

SoonerCare

Behavioral Health Prior Authorization Procedures

**Inpatient Behavioral Health • Therapeutic Foster Care
Intensive Treatment Family Care • Applied Behavior Analysis**



OKLAHOMA
Health Care Authority

Updated: August 3, 2021

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PURPOSE OF MANUAL

This manual contains the prior authorization procedures and medical necessity criteria for the Oklahoma Health Care Authority (OHCA) contracted behavioral health providers to utilize when requesting treatment services. All behavioral health services must be medically necessary. The medical record needs to reflect that medical necessity requirements/criteria are being followed.

Additional information about the SoonerCare program is contained in the SoonerCare State Plan and the administrative rules. The State Plan is posted at <http://www.okhca.org/> and official rules are published by the Oklahoma Secretary of State Office of Administrative Rules as Title 317 of the Oklahoma Administrative Code (OAC).

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

The staff of OHCA thanks all of the physicians/practitioners who provide behavioral health services to SoonerCare members.

ADMISSION AND EXTENSION PRIOR AUTHORIZATION REQUESTS ARE REQUIRED FOR THE FOLLOWING SERVICES

- Acute I
- Acute II/Psychiatric Residential Treatment Facility (PRTF)
- Therapeutic Foster Care (TFC)
- Intensive Treatment Family Care (ITFC)
- Applied Behavior Analysis (ABA)

PRIOR AUTHORIZATION REQUESTS QUESTIONS

- Call (405) 522-7597, or call toll-free the OHCA Provider Helpline, (800) 522-0114, and have your Provider ID number ready. Select:
- Option 1 for Provider,
- Option 6 for Prior Authorizations, and
- Option 2 for Behavioral Health

BILLING/CLAIMS QUESTIONS

- All billing/claims inquiries should be directed to the OHCA Provider Helpline at (800) 522-0114, Option 2.

ENROLLMENT QUESTIONS

- For Provider Enrollment (contract) questions, select Option 5 on the call tree.

PRIOR AUTHORIZATION PROCEDURE

- A face-to-face admission assessment by a Licensed Behavioral Health Practitioner (LBHP) is conducted prior to submitting the request.
- Complete the appropriate prior authorization form located on the [OHCA Behavioral Health Web Page](#).
- Fax the completed form to (405) 530-7260.
- **Requests are processed during business hours from 8:00am-5:00pm, Monday through Friday, excluding holidays.**
- **Prior authorization requests/forms must be submitted the next business day by 5:00pm following an admission for a PA start date of the date of admission.**
- **Extension prior authorization requests/forms should be submitted no later than the last business day of the current authorization before 5:00pm.**
- For a decision the same day following the submission, requests must be received by 10:00am. Requests received after 10:00am have until 5:00pm the following business day to be processed.
- If the provider has not received notification of a decision regarding a prior authorization within 24 hours of submission, then they should check the provider portal before contacting their clinical reviewer for resolution.
- Failure to follow these time frames could result in loss of day(s).
- Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met.

CHILDREN/ADOLESCENT INPATIENT UNDER THE AGE OF 18

ACUTE I ADMISSION REQUESTS

The Child/Adolescent Inpatient Admission PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, an acute admission may be authorized up to five **(5) days** based upon the documented need for care. The number of approved days is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

ACUTE ADMISSION REQUESTS “UPGRADING” FROM ACUTE II/PRTF LEVEL OF CARE

The Child/Adolescent Inpatient Extension PA Request Form, choosing request type “UPGRADE TO ACUTE LEVEL 1”, should be submitted.

MEDICAL NECESSITY CRITERIA FOR CHILDREN'S ACUTE I ADMISSION

(OAC 317:30-5-95.25)

Acute I psychiatric admissions for children must meet the terms or conditions contained in (1), (2),(3), (4) and one of (5)(A) to (D), and one of (6)(A) to (C) of this subsection.

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

ACUTE I EXTENSION REQUESTS

If the member should need additional inpatient services beyond the initial approved five (5) day period at a **medical/surgical hospital**, a prior authorization is not required. It is necessary for the facility to inform OHCA when the member discharged so that the prior authorization is extended to the discharge date in order for the facility to be paid.

For **psychiatric hospitals**, The Child/Adolescent Inpatient Extension PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, Acute extensions may be authorized up to three **(3) days** based upon the documented need for the extended care. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

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

ACUTE II/PRTF ADMISSION REQUESTS

The Child/Adolescent Inpatient Admission PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, Acute II/PRTF admissions may be authorized up to seven **(7) days** based upon the documented need for the extended care. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate

and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

| MEDICAL NECESSITY CRITERIA FOR CHILDREN’S ACUTE II/ PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY ADMISSION (OAC 317:30-5-95.29) | | | | |
|---|--|-----|---|---|
| Acute II/Psychiatric Residential Treatment Facility admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) to (D) of this subsection. | | | | |
| 1. | Yes | No | A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders. | |
| 2. | Yes | No | Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses). | |
| 3. | Yes | No | Patient has either received treatment in an Acute I care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program. | |
| 4. | Yes | No | Child must be medically stable. | |
| 5. | Within the past 14 days the patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by: | | | |
| | A. | Yes | No | Suicidal ideation and/or threat. |
| | B. | Yes | No | Current self-injurious behavior. |
| | C. | Yes | No | Serious threats or evidence of physical aggression. |
| D. | Yes | No | Current incapacitating psychosis or depression. | |
| 6. | Yes | No | Requires 24-hour observation and treatment as evidenced by: | |
| | Intensive behavioral management. | | | |
| | Intensive treatment with the family/guardian and child in a structured milieu. | | | |
| | Intensive treatment in preparation for re-entry into community. | | | |

DELAYED ACUTE II/PRTF ADMISSIONS

A face to face assessment for admission to Acute II/PRTF level of care is valid for three **(3) business days**. The prior authorization request may be submitted immediately to OHCA for a determination. If the member does not admit within the three business days, a new face to face

assessment will be required as well as a new prior authorization request. An exception may be made for out of state treatment that requires a more complex plan for travel arrangements.

