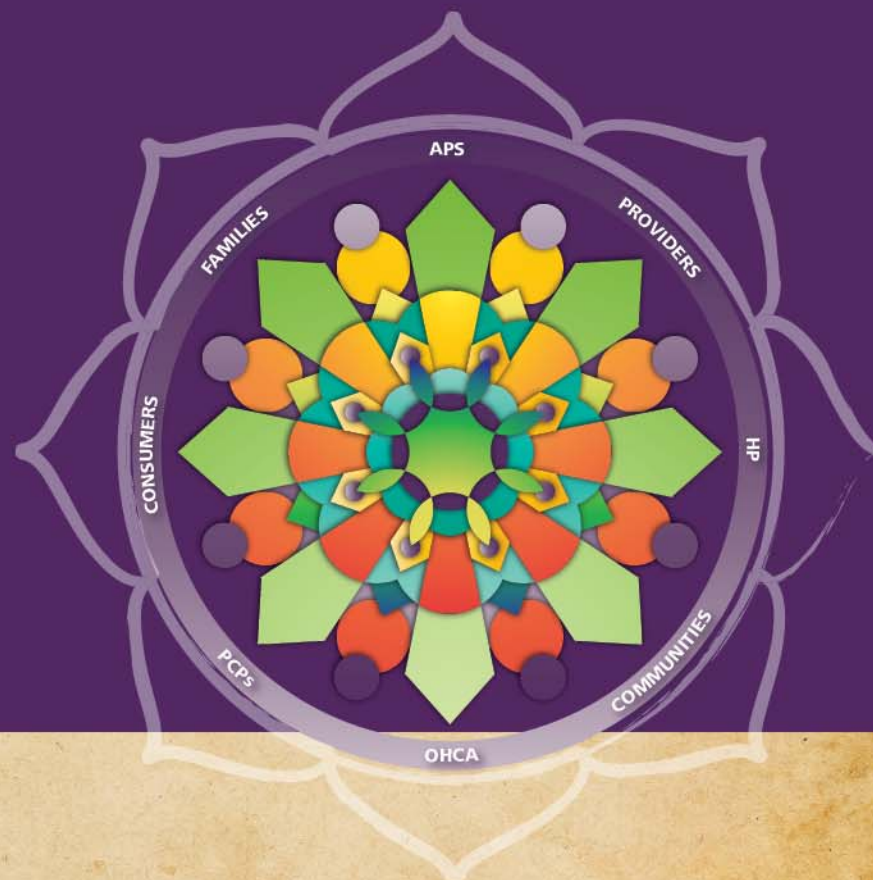


# 4<sup>th</sup> ANNUAL COLLABORATIVE BEHAVIORAL HEALTH PROVIDER TRAINING

April 7<sup>th</sup> and 8<sup>th</sup>, 2011



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# Inpatient Behavioral Health and Inspection of Care Update

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- As prior authorization procedures place emphasis on hospital diversion, all calls for initial acute and RTC prior authorization will be assessed for the appropriate level of services.
- If either the clinical information or availability of programs indicates the child's needs cannot be addressed by a lower level of care, then the clinical information will be evaluated for the appropriate hospital based level of care, (i.e. acute or RTC).





- The physician consultant for APS will review all the inpatient referrals for children under the age of 5.



# On-line Eligibility



Check the OHCA Recipient Eligibility Verification System (REVS) at 1-800-767-3949.

For instructions on using REVS, call 1-800-522-0310.

Providers can also check eligibility through the HP provider secure website with their 8-digit pin number.

Call the Provider Helpline at 1-800-522-0114 for assistance.





## Displays on Eligibility pages

- Title XIX is a Medicaid eligibility category.
- MHSAS is NOT a Medicaid eligibility category.
- In the future, there may be other eligibility displays on that page for other Oklahoma benefits.
- Call (REVS) at 1-800-767-3949 any time you see an eligibility that you do not recognize. Do NOT assume that it is a benefit program for OHCA.



# Care Connection Template Problems

## Section requesting:



- **Caller Name and Phone Number**
  - This should be the name and telephone number of the person that APS should contact for the telephonic review
- **Family-Guardian Participation in Admission Assessment**
  - This should be what family members were present at the time of the assessment and whether or not they participated in the assessment. (not a yes or no answer)





## Template Sections regarding:

- **Evidence of Active Treatment**
  - Describe the treatment that is being provided, please do not just put IT, FT, GT
- **Realistic Discharge Criteria/Date**
  - Put the date that the treatment team has decided would be a realistic discharge for the particular individual, not the average length of stay for a program.
- **Discharge Plan**
  - Put the specific plan, not “discharge to outpatient services”



# Discharge Planning



- Discharge planning is the responsibility of the provider and should begin at the time of admission.
- Discharge information should be documented in the patient record and Care Connection as soon as possible and no later than two weeks prior to discharge that includes dates and times of the appointments.
- Appointments should be no longer than 7 days of discharge.
- Reasons for outlier appointment times should be documented in the member's chart.





