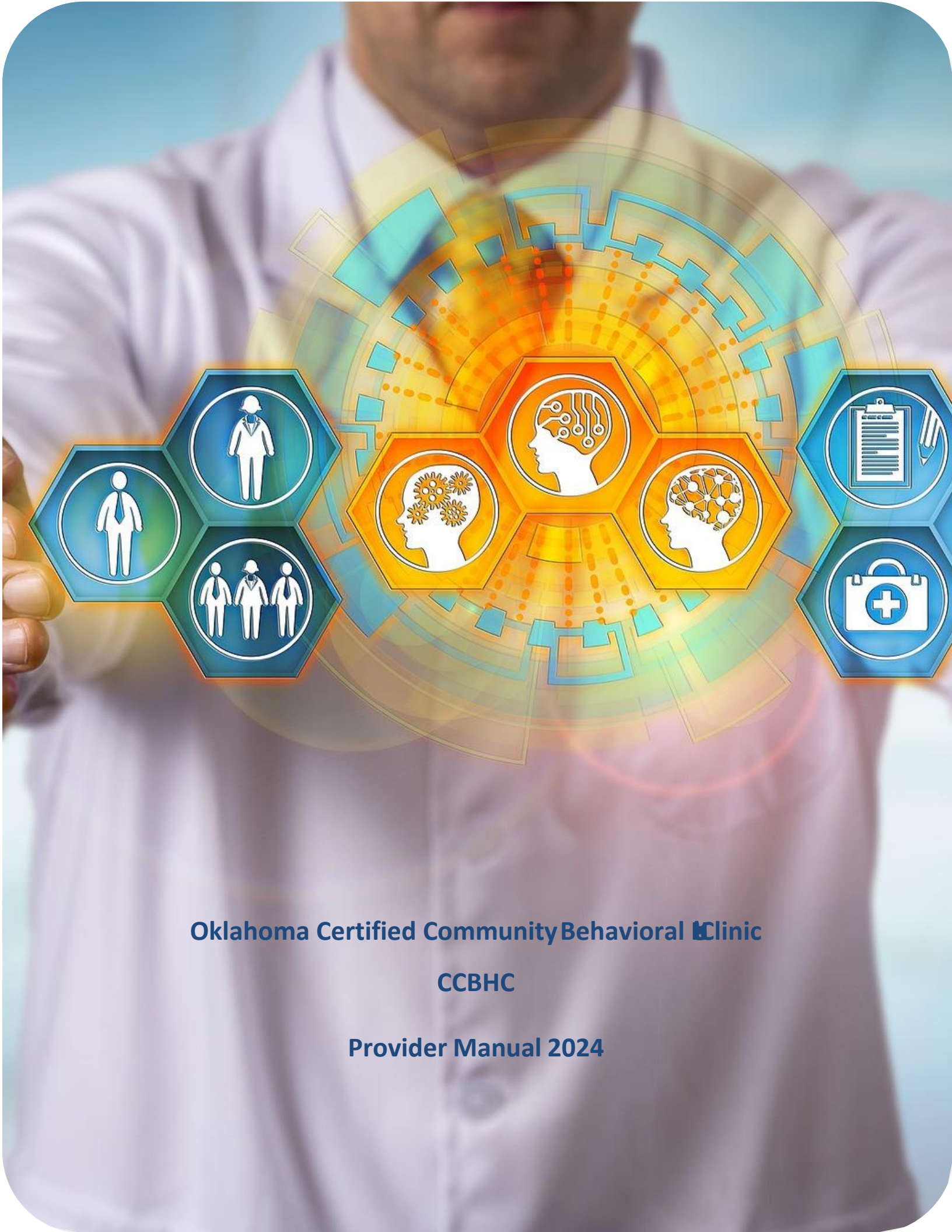

Oklahoma Certified Community Behavioral Health Clinic

CCBHC

Provider Manual 2024

This manual is intended as a reference document for Oklahoma Department of Mental Health and Substance Abuse certified providers with contracts for CCBHC Services. It contains requirements for provision, reimbursement, and reporting of CCBHC services, and is intended to complement existing policy. Although every effort is made to keep this Manual up to date, the information provided is subject to change.

SERVICE QUESTIONS - WHO TO CONTACT

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OKLAHOMA
Mental Health &
Substance Abuse

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THE OKLAHOMA 2024 CCBHC MANUAL INCLUDES SAMHSA CCBHC CRITERIA. NEW SAMHSA CRITERIA WITH PROGRAMMATIC CHANGES ARE MARKED WITH BLUE FONT.

PLEASE SEE SAMHSA REDLINE CRITERIA DOCUMENT Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA FOR FULL DETAILS.

CCBHCS MUST BE COMPLIANT WITH NEW CRITERIA BY JULY 1, 2024.

Background

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (H.R. 4302) was enacted, laying the ground-work for the establishment of Certified Community Behavioral Health Clinics or CCBHCs. CCBHCs are a comprehensive community behavioral health provider that provides an opportunity to improve the behavioral health system by increasing access to high quality, integrated care. Section 223 of the law authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) under the United States Department of Health and Human Services to develop certification criteria for CCBHCs, provide guidance to states on developing a prospective payment system (PPS) to reimburse CCBHCs, administer one year planning grants to states interested in developing a proposal for the two year program demonstration, and report findings and recommendations to Congress on CCBHC.

In October of 2015 the State of Oklahoma was awarded a one-year planning grant from SAMHSA and CMSto develop a proposal and program demonstration for the provision of CCBHC. Under the planning grant theState was charged with collaborating with key stakeholders, certifying at least two clinics as CCBHC per SAMHSA's guidelines, assisting clinics with meeting certification standards through training and technical assistance, developing a PPS methodology, and collecting and reporting data in preparation to participate inthe national evaluation.

The State of Oklahoma was successful in the planning grant period. Oklahoma submitted a proposal and was awarded a two-year demonstration grant starting in 2016. Oklahoma began CCBHC with three providers as part of the demonstration. As the end of the demonstration drew near, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to support CCBHC services in the state. CCBHC represent an opportunity for states to improve the behavioral health of their citizens by providingcommunity-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing service. CCBHCs must provide a broad arrayof services and care coordination across settings and providers on a fullspectrum of health, including acute, chronic, and behavioral health needs.The CCBHC model of care requires integrating mental health, substance use disorder, and physical health services at one location.

Values and Core Principles

To ensure enhancement of current behavioral health system, CCBHCs must adhere to the following values and core principles of services.

- Coordination and Collaboration: Care Coordination activities should be the foundation of CCBHC, along with efforts to foster individual responsibility for health awareness. These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships with the individual, family and other key natural supports and outside service providers. Services should be integrated – addressing both physical and behavioral health needs of individuals.

