and older; ODMHSAS 18 and older)

Level One – Adult SA/Integrated General Requirements (PG042):

Experiencing ***slight to moderate*** functional impairment.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR or ASI*):

CAR Scores (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.)

a. 20 – 29 in 3 domains (Domains 1 – 9) OR
b. 30 – 39 in 2 domains (Domains 1 – 9 OR
c. 20 – 29 in 2 domains and 30 – 39 in 1 or more domains (Domains 1 – 9)

ASI Scores: 4 or above in 2 areas, must include at least a 4 in alcohol or drug problem area

Level Two – Adult SA/Integrated General Requirements (PG043):

Experiencing ***moderate*** impairments in functioning.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR or ASI*)

CAR Scores (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, or b AND domain 3 must have a score of 20 or higher.)

a. 30 – 39 in 3 domains (Domains 1 – 9)OR
b. 40 – 49 in 1 domains (Domains 1 – 9 OR

ASI Scores: 5 or above in 3 areas, must include at least a 4 in alcohol or drug problem area

Level Three – Adult SA/Integrated General Requirements (PG044):

Experiencing ***moderate to severe*** functional impairment.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR or ASI*):

CAR Scores (A minimum of ONE of the following) (Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.)

a. 30 – 39 in 4 domains, with 2 domains being in 1,6,7 or 9; OR
b. 40-49 in 2 domains, with 1 domain in 1,6,7 or 9; OR
c. 30 – 39 in 2 domains and 40-49 in 1 domain, with either the 40 or 2 of the 30's being in domain 1,6,7 or 9 OR

ASI Scores: 6 or above in 3 areas, must include at least a 4 in alcohol or drug problem area

Level Four – Adult SA/Integrated General Requirements (PG045):

Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for 24-hour inpatient type care without intensive outpatient services.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR or ASI*):

CAR Scores (Substance Abuse and Integrated Requests using the CAR assessment must have a score of 20 or higher in domain 3): 40-49 in 4 domains, with 1 domain being in 1, 6, 7, or 9

ASI Scores: 7 or above in 3 areas, must include a 4 in alcohol or drug problem area.

Prevention and Recovery Maintenance Level Criteria – Adult SA/Integrated (PG001):

Experiencing ***slight*** functional impairment

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

CAR Scores, T-ASI, and/ or ASI Scores must be listed in the client's chart.

***For ODMHSAS the ASI is required for all Substance Abuse Requests. For Integrated Requests (Service Focus 6 or 13), either the ASI OR the CAR is required (if using the ASI you will need to put 99s in the CAR domains, and if using the CAR you will need to put 9s in the ASI domains).**

SUBSTANCE ABUSE/INTEGRATED CHILD CRITERIA FOR OPBH AGENCIES (Younger than 21)

Level One – Child SA/Integrated General Requirements (PG042 and PG046):

Experiencing ***slight to moderate*** functional impairment.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR, T-ASI or ASI*):

Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.

a. 20 - 29 in 3 or more domains (domains 1 - 9); OR
b. 30 - 39 in 2 domains (domains 1 - 9); OR
c. 20 - 29 in 2 domains AND 30 - 39 in 1 domain or more (domains 1 - 9)

T-ASI Scores: 2 or above in 3 areas, must include at least a 2 in Chemical Use Problem Area

ASI Score: 4 or above in 2 areas, must include at least a 4 in Alcohol or Drug Problem Area

Level Two – Child SA/Integrated General Requirements (PG043 and PG047):

Experiencing ***moderate*** functional impairment.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR, T-ASI or ASI*):

Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a or b AND domain 3 must have a score of 20 or higher

a. 30 - 39 in 3 domains (domains 1 - 9); OR
b. 40 - 49 in 1 domain (domains 1 - 9)

T-ASI Scores:

a. 3 or above in 2 areas; must include at least a 2 in Chemical Use Problem Area OR
b. 4 in one area; must include at least a 2 in Chemical Use Problem Area

ASI Scores: 5 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area

Level Three – Child SA/Integrated General Requirements (PG044 and PG048):

Experiencing ***moderate to severe*** functional impairment.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR, T-ASI or ASI*):

Substance Abuse and Integrated Requests using the CAR assessment must meet ONE condition in either a, b, or c AND domain 3 must have a score of 20 or higher.

a. 30 - 39 in 4 domains, with 2 domains being in 1, 6, 7, or 9; OR
b. 40 - 49 in 2 domains, with 1 domain being in 1, 6, 7, or 9; OR
c. 30 - 39 in 2 domains AND 40 – 49 in 1 domain, with EITHER the 40 OR 2 of the 30's being in domains 1, 6, 7, or 9

T-ASI Scores

a. 3 or above in 3 areas; must include at least a 2 in Chemical Use Problem Area OR
b. 4 in 2 areas; must include at least a 2 in Chemical Use Problem Area

ASI Scores: 6 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area

Level Four – Child SA/Integrated General Requirements (PG045 and PG049):

Experiencing ***very severe (incapacitating)*** functional impairment and potential risk for hospitalization without intensive outpatient services.