ACUTE II/PRTF ADMISSION REQUESTS “DOWNGRADING” FROM ACUTE I LEVEL OF CARE

The Child/Adolescent Inpatient Extension PA Request Form, choosing request type “DOWNGRADE TO ACUTE LEVEL II/PRTF”, should be submitted.

ACUTE II/PRTF EXTENSION REQUESTS

The Child/Adolescent Inpatient Extension PA Request Form can be submitted up to two **(2) business days** prior to the last day of the current authorization. Based on the OHCA Medical Necessity Criteria, Acute II/PRTF extensions may be authorized up to ten **(10) days** for standard Acute II/PRTF programs or up to twenty-one **(21) days** for specialized programs. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

MEDICAL NECESSITY CRITERIA FOR CHILDREN'S ACUTE II/ PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CONTINUED STAY

(OAC 317:30-5-95.30)

For continued stay Acute II/Psychiatric Residential Treatment Facility requests for children must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).

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

SPECIALTY CHILDREN'S ACUTE II/PYSCHIATRIC RESIDENTIAL TREATMENT REQUESTS

Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week. An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

The Child/Adolescent Inpatient Admission PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, Specialty Acute II/PRTF admissions may be authorized up to seven **(7) days** based upon the documented need for the extended care. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

MEDICAL NECESSITY CRITERIA FOR SPECIALTY CHILDREN'S ACUTE II/ PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY ADMISSION

(OAC 317:30-5-95.29)

Specialty Acute II/Psychiatric Residential Treatment Facility admissions for children must meet the terms and conditions in (1) to (4), (6), one of the conditions in (5) (A) to (D), (7) and (7) (A) or (B).

| | | | | |
|----|--|-----|---|---|
| 1. | Yes | No | A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders. | |
| 2. | Yes | No | Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses). | |
| 3. | Yes | No | Patient has either received treatment in an Acute I care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program. | |
| 4. | Yes | No | Child must be medically stable. | |
| 5. | Within the past 14 days the patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by: | | | |
| | A. | Yes | No | Suicidal ideation and/or threat. |
| | B. | Yes | No | Current self-injurious behavior. |
| | C. | Yes | No | Serious threats or evidence of physical aggression. |
| | D. | Yes | No | Current incapacitating psychosis or depression. |
| 6. | Yes | No | Requires 24-hour observation and treatment as evidenced by: Intensive behavioral management. Intensive treatment with the family/guardian and child in a structured milieu. Intensive treatment in preparation for re-entry into community. | |
| 7. | Yes | No | Have failed at other levels of care or have not been accepted by other non-specialty levels of care; and have an intellectual disability and/or developmental disability that meets at least one (1) of the following criteria: | |
| | A. | Yes | No | Intellectual disability characterized by a full-scale IQ of seventy (70) or less. |
| | B. | Yes | No | Developmental disability characterized by significant functional impairment, such as delayed or total lack of spoken language, inability to independently perform two (2) or more activities of daily living requiring multiple verbal cues at least fifty percent (50%) of the time to complete tasks, inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly, or other impairments requiring specialty care, subject to approval by OHCA. |

SPECIALTY CHILDREN'S ACUTE II/PYSCHIATRIC RESIDENTIAL TREATMENT EXTENSION REQUESTS

The Child/Adolescent Inpatient Extension PA Request Form can be submitted up to two **(2) business days** prior to the last day of the current authorization.

Based on the OHCA Medical Necessity Criteria, Specialty Children's Acute II/PRTF extensions may be authorized up to twenty-one **(21) days**. The number of days issued is determined by the reviewer. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

MEDICAL NECESSITY CRITERIA FOR CHILDREN'S SPECIALTY ACUTE II/ PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CONTINUED STAY

(OAC 317:30-5-95.30)

For continued stay Specialty Acute II/Psychiatric Residential Treatment Facility requests for children must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4).

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

COMMUNITY BASED TRANSITIONAL (CBT) ADMISSION REQUESTS

The Child/Adolescent Inpatient Admission PA Request Form should be submitted. The number of days authorized is based on the clinical information submitted by the treating facility. The initial authorization for CBT admissions may be up to seven **(7) days**. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

MEDICAL NECESSITY CRITERIA FOR CHILDREN'S COMMUNITY BASED TRANSITIONAL RESIDENTIAL TREATMENT ADMISSION

(OAC 317:30-5-95.29)

Community Based Transitional Residential Treatment admissions for children must meet the terms and conditions in (1) to (4), (6), and one of the conditions in (5) (A) to (D) of this subsection.

| | | | |
|--|---|----|--|
| 1. | Yes | No | A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders. |
| 2. | Yes | No | Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses). |
| 3. | Yes | No | <p>Patient has received treatment in an Acute I, Acute II/PRTF, or children's crisis unit or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.</p> <p>Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.</p> <p>Clinical documentation must support need for CBT, rather than facility-based crisis stabilization, therapeutic foster care, or intensive outpatient services.</p> <p>There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute II. stabilization/inpatient care.</p> <p>Personal safety Cognitive functioning Family relations Interpersonal relations Educational/vocational performance</p> |
| 4. | Yes | No | Child must be medically stable and not require 24 hour on-site nursing or medical care. |
| 5. | Patient demonstrates escalating pattern of self-injurious or assaultive behaviors as evidenced by: | | |
| A. | Yes | No | Suicidal ideation and/or threat. |
| B. | Yes | No | Current self-injurious behavior. |
| C. | Yes | No | Serious threats or evidence of physical aggression. |
| D. | Yes | No | Current incapacitating psychosis or depression. |
| 6. | Yes | No | Requires 24-hour observation and treatment as evidenced by: |
| <p>Intensive behavioral management.</p> <p>Intensive treatment with the family/guardian and child in a structured milieu.</p> <p>Intensive treatment in preparation for re-entry into community.</p> | | | |