- Accessible and Available: Services should be flexible and mobile and adapt to the specific and changing needs of each individual. CCBHCs should use non-four walls service delivery model, along with therapeutic methods and recovery approaches which best suit each individual's needs.

- Evidenced Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.

- Person Centered Care: Person-centered care involves the individual seeking services to the maximum extent possible,reflecting the individual's goals and emphasizing shared decision-making approaches that empowers, provide choice, and minimize stigma. Services should be self-directed, include family members and other key natural supports, emphasize wellness and attention to the person's overall wellbeing, and promote full community inclusion.

- Family Driven Care: Services that are family-focused emphasizes the important role of family in the service planning and delivery process for children. Family driven care promotes the wellbeing and developmental needs of the child, and supports relationships among the child, family, and service providers.

- Recovery Oriented: Recovery oriented services should incorporate "a process of change through which individuals improve their lives and wellness, live a self-directed life, and strive to reach their full potential". Guiding principles of recovery include hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/ responsibility, respect (Substance Abuse and Mental Health Services Administration [2012]).

- Trauma Informed: Trauma informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches. Trauma informed services and programs are more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA 2014).

- Data Driven: Providers should use data to determine outcomes, monitor performance, and promote health and wellbeing. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Purpose

The purpose of Oklahoma CCBHCs is to:

1) provide access to integrated services for all individuals regardless of pay source or ability to pay.
2) provide a full array of mental health and substance use disorder services available in every certified location, and provide, or coordinate with, primary care services.
3) provide quality driven services as demonstrated through data reports and outcomes reports generated by ODMHSAS or its contractor; and
4) provide enhanced integration and coordination of mental health, primary, and substance use disorder services and supports for persons across the lifespan. Services and supports will be delivered utilizing an inter-disciplinary, team-based approach.

Onboarding

Transforming a community mental health center into a Certified Community Behavioral Health Clinic (CCBHC) will require intensive commitment, flexibility, and teamwork. The leadership team must be working very closely together and will also need to ensure input from persons served and all staff.
Oklahoma's Community Mental Health Centers are already held to high standards by the ODMHSAS, and already meet many of the CCBHC criteria. However, there are important structures that must change and services that must expand. Below is a list of milestones your agency will need to achieve during your development year. You will need to ensure that you are:

- Integrating all of your programs and staff. Staff will begin working in integrated teams; implementing principles of Team Based Care across agency.
- Serving entire lifespan, including children zero to five, youth, adults, and older adults. This will require adding specialized staff and providing evidence- based training.
- Ensure integrated health and care coordination for all persons served, including primary care screening, and monitoring, and utilizing risk stratification to ensure appropriate care for those at greatest risk for adverse health outcomes.
- Develop a representative board Including clients, persons in recovery, and family members beginning with the needs assessment forward.
- Changing care planning procedures to ensure integration of all outpatient mental health, substance use disorder services, and primary care services. This includes: 1) perform an initial evaluation and care plan within 10 days of first contact to meet presenting needs and other immediate or urgent needs; 2) within 30 days, conduct mental health assessments, 3) within 60 days, develop a Comprehensive Care Plan; 4) update the Comprehensive Care Plan (CCP) as needed, and conduct a CCP update at every 6 months.
- Compiling and reporting cost report data to develop clinic specific rates.
- Collecting, analyzing, and reporting data measures, including CCBHC quality measures.

In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and State Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

Program Requirement 1: Staffing

This program requirement describes:
a. General staffing requirements, community needs assessment, and staffing plan
b. Licensure and credentialing of providers
c. Training related to cultural competence, trauma-informed care, and other areas
d. Linguistic competence

Criteria 1.A: General Staffing Requirements

1.a.1 As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix B: SAMHSA Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. Certifying states may specify additional community needs assessment requirements.

1.a.2 The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.

Note: See criteria 4.k relating to required staffing of services for veterans.

1.a.3 The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care.

1.a.4 The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers

1.b.1 All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.

1.b.2 The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core

workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed, or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced4 addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff.

The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

Examples of staff include a combination of the following:
(1) psychiatrists (including general adult psychiatrists and subspecialists),
(2) nurses,
(3) licensed independent clinical social workers,
(4) licensed mental health counselors,
(5) licensed psychologists,
(6) licensed marriage and family therapists,
(7) licensed occupational therapists,
(8) staff trained to provide case management,
(9) certified/trained peer specialist(s)/recovery coaches,
(10) licensed addiction counselors,
(11) certified/trained family peer specialists,
(12) medical assistants, and
(13) community health workers,
(14) behavioral health aid (for children)
(15) wellness coaches.

Note: *Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision.*

Criteria 1.C: Cultural Competence and Other Training

1.c.1 The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:

- Evidence-based practices
- Cultural competency (described below)
- Person-centered and family-centered, recovery-oriented planning and services
- Trauma-informed care
- The clinic's policy and procedures for continuity of operations/disasters
- The clinic's policy and procedures for integration and coordination with primary care
- Care for co-occurring mental health and substance use disorders

At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. Trainings may be provided on-line. Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.

Note: *See criteria 4.k relating to cultural competency requirements in services for veterans.*

1.c.2 The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.

1.c.3 The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.

1.c.4 Individuals providing staff training are qualified as evidenced by their education, training, and experience.

Criteria 1.D: Linguistic Competence

1.d.1 The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.

1.d.2 Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.

1.d.3 Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).

1.d.4 Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the

time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.

1.d.5 The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

Criteria 2.A: General Requirements of Access and Availability

This program requirement describes:

a. General requirements of access and availability
b. Requirements for timely access to services and assessment
c. Access to Crisis Management Services
d. Provision of services regardless of ability to pay and residence

2.a.1 The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.

2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.

2.a.3 Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.

2.a.4 The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.

2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.

2.a.6 Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.

Outreach in CCBHC:

- The CCBHC must have staff dedicated to outreach and engagement, who do not carry a caseload. Facility records will identify which staff members are responsible for specific elements of outreach and engagement.
- A CCBHC must conduct outreach activities to engage those clients who are difficult to find and engage, with an emphasis on the special population list also known as the "Most in Need" list that is determined and supplied to the CCBHC by the ODMHSAS.
- A CCBHC must have dedicated staff to work with The ODMHSAS on Care Coordination efforts for vulnerable populations.
- For those who are homeless, there should be at least two contact phone numbers for persons of the client's choice who know how to reach the client in the client's record, and/or a location most likely to find the client, and/or a location to find a person of the client's choice likely to know where the client is located.
- The CCBHC must have policies and procedures to describe how outreach and engagement activities will occur to assist clients and families to access benefits and formal or informal services to address behavioral health conditions and needs.

2.a.7 Services are subject to all state standards for the provision of both voluntary and court ordered services.