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

Assessment Results (Use the CAR, T-ASI or ASI*):

Substance Abuse and Integrated Requests using the CAR assessment must have a score of 40 or higher in domain 3: 40 - 49 in 3 domains, with 1 domain being in 1, 6, 7, or 9

T-ASI Scores: 4 in 3 areas; must include a 2 in the Chemical Use Problem Area

ASI Scores: 7 or above in 3 areas, must include at least a 4 in Alcohol or Drug Problem Area

Prevention and Recovery Maintenance Level Criteria – SA/Integrated Child (PG001):

Experiencing ***slight*** functional impairment

DSM 5 (in ICD Format) Diagnosis: Principal (Reason for Visit) Substance-Related disorder

CAR Scores, T-ASI and/or ASI Scores must be listed in the client's chart.

***For ODMHSAS the T-ASI (ages 12-17) or ASI (ages 18 and above) is required for all Substance Abuse Requests. For Integrated Requests (Service Focus 6 or 13), either the ASI/TASI <u>OR</u> the CAR is required (if using the ASI/TASI you will need to put 99s in the CAR domains, and if using the CAR you will need to put 9s in the ASI/TASI domains).**

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

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

Systems of Care (SOC) FOR OPBH AGENCIES (PG015 & PG055)	
General Requirements (Must meet all of the following conditions)	
Children/Youth (ages 6-24) **1.** The child/youth meets the criteria for Serious Emotional Disturbance (SED) if under age 18 or Serious Mental Illness (SMI) if 18-24; and **2**. The child/youth is at risk of out-of-home placement or out-of-school placement due to the impact of the serious emotional and/or behavioral disturbance; and **3.** The child/youth meets criteria for Level 3 or Level 4 on the Client Assessment Record (CAR); and **4.** The child/youth needs, has received or has requested services or support from two or more systems. **OR** **5.** The child/youth meets the criteria for a Substance Use diagnosis; and **6.** The child/youth meets criteria for Level 3 or Level 4 on the Teen Addiction Severity Index (TASI) or Addiction Severity Index (ASI). **Children (ages 0-5)*** **1.** The child is at risk of (or currently in) an out of home placement due to parental involvement with DHS, the legal system, drug court, or other reason approved by ODMHSAS; **AND/OR** **2.** The child is at risk of (or currently) "suspended/expelled" from a school, early childhood, and/or child care setting due to their behaviors; **AND/OR** **3.** The child's caregiver and/or the child is involved, or at high risk of involvement, with at least two (2) different service systems (Child e.g.: health services, child guidance services, developmental services, Head Start/Early Head Start) (Caregiver e.g.: DHS, OJA/DOC, mental health/substance abuse/co-occurring services, health and wellness related services) **AND** **4.** The child's family agrees to voluntarily participate in services, and form a Child and Family Team- consisting of both formal and natural supports. ***Children ages 0-3 served under SOC must also meet the Medical Necessity Criteria for "Child Age 0 Through 36 Months"** **Children/Youth (all ages)** Services must be provided by an ODMHSAS Systems of Care (SOC) contracted agency.	
Amount of Service Allowable	Requests for this level of service will be covered for a period of six (6) months. Prior authorization will be required every 6 months.

INCREASED CASE MANAGEMENT UNITS FOR OPBH AGENCIES	
General Requirements (Must meet one of the following conditions)	
1. Member has been admitted to behavioral health inpatient, crisis unit, mobile crisis or urgent care in the last five years (the ending date for eligibility is five years after the last discharge); or **2.** Member is an adult (18+) who is either: (a) enrolled at a certified substance abuse agency and have a substance abuse service focus on the CDC or (b) enrolled in a specialty court program (eligibility is only maintained while enrolled in those programs); or **3.** Member is currently homeless, as identified on the CDC as 'Homeless-Shelter' or 'Homeless-Streets' (eligibility only applies if currently homeless).	
Amount of Service Allowable	Regular case management units are 12 units per member per month. A member must meet the medical necessity criteria above to be eligible for increased case management units. If medical necessity criteria is met, the member will have access to 25 units per member per month.
Service Authorization, Billing & Post Payment Review	• If the member meets medical necessity criteria, but is not reflected in the PICIS or MMIS system as such, providers will need to submit a PA Adjustment with supporting documentation. • If provider bills for more than 12 units and it is later determined that the member did NOT meet medical necessity criteria, the claim will need corrected (a report in PICIS is available to assist providers in identifying claims which need correction). If the provider has not corrected the claim within 30 days of payment, the claim may be recouped.

TRANSITIONAL CASE MANAGEMENT FOR OPBH AGENCIES

General Requirements (Must meet all of the following conditions)

1. The child is between the ages of 0-21.
2. The child is currently receiving behavioral health inpatient level of care and needs assistance with transitioning from inpatient care to the community.
3. Services provided to the child shall occur within the last 30 days of their inpatient stay.
4. There is a written agreement between the OPBH and the inpatient facility outlining the transitional case management/discharge planning responsibilities between the two providers. This is to ensure optimal collaboration, and help to assure that there is no duplication of service. The written agreement should include, but not be limited to the following assurances:

a. The inpatient facility arranges for and oversees the provision of all services;
b. The inpatient facility maintains all medical records of the collaborative efforts they engage in with the OPBH in the provision of transitional case management while the individual is in inpatient care (this is in addition to the documentation required for the OPBH for the transitional case management services they are providing); and
c. The inpatient facility ensures that all services, including transitional case management, are furnished under the direction of a physician.