DELAYED CBT ADMISSIONS

A face to face assessment for admission to CBT level of care is valid for three **(3) business days**. The prior authorization request may be submitted immediately to OHCA for a determination. If the member does not admit within the three business days, a new face to face assessment will be required as well as a new prior authorization request. An exception may be made for out of state treatment that requires a more complex plan for travel arrangements.

CBT EXTENSION REQUEST

The Child/Adolescent Inpatient Extension PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, CBT extensions may be authorized up to twenty-one **(21) days**. The length is based on the level of impairment, severity of the symptoms, and the established medical necessity criteria. Decisions as to whether continued stay is approved are based on both behavioral information as well as documentation of the intensive treatment being provided without which the member would quickly decompensate and not be able to function in the community.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

MEDICAL NECESSITY CRITERIA FOR CHILDREN'S COMMUNITY BASED TRANSITIONAL RESIDENTIAL TREATMENT CONTINUED STAY

(OAC 317:30-5-95.30)

For continued stay Community Based Transitional Residential Treatment for children, requests must meet the terms and conditions contained in **(1), (2), (5), (6), and either (3) or (4).**

| | | | |
|----|-----|----|---|
| 1. | Yes | No | A diagnosis that is the primary focus of treatment outlined from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have any sequential personality disorders. |
| 2. | Yes | No | Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses). |
| 3. | Yes | No | There is documented continued need for 24 hour observation and treatment as evidenced by: Patient making measurable progress toward the treatment objectives specified in the treatment plan. Clinical documentation clearly indicates continued significant functional impairment in tow of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors: Personal Safety Cognitive functioning Family relations Interpersonal relations Educational/vocational performance OR |
| 4. | Yes | No | Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care. |
| 5. | Yes | No | Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment at this level of care. |
| 6. | Yes | No | Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date. |

CHEMICAL DEPENDENCY DETOXIFICATION ADMISSION REQUEST

The Child/Adolescent Inpatient Admission PA Request Form should be submitted. An initial

maximum of five **(5) days** for Chemical Dependency Detoxification (Detox) is allowable based on medical necessity. Chemical Dependency Detoxification will not be authorized for SoonerCare reimbursement for caffeine, nicotine or cannabis substances.

A prior authorization request is not necessary if a medical emergency exists and the services are delivered on a medical unit.

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

CHEMICAL DEPENDENCY DETOXIFICATION EXTENSION REQUEST

The Child/Adolescent Inpatient Extension PA Request Form should be submitted. If serious physiological evidence of detoxification persists after the admission authorization, up to three **(3) additional days** may be issued based on a case-by-case review of medical necessity criteria.

CHILDREN/ADOLESCENT INPATIENT PROCEDURES

INPATIENT SERVICES FOR CHILDREN UNDER 5 YEARS OF AGE

Under certain circumstances, inpatient services may be determined to be appropriate for children less than 5 years of age. Inpatient services for this age group are very difficult to locate and will only be approved in extraordinary cases. Reviewers will carefully manage these cases in an attempt to meet the child's needs at the least restrictive level of care. The physician consultant will review all the inpatient referrals for children under the age of 5.

OHCA APPROVAL OF OUT-OF-NETWORK INPATIENT TREATMENT SERVICES

Out-of-network inpatient treatment services will only be authorized when it is determined that the needed services are not available within OHCA's contracted network of providers. Many factors are considered by OHCA in approving a child for out-of-network treatment services. The primary issues to be considered are a) a lack of appropriate treatment resources within the contracted network and/or b) the child has exhausted the resources currently available.

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

PROSPECTIVE COMPLEXITY ADD-ON PER DIEM FOR NON VERBAL CHILDREN

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

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

Non-Verbal Prior Authorizations are reviewed by OHCA supervisor(s) for approval. If a denial is given by the OHCA supervisor, a reconsideration can be requested with new clinical information. The reconsideration will then go to our Psychiatric Consults for review. If the denial is upheld by the Psychiatric Consultant, further reviews will not be reconsidered unless a new request is submitted with additional information.

INTENSIVE TREATMENT SERVICES (ITS) ADD-ON PAYMENT CRITERIA – 1:1 STAFFING CRITERIA

1:1 AUTHORIZATION MNC - INITIAL

- Extent, frequency, severity and consistency of behaviors resulting in imminent danger to self/others cannot be managed with less than 1:1 staffing.
- Consistent failure of other interventions including active medication treatment.
- A clear specific individualized patient plan to transition off 1:1 and a realistic d/c date.

