**Oklahoma Health Care Authority**

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

**OHCA COMMENT DUE DATE:** February 18, 2020

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the July 2, 2019, November 5, 2019 and January 7, 2020 Tribal Consultation. The proposed rule changes will be presented at a Public Hearing on February 19, 2020. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on March 12, 2020 and the OHCA Board of Directors on March 18, 2020.

**Reference: APA WF 19-32**

**SUMMARY:**

**Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions** – The proposed rule changes will amend inpatient psychiatric services policy for members under twenty-one (21) to reflect current practice, update obsolete references, and reorganize sections for consistent application of policy. The proposed rule changes will also address SQR findings of deficiency regarding inpatient psychiatric facilities' compliance with federal regulations and OHCA administrative rules. Additionally, the proposed rule changes will create a general specialty add-on payment for children and adolescents with specialized treatment needs who are being served in a psychiatric residential treatment facility (PRTF), Acute II unit of a psychiatric hospital and general hospital with an Acute II psychiatric unit.

**LEGAL AUTHORITY**

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

**RULE IMPACT STATEMENT:**

**STATE OF OKLAHOMA**
**OKLAHOMA HEALTH CARE AUTHORITY**

TO: Maria Maule
Legal Services

FROM: Vanessa Andrade
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 19-32

A. Brief description of the purpose of the rule:

The proposed rule changes will amend inpatient psychiatric services policy for members under twenty-one (21) to reflect current practice, update obsolete references, and reorganize sections for consistent application of policy. Revisions will clarify levels of care such as Acute, Acute II, and PRTF.

Furthermore, the proposed rule changes will address SQR findings of deficiency regarding inpatient psychiatric facilities' compliance with federal regulations and OHCA administrative rules. These rule changes will assess a full or partial recoupment of paid claims, at the discretion of the OHCA, based on the severity of the deficiencies. Additionally, the proposed revisions will address corrective action plans and requests for reconsideration of deficiency/recoupment findings.

Finally, the proposed rule changes will create a general specialty add-on payment for children and adolescents with specialized treatment needs who are being served in a PRTF, Acute II unit of a psychiatric hospital and general hospital with an Acute II psychiatric unit.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare members and providers will be affected by the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes that address inpatient psychiatric services policy for members under twenty-one (21) and SQR findings of deficiency will benefit both members and providers by ensuring member's safety, quality care and compliance with applicable inpatient psychiatric services laws and regulations.

The proposed rule changes that create a general specialty add-on payment will benefit providers by helping offset the cost of providing the intensity of services needed for children and adolescents with complex needs. The proposed rule will also, ensure members have continued access to care for this level of service. Additionally, the proposed rule will benefit members by

increasing the availability of in-state placement options, keeping members under twenty-one (21) in-state and closer to their families for the duration of treatment.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes that amend inpatient psychiatric services policy for members under twenty-one would be budget neutral.

The proposed rule changes that address SQR findings of deficiency would potentially result in savings; however, the agency is unable to provide a measurable savings amount.

The proposed rule changes that create a general specialty add-on payment would potentially result in an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small business.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: December 11, 2019
Modified: December 17, 2019

**RULE TEXT:**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

**317:30-5-94. Definitions**

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

**"Adult"** means an individual twenty-one (21) and over, unless otherwise specified. Refer to Oklahoma Administrative Code (OAC) 317:30-1-4.

**"C.F.R."** means Code of Federal Regulations.

**"Child"** means an individual under the age of twenty (21) in an inpatient psychiatric setting as per 42 C.F.R. § 441. 151(a)(3). If an individual is receiving services before he or she reaches twenty-one (21), then the individual can continue to receive services until the individual no longer requires the services or the date the individual turns twenty-two (22), whichever comes first. For services other than inpatient psychiatric services or

otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA), refer to OAC 317:30-1-4.

**"C.M.S"** means Centers for Medicare and Medicaid Services.

**"General hospital"** means a general medical surgical hospital, as defined by Section 1-701 (2) of Title 63 of the Oklahoma Statutes.