Amount of Service Allowable	Requests for transitional case management units shall be held to the same unit limits set for standard case management (12 units per member per month for regular transitional case management*, and 54 units per member per month for SOC and PACT intensive transitional case management).
Post Payment Review	Quarterly review of paid claims for transitional case management will be conducted to ensure that all medical necessity criteria and documentation requirements have been met. Any findings that the above medical necessity criteria have not been met may result in recoupment.

* As medical necessity criteria for transitional case management requires the child to currently be receiving behavioral health inpatient level of care, regular transitional case management meets the Increased Case Management Units medical necessity criteria (see page 40).

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

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

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

2. For continuity and expediency, the Individual Plan of Care and Assessment from the higher level of care facility will be provided at the time of the client's discharge from that facility. This will serve as the treatment guide for the outpatient provider/agency in the first month of outpatient care.

3. If a pre-existing outpatient provider utilizes the Automatic Step-Down (PG014), the procedure code group that was being utilized must be discontinued and ended. Documentation in the medical record needs to reflect and support these changes in level of care.

4. Following the automatic step down utilization time period of one month, the appropriate level of care services (procedure code group) will need to be instituted based on the current clinical need of the client utilizing the medical necessity criteria for levels of care.

5. After the expiration or discontinuation of the automatic step down benefit/services, a valid service plan development moderate or low complexity is required and should be completed (valid with required signatures) in the medical record before the pre-determined/alternate level of care (procedure code group) services are provided.

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

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

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

After the first 14 days of missed appointments, if the client/guardian does not respond to letters, phone calls or other attempts to engage them in initiating or continuing in services, the outpatient provider/facility will provide this information to the PICIS HelpDesk at (405) 248-9326.

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

Service Definition and Requirements

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

Required Therapeutic Services:

1. Before engaging in IMH treatment services, the infant/young child must receive:
    - A diagnostic evaluation that has resulted in a diagnosis (see DC: 0-5 guidelines for infant mental health comprehensive evaluation); and
    - An individualized Service Plan that includes IMH treatment as an intervention.
2. IMH treatment services shall include the following:
    - Family Psychotherapy with and without the child present. A minimum of 70% of the services must be Family Psychotherapy with the child present
    - Service delivery is focused on infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child
    - Each IMH provider must address, at a minimum:
        - Increasing parents/caregivers' ability to consistently and appropriately provide for the child's basic emotional needs for comfort, stimulation, affection and safety;
        - Increase infant's/young child's ability to initiate and respond to most social interactions in a developmentally appropriate way;
        - Increase infant's/child's ability to socially discriminate and be selective in choice of attachment figures;
        - Provide parent/infant interaction in order to encourage language and play, interpretation of an infant's behavior and reinforcement of a parent's/caregiver's appropriate actions and interactions; and
        - Provider must also provide crisis intervention services as appropriate. See DC: 0-3R for related therapeutic issues.

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

Target Population

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

Documentation Requirements

The provider must provide the standard documentation in the individual client files in addition to the following:

- Diagnostic evaluation, including diagnosis
- Individualized Service Plan
- Progress notes that reflect the array of services provided
- Discharge or transition plan that documents the need for any continuation or support services.
    - NOTE: All of the above documents need to legible, have timespans of provided services stated and contain the signature and licensure of the practitioner rendering the service.
- CAR domains 1 - 9 must meet the level of care being requested.

Staffing Requirements

Qualified professionals: The treating professional is required to meet all of following specifications:

- Master's level licensed therapist or licensure candidate, or licensed psychologist.
- The services being provided to this population must be within the scope of practice of the therapist.
- Must be providing IMH services directly to infants, toddlers and their families/primary caregivers.
- Competency in the following areas is required. Supporting documentation should be available in the personnel file and available upon request for pre and/or post payment review:
    a. Early childhood development, diagnosis and treatment
    b. Infant mental health, diagnosis and treatment.
    c. Clinical experience with this age group.
    d. Service plan goals and objectives must be age and developmentally appropriate.
    e. DC: 0-5 (IN ICD FORMAT) diagnosis for the client/child. Diagnosis is for the child, not the parent.

Services NOT allowed for Children Ages 0 through 36 Months

- Individual/Interactive Psychotherapy
- Group Psychotherapy
- Psychosocial Rehabilitation (Individual or Group)
- Psychological Testing

PSYCHOLOGICAL EVALUATION/TESTING CRITERIA FOR OPBH AGENCIES, PSYCHOLOGISTS, AND LBHPS

General Requirements	Assessment Results and Documentation Requirements:
1. Appropriate (Must meet ALL of the following conditions): a. Client is experiencing difficulty in functioning with origins not clearly determined; AND b. An evaluation has been recommended and/or requested by a physician, psychiatrist, psychologist, or a licensed mental health professional; AND c. Results of evaluation will directly impact current treatment strategies. d. If client has been tested recently a different testing battery will be performed. 2. Inappropriate: a. Evaluation results will not directly impact current treatment or discharge; AND/OR b. Evaluation results will be utilized for academic placement/purposes or diagnosis of a learning disorder ***only***	DSM 5 (in ICD Format) Diagnosis – Principal (Reason for Visit) diagnosis (INCLUDING approved Z codes, T codes, and provisional diagnosis). Documentation Requirements must include ALL of the following information: Service plan must document: a. What tests will be used? b. How many hours will the testing require? c. Who will be performing the tests, and what are their credentials? d. What is the reason for the testing? e. How the evaluation results will specifically affect goals and objectives for the client? Notes: 1. A psychological technician for a Psychologist is defined by the State Board of Examiners of Psychologists as being "under the direct and continuing supervision of the licensed psychologist" [OAC 575:10-1-7]. 2. Qualified professionals for accredited outpatient behavioral health agency providers. Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP/Licensure Candidate.