## Discharge planning continued

- If an outpatient provider insists that the appointment be made by the parent, then schedule the appointment together during family therapy.
- The provider must call APS (1-800-762-1560, Option 7) on the morning of discharge from the RTC to notify of the discharge.
- When a member is discharged from the acute or RTC level of care to outpatient services, the RTC provider must enter the discharge in Care Connection once the SoonerCare member has left the facility.



# Discharge Barriers



- Lack of available local resources
- Lack of communication between local behavioral health providers in the area
- Lack of family commitment to follow through with discharge plans
- Agencies not accepting new clients or placing clients on a wait list
- Lack of facility communication
  - Resources identified at admission not passed on to therapist and/or care manager



- Follow up appointment not formalized prior to the discharge which results in an interruption in therapy and medication management
- Educational information not communicated to receiving school system
- Timeliness and ability to transition to a lower level of care
- Recidivism is a concern when discharges occur without a comprehensive discharge plan



# APS Discharge Procedure for Acute and RTC



- Call APS with discharge notification on the morning of planned discharge
- Enter the information into Care Connection with the discharge information including provider telephone numbers
- Push the discharge button on Care Connection once the child has left
- Against Medical Advice (AMA) discharges and follow up



# Denial Options

Effective July 1, 2011



Available to acute, RTC, Therapeutic Foster Care (TFC), and Children's Crisis Centers (CCU) Providers

- Provider has 24 hours from initial denial to provide additional clinical information.
- If the information is not provided, the denial stands.
- If additional information is given, it is reviewed with the APS physician.
- If the additional clinical information still does not meet medical necessity criteria (MNC), the APS physician will reaffirm the denial.



# Doctor to Doctor Reviews



- At this point, the treating facility physician may request a Doctor to Doctor telephonic review.
- The Doctor to Doctor telephonic review must be requested and scheduled to occur within 24 business hours of the initial APS physician denial.





# Doctor to Doctor Review

- If the Doctor to Doctor telephonic review is not requested, the denial will be considered upheld and final
- If the Doctor to Doctor telephonic review is not held within 24 business hours of the initial denial the APS Physician Advisors' denial will be considered final
- Allowances: reviews outside the timeframe will be made in extraordinary circumstances





# Doctor to Doctor Review

- The APS Physician may:
  - Uphold the original non-certification decision,
  - Approve the full request, or
  - Approve a partial request
  
- The APS Physician's determination is final, and may only be appealed as specified in the OHCA Behavioral Health Provider Manual





# Inpatient Inspection of Care

- Audited 33 facilities (to date)
  - 31 Instate
  - 2 out of state
- Average score: 65
  - Last year 73
- Range 39-79
  - Last year 41- 91





# In-state Providers

- 11 acute

Average score: 64

Last year: 74

Range: 49-71

Last year: 60-79

- 19 RTC

Average score: 73

Last year: 65

Range: 39-79

Last year: 41-91



# Out of State Providers



- 1 acute  
Score: 65
- 2 RTC
  - 63-67, Average: 65
- Last year
  - 5 RTC
  - Average Score:73
  - Range: 59-84



# IOC Findings--Assessments



- Assessments found that do not clearly support the need for that level of care (LOC)
- Assessments found that do not include history, exploration of signs/ symptoms, supporting diagnosis or timelines of admitting behaviors
- Clinical information in record does not support need for continued LOC
- Clinical information in record not congruent with information in CareConnection



# IOC Findings-Process Group Therapy



- Process Group Therapy ( PGT)—must be conducted by a LBHP
  - Documentation highly variable, from detailed, informative notes to little information on group purpose and patient’s response.
  - Must meet documentation/ content requirements or will be recoupable
  - See lots of PGT with the same generic group description for every session of PGT.
  - Responses are basically “attended/ participated”
  - Some PGT appear to be more RT like



# Inspection of Care Findings

- Documentation of Expressive and Rehab Therapy
  - Must meet activity and documentation requirements or will be recoupable.
  - Per OAC regs: documentation must be for each individual session of active treatment. Weekly summaries are not acceptable.
  - Often documentation does not reflect actual treatment goals of patient or therapeutic purpose of group.





## IOC Findings-continued

- Overall, improvement noted in Expressive Therapy (ET) notes
  - Need for therapeutic focus of group/ activity and response
- Rehab Therapy (RT) notes still problematic
  - Still see: cleaned unit; volleyball; free time; movie; attended and participated; social skills (no other information)
- IOC will continue to monitor ET and RT



# What to do when a therapy session is missed!



- An individual session may be provided to make up for a missed group session.

*However*----the problem is usually

- Make-up sessions are rarely documented or the make-up session lacks processing.
- Notes should be concrete, behaviorally descriptive, and related to identified treatment issues of the patient.