1:1 AUTHORIZATION MNC – EXTENSION

- Day to day, shift to shift or hour to hour extent, frequency, severity and consistency of severe behaviors resulting in imminent danger to self/others cannot be managed with less than 1:1 staffing.
- Consistent failure of other interventions including active medication treatment.
- A clear specific individualized patient plan to transition off 1:1 and a realistic d/c date.
- Failed attempts to reduce and transition off 1:1 with specific documentations of what worked and what failed and why.
- Exclusions for 1:1 staffing authorizations (Initial and Extension):
 - Medical conditions (such as a seizure disorder)
 - Attendance to ADL's
 - AWOL risk or behaviors
 - Group attendance

SPECIALTY ADD-ON PAYMENT CRITERIA

MEDICAL NECESSITY CRITERIA FOR SPECIALTY ADD-ON: INPATIENT CARE FOR CHILDREN

(OAC 317:30-5-96.3)

To use the specialty add-on for children in Acute Level II units of psychiatric hospitals, general hospitals with Acute Level II psychiatric units, or Psychiatric Residential Treatment Facilities (PRTFs), children must meet the medical necessity criteria for the respective level of care and also have the need for more intensive treatment/staffing, as evidenced by meeting two of the criteria in (1), (2), or (3) below OR meeting the criteria in (4) below.

Providers must supply evidence that the programming and/or treatment is a higher level or higher intensity than what is provided in non-specialty programs/treatment, or that a specialty program not currently available in the state will be provided.

| | | | |
|----|-----|----|--|
| 1. | Yes | No | Specifically described assaultive and/or self-injurious behavior that presents an imminent life threatening emergency or demonstrates escalation, and requires a higher level of assistance or higher intensity programming than what is offered in a non-specialty treatment program. |
| 2. | Yes | No | Co-occurring mental illness and an intellectual/developmental disability that requires a higher level of assistance or higher intensity programming than what is offered in a non-specialty treatment program. |
| 3. | Yes | No | Child has a history of multiple hospitalizations with minimal progress and requires a higher level of assistance or higher intensity programming than what is offered in a non-specialty treatment program. |
| 4. | Yes | No | In need of specialty treatment typically provided through specialty programs that are not <u>currently</u> available in Oklahoma, causing imminent risk for out of state hospitalization. |

ACTIVE TREATMENT

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

Elective categories for treatment consist of Expressive Therapy (ET), Individual Rehab (IR), Occupational Therapy (OT), Wellness Resource Skills Development (WRSD), and Recreational Therapy (RT), and Group Rehab (GR).

Elective treatment services will be prorated as follows:

Day 1 in Acute I is orientation. Day 2, 2 hours of treatment is required. Day 3, 4 hours of treatment is required. Day 4, 6 hours of treatment is required. Day 5, 8 hours of treatment is required. Day 6, 9 hours of treatment is required. Day 7, 10 hours of treatment is required.

Day 1 in Acute II/PRTF is Orientation. Day 2, 1 hour of treatment is required. Day 3, 3 hours of treatment is required. Day 4, 5 hours of treatment is required. Day 5, 7 hours of treatment is required. Day 6, 9 hours of treatment is required. Day 7, 9.5 hours of treatment is required.

Day 1 in Community Based Treatment is Orientation. Day 2, 1 hour of treatment is required. Day 3, 2 hours of treatment is required. Day 4, 3 hours of treatment is required. Day 5, 4 hours of treatment is required. Day 6, 5 hours of treatment is required. Day 7, 6 hours of treatment is required.

FAMILY THERAPY ‘IN AN INSTANCE’/ EXCEPTION REQUEST PROCEDURES

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

PHYSICIAN SERVICES

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

TELEMEDICINE GUIDELINES FOR INPATIENT/RESIDENTIAL PSYCHIATRIC TREATMENT PROVIDERS

The Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have collaborated with the provider community to develop guidelines for the use of telemedicine in the inpatient/PRTF/Acute II psychiatric facility setting. It is the expectation that services be provided in person whenever possible, but these guidelines are intended to provide flexibility in certain circumstances. The following guidelines are effective for services provided on and after March 1, 2017:

FAMILY THERAPY

- If the family lives more than 60 miles away from the facility;
- In the case of inclement weather preventing the family from physically attending a family session;
- The family member is physically unable to leave the home in order to attend the family session;
- Weekends/after hours.

INDIVIDUAL AND GROUP THERAPY

- Weekends and after regular business hours;
- In the case of inclement weather preventing the licensed behavioral health professional from physically attending a session;
- In the event that a client is experiencing a crisis and a licensed behavioral health professional is not on site.

PHYSICIAN SERVICES

- One in three physician visits may be done via telemedicine.
- The History and Physical **must** be done in person.

DOCUMENTATION

- Documentation must be maintained by the rendering provider to substantiate the services rendered.
- Documentation must indicate the services were rendered via telemedicine, and the location of the services.
- All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:
 - Chart notes
 - Start and stop times
 - Service provider's credentials
 - Provider's signature

RECREATIONAL THERAPY

(Effective September 12, 2014)

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

CASE MANAGEMENT

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

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

SERVICES UNDER ARRANGEMENT

Separate payment may be made directly to practitioners for services provided under arrangement for transitional case management services, Health Home transitioning services and evaluation and psychological testing by a licensed psychologist. In order to ensure optimal collaboration and help assure there is no duplication of service, there must be a written agreement in the medical record between the OPBH provider and the inpatient facility outlining transitional case management and Health Home transitioning activities including a differentiation in the responsibilities between the two providers. The written agreement includes but is not limited to the following assurances:

1. The inpatient facility arranges for and oversees the provision of all services;
2. The inpatient facility maintains documentation in the medical record of the collaborative efforts engaged in with the OPBH provider for the provision of transitional case management or Health Home transitioning services;
3. The inpatient facility ensures that all services are included under the direction of a physician.

For evaluation and psychological testing, the medical record must include a copy of the results as well as documentation of a review of the results and how the information guided treatment. A review of paid claims for transitional case management and Health Home transitioning services will be conducted annually to ensure that documentation requirements have been met. Any findings that the above assurances have not been met may result in recoupment. Psychologists may contact OHCA at 405-522-7597 for assistance in processing their claims for payment. OHCA will contact the inpatient facility to confirm appropriate medical record documentation prior to payment.