CHILDREN'S PARTIAL HOSPITALIZATION PROGRAM (PG012)

Service Definition and Requirements

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

Required Therapeutic Services:

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

Target Population

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

Documentation Requirements

- A nursing health assessment within 24 hours of admission.
- A physical examination and medical history is coordinated with the Primary Care Physician.
- Service Plan updates are required every 3 months or more frequently based on clinical need. See also 317:30-5-248 regarding: of records.
- Documentation needs to specify active involvement of the client's family, caretakers, or significant others involved in the individual's treatment.
- The CALOCUS scores should include the composite score and CALOCUS level.

Staffing Requirements

- **Qualified professionals:** All services in the PHP program are provided by a team, the following configuration: physician, registered nurse, licensed behavioral health professionals (LBHPs) or licensure candidates, case managers, or other Mental Health/Substance Abuse paraprofessional staff. The service plan is directed under the supervision of a physician. Behavioral Health Rehabilitation Services are provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC) or LBHP/Licensure Candidate who meets the professional requirements listed in 317:30-5-240.3.
- **Qualified Providers:** Provider agencies for PHP must be accredited by one of the national accrediting bodies. (The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA)) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of enrolled agency.
- RN trained and competent in the delivery of behavioral health services is available on site during program hours to provide necessary nursing care and/or psychiatric nursing care. (1 RN at minimum for program that can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and makes restraint assessments.
- Medical Director is a psychiatrist.
- A psychiatrist/physician is available 24 hours a day, 7 days a week

- Requirements at OAC 317:30-5-240.

Service/Reimbursement Limitations

Limitations: Services are limited to children 0 - 20 only. Behavioral Health Rehabilitation Services are not reimbursable for children ages 0-3, and are only reimbursable for children ages 4-5 if authorized through a PA Adjustment request.

Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be authorized. Although 4 hours per day can be billed; the monthly cap does not change. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered; those services are separately billable and are not a part of this cap. Academic instruction, meals, and transportation are not covered. Fractional/partial units are allowable.

Service Code Modifiers

HE – Mental Health
HF – Substance Abuse or Integrated

Prior Authorization / Medical Necessity Criteria

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

1. Partial hospitalization services are services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition. Partial hospitalization services are reasonably expected to improve the individual's condition, functional level and to prevent relapse or hospitalization.
2. The client needs to meet CALOCUS Level 4. You may photocopy and use this instrument in the original form. The manual for the CALOCUS is available as a PDF: http://communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/CALOCUSv15.pdf
3. CALOCUS is not required for step downs from an inpatient level of care (acute or RTC).
4. The data fields for the CAR on the CDC and the PA request are not required. Enter 99 in the CAR domain fields.
5. Current DSM 5 Principal (Reason for Visit) Diagnosis (in ICD format) that is consistent with symptoms.
6. Individual's condition can be expected to be stabilized at this level of care.
7. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.

B. ADMISSION CRITERIA SEVERITY OF ILLNESS

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

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

C. CONTINUED STAY CRITERIA

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

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

D. AMOUNT OF ALLOWABLE SERVICE

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

Children's Day Treatment (PG007 and PG011)

Service Definition and Requirements

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

The program is available at least four days per week and at least 3 hours per day.

Treatment activities to include the following every week:

- FT - *at least one hour per week* (Additional hours of FT may be substituted for other day treatment services. A strong family treatment focus is strongly encouraged and supported. It is seen as an integral part of day treatment.)
- GT - at least two hours per week
- IT - at least one hour per week

And at least one of the following per day:

- Medication training and support (nursing) - *once monthly if on medications*
- Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless prior authorization has been granted for children ages 4 and 5)
- Case Management - *as needed and part of weekly hours for the client*
- Occupational therapy - *as needed and part of weekly hours for the client*
- Expressive therapy - *as needed and part of weekly hours for the client*

On-call crisis intervention services 24 hours a day, 7 days a week. (When persons served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but is available at all times.)

The program provides assessment and diagnostic services and/or medication monitoring, when necessary.

Making all of the necessary provisions and/or linkage with educational activities/vocational activities is a requirement.

Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.

Target Population

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

Documentation Requirements

Service Plan updates are required every 3 months. The treating provider is required to follow all of the requirements listed in the OAC 317:30-5-240 – 317:30-5-249.