2.a.8 The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs, or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.

Criteria 2.B: General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation

2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up.

- If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made.
- If the triage identified routine needs, services will be provided, and the initial evaluation completed within 10 business days.
- For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed.

The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.

Note: *Requirements for these screenings and evaluations are specified in criteria 4.d.*

2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or applicable accreditation standards are more stringent.

2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.

Criteria 2.C: 24/7 Access to Crisis Management Services

2.c.1 In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.

2.c.2 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.

2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).

2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.

2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations.

Note: *See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.*

2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises.

Note: *See criterion 3.a.4 where precautionary crisis planning is addressed.*

Criteria 2.D: No Refusal of Services due to Inability to Pay

2.d.1 The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)); and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).

2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.

2.d.3 The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.

2.d.4 The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence

2.e.1 The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.

2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum,

- crisis response,
- evaluation,
- and stabilization services in the CCBHC service area regardless of place of residence.

The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking noncrisis services to the CCBHC or other clinics serving the individual's area of residence.

For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical.

These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCs may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability.

Criteria 3.A: General Requirements of Care Coordination

This section describes the requirements for:

a. General requirements of care coordination
b. Health information systems
c. Agreements to support care coordination
d. Treatment team, planning, and care coordination activities

Care Coordination is the cornerstone of behavioral healthcare integration. It involves actively bringing together various providers and information systems to coordinate health services, client needs and information to improve outcomes. It is the CCBHCs responsibility, as the primary provider of care to ensure the needs of the client are being addressed in a coordinated fashion. The CCBHC is responsible for care coordination with any other provider or facility providing any of the required CCBHC services.

3.a.1 Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services.

This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.

Note: *See criteria 4.k relating to care coordination requirements for veterans.*

3.a.2 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.

Note: *CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services.*

3.a.3 Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.

3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person.

To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.

3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.

3.a.7 The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.

Criteria 3.B: Care Coordination and Other Health Information Systems

3.b.1 The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.

3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.

3.b.3 The CCBHC uses technology that has been certified to current criteria under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs:

- Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).
- At a minimum, support care coordination by sending and receiving summary of care records.
- Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice.
- Provide evidence-based clinical decision support.
- Conduct electronic prescribing.

Note: *Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities.*

3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

3.b.5 The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.

Criteria 3.C: Care Coordination Partnerships

3.c.1 The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area:

- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
- Indian Health Service youth regional treatment centers
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services

CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following;

- Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders
- Suicide and crisis hotlines and warmlines
- Indian Health Service or other tribal programs
- Homeless shelters
- Housing agencies
- Employment services systems

- Peer-operated programs
- Services for older adults, such as Area Agencies on Aging
- Aging and Disability Resource Centers
- State and local health departments and behavioral health and developmental disabilities agencies
- Substance use prevention and harm reduction programs
- Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers
- Legal aid
- Immigrant and refugee services
- SUD Recovery/Transitional housing
- Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs
- Coordinated Specialty Care programs for first episode psychosis
- Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food, and transportation programs)

In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.4 The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

3.c.5 The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings.

This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. The CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged.

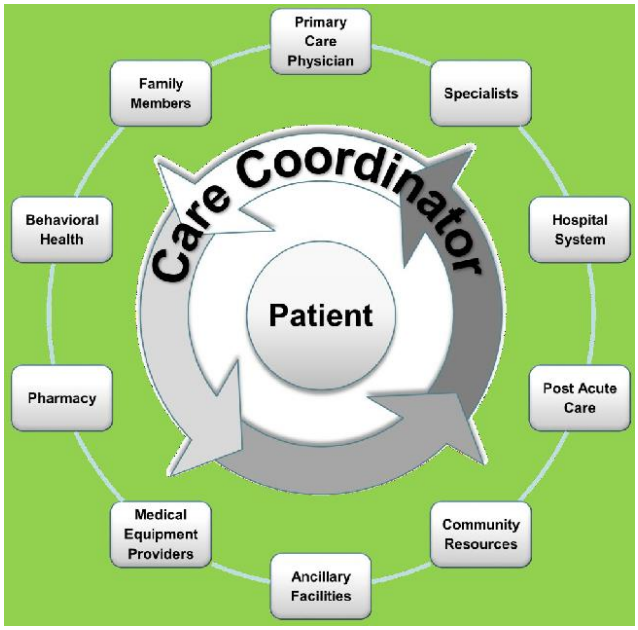
The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge.

For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk.

Note: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*

Examples of coordination of care include:

- Ensuring that every enrollee is aligned with a PCP through which care is coordinated.
- Partnerships or Formal Agreements with treating providers or service agencies.
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or otherqualified health care professional. This care coordination involves not only referral but follow up after referral to ensure that services were obtained, to gather the outcome of those services, and to identify next steps needed.
- Researching issues to provide education and address questions from patient, family, guardian, and/or caregiver.
- Reviewing HIE, Population Health Management and other information sources, such as dashboards and registries to improve health outcomes at the individual level.
- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, labs, home health agencies, etc.) utilized by the client.
- Monitoring and follow-up activities with treatment or service providers for the purposes of monitoring client attendance of scheduled physician, medication, therapy, rehabilitation, or other supportive service.
- Development of Clinical Pathways.
- Transitional Care including transitions from inpatient, residential or crisis centers, as well as transitions between levels of care within the agency and/or transitions from different age groups. The CCBHC will provide care coordination while the client is hospitalized as soon as it becomes known. A team member will go to the hospital setting to engage the client in person and/or will connect through telehealth as a face-to-face meeting. Reasonable attempts to fulfill this important in-person contact will be documented.
- Structured staffings including but not limited to team huddles, team meetings, and case conferences.
- Participation in high need staffings as organized by ODMHSAS Care Coordination Team, for Most in Need clients, partner state agency referrals and hospital discharges.



Care coordination in crisis, will be carried outin keeping with the client's preferences and needs for care, to the extent possible and in accordance with the client's expressed preferences, with the client's family/caregiver and other supports identified by the client. Thefacility will work with the client in developing a **crisis plan** with each client, such as a **Psychiatric Advanced Directive** or **WellnessRecovery Action Plan**. These plans should be available in the chartsfor review.