TRANSFERRING A MEMBER REMAINING AT THE SAME LEVEL OF CARE TO AN INTERNAL UNIT OR EXTERNAL PROVIDER

All internal unit and external provider transfers require prior authorization. Observe the following protocol for both internal unit and external provider transfers.

- ORIGINATING facility/unit will specify on the Acute I, Acute II, or PRTF Extension form that the Level of Care is a "Transfer".
- ORIGINATING facility/unit will provide the clinical rationale why the member needs to be transferred to the RECEIVING facility/unit. The clinical rationale should be documented in the "Reserve this field to provide additional information requested by OHCA physicians/reviewers" section of the form.
- If the request is approved, the RECEIVING facility/unit will be authorized the number of days remaining from the ORIGINATING facility/unit's authorization at the time the transfer actually occurs. If a child transfers with five (5) days or less remaining on the authorization, the ORIGINATING facility/unit is expected to provide the next extension request for the RECEIVING facility/unit.

ADULT INPATIENT (AGES 18 TO 64)

ACUTE I ADMISSION REQUESTS

(Effective September 17, 2018)

The Adult Inpatient Psychiatric PA Request Form should be submitted. Based on the OHCA Medical Necessity Criteria, an acute admission will be authorized up to seven **(7) days** based upon the documented need for care.

In some instances, the reviewer may choose to refer to a physician consultant before making a final determination. Facilities may be asked to provide additional documentation to support Acute medical necessity criteria such as psychiatric evaluations, psychological testing reports, progress notes, Medication Administration Record (MAR), and the current individual plan of care.

If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

MEDICAL NECESSITY CRITERIA FOR ADULT (AGES 18 to 64) ACUTE I PSYCHIATRIC ADMISSION

(OAC 317:30-5-41.1)

Acute I psychiatric admissions for adults (ages 18 to 64) must meet the terms or conditions contained in (1), (2),(3), (4) and one of (5)(A) to (D), and one of (6)(A) to (C).

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

ADULT (AGES 18 to 64) ACUTE I ADMISSION IMPORTANT INFORMATION

- Adults ages 18 to 64 years old may receive acute care services at a General Medical/Surgical Hospital or a Psychiatric Hospital.
- In lieu of a qualifying diagnosis, adults 18-21 years old may have a diagnosis of any personality disorder.
- Adults ages 65 and older DO NOT require a prior authorization.

- Members who have Medicare insurance coverage DO NOT require a prior authorization except if the member has opted to participate in a Medicare Advantage Plan (aka Medicare replacement or Part C) or they have exhausted the lifetime Medicare benefit. If so, then a prior authorization is required and a **verification of coverage** or **verification of exhausted lifetime Medicare benefits** should be faxed in.

ADULT (AGES 18 to 64) ACUTE I EXTENSION REQUESTS

If the member should need additional inpatient services beyond the initial approved seven (7) day period at a **medical/surgical hospital**, a prior authorization is not required. It is necessary for the facility to inform OHCA when the member discharged so that the prior authorization is extended to the discharge date in order for the facility to be paid.

For **psychiatric hospitals**, to request an extension of care, choose "PSYCH EXTENSION - PSYCH HOSPITALS ONLY" as the request type.

Provide updated clinical for fields "Criteria #1" through "Criteria #6" by typing a line below the submitted on the admission request and documenting the member's new behaviors that have occurred over the past 48 hours. Please provide specific behaviors with dates when documenting. If additional extensions are requested, continue the same protocol. DO NOT DELETE OR MODIFY any previous submitted clinical.

ADULT INPATIENT CHEMICAL DEPENDENCY DETOXIFICATION/WITHDRAWAL MANAGEMENT ADMISSION REQUEST

The Adult Inpatient Admission Chemical Dependency Detoxification/Withdrawal Management PA Request Form should be submitted. An initial maximum of five **(5) days** for Chemical Dependency Detoxification/Withdrawal Management is allowable based on medical necessity. Chemical Dependency Detoxification/Withdrawal Management will not be authorized for SoonerCare reimbursement for caffeine, nicotine or cannabis substances.

A prior authorization request is not necessary if a medical emergency exists and the services are delivered on a medical unit.

MEDICAL NECESSITY CRITERIA FOR ADULT (AGES 21 to 64) INPATIENT CHEMICAL DEPENDENCY DETOXIFICATION/WITHDRAWAL MANAGEMENT

(OAC 317:30-5-95)

Admission for adult (ages 21-64) inpatient chemical dependency detoxification/withdrawal management must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D).

| | | | |
|----|--|----|--|
| 1. | Yes | No | Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies. |
| 2. | Yes | No | Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). |
| 3. | Yes | No | It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program. |
| 4. | Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by: | | |
| A. | Yes | No | Need for active and aggressive pharmacological interventions. |
| B. | Yes | No | Need for stabilization of acute psychiatric symptoms. |
| C. | Yes | No | Need extensive treatment under physician direction. |
| D. | Yes | No | Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision. |

THERAPEUTIC FOSTER CARE (TFC)

INITIAL TFC REQUESTS

After the treatment facility has completed a face to face assessment of the child, the provider should fax the completed prior authorization request.

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

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

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

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

MEDICAL NECESSITY CRITERIA FOR THERAPEUTIC FOSTER CARE ADMISSION

(OAC 317:30-5-741)

A child must meet ALL of the following conditions.

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

TFC EXTENSION REQUESTS

Extension requests should be submitted 30 days from the expiration of the current authorization. Failure to follow this time frame will result in loss of day(s). **Effective 9-14-2020 TFC extension prior authorizations can be approved up to a maximum of six months.** The number of days allowed will be determined by the reviewer and based on the level of severity and chronicity of the symptoms that meet Medical Necessity Criteria, including the need for 24 hour crisis intervention.

