

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-25. Oklahoma Foundation for Medical Quality

All inpatient services are subject to post-payment utilization review by the Oklahoma Foundation for Medical Quality (OFMQ). These reviews will be based on severity of illness and intensity of treatment.

(1) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and or extended stay of a Medicaid recipient. If the OFMQ upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted in accordance with the Medicare time frame. Additional information submitted with the reconsideration request will be reviewed by the OFMQ who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(2) If the hospital or attending physician did not request reconsideration by the OFMQ, the OFMQ informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician informing of recoupment of Medicaid payment previously made on the denied admission.

(3) If an OFMQ review results in denial and the denial is upheld throughout the ~~appeal~~ review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed the patient can be billed.

PART 3. HOSPITALS

317:30-5-41. Coverage for adults

For persons 21 years of age or older, payment is made to

hospitals for services as described in this Section.

(1) **Inpatient hospital services.**

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(B) Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care hospitals will no longer be subject to the 24 days per person per fiscal year limit. Claims will be reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.

(C) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review

results in denial and the denial is upheld throughout the ~~appeal~~ review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(D) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(E) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.

(2) Outpatient hospital services.

(A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.

(B) **Level I - Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.

(C) **Level II - Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(i) with equipment capable of producing targeted quality evaluations; and

(ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all

services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).

(E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(F) **Laboratory.** Payment is made for medically necessary outpatient services.

(G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.

(H) **Ambulance.**

(I) **Pharmacy.**

(J) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.

(i) Payment is made for home health services provided in a patient's residence to all categorically needy individuals.

(ii) Payment is made for a maximum of 36 visits per year per eligible recipient.

(iii) Payment is made for standard medical supplies.

(iv) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(v) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.

(vii) Payment may be made to home health agencies for prosthetic devices.

(I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA-484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.

(II) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(III) Sterile tracheostomy trays are covered.

(IV) Payment is made for colostomy and urostomy bags and accessories.

(V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. CC-17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached.

(VI) Payment is made for ventilator equipment and supplies when prior authorized. CC-17 should be submitted to the Medical Authorization Unit.

(VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(K) **Outpatient hospital services, not specifically addressed.** Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.

(L) **Outpatient chemotherapy and radiation therapy.** Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(M) **Ambulatory surgery.**

(i) **Definition of Ambulatory Surgical Center.** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:

(I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;

(II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and

(III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.

(ii) **Certification.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) **Outpatient surgery services.** The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

(i) **Services included in the facility reimbursement rate.** Services included in the facility reimbursement rate are:

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or

reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(VII) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.

(ii) **Services not included in facility reimbursement rates.** The following services are not included in the facility reimbursement rate:

(I) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set "global" fee for a given surgical procedure.

(II) The sale, lease, or rental of durable medical equipment to facility patients for use in their homes. If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis

is intra-ocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(VI) Artificial legs, arms, and eyes. This equipment is not considered part of the facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(VII) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(iii) **Reimbursement - facility services.** The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups.

(iv) **Compensable procedures.** The HCPCS codes identify the compensable procedures and should be used in billing.

(O) **Outpatient hospital services for persons infected with tuberculosis (TB).** Outpatient hospital services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) **Mammograms.** Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up

mammograms.

(Q) **Treatment/Observation.** Payment is made for the use of a treatment room, or for the room charge associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Payment is not made for treatment/observation on the same day as an emergency room visit. Observation services are limited to one 24 hour period per incident. Observation services are not covered in addition to an outpatient surgery.

(R) **Clinic charges.** Payment is made for a facility charge for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

(3) **Exclusions.** The following are excluded from coverage:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(C) Reversal of sterilization procedures for the purposes of conception are not covered.

(D) Medical services considered to be experimental.

(E) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.

(F) Refractions and visual aids.

(G) Payment for the treatment of obesity.

(H) Charges incurred while patient is in a skilled nursing or swing bed.

PART 4. LONG TERM CARE HOSPITALS

317:30-5-62. Coverage by category

(a) **Adults.** There is no coverage for adults.

(b) **Children.** Payment is made to long term care hospitals for subacute medical and rehabilitative services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member.