Criteria 3.D: Care Treatment Team, Treatment Planning, and Care Coordination Activities

3.d.1 The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

3.d.2 The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

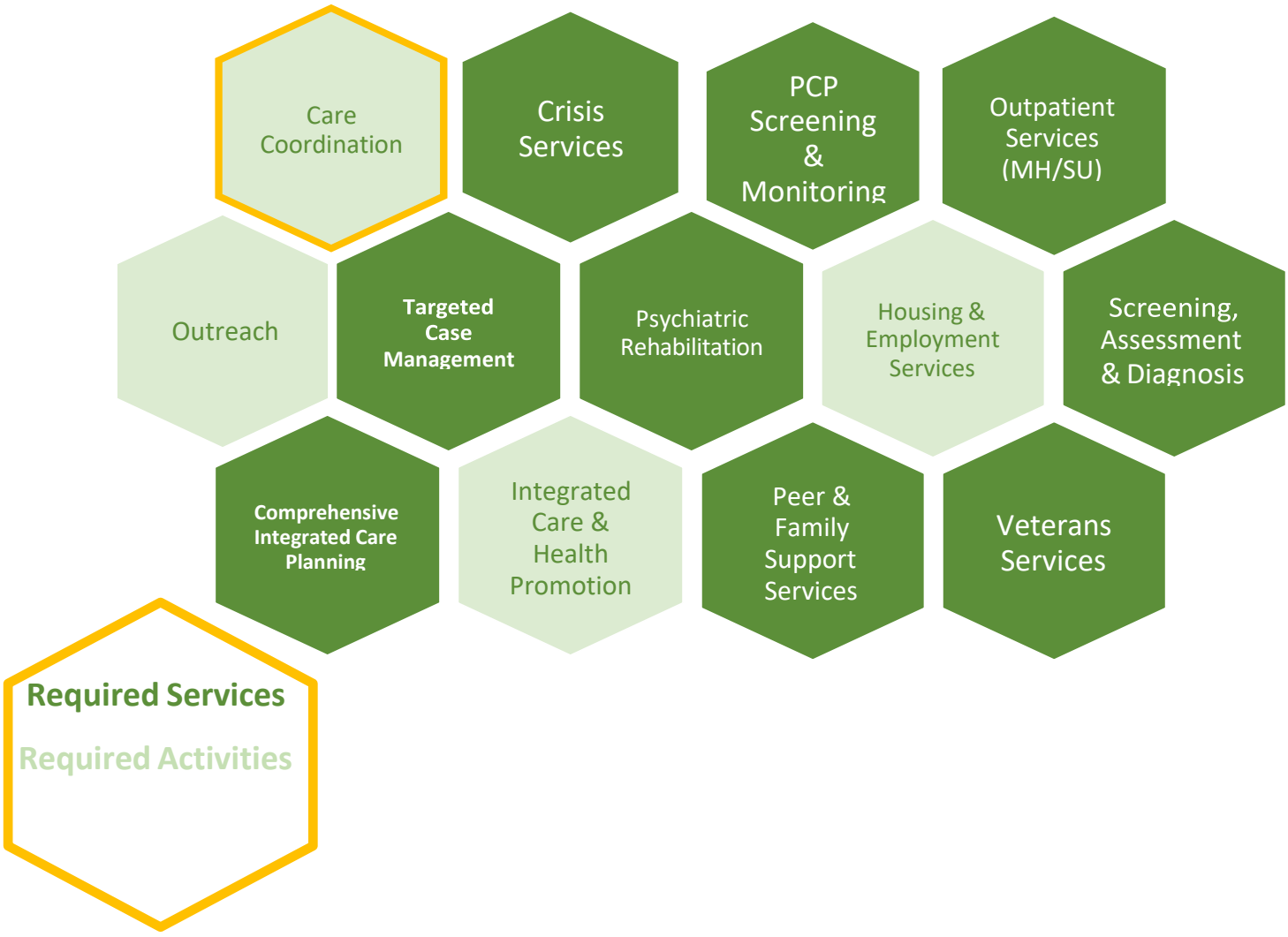
3. d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan.

Note: *See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.*

Criteria 4.A: General Service Provisions

This program requirement describes the nine services delivered by the CCBHC directly or through its DCOs, in a manner reflecting person-centered and family-centered care.

1. Crisis Services;
2. Screening, Assessment, and Diagnosis;
3. Person-Centered and Family-Centered Treatment Planning;
4. Outpatient Mental Health and Substance Use Services;
5. Primary Care Screening and Monitoring;
6. Targeted Case Management Services;
7. Psychiatric Rehabilitation Services;
8. Peer Supports and Family/Caregiver Supports;
9. Community Care for Uniformed Service Members and Veterans.



4.a.1 Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. The CCBHC organization will directly deliver the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.

4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.

4.a.3 With regard to either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.

4.a.4 DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

Oklahoma CCBHCs will follow SAMHSA's guidance on CCBHC scope of service. SAMHSA differentiates between "services' and "activities".

Oklahoma CCBHC Required Services include: crisis services, screening/assessment/diagnosis, care planning, outpatient mental health/substance use services, targeted case management, psychiatric rehabilitation services, peer/family support services and veteran's services. CCBHC Required Services trigger a PPS rate.

Oklahoma CCBHC Activities are activities that have the purpose of coordinating and managing the careand services furnished to each client, including both behavioral and physical healthcare, regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. CCBHC Activities are required and tracked for dataand outcomes, however CCBHC Activities alone do not trigger a PPS rate.

Oklahoma CCBHC Required Activities include: care coordination, outreach/engagement, housing and vocational services, primary care screening, health promotion and other integrated care activities.

Criteria 4.B: Requirement of Person-Centered and Family-Centered Care

4.b.1 The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.

Note: *See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.*

4.b.2 Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.

Criteria 4.C: Crisis Behavioral Health Services

4.c.1 The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so. Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria. PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:

• **Emergency crisis intervention services:** The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

• **24-hour mobile crisis teams:** The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should align their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services.

• **Crisis receiving/stabilization:** The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity

individuals in this ambulatory setting. Crisis stabilization services should be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.

Note: *See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.*

Criteria 4.D: Screening, Assessment, and Diagnosis

4.d.1 The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services.

Note*: See program requirement 3 regarding coordination of services and treatment planning.*

4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.

Note*: Psychological testing is an allowable service as part of screening, assessment, and diagnosis however treatment services are limited to mental health and substance use disorders.*

4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:

1. Preliminary diagnoses
2. The source of referral
3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications

6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful
7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence
10. Assessment of need for medical care (with referral and follow-up as required)
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies
13. At least one immediate treatment goal.

4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include:

1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services.
2. An overview of relevant social supports; social determinants of health; and health-related social needs such As housing, vocational, and educational status; family/caregiver and social support; legal issues; and Insurance status.
3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
4. Pregnancy and/or parenting status.
5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
6. Relevant medical history and major health conditions that impact current psychological status.
7. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.
8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care) and substance use disorders (including tobacco, alcohol, and other drugs).
9. Basic cognitive screening for cognitive impairment.
10. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.
11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services.
12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services).

13. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate.
14. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services.
15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.

4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix G. The CCBHC should not take non-inclusion of a specific metric in Appendix G as a reason not to provide clinically indicated behavioral health screening or assessment. The state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.4 or Appendix G.