**"Institution for Mental Diseases (IMD)"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

**"Licensed behavioral health professional (LBHP)"** means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;
(ii) Social work (clinical specialty only);
(iii) Professional counselor;
(iv) Marriage and family therapist;
(v) Behavioral practitioner; or
(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

**"Licensure candidate"** means a practitioner actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(3) Agree with the current plan for the member;

(4) Confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

**"OHCA"** means Oklahoma Health Care Authority.

**"OAC"** means Oklahoma Administrative Code.

**"O.S."** means Oklahoma Statutes.

**"Psychiatric hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by Section 1395x(f) of Title 42 of the United States Code.

**"Psychiatric residential treatment facility (PRTF)"** means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

**"U.S.C."** means United States Code.

**317:30-5-95. General provisions and eligible providers**

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

~~(1) **"C.F.R."** means Code of Federal Regulations.~~

~~(2) **"CMS"** means Centers for Medicare and Medicaid Services.~~

~~(3) **"General Hospital"** means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).~~

~~(4) **"Institution for Mental Diseases (IMD)"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.~~

~~(5) **"OHCA"** means Oklahoma Health Care Authority.~~

~~(6) **"O.S."** means Oklahoma Statutes.~~

~~(7) **"Psychiatric Hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 United States Code, Sec. 1395x(f).~~

~~(8) **"Psychiatric Residential Treatment Facility (PRTF)"** means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.~~

~~(9) **"U.S.C."** means United States Code.~~

(b) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(c) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) is a psychiatric hospital that:

(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) is a general hospital with a psychiatric unit that:

(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) is contracted with the OHCA; and

(5) if located within Oklahoma and serving members under

~~eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.~~

~~(d) **PRTF.** Every PRTF must:~~

~~(1) be individually contracted with OHCA as a PRTF;~~

~~(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;~~

~~(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and~~

~~(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).~~

~~(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).~~

~~(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine

whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately

licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).
(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

**317:30-5-95.4. Individual plan of care for adults aged twenty-one (21) to sixty-four (64)**

(a) Before admission to a psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each member aged twenty-one (21) to sixty-four (64). The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;
(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
(5) Plans for continuing care, including review and modification to the plan of care; and
(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

**317:30-5-95.14. Individual plan of care for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services**

(a) Before admission to a psychiatric hospital or psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or member. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

**317:30-5-95.22. Coverage for children**

~~(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.~~

~~(b) **Definitions**. The following words and terms, when used in Sections OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the~~

following meaning, unless the context clearly indicates otherwise:

(1) **"Acute care"** means care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.

(3) **"Chemical Dependency/Substance Abuse services/ Detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

(4) **"Community Based Extended"** means a PRTF with 16 beds or more but less than 30 beds. The typical facility is not a locked facility.

(5) **"Community based transitional residential treatment"** means a level of care designed for children that require the continued structure, psychiatric intervention of 24 hour care but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community based transitional are non- secure PRTFs with 16 beds or less.

(6) **"Designated Agent"** means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.

(7) **"Enhanced Treatment Unit or Specialized Treatment Unit"** means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

(8) **"Evidenced Based Practice (EBP)"** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.

(9) **"Freestanding PRTFs"** are generally for profit secure facilities which range from 50 to over 100 beds and are generally staffed higher with RN personnel.

(10) **"Out-of-State Placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA

~~Behavioral Health Unit.~~

~~(11) **"Provider Based"** facilities are secure residential treatment facilities that are affiliated with private medical/surgical hospitals. The RN hours per day average 2.4 hours.~~

~~(12) **"Public facilities"** are Oklahoma government owned or operated facilities.~~

~~(13) **"Residential Treatment services"** means psychiatric services that are designed to serve children who need longer term, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization.~~

~~(14) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members~~.

(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.

(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "Acute" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) "Acute II" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.

(3) "Border placement" means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).