(1) **Inpatient services.**

(A) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority,

or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent of the Oklahoma Health Care Authority to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Title XIX payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Title XIX payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the ~~appeal~~ review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(B) If a hospital or physician believes that an long term care facility admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient must be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(2) Utilization control requirements.

(A) Certification and recertification of need for inpatient care. The certification and recertification of

need for inpatient care must be in writing and must be signed and dated by the physician who has knowledge of the case that continued inpatient care is required. The certification and recertification documents for all Medicaid patients must be maintained in the patient's medical records or in a central file at the facility where the patient is or was a resident.

(i) **Certification.** A physician must certify for each applicant or recipient that inpatient services in a long term care hospital were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(ii) **Recertification.** A physician must recertify for each applicant or recipient that inpatient services in the long term care hospital are needed. Recertification must be made at least every 60 days after certification.

(B) **Individual written plan of care.**

(i) Before admission to a long term care hospital, an interdisciplinary team including the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

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

(II) the acuity level of the individual,

(III) Objectives,

(IV) 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 patient,

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

(VI) Plans for discharge.

(ii) The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

(iii) All plans of care and plan of care reviews must be clearly identified as such in the patient's medical records. All must be signed and dated by the physician and other treatment team members in the required review interval.

(iv) The plan of care must document appropriate patient and/or family participation in the development and implementation of the treatment plan.

(C) **Continued stay review.** The facility must complete a continued stay review at least every 90 days.

(i) The methods and criteria for the continued stay review must be contained in the facility utilization review plan.

(ii) Documentation of the continued stay review must be clearly identified as such, signed and dated by the committee chairperson, and must clearly state the continued stay dates and time period approved.

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.2. Coverage for children

The following apply to coverage for inpatient services for persons under age 21 in acute care hospitals, freestanding psychiatric hospitals and residential psychiatric treatment facilities:

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agent designated by the Oklahoma Health Care Authority. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.

(A) **Length of stay.** The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in (2)(A)-(G) of this subsection.

(B) **Facility placements.** Out of state placements must be approved by the agent Designated by OHCA and subsequently approved by OHCA Medicaid/Medical Services Division. Requests for admission to Residential Treatment Centers or Acute Care Units will be reviewed for consideration of level of care, availability, suitability and proximity of suitable services. 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 Oklahoma Medicaid provisions as part of the per-diem rate.

(2) **Inpatient services.**

(A) **Inpatient service limitations.** Inpatient psychiatric services in all hospitals and residential psychiatric treatment facilities are limited to the approved length of stay. The Agent designated by OHCA will approve lengths of stay using the current OHCA Behavioral Health medical

necessity criteria and following the current gatekeeping manual approved by the OHCA. The approved length of stay applies to both hospital and physician services.

(B) **Medical necessity criteria for acute psychiatric admissions.** Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (i),(ii),(iii) and two of the (iv)(I) to (v)(III) of this subparagraph. Children 12 or younger must meet the terms or conditions contained in (i),(ii),(iii) and one of (iv)(I) to (iv)(IV), and one of (v)(I) to (v)(III) of this subparagraph.

(i) Any DSM-IV-R Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.

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

(iii) It has been determined by the Gatekeeper that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.

(iv) Within the past 48 hours the behaviors present an imminent life threatening emergency such as evidenced by:

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

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

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

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

(v) Requires secure 24-hour nursing/medical supervision as evidenced by:

(I) Stabilization of acute psychiatric symptoms.

(II) Needs extensive treatment under physician direction.

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

(C) **Medical necessity criteria for continued stay - acute psychiatric admission.** Continued stay - acute psychiatric admissions must meet all of the conditions set forth in (i) to (iv) of this subparagraph.

(i) Any DSM-IV-R axis 1 primary diagnosis with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

(ii) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.

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

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

(iii) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

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

(D) **Medical necessity criteria for admission - inpatient chemical dependency detoxification.** Inpatient chemical dependency detoxification admissions must meet the terms and conditions contained in (i),(ii),(iii), and one of (iv)(I)-(iv)(IV) of this subparagraph.

(i) Any psychoactive substance dependency disorder described in DSM-IV-R with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

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

(iii) It has been determined by the gatekeeper that the

current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

(iv) Requires secure 24-hour nursing/medical supervision as evidenced by:

(I) Need for active and aggressive pharmacological interventions.