Staffing Requirements

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

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

Service/Reimbursement Limitations

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

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

Service Code Modifiers

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

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

Service Requirement

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

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

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

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

Target Population

Child (under the age of 21)

Documentation Requirements

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

Staffing Requirements

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

Service/Reimbursement Limitations

Procedure code clinical requirements:

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

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

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

Documentation Requirements:

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

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

Adult Partial Hospitalization Program (PG012)

Service Definition and Requirements

PHP is an intensive nonresidential, structured therapeutic treatment for individuals with substance use disorder, mental health diagnoses, and/or co-occurring disorders. It is used as an alternative to and/or a step-down from inpatient or residential treatment, or to stabilize a deteriorating condition that may result in a need for inpatient or residential care. PHP services are:
(1) Reasonable and necessary for the diagnosis or active treatment of the individual's condition; and
(2) Reasonably expected to improve the individual's condition and functional level and to prevent relapse or hospitalization/residential care.
The length of participation in the program is based on the individual's needs and medical necessity. The program shall offer treatment services a minimum of three (3) hours per day, five (5) days per week. An hour of service constitutes 60 minutes. The treating provider is required to follow all of the requirements listed in the OAC 317:30-5-241.2.2.

Required Therapeutic Services

PHP service components include the following, provided by qualified professionals:
1. Program services are overseen by a psychiatrist. Frequency of psychiatrist visits should occur based on the individual's needs, at minimum twice per month. (Physician services are billed separately and not included in the PHP rate.)
2. Behavioral health/alcohol and drug assessment;
3. Behavioral health/alcohol and drug service plan development;
4. Individual/family/group therapy for behavioral health and/or substance abuse;
5. Psychosocial rehabilitation services/substance abuse skills development (individual and group);
6. Medication training and support;
7. Case management;
8. Crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week.
10. Active involvement of the client's family, caretakers or significant others involved in the individual's treatment is required
Note: Group size: Not to exceed 8 as clinically appropriate given diagnostic and developmental functioning.

Target Population

Adults ages 21 and over

Documentation Requirements

1. A nursing health assessment within 24 hours of admission.
2. Service Plan updates are required every 3 months or more frequently based on clinical need. See also 317:30-5-248 regarding documentation of records.
3. Documentation needs to specify active involvement of the client's family, caretakers, or significant others involved in the individual's treatment.

Staffing Requirements

(1) A registered nurse (RN) trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available on-site during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by a licensed practical nurse (LPN) but an RN must always be on site].
(2) Medical director must be a licensed psychiatrist.
(3) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week.
(4) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

Service/Reimbursement Limitations

- Comprehensive psychological testing by a licensed psychologist is billed separately.
- Physician services are billed separately.
- Medications are billed separately.

PHP may not be billed concurrently with any other service other than those listed above, including but not limited to:

- Inpatient/residential psychiatric or residential substance use disorder services;
- Individual/family/group therapy for behavioral health and/or substance abuse;
- Psychosocial rehabilitation services/substance abuse skills development (individual and group);
- Targeted Case Management;
- Mobile crisis intervention provided within the PHP setting;
- Peer Recovery Support;
- Program of Assertive Community Treatment;
- Therapeutic Day Treatment;
- Multi-Systemic Treatment; and/or
- Certified Community Behavioral Health services.

Service Codes and Modifiers

H0035 HE/HF/HH

Prior Authorization/Medical Necessity Criteria

A. General Requirements

Partial hospitalization services are services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition. Partial hospitalization services are reasonably expected to improve the individual's condition, functional level and to prevent relapse or hospitalization.

B. Admission Criteria

Mental Health

- A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM)
- Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention
- It has been determined that the current disabling symptoms could not have been managed, or have not been manageable, in a less intensive treatment program.
- Individual must be medically stable.
- Individual's symptoms require: 1) intensive behavioral management, 2) intensive treatment with the family, and/or 3) intensive treatment in preparation for re-entry into the community

Substance Use Disorder

- A diagnosis of a substance use disorder that is the primary focus of treatment
- ASAM placement level of 2.5 or higher, as indicated by the ODMHSAS ASAM tool
- Conditions are directly attributable to a substance use disorder as the primary need for professional attention
- It has been determined that the current disabling symptoms could not have been managed, or have not been manageable, in a less intensive treatment program.
- Individual must be medically stable.
- Individual's symptoms require: 1) intensive behavioral management, 2) intensive treatment with the family, and/or 3) intensive treatment in preparation for re-entry into the community

C. Continued Stay Criteria

Mental Health

- A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM)
- Meet Level 4 Adult General Requirements as specified in the Prior Authorization Manual
- Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention
- It has been determined that the current disabling symptoms cannot be managed in a less intensive treatment program.
- Patient is:
    - Making measurable progress toward the treatment objectives specific in the treatment plan; or
    - Experiencing the same or worsened symptoms (with documentation of re-evaluation of treatment objectives and interventions)

Substance Use Disorder

- A diagnosis of a substance use disorder that is the primary focus of treatment
- ASAM placement level of 2.5 or higher, as indicated by the ODMHSAS ASAM tool
- Conditions are directly attributable to a substance use disorder as the primary need for professional attention
- It has been determined that the current disabling symptoms cannot be managed in a less intensive treatment program.
- Patient is:
    - Making measurable progress toward the treatment objectives specific in the treatment plan; or
    - Experiencing the same or worsened symptoms (with documentation of re-evaluation of treatment objectives and interventions)

D. Amount of Allowable Service

Initial requests for this level of service will be authorized for a maximum period of sixty (60) days.
Extension requests are based on continued Medical Necessity Criteria documentation and may be granted for maximum of thirty additional (30) days.