(4) "Border status" means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.

(5) "Chemical dependency/substance abuse services/detoxification" means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

(6) "Community-based extended" means a PRTF with sixteen (16)

beds or more but less than thirty (30) beds. The typical facility is not a locked facility.
(7) "Community-based transitional (CBT)" means a PRTF level of care designed for individuals under twenty-one (21) who require the continued structure and psychiatric intervention of twenty-four (24) hour care, but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community-based transitional facilities are non-secure PRTFs with sixteen (16) beds or less.
(8) "Enhanced treatment unit or specialized treatment" means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.
(9) "Evidence-based practice (EBP)" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).
(10) "Out-of-state placement" means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.
(11) "Public facilities" means Oklahoma government owned or operated facilities.
(12) "Trauma-informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

**317:30-5-95.24. Prior ~~Authorization~~authorization of inpatient psychiatric services for ~~children~~individuals under twenty-one (21)**

~~(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.~~
~~(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is~~

~~considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.~~

~~(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at Oklahoma Administrative Code (OAC) 310:667-15-3 and OAC 310:667-33-2(a)(3).~~

~~(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.~~

~~(e) Specialty residential treatment at this level 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.~~

~~(f) A Psychiatric Residential Treatment Facility (PRTF) will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.~~

~~(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.~~

~~(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for Residential Treatment Center (RTC) and also meet at least two or more of the following:~~

- ~~(1) Have failed at other levels of care or have not been accepted at other levels of care;~~
- ~~(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management~~

and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

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

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(j) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.

(k) For out-of-state placement policy, refer to OAC 317:30-3-89

~~through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.~~

~~(l) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.~~

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d) and (h). The facility cannot use staff that is also on duty in other units of the facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the

supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) 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.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members.

(h) Criteria for classification as a specialty Acute II or PRTF will require a staffing ratio of one (1) staff: three (3) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II or PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:

(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care;

(2) Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger but, do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward

self and/or others regularly;
(C) Failure to develop peer relationships appropriate to developmental level;
(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;
(E) Lack of social or emotional reciprocity;
(F) Lack of attachment to caretakers;
(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;
(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;
(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
(J) Stereotyped and repetitive use of language or idiosyncratic language;
(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
(L) Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
(M) Inflexible adherence to specific, nonfunctional routines or rituals;
(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements); and/or
(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment; and/or
(4) Has full-scale IQ below forty (40) (profound intellectual disability).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.
(j) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.
(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.
(l) Inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to

the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

**317:30-5-95.29. Medical necessity criteria ~~for admission – psychiatric residential treatment~~ Acute II and PRTF admissions for children**

~~(a) Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1), (2), (3), (4), (6) and one of (5)(A) through (5)(D) of this subsection.~~

~~(1) A primary diagnosis 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 detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.~~

~~(2) 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) Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past 14 calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).~~

~~(A) Suicidal ideation and/or threat.~~

~~(B) History of or current self-injurious behavior.~~

~~(C) Serious threats or evidence of physical aggression.~~

~~(D) Current incapacitating psychosis or depression.~~

~~(6) Requires 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

~~(b) Community Based Transitional Residential Treatment (CBT) facility admissions for children must meet the terms and conditions in (1) through (6) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of the DSM with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms~~

~~supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral or status offenses).~~

~~(3) Patient has either received treatment in an acute, RTC or children's crisis unit care setting or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.~~

~~(B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, or intensive outpatient services.~~

~~(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.~~

~~(i) Personal safety.~~

~~(ii) Cognitive functioning.~~

~~(iii) Family relations.~~

~~(iv) Interpersonal relations.~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable and not require 24 hour on-site nursing or medical care.~~

~~(5) Within the past 14 calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).~~

~~(6)Within the past 14 calendar days, the patient's behaviors have created significant functional impairment.~~