4.d.6 The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.

4.d.7 The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.

4.d.8 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2. b.1.

Criteria 4.E: Person-Centered and Family Centered Treatment Planning

4.e.1 The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities). Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction.

Note: *See program requirement 3 related to coordination of care and treatment planning.*

4.e.2 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.

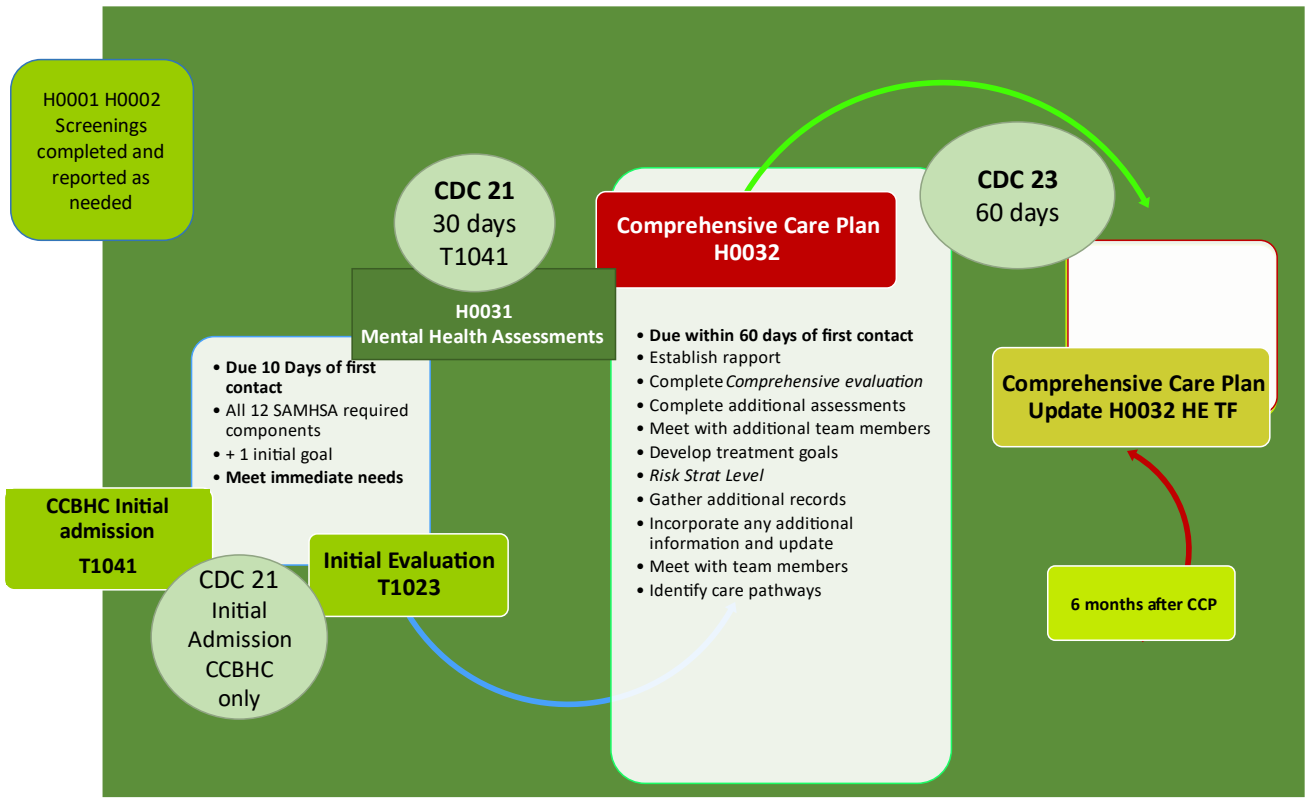
4.e.3 The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.

4.e.4 Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.

4.e.5 The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.

4.e.6 Where appropriate, consultation is sought during treatment planning as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).

4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services.



Criteria 4.F: Outpatient Mental Health and Substance Use Services

4.f.1 The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental, and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use.

Note: *See also program requirement 3 regarding coordination of services and treatment planning.*

Based upon the findings of the community needs assessment as required in program requirement 1, certifying states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long-acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; effective but underutilized medications such as clozapine and FDA-approved medications for substance use disorders including smoking cessation. This list is not intended to be all inclusive. Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.

It is the expectation that Oklahoma CCBHCs will utilize and provide Evidenced Based Practices to the highest standard of care. All requirements set forth by ODMHSAS program staff, ODMHSAS program requirements, contracts, statements of work, and fidelity to the models should be adhered to.

The following practices were selected as minimum standards; however, a CCBHC may choose to employ additional EBPs as indicated by needs assessment and the population being served.

Oklahoma's Evidenced Based Practices

Required	Recommended
Motivational Interviewing	Wellness Recovery Action Plan (WRAP)
Cognitive Behavioral Therapy (CBT)	Recovery Oriented Cognitive Therapy
CBT for Suicide Prevention	Matrix Model
Trauma Focused CBT	Dialectical Behavioral Therapy (DBT)
Collaborative Assessment and Management of Suicidality (CAMS)	Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
Medication Assisted Treatment (MAT)	Strengthening Families
Wraparound	Celebrating Families
Seeking Safety	Transition to Independence Process (TIP)
Peer Recovery Support	Circle of Security
Individual Placement and Supports (IPS)	Child Parent Psychotherapy (CPP)
Housing First	Parent Child Interaction (PCIT)
Enhanced Illness Management and Recovery (eIMR)	Motivational Enhancement Therapy
CCBHCs are required to have an EBP for high need individuals, but specific model is determined by the CCBHC as indicated by need.	Program of Assertive Community Treatment (PACT)
	Critical Time Intervention (CTI)
	First Episode early intervention for psychosis
	Attachment Biobehavioral Catch-up (ABC)
	Program to Encourage Active Rewarding Lives (PEARLS)
	Functional Family Therapy (FFT)
	Attachment Based Family Therapy (ABFT)
	Multisystemic Therapy-Psychiatric (MST-Psych)
	Safe Alternatives for Teens and Youth (SAFETY)
	Integrated Cognitive Behavioral Therapy (I-CBT)
	Youth-nominated Support Team - Version II (YST-II)
	Arthritis-Appropriate, Evidence-Based Interventions: Tai Chi
	Arthritis-Appropriate, Evidence-Based Interventions: Walk with Ease
	Building Resilience for Individuals through Trauma Education (BRITE)
	Facilitating Attuned Interactions (FAN)

4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment.

- When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver-driven.
- When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided.
- When treating individuals with developmental or other cognitive disabilities in addition to behavioral health concerns, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.

4.f.3 Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.