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

Necessity Criteria. The clinical information must include current, relevant information.

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

CONTINUED STAY THERAPEUTIC FOSTER CARE MEDICAL NECESSITY CRITERIA

(OAC 317:30-5-741)

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

THERAPEUTIC FOSTER CARE (TFC) PROCEDURES

TFC CLIENTS THAT ARE PLACED IN ACUTE I OR PRTF/ACUTE II

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

TELEMEDICINE FOR TFC

The purpose of this section is to implement telemedicine policy that improves access to health care services, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of telemedicine, hands-on-assessment and/or in person care must be provided for the member.

REIMBURSEMENT

- Services provided by telemedicine must be billed with appropriate modifier.
- If the technical component of an X-ray, ultrasounds or electrocardiogram is performed during a telemedicine transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.
- The cost of telemedicine equipment and transmission is not reimbursed by SoonerCare.

DOCUMENTATION

- Documentation must be maintained by the rendering provider to substantiate the services rendered.
- Documentation must indicate the services were rendered via telemedicine and the location of the services.
- All other SoonerCare documentation guidelines apply to the services rendered telemedicine. Examples include but are not limited to:

1. Chart notes;
2. Start and stop times;
3. Service provider's credentials; and
4. Provider's signature.
5. The OHCA has discretion and the final authority to approve or deny any telemedicine services based on agency and/or SoonerCare members' needs.

TFC CLIENTS FIVE YEARS OF AGE AND YOUNGER

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

TFC PG GROUPS WITH REHAB CHANGES

(Effective September 12, 2014)

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

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

- Psychosocial Assessment
- Developmental appropriateness (how can the child benefit from a curriculum-based treatment intervention?)
- Please provide the name of the curriculum used to determine developmental appropriateness.
- A denial for Psychosocial Rehabilitation will go through a two level review process:
- The initial request for Psychosocial Rehabilitation (PSR) will be given by the clinical reviewer.
- If the TFC agency request a reconsideration for PSR once the initial denial is given, then it will go to the Psychiatric Consultant for final determination.

INTENSIVE TREATMENT FAMILY CARE (ITFC)

ITFC INITIAL REQUESTS

After the treatment facility has completed a face to face assessment of the child, the provider should fax the completed prior authorization request.

| MEDICAL NECESSITY CRITERIA FOR INTENSIVE TREATMENT FAMILY CARE ADMISSION (OAC 3317317:30-5-753(3)) | | | |
|--|-----|----|--|
| A child must meet ALL of the following conditions. | | | |
| 1. | Yes | No | A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-3-31 within the 30 day period resulting in a primary diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting. |
| 2. | Yes | No | Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention. |
| 3. | Yes | No | It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program. |
| 4. | Yes | No | Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home. |
| 5. | Yes | No | The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services. |
| 6. | Yes | No | The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning. |

All denials will be reviewed by a physician consultant during working hours within (1) business day. When services have been denied, further extension requests CANNOT be considered. A new

initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The clinical information must include current, relevant information. The ITFC Provider will be responsible for providing the reviewer with information regarding DHS/OJA participation in the child's treatment needs and planning.

ITFC EXTENSION REQUEST

Extension requests should be submitted within 30 days from the expiration of the current authorization. Failure to follow this time frame will result in loss of day(s).

After the first ITFC authorization, extensions may be authorized **up to 90** days.

The number of days allowed will be determined by the reviewer and based on the level of impairment, severity and chronicity of the symptoms that meet Medical Necessity Criteria, including the need for 24 hour crisis intervention.

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

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

APPLIED BEHAVIOR ANALYSIS (ABA)

ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. **ABA treatment is time limited. ABA services is limited to the following CPT codes 97151, 97153, 97155, and 97156.**

| MEDICAL NECESSITY CRITERIA FOR APPLIED BEHAVIOR ANALYSIS SERVICES (OAC 317:30-3-65.12) | | | |
|--|-----|----|---|
| A child must meet ALL the following conditions. | | | |
| 1. | Yes | No | The member is under twenty-one (21) years of age with a definitive diagnosis of Autism Spectrum Disorder (ASD) from a following provider: <ul style="list-style-type: none"> A. Pediatric neurologist or neurologist; B. Developmental pediatrician; C. Licensed Psychologist; D. Psychiatrist or Neuropsychiatrist; or E. Other Licensed Physician experienced in the diagnosis and treatment of autism. |
| 2. | Yes | No | A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must: <ul style="list-style-type: none"> A. Be completed within the last two (2) years; B. Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and C. Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale. |
| 3. | Yes | No | There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit: <ul style="list-style-type: none"> A. The ability/capacity to learn and develop generalized skills to assist with his or her independence; and B. The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD. |

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| 4. | Yes | No | The member is medically stable and does not require twenty-four hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID). |
| 5. | Yes | No | The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to: A. Impulsive aggression toward others B. Self-injury behaviors C. Intentional property destruction |
| 6. | Yes | No | The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") |
| 7. | Yes | No | It has been determined that there is no less intensive or more appropriate level of services which can be safely and effectively provided. |

INITIAL ABA REQUEST

ABA initial requests are considered non-emergent. Requests can be received seven (7) days prior to the initial start date. Late requests may result in denial of days.

Each section of the Initial ABA Request must be completed in the designated boxes on the template and "please see attachment" will not be accepted. All supportive documentation must be submitted with the request or could result in denial of days. **Please submit the number of requested hours per week for each ABA CPT code requested on the clinical template.**

The number of days authorized is based on the clinical information submitted by the treating agency. The initial authorization for the ABA initial request may be up to six (6) months. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

Please note if you are requesting 30-40 hours a week of RBT services please provide us with the curriculum/transcript that will show the hourly breakdown of what services will be provided daily.