(a) Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) 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) Patient has either received treatment in an acute setting or it has been determined by the OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.
(4) Member must be medically stable.
(5) Requires twenty-four (24) hour observation and treatment as evidenced by:
(A) Intensive behavioral management;
(B) Intensive treatment with the family/guardian and child in a structured milieu; and
(C) Intensive treatment in preparation for re-entry into community.
(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).
(A) Suicidal ideation and/or threat.
(B) History of/or current self-injurious behavior.
(C) Serious threats or evidence of physical aggression.
(D) Current incapacitating psychosis or depression.
(b) CBT admissions for children must meet the terms and conditions in (1) through (6) of this subsection.
(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.
(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral, or status offenses).
(3) Patient has either received treatment in Acute, Acute II, PRTF or children's crisis unit setting (refer to OAC 317:30-5-241.4), or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.
(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.
(B) Clinical documentation must support need for CBT, rather than facility-based crisis stabilization, therapeutic foster care, intensive treatment foster care, or intensive outpatient services.
(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would

result in rapid and marked deterioration of functioning in at least two (2) of the five (5) critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.

(i) Personal safety;

(ii) Cognitive functioning;

(iii) Family relations;

(iv) Interpersonal relations; or

(v) Educational/vocational performance.

(4) Child must be medically stable.

(5) Within the past fourteen (14) calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(6) Within the past fourteen (14) calendar days, the patient's behaviors have created significant functional impairment.

**317:30-5-95.30. Medical necessity criteria for ~~continued stay - psychiatric residential treatment center for children~~Acute II and PRTF continued stay for children**

~~(a) For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4) of this subsection.~~

~~(1) A primary diagnosis 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 abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have a secondary diagnosis of any personality disorder.~~

~~(2) 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) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.~~

~~(B) Patient has made gains toward social responsibility and independence.~~

~~(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.~~

~~(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.~~

~~(4) Child's condition has remained unchanged or worsened.~~

~~(A) Documentation of regression is measured in behavioral terms.~~

~~(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.~~

~~(5) There is documented continuing need for 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

~~(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.~~

~~(b) For continued stay Community Based Transitional Residential Treatment (CBT), children must meet the terms and conditions found in (1) through (5) of this subsection.~~

~~(1) A primary diagnosis from the most recent DSM with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.~~

~~(2) 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, etc.).~~

~~(3) There is documented continued need for 24 hour observation and treatment as evidenced by:~~

~~(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(B) Clinical documentation clearly indicates continued significant functional impairment in two of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors:~~

~~(i) Personal safety.~~

~~(ii) Cognitive functioning.~~

~~(iii) Family relations.~~

~~(iv) Interpersonal relations.~~

~~(v) Educational/vocational performance.~~

~~(4) 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) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.~~

(a) For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V

codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

(4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) Patient has made gains toward social responsibility and independence.

(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.

(6) Child's condition has remained unchanged or worsened.

(A) Documentation of regression is measured in behavioral terms.

(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

(b) For continued stay in a CBT, members must meet the terms and conditions found in (1) through (5) of this subsection.

(1) A primary diagnosis from the DSM-V with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continued need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.

(B) Clinical documentation clearly indicates continued significant functional impairment in two (2) of the following five (5) critical areas, as evidenced by specific clinically relevant behavior descriptors:

(i) Personal safety;
(ii) Cognitive functioning;
(iii) Family relations;
(iv) Interpersonal relations; or
(v) Educational/vocational performance.

(4) 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) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.

**317:30-5-95.31. Prior ~~Authorization~~authorization and extension procedures for children**

~~(a) Prior authorization for inpatient psychiatric services for children must be requested from the Oklahoma Health Care Authority (OHCA) or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.~~

~~(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of fifteen (15) days and in a psychiatric residential treatment facility for three (3) months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.~~

~~(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.~~

~~(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under Oklahoma Administrative Code 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the initial decision.~~

(a) Prior authorization for inpatient psychiatric services for members must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A

prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent, is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.
(b) Extension requests (psychiatric) must be made through OHCA or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a member who has been in an Acute psychiatric program for a period of fifteen (15) days and an Acute II or PRTF program for three (3) months will require a review of all treatment documentation completed by the OHCA, or its designated agent, to determine the efficiency of treatment.
(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.
(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member may request an evidentiary hearing under OAC 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the date of the notice of the initial decision.