Criteria 4.G: Outpatient Clinic Primary Care Screening and Monitoring

4.g.1 The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions:

- HIV and viral hepatitis
- Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix G
- Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC's populations.

The CCBHC will ensure children receive age-appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age-appropriate screening and preventive interventions.

4.g.2 The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include:

- Ensuring that people receiving services are asked about physical health symptoms; and
- Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4. g.

In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC.

The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4. g.

4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:

1. ensuring individuals have access to primary care services;
2. ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;
3. coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
4. promoting a healthy behavior lifestyle.

Note*: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.*

Note: See also program requirement 3 regarding coordination of services and treatment planning.

Required Activity: Integrated Care in CCBHC

CCBHCs are required to offer a full array of services to treat and support the client base of the community they serve. CCBHCs are expected to build upon the foundation of Health Homes within the Community Mental Health Center model to promote enhanced integration and coordination of behavioral health, primary care, acute care, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

The CCBHC directly provides outpatient mental health and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual clients as identified in their individual care plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental health and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services.

Care is delivered using an integrated team that will comprehensively address mental health needs, substance use disorder treatment needs and physical health needs; with a goal to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and avoid unnecessary care.

Criteria 4.H: Targeted Case Management Services

4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case management should also be accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services.

Criteria 4.I: Psychiatric Rehabilitation Services

4.i.1 The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery supports that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with on-going support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to:

- Participate in supported education and other educational services;
- Achieve social inclusion and community connectedness;
- Participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and
- Find and maintain safe and stable housing. Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation: facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers.

Criteria 4.J: Peer Supports, Peer Counseling, and Family/Caregiver Supports

4.j.1 The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include: community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support.

Note: *See program requirement 3 regarding coordination of services and treatment planning.*

Criteria 4.K: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

4.k.1 The CCBHC is responsible for providing directly, or through a DCO, intensive, community based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook.

Note: *See program requirement 3 regarding coordination of services and treatment planning.*

4.k.2 All individuals inquiring about services are asked whether they have ever served in the U.S. military. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner:

1. Active-Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF.
2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations.
3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE authorized provider, network or non-network. Veterans: Persons affirming former military service (veterans) are aided enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics).

Note: *See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.*

4.k.3 The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

4.k.4 Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:

1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.
2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.
3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity).
4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.
5. The treatment plan is revised, when necessary.
6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (See information regarding Advance Care Planning Documents in VHA Handbook 1004.2).
7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

4.k.5 Behavioral health services are recovery oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery:

- Hope
- Person-driven
- Many pathways

- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect as implemented in VHA recovery, the recovery principles also include the following:
- Privacy
- Security
- Honor

Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

4.k.6 All behavioral health care is provided with cultural competence.

1. Any staff who is not a veteran has training about military and veterans' culture to be able to understand the unique experiences and contributions of those who have served their country.
2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

4. k.7 There is a behavioral health treatment plan for all veterans receiving behavioral health services.

1. The treatment plan31 includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.
4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
5. The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Program Requirement 5: Quality and Other Reporting

Criteria 5.A: Data Collection, Reporting, and Tracking

This program requirement describes:

1. Data collection, reporting, and tracking
2. Continuous quality improvement planning

5.a.1 The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix G. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards.

Note: See criteria 3.b for requirements regarding health information systems.

5.a.2 Section 223 Demonstration CCBHCs must collect and report the Clinic-Collected quality measures identified as required in Appendix G. Reporting is annual and, for Clinic Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states.

States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix G. The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Certifying states also may require certified CCBHCs to collect and report any of the optional Clinic-Collected measures identified in Appendix G.

Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected). Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12) months after the end of the measurement year, as that term is defined in the technical specifications.

States participating in the Section 223 Demonstration program are expected to share the results from the State-Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person.

5.a.3 In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix G that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually.

To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.

5.a.4 CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS.

***Note**: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.*

Criteria 5.B: Continuous Quality Improvement (CQI) Plan

5.b.1 In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

5.b.2 The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30-day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.

Quality Measures

The CCBHC Quality Measures are requirements placed on CCBHCs as part of the Demonstration Program to improve community mental health services, found in Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). Data and quality measure reporting have multiple objectives. Collection and reporting of this information offer providers, states, and other stakeholders a better method for assessing the way care is accessed and provided. The information can be used for internal quality improvement (QI) processes to determine the degree of progress achieved or to determine where new or additional improvement is needed. The data can be used for accountability, and may be used to evaluate programs, such as the national evaluation of the CCBHC Demonstration Program. Measures are collected at the facility and state-level and reported annually.

The February 2024 update to the technical specifications for the Behavioral Health Clinic (BHC) quality measures provides information about the required quality measures under the Section 223 State Demonstration programs. The new quality measures will be implemented on January 1, 2025. The technical specification for the new quality measures can be found at the link below.
Quality Measures for Behavior Health Clinics - Technical Specifications and Resource Manual (samhsa.gov)

Beginning with the Calendar Year (CY) of January 1, 2025-December 31, 2025, SAMHSA and its Federal Partners are shifting from using the Section 223 Demonstration Years (DY) as the quality measure Measurement Year (MY) for the Behavioral Health Clinic (BHC) measures to using the CY. Guidance for Quality Measure Transition Planning for Existing Section 223 Demonstration States can be found at the link below.

guidance-for-quality-measure-transition-planning.docx (live.com)

Health Information Technology

The use of health information technology (HIT) has been shown to improve the quality and effectiveness of health care; promote individual and public health, increase the accuracy of diagnoses, while reducing costs and medical errors. According to the Office of the National Coordinator for Health Information Technology, by strategically combining HIT tools and effective health communication processes, there is the potential to:

- Improve health care quality and safety.
- Increase the efficiency of health care and public health service delivery.
- Support care in the community and at home.
- Facilitate clinical and client decision-making; and
- Build health skills and knowledge.

CCBHCs are required to incorporate HIT in their clinical processes to increase individual and population healthcare quality and improvement. Towards this end, CCBHCs are required to have a certified Electronic Health Record (EHR), utilize a Health Information Exchange (HIE), and utilize and contribute client information to a population performance management system.

Using software that has received **EHR** certification is important because it guarantees specific safeguards. It protects the confidentiality of patient information, makes sure the data is secure, provides a standard way of entering information so it can be shared between providers and ensures a consistent way of recording data for the CQMs.

An **HIE** is a vehicle for improving quality and safety of patient care by getting the right information to the right person at the right time. Data gained from an HIE has been shown to be effective in reducing medication and medical errors, in- creasing efficiency by eliminating unnecessary paperwork and tests and providing caregivers with clinical decision support tools for more effective care and treatment.

A **population performance management system** allows providers to monitor performance on key metrics related to value-based care initiatives; identify high risk clients and understand the care gaps and utilization patterns of all clients to provide better care.