# IOC Findings-continued

- If treatment is for mental health issues co-occurring with substance abuse, then the medical record must indicate active treatment primarily for documented the mental health diagnosis
- Could result in a full day recoupement
- Sooner Care treatment hour is a full sixty (60) minutes.





# IOC Findings-continued

- Passes not included on Individual Plan of Care (IPC) with treatment goals identified and without safety plans developed.
- Incongruent medications and diagnosis without supporting documentation
- Diagnosis on IPC does not agree with Psychiatric Evaluation or diagnosis not changed on IPC as physician changes it (focus of treatment/ re-evaluation)
- Diagnoses- Primary Axis I: Rule out, “V” codes, by history or substance abuse are not allowed--Full day recoupment
- Pervasive developmental disorders/ mental retardation: lack documentation of escalating behaviors or mental health diagnosis to support need for inpatient treatment





# IOC Findings-continued

- Clinical documents for any service provided by someone under supervision for licensure as a behavioral health professional (LBHP), must be co-signed by an LBHP that is a part of the treatment team
- Treatment team signatures on treatment plans must be dated for the date that the team member actually signs.
  - Typed dates and “one date fits all” will not be accepted.
  - Legibility of staff name and credentials

Discharge planning needs to be continually updated on Individual Plan of Care





# IOC Findings-continued

- Active treatment must meet documentation and content requirements in OAC 317.
- Modifications due to child's needs/ functional ability (PDD, MR, learning disabled, dyslexia, other communication problems such as receptive or expressive language, etc)
- Overlapping documentation of services will result in recoupement



# Inspection of Care



- Beginning July 1, 2011, Inspections of Care will be completed on
  - Acute psychiatric units
  - Psychiatric Residential Treatment Facilities
  - RBMS Group Homes, Level D and E
  - Facility Based Crisis Stabilization Centers
  - Therapeutic Foster Care Agencies

Specifics in regard to the IOC for Group homes and Facility Based Crisis Stabilization Centers will be developed soon. Call Jolene at 405-522-7446 if you would like to participate in this project.



# Therapeutic Foster Care Inspection of Care Scores



- Audited 9 agencies (to date)
- Average score:68
- Range: 49-78



# TFC IOC Findings



- Lack of information on transfers from other TFC agencies or step downs from inpatient care
- Assessments not supporting need for TFC
  - Little more than “sounds like” information and does not clearly indicate a face to face assessment
  - Little documentation of adjustment of treatment to meet developmental or learning disabilities needs
- Lack of documentation of planned therapeutic passes and respite care

# TFC Findings



- Individual Plan of Care (IPC) not clearly detailing active treatment frequency and the needs for individual, family, master's or rehab group
- IPC not clearly detailing/ updating Basic Living Skills or Social Skills needs/ progress
- Basic Living and Social Skills documentation: little or no information on response, progress (can lead to partial recoupment)



## TFC Findings-continued:

- Some TFC agencies still do not have Therapeutic Foster Parents education documentation (diploma or GED)
- Lack of documentation of crisis services when emergency respite or inpatient/crisis unit care result
- Lack of discharge planning, coordination
- Need to enter discharge and aftercare information in CareConnection





**A case may be staffed with an APS physician for treatment recommendations or possible decertification during the IOC if the medical record:**

1. does not support medical necessity criteria for admission or continued stay,
2. does not indicate active treatment,
3. appears the child has maximized benefit of treatment or
4. the stay appears to be placement.



# Therapeutic Passes

## RTC and TFC



- Passes for overnight may be authorized when they are based on the clinical need of the child for a successful transition back into the home and/or community.
- Planned therapeutic passes should be a part of the Individual Plan of Care that includes goals and objectives that the client and family will be working on during the pass.
- Crisis or safety plans should also be developed and discussed with all parties prior to the pass.
- The provider should have a plan to have contact with the family during the visit to discuss any problems or concerns or to suggest interventions.





- Tremendous increase in referrals for TFC when the child has not ever received any outpatient behavioral health services.
- Calocus Assessment will eliminate the need to drive a long distance before knowing if a child meets OHCA's medical necessity criteria.





- Prior authorization questions should be directed to APS at 800-762-1560.
- Billing questions should be directed to the OHCA Provider Helpline at 1-800-522-0114.
- Policy questions should be directed to Jolene Ring at 405-522-7446.



# Important Websites



- Oklahoma HealthCare Authority Website: [OKHCA.org](http://OKHCA.org)
- APS Website: [APShealthcare.com](http://APShealthcare.com)
- Soonerpro Website: <http://www.soonerpro.com>
- Sooner Help Desk:  
[soonerprohelpdesk@apshealthcare.com](mailto:soonerprohelpdesk@apshealthcare.com)
- CareConnection Website:  
<https://careconnectionok.apshealthcare.com>





***Thank you for your diligence and  
patience this past year in your  
service to the children of Oklahoma.***



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*Questions?*