All denials will be reviewed by a physician consultant during working hours within (2) business day. When services have been denied, a new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The clinical information must include current, relevant information.

EXTENSION ABA REQUEST

ABA concurrent request are considered non-emergent. Request can be received seven (7) days prior to the initial start date. Late request may result in denial of days.

Each section of the Extension ABA Request must be completed in the designated boxes on the template and “please see attachment” will not be accepted. All supportive documentation must be submitted with the request, or could result in denial of days. **Please submit on the clinical template the number of requested hours per week for each ABA CPT code requested.**

Please note on the extension request form please list all dates of sessions, goals, objectives, and family response to treatment in the box provided on the template. Accompany the ABA Extension Clinical template with additional information that will cover the time, goals, & objectives that were utilized (i.e. submission of treatment plan or something equivalent to show the full scope of what services were provided within the last 6 months and the member’s response to treatment), if you are unable to provide the complete overview within the box.

The number of days authorized is based on the clinical information submitted by the treating agency. The concurrent authorization for ABA extension request may be up to six (6) months. In some instances, the reviewer may choose to refer to a physician consultant before making a final determination.

If you are requesting 30-40 hours a week of RBT services please provide us with the curriculum/transcript that will show the hourly breakdown of what services will be provided daily.

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

OTHER POLICIES & PROCEDURES

FAX CONFIRMATIONS AS PROOF OF TIMELY SUBMISSION

Fax errors may prevent OHCA from receiving a prior authorization request. It is the provider's responsibility to monitor/track if their prior authorization submissions were successfully received by OHCA. If a medical necessity determination has not been entered into the provider portal after 24 hours following the provider's submission, contact our department immediately to follow up. If an error did occur, a fax confirmation sheet may be submitted as proof of timely submission if it is received by OHCA within 48 hours of the provider's initial submission. If received after 48 hours, a technical denial may result due to late submission of the proof and OHCA will start the authorization request the day the proof is submitted.

The fax confirmation sheet must contain the following information to be accepted as proof:

1. Fax transmittal date and time; and
2. Name and/or Medicaid number on either the cover page or the first/last page of prior authorization request.

No fax confirmation sheets without the forementioned information will be accepted as proof of timely submission.

IMPORTANT: Due to the nature of prior authorization requests that require a Certificate of Need, OHCA will be unable to retro approve back to the start date if the proof is received beyond 48 hours after the start date of the request. OHCA will start the request, the date the proof of timely submission is received.

DENIED REQUESTS AND RECONSIDERATION TIME LINE

All prior authorization requests go through a two level review process when a denial decision is issued. The final denial for an inpatient or TFC authorization request is issued by a Physician Consultant who is a Board Certified Child and Adolescent Psychiatrist.

Once the facility is notified of a denial for an initial or extension prior authorization request, the provider is allowed until 5pm the following business day to submit additional information for reconsideration.

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

If the denial is upheld after the additional information is reviewed, the provider has another 24 business hours to schedule a physician to physician review.

When services have been denied, further extension requests CANNOT be considered. If a review

is given partial days after review from the Psychiatric Consult then a physician to physician review can't be requested. A new initial review may be requested at any time that it is believed the child meets the Medical Necessity Criteria. The facility must use the inpatient prior authorization process. The clinical information must include **current, relevant information**. If the Medical Necessity Criteria is not met, the reviewer will assist in locating appropriate treatment services.

CORRECTION REQUESTS

When a facility finds that a data entry error has been made (e.g., typographical error, wrong provider number, wrong procedure code, wrong SoonerCare member number, etc.), the facility will notify the reviewer by fax using the correction request form.

NODOS PROCESS

NODOS is an electronic request made by a hospital to reserve a date of service. It allows hospitals to notify OHCA of needed medical services for potential members. The NODOS allows a SoonerCare application to be backdated no more than five (5) days from the date the NODOS is submitted. An application must be completed and the member found eligible within fifteen (15) days of the NODOS being created.

- Example: A NODOS is submitted on 4/10/2016.
- The member has until 4/25/2016 to submit a completed application.
- Coverage can be backdated to 4/5/2016.

The only way the provider can be reimbursed for services rendered is if the patient becomes eligible for that date of service. The NODOS is the only way to have eligibility backdated. Those with access to the eligibility screen on the SoonerCare Provider Portal have access to submit a NODOS.

All users should have a clear understanding that:

- The NODOS feature is site specific; meaning the Provider ID submitting the NODOS is the location where the patient was seen. Admission records should be available in the event of an audit.
- The NODOS must be submitted before an application is submitted. Failure to do so may cause the provider to miss payments for compensable services.
- Before starting a NODOS, please have the patient's first/last name, date of birth, gender, citizenship status, social security number, and mailing address.
- Submission of multiple NODOS forms for the same individual will cause delays in processing and payment of claims.
- The original NODOS is good for 15 days after submission.

PRIOR AUTHORIZATION REQUESTS FOR NEWLY ELIGIBLE MEMBERS WHEN A NODOS IS COMPLETED

- Once the member's eligibility is activated in OHCA's MMIS system, the provider has up to 5 business days to submit a Prior Authorization request to OHCA using the PA Admission template to request up to 5 days for an Acute I admission or up to 7 days for a PRTF/Acute II admission.
- If the member's eligibility is not activated in OHCA's MMIS system until after the PA Admission timeframes, the provider will also complete the PA extension template and submit both the PA Admission and Extension template to OHCA at the same time.
- Choose "Newly Eligible" as the REQUEST TYPE when filling out the PA templates.
- Submit the NODOS confirmation with the PA templates.