While these are the basic requirements, CCBHCs are encouraged to utilize a variety of HIT to improve population health outcomes and healthcare quality, and to achieve health equity for the people we serve.

Program Requirement 6: Organizational Authority, Governance, and Accreditation

This program requirement describes:
1. Organizational Authority and Financing
2. Governance

Criteria 6.A: General Requirements of Organizational Authority and Finances

6.a.1 The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria:
- Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States

Internal Revenue Code

- Is part of a local government behavioral health authority
- Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.)
- Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)

Note: *A CCBHC is considered part of a local government behavioral health authority when a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.*

6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.

6.a.3 An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

Criteria 6.B: Governance

6.b.1 CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making. CCBHCs reflect substantial participation by one of two options:

Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.

Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternative approach that are equivalent to the support given to the governing board. Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

1. Identifying community needs and goals and objectives of the CCBHC
2. Service development, quality improvement, and the activities of the CCBHC

3. Fiscal and budgetary decisions
4. Governance (human resource planning, leadership recruitment and selection, etc.)

Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.

6.b.2 If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

For certifying states, if option 2 is chosen then states will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

6.b.3 To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6. b.1.

6.b.4 Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.

Criteria 6.C: Accreditation

6.c.1 The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.

6.c.2 CCBHCs must be certified by their state as a CCBHC. State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. Certifying states may use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to

the CCBHC Certification Criteria.

6.c.3 States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean "deemed" status.

APPENDIX A: REIMBURSEMENT GUIDANCE

GENERAL CCBHC REIMBURSEMENT METHODS

This section delineates the criteria governing the reimbursement of services falling under the demonstration (CCBHC services), as well as non-CCBHC services provided at non-CCBHC locations. It outlines the parameters, conditions, and considerations, encompassing the special characteristics of crisis services that may affect reimbursement.

1.a.1 PPS Rate Methodology Overview

In this demonstration, participating states were required to choose between two Prospective Payment System (PPS) rate methodologies. Oklahoma opted for the CC PPS-2 Alternative methodology to facilitate payments for the covered services provided by Certified Community Behavioral Health Clinics (CCBHCs). During the first demonstration year (DY1) Oklahoma had three participating CCBHCs. The PPS-2 method utilizes cost-based, monthly rates per clinic that are consistently applied to all CCBHC services (refer to criteria 4C through 4K). Each clinic's rate is determined by dividing its allowable costs, including designated collaborating organization (DCO) costs, by the number of monthly encounters within a year. Monthly encounters are calculated based on the number of visit months in which a patient has at least one encounter, irrespective of the duration or quantity of services received. A CCBHC receives the monthly rate whenever at least one CCBHC service is delivered during the month to a Medicaid beneficiary by the CCBHC; It's important to note that costs related to care coordination may be included in the overall allowed demonstration cost. For detailed information on the development of PPS-2 rates, please refer to the PPS-2 Demonstration Guidance. This guidance was updated February, 2024.

1.a.2 Encounters that Trigger PPS Payment Clarification

PPS payments are contingent on the concept of "visit months," where a visit is defined as a month containing at least one face-to-face encounter or an eligible telehealth encounter between a qualified practitioner and an eligible participant, involving the provision of a CCBHC service. The quantity of services an individual receives within a month does not impact the payment; the CCBHC is compensated with a monthly bundled rate. Enumerating a visit is contingent upon the delivery of at least one of the required services outlined in SAMHSA criteria 4C through 4K (excluding behavioral health screenings, preliminary triage, and risk assessment). This service must be provided by either the CCBHC or a Designated Collaborating Organization (DCO).

It's important to note that while care coordination is a required activity, it does not itself trigger an enumerated visit. In terms of modality, telephone calls, emails, and texts are not considered enumerated visits, especially after the conclusion of the Public Health Emergency (PHE). Note: telehealth services are considered face to face, per CMS guidance. Regarding locations, CCBHC services may be provided in various settings, including the clinic, mobile locations, or community settings. This flexibility ensures that individuals can receive the necessary services in environments that best suit their needs.

CCBHC activities are activities that have the purpose of coordinating and managing the care and services furnished to each client, including both behavioral and physical healthcare, regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Required activities include care coordination, outreach/engagement, housing and vocational services, health promotion and other integrated care activities. CCBHC activities are required and tracked for data and outcomes, however CCBHC activities alone do not trigger an enumerated visit.

(Refer to Appendix C. Scope of Services and Activities (SOSA) list that identifies the activities and procedures covered in the PPS rate as well as which services align with the nine required services that ultimately trigger a PPS rate.

In terms of modality, telephone calls, emails, and texts are not considered enumerated visits, especially after the conclusion of the Public Health Emergency (PHE). Note: telehealth services are considered face to face, per CMS guidance.

Regarding locations, CCBHC services may be provided in various settings, including the clinic, mobile locations, or community settings. This flexibility ensures that individuals can receive the necessary services in environments that best suit their needs.

1.a.3 Demonstration Expansion and Rate Transition

Oklahoma received approval to augment the demonstration by incorporating eleven (11) additional sites, effective from October 1, 2023. New clinics seeking inclusion must meet certification criteria and adhere to the prospective payment system (PPS) guidance in effect. Certification as a Certified Community Behavioral Health Clinic (CCBHC) by the state is a prerequisite for participation in the Demonstration.

Monthly bundled rates for CCBHCs certified under the Medicaid State Plan have been established according to the approved methodology outlined in Attachment 4.19 B, pages 30a to 30a-1 under a State Plan Amendment (SPA). For clinics being added to the demonstration, effective October 1, 2023, the monthly bundled rates, set for the rate year ending on June 30, 2024, will serve as the transitional demonstration rates until June 30, 2024. Acknowledging variations in services and bundled rate calculations between the Medicaid SPA CCBHC scope and Medicaid CCBHC services within the demonstration, the state assures the provision of the nine services outlined in criteria 4C through 4K. This assurance is based on the rates paid to CCBHCs effective October 1, 2023.

Should adjustments be deemed necessary, transitional demonstration rates may be modified, effective July 1, 2024, to accommodate the anticipated costs of services not covered under the SPA but required under the demonstration, beginning October 1, 2023. It is important to note that there will be no retroactive adjustment. Furthermore, transitional rates for new clinics will be trended forward utilizing the Medicare Economic Index (MEI) effective July 1, 2024, to reflect changes due to inflation. DY1 rates for newly added clinics will encompass the period July 1, 2024, to June 30, 2025 (representing the first full year of the demonstration). The DY1 rate will be updated again for DY2 by the MEI or by rebasing of the PPS to adjust for any anticipated costs, and every three years thereafter.