**317:30-5-95.33. Individual plan of care for ~~members under the age of twenty-one (21)~~children**

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

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

~~(2) **"Licensure candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:~~

~~(A) Psychology,~~
~~(B) Social Work (clinical specialty only),~~
~~(C) Professional Counselor,~~
~~(D) Marriage and Family Therapist,~~
~~(E) Behavioral Practitioner, or~~
~~(F) Alcohol and Drug Counselor.~~

~~(3) **"Individual plan of care (IPC)"** means a written plan developed for each member within four (4) calendar days of admission to an acute psychiatric facility or a PRTF that~~

directs the care and treatment of that member. The IPC must be recovery focused, trauma informed, and specific to culture, age, and gender and include:

(A) A primary diagnosis 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 abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis;

(B) The current functional level of the individual;

(C) Treatment goals and measurable, time-limited objectives;

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

(E) Plans for continuing care, including review and modification to the IPC; and

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

(b) The IPC:

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

(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by Oklahoma Administrative Code (OAC) 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to

~~the member's age, culture, strengths, needs, abilities, preferences, and limitations;~~
~~(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;~~
~~(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;~~
~~(6) Must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;~~
~~(7) Must be reviewed, at a minimum, every five (5) to nine (9) calendar days for members admitted to an acute care setting; every fourteen (14) calendar days for members admitted to a regular PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty PRTF; and every thirty (30) calendar days for members admitted to a Community Based Transitional PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;~~
~~(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,~~
~~(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC~~

~~and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (DHS/OJA) worker for review, the parent/legal guardian and/or DHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.~~

~~(10) Medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.~~

(a) An individual plan of care (IPC) is a written plan developed for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;

(2) The current functional level of the individual;

(3) Treatment goals and measurable, time-limited objectives;

(4) Any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies,

social services, diet, and special procedures recommended for the health and safety of the member;
(5) Plans for continuing care, including review and modification to the IPC; and
(6) Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:
(1) Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;
(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:
(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or
(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:
(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and
(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and
(iii) An LBHP.
(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;
(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(6) Must include specific discharge and aftercare plans that are

appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;

(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF; and every thirty (30) calendar days for members admitted to a CBT PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of

Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

**317:30-5-95.34. Active treatment for children**

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

~~(1) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.~~

~~(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.~~

~~(3) **"Family therapy"** means interaction between a licensed behavioral health providers (LBHP) or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.~~

~~(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).~~

~~(5) **"Individual rehabilitative treatment"** means a face-to-face,~~

one-on-one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform ADL.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment." Active treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of eighteen (18) up to twenty-one (21), it is understood that family members and guardians will not always be involved in the member's treatment. Active treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence-based practices such as trauma informed methodology should be utilized to minimize the use of restraint and seclusion.

(c) For individuals age eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face to face. Services, including type and frequency, will be specified in the individual plan of care.

(d) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being

~~dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) treatment must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty (60) minutes is the expectation to equal one (1) hour of treatment. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each on the condition that the active treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:~~

~~(1) **Core Services.**~~

~~(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for acute care and one (1) time a week in PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in PRTFs, never exceed seven (7) calendar days in a specialty PRTF and never exceed thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.~~

~~(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in acute care and one (1) hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.~~

~~(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week for acute care and residential. One (1) 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 an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in acute care and two (2) hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in acute care and thirty (30) minutes per week in residential and CBT. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery

principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** 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 an individual or group setting. 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.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(c) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in a residential treatment center (RTC), PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child

