

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: November 9, 2020

The proposed policy is an Emergency Rule. The proposed policy was presented at the July 7 and September 1, 2020 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on November 12, 2020 and the OHCA Board of Directors on November 12, 2020.

Reference: APA WF # 20-15B

SUMMARY:

Residential substance use disorder (SUD) treatment coverage – The proposed revisions will establish residential SUD treatment coverage for Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and members under the age of twenty-one (21) in residential SUD treatment facilities with seventeen (17) beds or more and/or residential SUD treatment facilities with sixteen (16) beds or less. Further revisions will outline provider requirements, medical necessity, service plan, and reimbursement policies as well as clarify language and remove the Medicaid institutions for mental disease (IMD) exclusion in certain policy sections.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 CFR 440.130(d); Section 1115 of the Social Security Act.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-15B

A. Brief description of the purpose of the rule:

The proposed revisions will add residential substance use disorder (SUD) treatment coverage for Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and members under the age of twenty-one (21) in residential SUD treatment facilities with seventeen (17) beds or more and/or residential SUD

treatment facilities with sixteen (16) beds or less. Further revisions will outline provider requirements, medical necessity, service plan, and reimbursement policies. Other revisions will involve limited rewriting aimed at clarifying outdated policy sections and removing the institution for mental disease (IMD) exclusion for members, ages twenty-one (21) to sixty-four (64). Lastly, the proposed changes are authorized under 42 CFR 440.130(d) and comply with Oklahoma's 1115(a) IMD for serious mental illness (SMI) and SUD waiver request.

- 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 seeking access to residential SUD treatment and/or members, ages twenty-one (21) to sixty-four (64), seeking inpatient psychiatric services, who were previously denied based on the IMD exclusion, will most likely be positively affected by the proposed rule changes.

Residential SUD treatment providers and psychiatric hospital providers will most likely be positively affected by the proposed rule changes.

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

The proposed rule changes will benefit SoonerCare members ages twenty-one (21) to sixty-four (64), members under the age of twenty-one (21), and members ages twenty-one (21) to sixty-four (64) seeking SUD treatment and/or inpatient psychiatric services previously denied due to the IMD exclusion, by enhancing member access to behavioral health services.

The proposed rule changes will benefit residential SUD treatment providers and psychiatric hospital providers by providing reimbursement for the delivery of residential SUD treatment and inpatient psychiatric services previously unavailable due to the IMD exclusion, respectively.

- 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 estimated budget impact for coverage of services provided under the IMD Waiver authority is \$12,604,149 total/\$6,427,171 state savings (6 months) for SFY2021. The estimated budget impact is \$28,003,402 total/\$12,854,341 state savings for SFY2022. The estimated budget impact reflect savings for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) from the movement of state-funded services to Medicaid compensable services.

The estimated budget impact for residential SUD treatment coverage in residential SUD treatment facilities with sixteen (16) beds or less (non-IMDs) is \$523,644 total/\$275,136 state savings (9 months) for SFY2021. The estimated budget impact is \$727,041 total/\$370,736 state savings for SFY2022. The estimated budget impact reflect savings for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) from the movement of state-funded services to Medicaid compensable services.

- 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 a positive effect on the public health, safety, and environment due to increase access to care.

- 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: September 1, 2020

Modified: October 16, 2020

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 AND SUBSTANCE USE DISORDER SERVICES

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

(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)~~(1) 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; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical

dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(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.

317:30-5-95.1. Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64)

(a) **Coverage for adults.** Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital or in a psychiatric hospital (see ~~Oklahoma Administrative Code (OAC)~~ 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5) (A) to (5) (D), and one of (6) (A) to (6) (C) 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 a detailed description of the symptoms supporting the diagnosis.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). Adjustment or substance related disorder may be a secondary diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for ~~chemical dependency/ substance use/ detoxification~~ chemical dependency detoxification/withdrawal management must meet the terms and conditions contained in (1), (2), (3), and one of (4) (A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities

(a) ~~The service quality review (SQR)~~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 and residential substance use disorder 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~~and may include 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~~currently at the facility as well as records of members on for which claims have been filed with OHCA for acute, or PRTF, or residential SUD 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 in writing 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, if applicable, 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, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria ~~will~~may 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~~any 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, and 317:30-5-95.47(1).

(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, and 317:30-5-95.47(2).

(3) Certification of need (CON). CONs for psychiatric facilities 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, and 317:30-5-95.46(b).

(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 317:30-5-95.47 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, 317:30-5-95.46(b) 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. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within 24-hours following each use of physical restraint.

(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.

317:30-5-95.43. Residential substance use disorder treatment

(a) **Purpose.** The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing substance use disorder services.

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

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding

service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) "ASAM level 3.7" means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

(3) "ASAM criteria" means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(4) "Co-occurring disorder (COD)" means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(5) "DSM" means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(6) "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(7) "Service plan" means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

(8) "Substance use disorder (SUD)" means alcohol or drug dependence or psychoactive substance use disorder as defined by the most recent DSM criteria.