(II) Need for stabilization of acute psychiatric symptoms.

(III) Need extensive treatment under physician direction.

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

(E) Medical necessity criteria for continued stay - inpatient chemical dependency program. No continued stay in inpatient chemical dependency program is allowed. Initial certification for admission is limited to up to five days; exceptions may be made up to seven to eight days based on a case-by-case review.

(F) Medical necessity criteria for admission - residential treatment (psychiatric and chemical dependency). Residential Treatment Center admissions must meet the terms and conditions in (i) to (iv) and one of (v)(I)-(v)(IV), and one of (vi)(I)-(vi)(III) of this subparagraph.

(i) Any DSM-IV-R Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

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

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

(iv) Child must be medically stable.

(v) Patient demonstrates escalating pattern of self

injurious or assaultive behaviors as evidenced by:

(I) Suicidal ideation and/or threat.

(II) History of or current self-injurious behavior.

(III) Serious threats or evidence of physical aggression.

(IV) Current incapacitating psychosis or depression.

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

(I) Intensive behavioral management.

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

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

(G) **Medical necessity criteria for continued stay - residential treatment center.** Continued stay residential treatment center admissions must meet the terms and conditions contained in (i), (ii), (v), (vi), and either (iii) or (iv) of this subparagraph.

(i) Any DSM-IV-R Axis I primary diagnosis 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 Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.

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

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

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

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

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

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

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

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

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

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

(I) Intensive behavioral management.

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

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

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

(3) Pre-authorization and extension procedures.

(A) Pre-admission authorization for inpatient psychiatric services must be requested from the OHCA designated agent. The OHCA or designated agent will evaluate and render a decision within 24 hours of receiving the request. A Certificate of Need will be issued by the OHCA or its designated agent, if the recipient meets medical necessity criteria.

(B) Extension requests (psychiatric) must be made through the OHCA designated agent. All requests shall be made prior to the expiration of the approved extension following the guidelines in the Gatekeeping Manual. Extension requests for the continued stay of a child who has been in an acute psychiatric program for a period of 30 days will require an evaluation by the gatekeeper and/or OHCA designated agent to determine the efficacy of treatment. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 60 days will require a review of all treatment documentation completed by the OHCA designated agent.

~~(C) If a denial decision is made, a reconsideration request may be made directly to the OHCA designated agent within 10 working days of notification of the denial. The agent will return a decision within 10 working days from the time of receiving the reconsideration request. If the denial decision is up held, the denial can be appealed to the Oklahoma Health Care Authority within 20 working days of notification of the denial by the OHCA designated agent. Providers seeking prior authorization will follow OHCA's designated agent's prior authorization process~~

guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient.

(4) **Appeal and Review Procedures.** In the event a recipient disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The recipient's request for such an appeal must commence within 20 calendar days of the initial decision. Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. The provider has ten business days of receipt of the decision to request the contractor to reconsider its decision. The agent will return a decision within ten working days from the time of receiving the provider's reconsideration request. The reconsideration process will end on July 1, 2006.

~~(4)~~ (5) **Quality of care requirements.**

(A) **Admission requirements.**

(i) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with written explanation of the facility's policy regarding the following:

(I) Patient rights.

(II) Behavior Management of patients in the care of the facility.

(III) Patient Grievance procedures.

(IV) Information for contact with the Office of Client Advocacy.

(V) Seclusion and Restraint Policy.

(ii) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in Active Treatment. The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in Active Treatment while the patient remains in the care of the facility. The conditions include provisions of participation required for the continued Medicaid compensable treatment.