~~is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.~~

~~(1)~~ **~~Individual treatment provided by the physician.~~**

~~(A) In acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.~~

~~(B) In RTC, PRTF or CBT, one (1) visit during admission week is required. In RTCs, one (1) visit during the admission week is required, then once a week thereafter. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. In CBT, one (1) visit is required within seven (7) days of admission. Individual treatment provided by the physician will never exceed ten (10) days between sessions in PRTFs, never exceed seven (7) days in a specialty PRTF and never exceed thirty (30) days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.~~

~~(2)~~ **~~Individual therapy.~~**

~~(A) In acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.~~

~~(B) In residential treatment (including PRTF and CBT), by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.~~

~~(3)~~ **~~Family therapy.~~**

~~(A) In acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial~~

~~evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.~~

~~(B) In residential treatment (including PRTF and CBT), by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.~~

~~(4) **Process group therapy.**~~

~~(A) In acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.~~

~~(B) In residential treatment (including PRTF and CBT), by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.~~

~~(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (registered nurse (RN)/licensed practical nurse (LPN)), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.~~

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

(1) **"Active treatment"** means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic

physical activities, and experiential (e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) **"Family therapy"** means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals age eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In

Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals in Acute must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Individuals in CBT PRTFs must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF, and never exceed thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative

therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) 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 an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff

with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. 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.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert

and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include individual/ group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, not including CBTs, one (1) visit during the admission week is required, then once a week thereafter. In CBT, one (1) visit is required within seven (7) days of admission, then once a month thereafter. Individual treatment provided by the physician will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs and never exceed thirty (30) days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.

(2) **Individual therapy.**

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week.

The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

**317:30-5-95.35. Certificate of need requirements for ~~members under the age of twenty-one (21)~~children in psychiatric ~~hospital~~hospitals and PRTFs**

~~(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to members under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting~~

~~of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.~~

~~(b) **Definitions.** The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.~~

~~(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one other licensed behavioral health professional, as defined by OAC 317:30-5-240.3.~~

~~(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBED) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBED. The interdisciplinary team must also include one of the following:~~

~~(A) a licensed clinical social worker;~~

~~(B) a Registered Nurse with specialized training or one (1) year of experience in treating mentally ill individuals;~~

~~(C) and a psychologist licensed by the OSBED who has a doctoral degree in clinical psychology; or,~~

~~(D) an occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.~~

~~(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:~~

~~(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;~~

~~(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and~~

~~(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.~~

~~(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:~~

~~(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.~~

~~(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.~~

~~(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.~~

~~(e) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.~~

(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to individuals under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.

(b) **Definitions.** The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one (1) other LBHP.

(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBEP) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training

and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBEP. The interdisciplinary team must also include one (1) of the following:

(A) A licensed clinical social worker;

(B) A registered nurse (RN) with specialized training or one (1) year of experience in treating mentally ill individuals;

(C) A psychologist licensed by the OSBEP who has a doctoral degree in clinical psychology; or

(D) An occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.

(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;

(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.

(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:

(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.

(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.

(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.

**317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children**

~~The member's medical record must contain complete medical, psychiatric and social evaluations.~~

~~(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:~~

~~(A) History and physical evaluation must be completed within 24 hours of admission by a licensed independent practitioner~~

~~(M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.~~

~~(B) Psychiatric evaluation must be completed within 60 hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.~~

~~(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.~~

~~(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.~~

~~(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than 30 calendar days from admission. For continued stays at the same level of care, evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.~~

~~(4) Existing evaluations of 30 days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary and signed and dated by the appropriate level of professional as defined by the type of evaluation.~~

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) in Acute, Acute II, and PRTFs, excluding CBTs, and within seven (7) calendar days of admission in a CBT.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry in Acute, Acute II, and PRTFs, excluding CBTs, and within seven (7) calendar days of admission in a CBT.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs, including CBTs, by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at

the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

**317:30-5-95.38. Nursing services for children**

~~Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. In a Community Based Transitional RTC, an RN must be on site at least one hour each day and be available 24 hours a day when not on site. A registered nurse must document member progress at least weekly except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the member's progress as it relates to the individual plan of care goals and objectives.~~

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. In a CBT, an RN must be on site at least one (1) hour each day and be available twenty-four (24) hours a day when not on site. An RN must document member progress at least weekly, except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

**317:30-5-95.40. Other required standards**

~~The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Psychiatric Residential Treatment Facilities may substitute CARF accreditation in lieu of TJC or AOA accreditation.~~

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission' (TJC) and American Osteopathic Association' (AOA) standards for

behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services' (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation.