THIRD PARTY LIABILITY

As the state Medicaid agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. In accordance with OAC 317: 30-3-24, when other health coverage resources are available, those resources must first be utilized by a member prior to filing a SoonerCare claim. This includes coverage by health maintenance organizations (HMO), preferred provider organizations (PPO) and any other insuring arrangements which provide a member access to health care. Members must comply with all requirements of their primary insurance and SoonerCare in order to take advantage of both coverages.

For more information, refer to Chapter 14 of the OHCA billing manual on our website: www.okhca.org/billing-manual, or contact OHCA provider services at 800-522-0114 for onsite training.

TRAVEL ASSISTANCE

Each inpatient facility must have a travel assistance policy/plan to assist those SoonerCare families that need assistance with the expenses of traveling to attend family therapy while their child is receiving inpatient psychiatric care. The inpatient facility is responsible for notifying the families of this assistance and the procedure the family must follow.

SERVICE QUALITY REVIEW (SQR)

- All facilities contracted with the state of Oklahoma that provide Acute I, Acute II/PRTF, and TFC services to SoonerCare recipient under the age of 21 during the past fiscal year will be reviewed by the OHCA contractor.
- Service Quality Reviews (SQR) will be done as a combination of desktop or on-site audits.
- Records must be submitted **electronically** through our secure Provider Portal (www.ohcaprovider.com) when a desktop review is done.
- All documents must be scanned when onsite. Scanner issues will be the only exception to this.
- Each facility will be reviewed one time within the fiscal period, but OHCA has the right to request the OHCA SQR team to perform an additional ad hoc review at any time.
- Local/in-state and border facilities and agencies may have a complete onsite review. The SQR team may also choose to conduct complete onsite reviews if the facility has special issues that the team believes are best monitored directly or could be missed when records are submitted by the facility or agency.
- When a facility or agency is found by the review team to have issues that are considered unsafe, or fail to provide services that meet minimum treatment standards as determined by the entire team then a second review is conducted within 60 days. The facility or agency may also be referred to the OHCA Quality Assessment team.
- Service Quality Reviews are performed as referenced in OAC 317:30-5-95.42 for inpatient providers and in OAC 317:30-5-743.1 for TFC providers.
- Out of State facilities with existing contracts with the Oklahoma Health Care Authority will receive audit reviews through the following steps:
 1. Out of State facilities will have an annual desktop review and three year rotations for onsite visits.
 2. Out of State facilities that may have one Oklahoma Medicaid Behavioral Member under 21 that admits occasionally will have a desktop review within the fiscal year following the date of admit and will be asked to provide reports from their state agencies' onsite inspections (fire marshal, licensing, accreditation, etc.).The following fiscal year is used because data is pulled from claims billed, (providers have 6 months to bill) and prior authorizations.
 3. The member's medical record and those documents determine appropriate to request by the OHCA legal department will be requested.
- The documentation reviewed during inpatient provider SQR includes (but is not limited to):
 1. DSM-V primary diagnosis
 2. Clinical information supporting medical necessity criteria and the need for requested level of care. Medical, psychiatric, and social evaluation were completed within the time frame specified by OAC 317: 30-5-95.37
 3. Parent(s)/Guardian received copies of the information of behavioral management of patient, guidelines, conditions, grievance procedures, address, and phone number for DHS Advocacy office, patient bill of rights, seclusion/restraint policy and consent for case management
 4. Informed consent signed by parent/guardian for use of psychotropic medications; Medical issues are identified and receiving appropriate care

5. Individual Plan of Care (service plan) completed and addresses areas specified by OAC 317:30-5-95.33, including dated signatures of treatment team members, collaboration of parent/guardian medications and dosages and discharge plan
 6. RN documentation every 24 hours for Acute I and every 7 days for Acute II/PRTF levels of care
 7. Services provided for SoonerCare member with developmental disabilities or any disability are rendered appropriately
 8. Use of Seclusion/Restraint
 9. Frequency of active treatment components as specified in OAC 317: 30-5-95.34
 10. Facility accreditation, policies, and procedures
 11. Employee licensure, CPR, and crisis management competencies and background checks
- Telemedicine
 1. The facility must document in the member record the method and rationale for utilizing telemedicine.
 2. It must be documented in the record if the services provided were done via telemedicine (i.e. individual therapy, family therapy, group therapy, or physicians services).
 3. The facility will provide the SQR team with the IT policy surrounding the electronic media utilized to provide telemedicine as to assure that a secure network is being used.
 4. Interactive audio and video telecommunication must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member.
 5. The medical or behavioral health related service must be provided in an appropriate site for deliver wherein proper security measures are in place.
 6. The consent for telemedicine is no longer required.
 7. A Physician (M.D. or D.O.) is the only one who can render the one in three physicians' visits via telemedicine
 8. The HMP must still be done in person.
 - The documentation reviewed during TFC provider SQR reviews includes (but is not limited to):
 1. DSM-V primary diagnosis
 2. Clinical information supporting the need for requested level of care
 3. Medical, psychiatric, and social evaluation were completed within the time frame specified by OAC 317:30-5-95.42
 4. Individual Plan of Care (service plan) completed and addresses areas specified by OAC 317:30-5-742.2, including dated signatures of treatment team members, collaboration of guardian, medications, dosages, and discharge plan
 5. Frequency of active treatment components as specified in OAC 317:30-5-742
 6. Involvement of biological parents, as clinically indicated
 7. The facility's use of crisis intervention
 8. The facility's accreditation, policies, and procedures; employee licensure and background checks