(B) **Individual plan of care.**

(i) "Individual plan of Care" means a written plan

developed for each recipient within four days of any admission to an inpatient program which includes:

- (I) the complete record of the DSM-IV five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission,
- (II) the current functional level of the individual,
- (III) treatment goals and measurable time limited objectives,
- (IV) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,
- (V) plans for continuing care, including review and modification to the plan of care, and
- (VI) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(ii) The individual plan of care:

- (I) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual patient and reflects the need for inpatient psychiatric care;
- (II) must be developed by a team of professionals as specified in (D) of this paragraph in collaboration with the recipient, and his/her parents, legal guardians, or others in whose care he/she will be released after discharge;
- (III) must establish treatment goals that are general outcome statements and reflective of informed choices of the patient served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;
- (IV) must establish measurable and time limited treatment objectives that reflect the expectations of the patient served and parent/legal guardian as well as being age, developmentally and culturally appropriate. The treatment objectives must be achievable and understandable to the patient and the parent/guardian. The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

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

(VI) must include specific discharge and after care plans that are appropriate to the patient's needs and effective on the day of discharge. At the time of discharge, after care plans will 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 recipient into their family school, and community.

(VII) must be reviewed at least every seven days by the team specified to determine that services are being appropriately provided and to recommend changes in the individual care plan as indicated by the recipient=s overall adjustment, progress, symptoms, behavior, and response to treatment;

(VIII) development and review must satisfy the utilization control requirements for physician recertification and establishment of periodic reviews of the individual plan of care; and,

(IX) and each individual plan of care review must be clearly identified as such and be signed and dated by the physician, licensed mental health professional, patient, parent/guardian, registered nurse, and other required team members. Individual plans of care and individual plan of care reviews not completed and appropriately signed will merit a penalty recoupment or will render those days non-compensable for Medicaid.

(C) **Active treatment.** Inpatient psychiatric programs must provide "Active Treatment". "Active Treatment" involves the patient and their family or guardian from the time of an admission throughout the treatment and discharge process. "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. "Active Treatment" consists of integrated therapy components that are provided on a regular basis and will remain consistent with the patient's ongoing needs for care. The following components meet the minimum standards required for AActive Treatment@, although an individual child=s needs for treatment may exceed this minimum standard:

(i) Individual treatment provided by the physician. Individual treatment provided by the physician, is required three times per week for acute care and one time a week for residential care. Weekly residential treatment provided by the physician will never exceed 10 days between sessions. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(ii) Individual therapy. Individual therapy is defined as a method of treating existing primary mental health disorders and/or any secondary alcohol and other drug (AOD) disorders using face to face, one on one interaction between a Mental Health Professional (MHP) and a patient to promote emotional or psychological change to alleviate disorders. MHP=s 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 patient=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 patient=s plan of care and the patient=s developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a mental health professional as described in OAC 317:30-5-240(c). One hour of family therapy may be substituted for one hour of individual therapy at the treatment teams discretion.

(iii) Family therapy. Family therapy is defined as interaction between a MHP, patient and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The focus of family therapy must be directly related to the goals and objectives on the individual patient=s plan of care. Family therapy must be provided one hour per week for acute care and residential treatment. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a mental

health professional as described in OAC 317:30-5-240(c).

(iv) Process group therapy. Process group therapy is defined as a method of treating existing primary mental health disorders and/or any secondary AOD disorders using the interaction between a mental health professional as defined in OAC 317:30-5-240(c), and two or more patients to promote positive emotional or behavioral change. The focus of the group must be directly related to goals and objectives on the individual patient=s plan of care. The individual patient=s behavior and the focus of the group must be included in each patient=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 hours per week in acute care and two hours per week in residential treatment by a mental health professional as defined in OAC 317:30-5-240(c). In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(v) Expressive group therapy. Expressive group therapy is defined as art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies. Through active expression, inner-strengths are discovered that can help the patient 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 patient=s plan of care. Documentation must include how the patient 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. Expressive group therapy must be provided four hours per week in acute care and three hours per week in residential treatment. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(vi) Group Rehabilitative treatment. Group rehabilitative treatment is defined as behavioral

health remedial services, as specified in the individual treatment plan which are necessary for the treatment of the existing primary mental health disorders and/or any secondary AOD disorders. 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. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(vii) Individual rehabilitative treatment. Individual rehabilitative treatment is defined as a face to face service which is performed to assist patients who are experiencing significant functional impairment due to the existing primary mental disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living. 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 patient's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(D) Credentialing requirements for treatment team members.