**317:30-5-95.41. Documentation of records for ~~children's~~children receiving inpatient services**

~~(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:~~

~~(1) date;~~

~~(2) start and stop time for each session;~~

~~(3) dated signature of the therapist and/or staff that provided the service;~~

~~(4) credentials of the therapist;~~

~~(5) specific problem(s) addressed (problems must be identified on the plan of care);~~

~~(6) method(s) used to address problems;~~

~~(7) progress made towards goals;~~

~~(8) member's response to the session or intervention; and~~

~~(9) any new problem(s) identified during the session.~~

~~(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.~~

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, family, process group, expressive group, individual rehabilitative, and group rehabilitative services documentation must include, at a minimum, the following:

(1) Date;
(2) Start and stop time for each session;
(3) Dated signature of the therapist and/or staff that provided the service;
(4) Credentials of the therapist;
(5) Specific problem(s) addressed (problems must be identified on the plan of care);
(6) Method(s) used to address problems;
(7) Progress made towards goals;
(8) Member's response to the session or intervention; and
(9) Any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of eighteen (18), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of eighteen (18), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy, and process group therapy must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(c) Candidates for licensure for licensed professional counselor, social work (clinical specialty only), licensed marital and family therapist, licensed behavioral practitioner, licensed alcohol and drug counselor, and psychology (mental health specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy, and process group therapy as long as they are involved in supervision that complies with their respective, approved licensing regulations and licensing boards. Additionally, their work must be co-signed and dated by a fully-licensed LBHP in good standing, who is a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed in one (1) of the areas of practice in OAC 317:30-5-240.3(a)(2) must have their work co-signed by a fully-licensed LBHP in good standing, who is a member on the treatment team. All co-signatures by fully-licensed LBHPs in good standing, must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully-licensed LBHP in good standing.

**317:30-5-95.42. Service quality review (SQR) of psychiatric facilities ~~providing services to children~~**

~~(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.~~

~~(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the Medical Necessity Manual. OHCA or its designated agent may conduct ad hoc reviews. Ad hoc reviews may be conducted at the discretion of the agency.~~

~~(c) The Oklahoma Health Care Authority will designate the members of the Service Quality Review team. The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.~~

~~(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.~~

~~(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.~~

~~(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:~~

- ~~(1) History and physical evaluation;~~
- ~~(2) Psychiatric evaluation;~~
- ~~(3) Psychosocial evaluation; and~~
- ~~(4) Individual Plan of Care.~~

~~(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment.~~

~~(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.~~

~~(i) In the event that CMS recoups from OHCA an amount that exceeds~~

~~the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.~~

~~(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.~~

(a) The service quality review (SQR) conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation as well as observation and contact with members. The clinical record review will consist of those records of members present or listed as facility residents at the beginning of the visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.

(e) Following the SQR, the SQR team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency and any licensing agencies.

(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation or in which a member does not meet medical necessity criteria will result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during the on-site portion of the SQR.

(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) **Assessments and evaluations.** Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6 and 317:30-5-95.37.

(2) **Plan of care.** Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4 and 317:30-5-96.33.

(3) **Certification of need (CON).** CONs must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) **Active treatment.** Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10 and 317:30-5-95.34.