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

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

- Appropriate (Must meet ALL of the following conditions)
  a. Experiencing severe functional impairment, illustrating the need for additional treatment beyond the required services; AND
  b. Demonstrates the need for specialized treatment to augment the services provided by the RBMS; AND
  c. Able to actively participate in and derive a reasonable benefit from treatment as evidenced by sufficient affective, adaptive and cognitive abilities, communication skills, and short-term memory.
- Inappropriate: Imminent danger to self and/or others (medically unstable); AND/OR Extreme level of functional impairment, meeting medical necessity criteria for acute inpatient hospitalization.
- The treating provider is required to follow all of the requirements listed in OAC: 317:30-5-240 – 317:30-5-249.

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

1. DSM 5 (in ICD Format) Diagnosis (a OR both a AND b):
   a. Principal (Reason for Visit) Mental Health disorder: any diagnosis is allowable including approved Z codes and T codes; a provisional diagnosis is not allowed.
   b. Personality disorder: only for 18 – 20 years of age (if younger than 18 must include well documented psychiatric supporting evidence).
2. Assessment Results (Use the CAR or T-ASI*):
   - CAR Scores (A minimum of ONE of the following) (CAR descriptors for domains 1 – 9 must be appropriately documented. Caregiver Resources must be documented as noted on the Addendum as part of the member record.).
     a. 30 - 39 in 4 domains, with 2 domains being in 1, 6, 7, or 9; OR
     b. 40 - 49 in 2 domains, with 1 domain being in 1, 6, 7, or 9; OR
     c. 30 - 39 in 2 domains AND 40 - 49 in 1 domain, with the 40 or 2 -30's being in 1, 6, 7, or 9
   - The T-ASI can be used for those children in need of SA treatment. T-ASI Scores:
     a. 3 or above in 3 areas; must include at least a 2 in Chemical Use Problem Area OR
     b. 4 in 2 areas; must include at least a 2 in Chemical Use Problem Area
3. An explanation of the need for the specialized or additional treatment or therapeutic intervention employed by the therapist that is not being provided by the TFC or group home under their per diem treatment services requirement.

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

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

ICF/IID Criteria
(PG019)

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

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

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

1. DSM Diagnosis in BOTH a AND b (using the most recent version of the DSM, and ICD format):
   a. Principal (Reason for Visit) Mental Health and/or Substance-Related disorder: any diagnosis is allowable including approved Z codes, T codes and provisional diagnosis
   b. Intellectual Disability (319) - Mild, Moderate, Severe or Profound

2. The following items need to be present in the member record to support that Medical Necessity Criteria has been met:
   a. A letter from the ICF/IID facility indicating the required diagnoses (using the most recent version of the DSM, and ICD format), specific behavioral concerns, reason for referral, and signed by an ICF/IID representative.
   b. The Individual Habilitation Plan that reflects the member's need for the requested behavioral health services. The current annual plan is required including signature page and legible date of most recent update/revision.
   c. Major discrepancies between information obtained from the ICF-IID and providers documentation are to be resolved by the provider. It must be clear the member can benefit from outpatient therapy services.
   d. Psychological Testing documenting IQ Score, Vineland Adaptive Scale, and any additional clinical assessment reports that support the requested services.
   e. Communication domain at the end of the CAR must be completed; AND
   f. For SEVERE or PROFOUND Intellectual Disability diagnosis, the approach(s) to treatment, such as behavior modification, applied behavior analysis, or another widely accepted theoretical framework for treating members with this diagnosis, must be noted in the Addendum as part of the member record.

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

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

CLIENT ASSESSMENT RECORD
(CAR)

GENERAL INFORMATION

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

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

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

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

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

CAR DOMAIN DEFINITIONS

1. FEELING/MOOD/AFFECT: Measures the extent to which the person's emotional life is well moderated or out of control.
2. THINKING/MENTAL PROCESS: Measures the extent to which the person is capable of and actually uses clear, well-oriented thought processes. Adequacy of memory and overall intellectual functioning are also to be considered in this scale.
3. SUBSTANCE USE: Measures the extent to which a person's current use of synthetic or natural substances is controlled and adaptive for general well-being and functioning. Although alcohol and illegal drugs are obvious substances of concern, any substance can be subjected to maladaptive use or abuse, especially if compounded by special medical or social situations.
4. MEDICAL/PHYSICAL: Measures the extent to which a person is subject to illness, injury and/or disabling physical conditions, regardless of causation. Demonstrable physical effects of psychological processes are included, but not the effects of prescribed psychotropic medications. Physical problems resulting from assault, rape, or abuse are included.
5. FAMILY: Measures the adequacy with which the customer functions within his/her family and current living situation. Relationship issues with family members are included as well as the adequacy of the family constellation to function as a unit.
6. INTERPERSONAL: Measures the adequacy with which the person is able to establish and maintain interpersonal relationships. Relationships involving persons other than family members should be compared to similar relationships by others of the same age, gender, culture, and life circumstances.
7. ROLE PERFORMANCE**:** Measures the effectiveness with which the person manages the role most relevant to his or her contribution to society. The choice of whether job, school, or home management (or some combination) is most relevant for the person being rated depends on that person's age, gender, culture and life circumstances. If disabled, intellectually, mentally or physically, the client would be scored relative to others with the same disability and in the same situation. Whichever role is chosen as most relevant, the scale is used to indicate the effectiveness of functioning within the role at the present time.
8. SOCIO-LEGAL**:** Measures the extent and ease with which the person is able to maintain conduct within the limits prescribed by societal rules and social mores. It may be helpful to consider this scale as a continuum extending from pro-social to anti-social functioning. ******Other Behavioral Non-Chemical Addictions would be rated here: gambling, internet, pornography, sexual, etc.***
9. SELF CARE/BASIC NEEDS: Measures the adequacy with which the person is able to care for him/herself and provide his/her own needs such as food, clothing, shelter and transportation. If the customer lives in a supportive or dependent situation for reasons other than lack of ability (e.g. confined on criminal sentence), estimate the ability to make arrangements independently and freely. Children, the disabled and elderly persons who are cared for by others should also be rated on their own ability to make arrangements compared to others their age.