(9) "Therapeutic services" means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(10) "Treatment hours - residential" means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

317:30-5-95.44 Residential substance use disorder - Eligible providers and requirements

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of substance use disorder (SUD) services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

- (2) Have a contract with the OHCA;
- (3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2.
- (4) Have a current accreditation status appropriate to provide residential behavioral health services from:
 - (A) The Joint Commission; or
 - (B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or
 - (C) The Council on Accreditation (COA).
- (b) Providers certified by ODMHSAS as a residential level of care provider of SUD services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.
- (c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

317:30-5-95.45. Residential substance use disorder - Coverage by category

- (a) **Adults.** Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.
 - (1) The member must meet residential level of care as determined through completion of the designated ASAM level of care tool as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.
 - (2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.
- (b) **Children.** Coverage for children is the same as adults.
- (c) **Individuals with dependent children.** Coverage for individuals with dependent children is the same as adults and/or children.

317:30-5-95.46. Residential substance use disorder - Covered services and medical necessity criteria

- (a) In order for the services described in this Section to be covered, individuals shall:
 - (1) Be diagnosed with a substance use disorder as described in the most recent edition of the DSM; and
 - (2) Meet residential level of care in accordance with the American Society of Addiction Medicine (ASAM) criteria, as determined by the ASAM level of care determination tool designated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
 - (3) For additional medical necessity criteria, refer to the

ODMHSAS Prior Authorization Manual available at <http://www.odmhsas.org/arc.htm>.

(b) Coverage includes the following services:

(1) Clinically managed low intensity residential services (ASAM Level 3.1).

(A) Halfway house services - Individuals age thirteen (13) to seventeen (17).

(i) **Service description.** This service places a major emphasis on continuing substance use disorder care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, and educational support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided.

(B) Halfway house services - Individuals age eighteen (18) to sixty-four (64).

(i) **Service description.** This service places a major emphasis on continuing substance use disorder care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide

treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided.

(C) Halfway house services - Individuals with minor dependent children or women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, peer recovery support services, parenting/ child development services, educational/vocational support services, and other services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. Dependent children shall be provided treatment services in accordance with the child's service plan.

(2) Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).

(A) Residential treatment for adults with co-occurring disorders.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven / (7) days a

week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include, but are not limited to, medication monitoring, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services and educational/vocational support services. Psychiatric and/or psychological and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5-95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the twenty-four (24) service hours each week.

(3) Clinically managed medium and high intensity (ASAM Level 3.5).

(A) Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment for chemically dependent members. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including but not limited to, therapy, rehabilitation services, case management, crisis intervention, and educational support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven

(7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-one (21) treatment hours for members not attending academic training shall be provided. Treatment hours shall include a minimum of ten (10) weekly hours of therapeutic services, including but not limited to, individual, family and group therapy.

(B) Residential treatment, high intensity - adults.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the twenty-four (24) service hours each week.

(C) Intensive residential treatment, high intensity - adults.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services, and educational/vocational support

services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of eleven (11) hours of educational support services may count toward the thirty-seven (37) service hours each week.

(D) Residential treatment for individuals with minor dependent children and women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide substance use disorder treatment services to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, parenting/child development support services, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment

services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant; this requirement may be reduced to a weekly minimum of twenty-one (21) service hours for Temporary Assistance for Needy Families (TANF) recipients. Treatment hours shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the required service hours each week. Dependent children shall be provided treatment services in accordance with the child's service plan.

(E) Intensive residential treatment for individuals with dependent children and women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide substance use disorder treatment services to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, parenting/child development support services, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of eleven (11) hours of educational support services may count toward the thirty-five (35) service hours each week. Dependent children shall be provided treatment services in accordance with the child's service plan.

(4) **Medically monitored high intensity withdrawal management (ASAM Level 3.7).**

(A) **Medically supervised withdrawal management - individuals age thirteen (13) to seventeen (17).**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily substance use disorder withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

(B) **Medically supervised withdrawal management - adults.**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily substance use disorder

withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

317:30-5-95.47. Residential substance use disorder - Individualized service plan requirements

All substance use disorder services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.

(1) **Assessment.** A biopsychosocial assessment shall be completed to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(A) **Assessments for adolescents.** A biopsychosocial assessment using the Teen Addiction Severity Index (T-ASI) shall be completed. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults.** A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** In accordance with OAC 450:18-7-25, assessments of children (including infants) accompanying their parent into treatment shall include the following items:

- (i) Parent-child relationship;
- (ii) Physical and psychological development;
- (iii) Educational needs;
- (iv) Parent related issues; and
- (v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** In accordance

with OAC 450:18-7-25, assessments of the parent and/or pregnant women bringing their children into treatment shall include the following items:

- (i) Parenting skills;
- (ii) Knowledge of age appropriate behaviors;
- (iii) Parental coping skills;
- (iv) Personal issues related to parenting; and
- (v) Family issues as related to the child.

(E) Assessments for medically supervised withdrawal services.

In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process.

(F) Assessment timeframes. Biopsychosocial assessments shall be completed within seven (7) days of admission (Refer to OAC 450:18-7-26).