(5) **Documentation of services.** Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing.** Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d)& (h)and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will

be part of the report documentation sent to the facility.
(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

**317:30-5-96.2. Payments definitions**

~~The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"Allowable costs"** means costs necessary for the efficient delivery of member care.~~

~~**"Ancillary Services"** means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.~~

~~**"Border Status"** means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.~~

~~**"Developmentally disabled child"** means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.~~

~~**"Eating Disorders Programs"** means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.~~

~~**"Professional services"** means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.~~

~~**"Psychiatric Residential Treatment Facility (PRTF)"** means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.~~

~~**"Routine Services"** means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:~~

~~(A) room and board;~~
~~(B) treatment program components;~~
~~(C) psychiatric treatment;~~
~~(D) professional consultation;~~
~~(E) medical management;~~
~~(F) crisis intervention;~~
~~(G) transportation;~~
~~(H) rehabilitative services;~~
~~(I) case management;~~
~~(J) interpreter services (if applicable);~~
~~(K) routine health care for individuals in good physical health; and~~

~~(L) laboratory services for a substance abuse/detoxification program.~~

~~**"Specialty treatment program/specialty unit"** means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.~~

~~**"Treatment Program Components"** means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.~~

~~**"Usual and customary charges"** refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.~~

The following words and terms, when used in OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

**"Add-on payment"** means an additional payment added to the per diem to recognize the increased cost of serving members with complex needs in a PRTF or Acute II.

**"Allowable costs"** means costs necessary for the efficient delivery of member care.

**"Ancillary services"** means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology, and prescription drugs.

**"Border status"** means a placement in a state that does not border Oklahoma. Reimbursement for out-of-state services is made in accordance with OAC 317:30-3-89 through 317:30-3-92 and the Oklahoma Medicaid State Plan.

**"Developmentally disabled child"** means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

**"Eating disorder programs"** means acute or intensive residential behavioral, psychiatric, and medical services provided in a discreet unit to individuals experiencing an eating disorder.

**"Professional services"** means services of a physician, psychologist, or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

**"Routine services"** means services that are considered routine in the Acute II and PRTF levels of care setting. Routine services

include, but are not limited to:

(A) Room and board;

(B) Treatment program components;

(C) Psychiatric treatment;

(D) Professional consultation;

(E) Medical management;

(F) Crisis intervention;

(G) Transportation;

(H) Rehabilitative services;

(I) Case management;

(J) Interpreter services (if applicable);

(K) Routine health care for individuals in good physical health; and

(L) Laboratory services for a substance abuse/detoxification program.

**"Specialty treatment program/specialty unit"** means Acute or other intensive behavioral, psychiatric, and medical services that provide care to a population with special needs or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

**"Treatment program components"** means therapies, activities of daily living, and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

**"Usual and customary charges"** refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

**317:30-5-96.3. Methods of payment**

~~(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:~~

~~(1) Diagnosis Related Group (DRG);~~

~~(2) cost based; or~~

~~(3) a predetermined per diem payment.~~

~~(b) **Acute Level of Care.**~~

~~(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;~~

~~(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.~~

~~(c) **Residential Level of Care**~~

~~(1) **Instate Services.**~~

~~(A) Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.~~

~~(B) Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.~~

~~(2) **Out-of-state services.**~~

~~(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.~~
~~(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.~~

~~(d) **Health Home Transitioning Services.** Health Home services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last 30 days of a covered acute or residential stay. Payment for Health Home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the Health Home outside of the facility's per diem or DRG rate.~~

(a) **Reimbursement.**

(1) Covered inpatient psychiatric and/or substance use disorder services will be reimbursed using one (1) of the following

methodologies:

(A) Diagnosis related group (DRG);

(B) Cost-based; or

(C) A predetermined per diem payment.

(2) For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11.

(b) **Levels of care.**

(1) **Acute.**

(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(2) **Acute II.**

(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(3) **PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(c) **Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current

payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) **Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.** Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the increased cost of serving members with complex needs.

(e) **Services provided under arrangement.**

(1) **Health home transitioning services.**

(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility's per diem or DRG rate.

(2) **Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

(3) **Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.