LEVEL OF FUNCTIONING RATING SCALE

1 - 9 (Above Average): Functioning in the particular domain is consistently better than that which is typical for age, gender, and subculture, or consistently average with occasional prominent episodes of superior, excellent functioning. Functioning is never below typical expectations for the average person.

10 - 19 (Average): Functioning in the particular domain as well as most people of same age, gender, and subculture. Given the same environmental forces is able to meet usual expectations consistently. Has the ability to manage life circumstances.
20 - 29 (Mild to Moderate): Functioning in the particular domain falls short of average expectation most of the time, but is not usually seen as seriously disrupted. Dysfunction may not be evident in brief or casual observation and usually does not clearly influence other areas of functioning. Problems require assistance and/or interfere with normal functioning.
30 - 39 (Moderate to Severe): Functioning in the particular domain is clearly marginal or inadequate, not meeting the usual expectations of current life circumstances. The dysfunction is often disruptive and self-defeating with respect to other areas of functioning. Moderate dysfunction may be apparent in brief or casual interview or observation. Serious dysfunction is evident.
40 - 49 (Incapacitating): Any attempts to function in the particular domain are marked by obvious failures, usually disrupting the efforts of others or of the social context. Severe dysfunction in any area usually involves some impairment in other areas. Hospitalization or other external control may be required to avoid life-threatening consequences of the dysfunction. Out of control all or most of the time.
50 (EXTREME): The extreme rating for each scale, suggests behavior or situations totally out of control, unacceptable, and potentially life threatening. This score indicates issues that are so severe it would not be generally used with someone seeking outpatient care.

CAR DOMAIN SCORING EXAMPLES

FEELING / MOOD AFFECT

1 – 9 (ABOVE AVERAGE): Anxiety, depression, or disturbance of mood is absent or rare. The person's emotional life is characterized by appropriate cheer and optimism given a realistic assessment of his/her situation. Emotional control is flexible, with both positive and negative feelings clearly recognized and viewed as within his/her control. Reactions to stressful situations are clearly adaptive and time limited.

10 – 19 (AVERAGE): No disruption of daily life due to anxiety, depression or disturbance of mood. Emotional control shows consistency and flexibility. A variety of feelings and moods occur, but generally the person is comfortable, with some degree of pleasant or warm affect. When strong or persistent emotions occur, the object and approximate causes are readily identified.
ADULT: Able to cope, either alone or with the help of others, with stressful situations. Not overwhelmed when circumstances seem to go against him/her. Doesn't dwell on worries; tries to work out problems. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Considers self a worthy person.
CHILD: Not overwhelmed when circumstances seem to go against him/her. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Reactions to stressful events are age appropriate.

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

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

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

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

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

THINKING/MENTAL PROCESS

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

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

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

20 – 29 (Mild to Moderate): Occasional disruption of daily life due to impaired thought and thinking processes. Intellectual capacity slightly below average ("Dull Normal" to Borderline) and/or thinking occasionally distorted by defensive, emotional factors and other personal features. Poor judgment may occur often, but is not characteristic of the person. Communications may involve misunderstandings due to mild thought disorders. Includes specific impairments of learning or attention and the ability to generalize from acquired knowledge.

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

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

40 – 49 (Incapacitating): Incapacitated due to impaired thought and thinking processes. Severe to profound mental retardation and/or extreme disruption or absence of rational thinking may exist. Delusions or frequent hallucination that the person cannot distinguish from reality may occur. Communication is extremely difficult
ADULT: Unable to function independently. Severely disoriented most of the time. Significant loss of memory.
CHILD: Severely disoriented most of the time. Loss of memory. If speech is present, it may manifest itself in peculiar patterns.

50 (EXTREME): Profound retardation, comatose, or vegetative. No process that would ordinarily be considered "thinking" can be detected, although person may appear to be conscious. Communication is virtually impossible. Extreme catatonia.

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

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

SUBSTANCE USE

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

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

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

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

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

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

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

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

Scoring Tips:
When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Substance abuse dominated the person's life to the almost total exclusion of other aspects".