(2) Service plan. Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member, including dependent children. The service plan is performed with the active participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of eighteen (18), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate.

(A) Service plan development. The service plan shall:

- (i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.
- (ii) Be initiated by a licensed physician or licensed registered nursing staff for medically supervised withdrawal services.
- (iii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.
- (iv) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.
- (v) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) Service plan content. Service plans must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under eighteen (18) and allowed by law], and the primary service practitioner. Signatures must be obtained after the service plan is completed. The contents of

a service plan shall address the following:

- (i) Member strengths, needs, abilities, and preferences;
- (ii) Identified presenting challenges, needs, and diagnosis;
- (iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;
- (iv) Type and frequency of services to be provided;
- (v) Description of member's involvement in, and response to, the service plan;
- (vi) The service provider who will be rendering the services identified in the service plan; and
- (vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.
- (viii) Plans to address the medical stabilization treatment and service needs of each member receiving medically supervised withdrawal management services.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under eighteen (18) and allowed by law], and the LBHP and licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

- (i) Progress on previous service plan goals and/or objectives;
- (ii) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;
- (iv) Change in frequency and/or type of services provided;
- (v) Change in staff who will be responsible for providing services on the plan; and
- (vi) Change in discharge criteria.

(D) **Service plan timeframes.** Service plans shall be completed within eight (8) days of admission, with the exception of service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) **Progress notes.** Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) **Content.** Progress notes shall address the following:

- (i) Date;
- (ii) Member's name;

- (iii) Start and stop time for each timed treatment session or service;
- (iv) Signature of the service provider;
- (v) Credentials of the service provider;
- (vi) Specific service plan needs, goals and/or objectives addressed;
- (vii) Services provided to address needs, goals, and/or objectives;
- (viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
- (ix) Member (and family, when applicable) response to the session or service provided; and
- (x) Any new needs, goals and/or objectives identified during the session or service.

(B) **Frequency.** Progress notes shall be completed in accordance with the following timeframes:

- (i) Progress notes for therapy, crisis intervention and case management must be documented in an individual note and reflect the content of each session provided.
- (ii) Documentation for rehabilitation services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(4) **Transition/discharge planning.** All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using ASAM criteria to determine a clinically appropriate placement in the least restrictive level of care. Transition/discharge plans and discharge summaries shall be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(A) **Transition/discharge plans.** Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan shall be included in the discharge summary. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.

(B) **Discharge summary.** The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

317:30-5-95.48. Staff training

(a) All clinical and direct care staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter.

(b) All staff shall receive training in accordance with OAC 450:18-9-3(f).

317:30-5-95.49. Residential substance use disorder - Reimbursement

(a) In order to be eligible for payment, residential treatment providers of substance use disorder (SUD) services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma State Medicaid Plan.

(b) All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(c) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan.

(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan.

317:30-5-96.3. Methods of payment

(a) Reimbursement.

(1) Covered inpatient psychiatric and/or substance use disorder chemical dependency detoxification/withdrawal management 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. For members twenty-one (21) to sixty-

four (64) years of age, payment shall not be made for any inpatient psychiatric episodes over sixty (60) days in a facility that qualifies as an IMD.

(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.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) Description of behavioral health case management services.

Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The

relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

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

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

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

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

- (iv) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member.

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

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

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

- (viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community [~~except individuals ages twenty-two (22) to sixty-four (64) who reside in an IMD or~~ individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) Levels of case management.

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) Excluded services. SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

- (B) Managing finances;
- (C) Providing specific services such as shopping or paying bills;
- (D) Delivering bus tickets, food stamps, money, etc.;
- (E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;
- (F) Filling out forms, applications, etc., on behalf of the member when the member is not present;
- (G) Filling out SoonerCare forms, applications, etc.;
- (H) Mentoring or tutoring;
- (I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;
- (J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;
- (K) Monitoring financial goals;
- (L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

- (A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;
- (B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
- (C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;
- (D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;
- (E) Members receiving services in the health home program;
- (F) Members receiving case management through the ADvantage waiver program;
- (G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
- (H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); or
- (I) Members receiving Early Intervention case management (EICM);
- (J) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
- (K) Members receiving partial hospitalization services; or

(L) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;

(B) Person(s) to whom services are rendered;

(C) Start and stop times for each service;

(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];

(E) Credentials of the service provider;

(F) Specific service plan needs, goals, and/or objectives addressed;

(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;

(H) Progress and barriers made towards goals, and/or objectives;

(I) Member/family (when applicable) response to the service;

(J) Any new service plan needs, goals, and/or objectives identified during the service; and

(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

- (1) Employment services;
- (2) Personal care services;
- (3) Childcare
- (4) Respite services; and
- (5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

- ~~(1) Members receiving care in an IM);~~
- ~~(2)~~ (1) Members residing in a nursing facility or ICF/IID;
- ~~(3)~~ (2) Inmates of a public correctional institution; and
- ~~(4)~~ (3) SoonerCare members being served by a PACE provider.

(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.