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

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

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

(E) **Treatment team.** An interdisciplinary team of a physician, mental health professionals, registered nurse, patient, parent/legal guardian, and other personnel who provide services to patients in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be capable of:

(i) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities,

(ii) Assessing the potential resources of the recipient's family, and actively involving the family in the ongoing plan of care,

(iii) Setting treatment objectives,

(iv) Prescribing therapeutic modalities to achieve the plan objectives, and

(v) Developing appropriate discharge criteria and plans.

(F) **Medical, psychiatric and social evaluations.** The patient's medical record must contain complete medical, psychiatric and social evaluations.

(i) The evaluations must be completed as follows:

(I) History and physical evaluation must be completed within 60 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N.P., or P.A.).

(II) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O.

(III) Psychosocial evaluation must be completed within seven days of admission by a licensed

independent practitioner (M.D., D.O., A.P.N.P., or P.A.) or a mental health professional as defined in OAC 317:30-5-240(c).

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

(iii) Each of the evaluations must be completed when the patient changes levels of care if the existing evaluation is more than 30 days from admission. Evaluations remain current for 12 months from the date of admission and must be updated annually.

(G) Nursing services (inpatient psychiatric acute only).

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 patient. A registered nurse must document patient progress at least weekly. The progress note must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the patient's progress as it relates to the treatment plan goals and objectives.

(H) Seclusion and restraint incident reporting requirements. The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(i) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(ii) Information regarding the Medicaid recipient involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to patient outcome, staff debriefing and programmatic changes implemented (if applicable).

(iii) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).

(iv) Patient death must be reported to the OHCA as well as to the Center for Medicare/Medicaid Regional office in Dallas, Texas.

(v) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care (Section 5, Quality of Care), or

using other methodologies.

(I) **Other required standards.** The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, JCAHO/AOA standards for Behavioral Health Care, State Department of Health Hospital Standards for Psychiatric Care, and State Department of Human Services Licensing Standards for Residential Treatment Facilities. Residential treatment facilities may substitute CARF accreditation in lieu of JCAHO or AOA accreditation.

~~(5)~~ (6) **Documentation of records.**

(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:

- (i) date;
- (ii) start and stop time for each session;
- (iii) signature of the therapist and/or staff;
- (iv) credentials of the therapist;
- (v) specific problem(s) addressed (problems must be identified on the plan of care);
- (vi) method(s) used to address problems;
- (vii) progress made towards goals;
- (viii) patient=s response to the session or intervention; and
- (ix) any new problem(s) identified during the session.

(B) Signatures of the patient, parent/ guardian, doctor, MHP, and RN are required on the Master Plan of Care and all plan of care reviews. The plan of care and plan of care review are not valid until signed and separately dated by the patient, parent/legal guardian, doctor, RN, MHP, and all other requirements are met.

~~(6)~~ (7) **Inspection of care.**

(A) There will be an on site inspection of care of each psychiatric facility that provides care to recipients which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team. This team will consist of a Licensed Mental Health Professional, a Registered Record Administrator, and a Registered Nurse. At the team=s discretion, an additional Mental Health Professional may be substituted for the Registered Record Administrator. The inspection will include observation

and contact with recipients. The Inspection of Care Review will consist of recipients present or listed as facility residents at the beginning of the Inspection of Care visit as well as recipients on which claims have been filed with OHCA for acute or RTC levels of care. The review includes validation of certain factors, all of which must be met for the Medicaid Services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. Deficiencies may result in a monetary penalty, (partial per-diem) or a total (full per-diem) recoupment of the compensation received. If the review findings have resulted in a penalty status, a penalty (partial per-diem) of \$50.00 per event and the days of service involved will be reported in the notification. If the review findings have resulted in full (full per-diem) recoupment status, the non-compensable days of services will be reported in the notification. In the case of non-compensable days (full per-diem) or penalties (partial per-diem) the facility will be required to refund the amount.

(B) Penalties or 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 Medicaid compensable or billable to the patient or the patient's family.

(C) If a denial decision is made, a reconsideration request may be made directly to the OHCA designated agent within 10 working days of notification of the denial. The agent will return a decision within 10 working days from the time of receiving the reconsideration request. If the denial decision is up held, the denial can be appealed to the Oklahoma Health Care Authority within 20 working days of notification of the denial by the OHCA designated agent.