In addition to scoring substance use in this domain, you can also score substance dependence for someone who is not using at this time. Example of this would be- how frequently is someone thinking of using and how does that impact their daily functioning (i.e. if someone is thinking of using all the time, and is participating in 5 AA meetings daily to keep from using- this may be impacting their ability to hold down a job, etc.).

MEDICAL/PHYSICAL

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

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

20 – 29 (Mild to Moderate): Occasional or mild physical problems that interfere with daily living. Physical condition worse than what is typical of age, sex, and culture and life circumstances; manifested by mild chronic disability, illness or injury, or common illness more frequent than most. Includes most persons without specific

disability, but frequent undiagnosed physical complaints. Disorders in this range could become life threatening only with protracted lack of care.
ADULT: Controlled allergies. Needs glasses, hearing aid, or other prostheses, but can function without them. Needs medication on a regular basis to control chronic medical problem.
CHILD: Illnesses more frequent than average. Controlled allergies. Needs glasses, hearing aid, or other prostheses, etc.

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

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

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

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

Scoring Tips:
When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "but all cases in this range require at least regular nursing-type care".

When determining if a person scored in the 30-39 range, please note that just having Diabetes, Asthma, etc. does not automatically equate a score in this range. In addition, symptoms/condition "definitely limits physical functioning".

FAMILY

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

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

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

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

20 – 29 (Mild to Moderate): Relationships within the family are mildly unsatisfactory. May include evidence of occasional violence among family members. Family disruption is evident. Significant friction and turmoil evidenced, on some consistent basis, which is not easily resolved.

ADULT: Family difficulties such that client occasionally thinks of leaving. Some strife with children.
CHILD: Problems with parents or other family members are persistent, leading to generally unsatisfactory family life. Evidence of recurring conflict or even violence involving adults and children.

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

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

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

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

Scoring Tips:
When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Abusive or abused" for adults, and "Abused or neglected" for children.

Score only the current family system (in the last 30 days). Family system can include anyone that the person identifies as family (ex: common law husband/wife might be scored here). Please note that if someone is identified and scored as family, they should not be included and scored again under domain 6- Interpersonal.

INTERPERSONAL

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

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

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

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

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

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

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

Scoring Tips:
When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "No close relationships".

This domain scores only the person's ability to make and maintain relationships outside of the family system-not the type of people they choose to have relationships with. If they are maintaining relationships with people who are getting them into trouble/putting them at risk, this may be a consideration for poor judgment when scoring in domain #2.

ROLE PERFORMANCE

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

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

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

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

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

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

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

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

SOCIO-LEGAL

1 – 9 (ABOVE AVERAGE): Almost conforms to rules and laws with ease, abiding by the "spirit" as well as the "letter" of the law. Any rate deviations from rules or regulations are for altruistic purposes.

10 – 19 (AVERAGE): No disruption of socio-legal functioning problems. Basically a law-abiding person. Not deliberately dishonest, conforms to most standards of relevant culture. Occasional breaking or bending of rules with no harm to others.
ADULT: No encounters with the law, other than minor traffic violations.
CHILD: Generally conforms to rules. Misbehavior is non-repetitive, exploratory or mischievous.

20- 29 (Mild to Moderate): Occasional or mild disruption of socio-legal functioning. Occasionally bends or violates rules or laws for personal gain, or convenience, when detection is unlikely and personal harm to others is not obvious. Cannot always be relied on; may be in some trouble with the law or other authority more frequently than most peers; has no conscious desire to harm others.
ADULT: Many traffic tickets. Creates hazard to others through disregard of normal safety practices.
CHILD: Disregards rules. May cheat or deceive for own gain

30 – 39 (Moderate to Severe): Occasional major or frequent disruption of socio-legal functioning. Conforms to rules only when more convenient or profitable than violation. Personal gain outweighs concern for others leading to frequent and/or serious violation of laws and other codes. May be seen as dangerous as well as unreliable.
ADULT: Frequent contacts with the law, on probation, or paroled after being incarcerated for a felony. Criminal involvement. Disregard for safety of others.
CHILD: Unable to consider rights of others at age appropriate level. Shows little concern for consequences of actions. Frequent contact with the law. Delinquent type behaviors.

40 – 49 (Incapacitating): Serious disruption of socio-legal functioning. Actions are out of control without regard for rules and law. Seriously disruptive to society and/or pervasively dangerous to the safety of others.
ADULT: In confinement or imminent risk of confinement due to illegal activities. Imminent danger to others or property.
CHILD: In confinement or imminent risk of confinement due to delinquent acts.

50 (EXTREME): Total uncontrolled or antisocial behavior. Socially destructive and personally dangerous to almost all unguarded persons.

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

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

SELF CARE/BASIC NEEDS

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

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

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

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

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

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

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

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

CAR TRAINING

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

ADDICTION SEVERITY INDEX (ASI)
AND

TEEN ADDICTION SEVERITY INDEX (T-ASI)

Addiction Severity Index (ASI)

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

Problem Areas

- Medical Status
- Employment/Support Status
- Alcohol
- Drugs
- Legal Status

- Family/Social Relationships
- Psychiatric Status

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

Teen Addiction Severity Index (T-ASI)

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

<u>Problem Areas</u>

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

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