1.a.4 Cost Reporting Process

The CCBHC PPS-2 payment methodology relies on a comprehensive cost reporting system, utilizing the Centers for Medicare & Medicaid Services (CMS) CCBHC cost report that follows federal cost reporting regulations. Each clinic must submit a detailed cost report, covering allowable costs necessary to fulfill CCBHC criteria, along with data on qualifying visit months. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) meticulously reviews all cost reports to establish individual rates for each CCBHC.

Under the Section 223 Demonstration program, CCBHCs are required to submit an annual cost report, along with supporting data, within six months after the conclusion of each Section 223 Demonstration year to the state. Oklahoma's demonstration year spans from July 1 to June 30 for annual reporting purposes. ODMHSAS conducts a thorough review of these submissions for completeness. Within nine months after the end of each Section 223

Demonstration year, the report, along with any additional clarifying information, is forwarded to CMS. ODMHSAS is obligated to submit cost reports to CMS annually, even in years when the state's rates are only adjusted for trends and not completely recalculated.

To ensure compliance with cost reporting and PPS payment processes, ODMHSAS engages the services of FORVIS, LLP, which provides valuable assistance in maintaining accuracy and adherence to regulatory requirements.

1.a.5 PPS-2 Components

The PPS-2 framework comprises essential components designed to ensure comprehensive reimbursement for CCBHCs. These elements include:

1. **Monthly Base Rate:** A standard monthly rate is established to reimburse CCBHCs for the provision of services to the standard population, encompassing both adults and children.
2. **Special Population Rates:** In addition to the standard rate, separate monthly PPS special population rates have been established to address the increased costs associated with delivering services to those who are considered high need. The special population category is defined by specific criteria set by ODMHSAS to identify individuals requiring intensive services and facing challenges in community-based services. Special populations include individuals on the "Most In Need "(MIN) list, individuals receiving treat to competency services and other populations as defined by ODMHSAS. **The 'Most in Need'** category is defined as adult clients (18 years and older) and children/youth (6–17 years) meeting one or more of the following criteria within the past 12 months:
    1. Two or more psychiatric inpatient episodes.
    2. Three or more community-based structured crisis episodes.
    3. Twelve or more emergency department visits with a mental health or substance abuse diagnosis.
    4. Two or more substance abuse residential treatment episodes (confidentiality laws impact reporting until admission).
    5. Discharge from a psychiatric inpatient episode within the last 90 days.
    6. Treat to Competency category is defined as individuals in the criminal justice system, deemed incompetent per court ordered competency evaluation, who are receiving outpatient competency restoration services.
3. **Quality Bonus Payments (QBP):** Beyond the standard PPS, Quality Bonus Payments are implemented to incentivize and reward high-quality service delivery by CCBHCs.
    - Quality Bonus Payments (QBPs). Based on federal criteria, Oklahoma has established an overall QBP pool of $1,000,000. Only the clinics that meet the state defined threshold for all seven required quality measures for CCBHCs are eligible for payment for their allocation of the bonus pool. Clinics that do not qualify for the QBPs may participate in the state's Enhanced Tier Payment System (ETPS) value-based payment pool.

1.a.6 Cost Updates

The PPS-2 model ensures reimbursement reflects current economic realities by incorporating regular cost updates using either the Medicare Economic Index (MEI) or through a process of rebasing at least every three years. In the case of demonstration clinics in Oklahoma, the state will adhere to a two-year rebasing timeline, as outlined in Attachment 4.19 B, page 30a-1 of the Oklahoma Medicaid State Plan. Providers are encouraged to align their planning cycles with this rebasing timeline, such as strategic planning for new initiatives.

CCBHC states are obligated to submit cost reports to CMS on an annual basis, even in years where the state's rates are only trended and not rebased. Provider-specific monthly rates undergo annual updates facilitated by the Medicare Economic Index (MEI), reflecting changes due to inflation, or are rebased in accordance with the CMS rebasing cadence.

1.a.7 Fee for Service (FFS) Method

The Fee-for-Service (FFS) method is a payment model characterized by the unbundling of services, with each service being paid for individually. In the context of Certified Community Behavioral Health Clinics (CCBHCs), the FFS method is applied to compensate for Medicaid-covered non-CCBHC services provided at a non-CCBHC location. These services are reimbursed based on the Medicaid fee schedule, and it is crucial to identify and exclude them from the cost report to accurately calculate the Prospective Payment System (PPS). In essence, this approach ensures that specific services covered by Medicaid, but falling outside the CCBHC scope, are accounted for separately to determine the appropriate payment under the FFS model.

1. B CCBHC BILLING AND PAYMENT

Within this subsection, the procedural aspects of billing and the subsequent payment process are detailed. Additionally, specific details such as billing codes or formats are provided to ensure clarity and adherence to standardized billing procedures for both CCBHC and non-CCBHC services.

New Clients	"New" to CCBHC, means they have not been served by the clinic in the six months before the current service, and must receive the following to become a person receiving CCBHC services: • Receive a non-crisis service at a CCBHC location. • An initial evaluation and risk assessment must be completed at first contact, and • An Initial Evaluation must be completed within 10 days of first contact.
Established/Existing Clients	Person receiving CCBHC services
Non-Established/ Clients	**Clients that:** • Receive crisis services without a pre-admission within the last 60 days or a current outpatient admission at the CCBHC, • Are referred to the CCBHC directly from other outpatient behavioral health agencies for enhanced case management and pharmacologic management only, (e.g., Drug Court and Specialty Courts clients being served at a different treatment facility).

1.b.2 Claims for Established Clients – CCBHC Services (PPS Rates)

Standard Population: The standard population rate is the base payment for both adults and children. The PPS rate for the standard population is made when a CCBHC bills procedure code T1041 and delivers at least one (1) CCBHC covered service that triggers the PPS rate for the calendar month. (Refer to PPS code list in Appendix D.). Providers are also required to "shadow report" all services provided. These services will be paid at 0.00. CCBHCs should continue to report the correct contract source on the claims.

- CCBHC clients can only receive one standard monthly payment per month.
- For a client that has been seen at two or moreCCBHCs in one month, the first CCBHC to bill the T1041 will receive the monthly payment.
- Care coordination and other activities must be reported but do not trigger a payment when billed alone in a calendar month.
- ODMHSAS pays the standard monthly rate only after a CCBHC service has been delivered.
- The T1041 must be billed with a shadow reported covered service during the same month on the same claim which triggers the monthly rate. For example, if the claim has a T1041 for January and February, a covered service must be reported for both January and February on the same claim.

Special Population: CCBHCs may bill an additional payment each month for special population clients served. The additional payment equals the difference between the special population rate and the standard rate. The corresponding payment code for the additional amount is **H0046** and does not need to be billed with an additional shadow reported service. For example, if the standard population rate is $500 and the special population rate is $750, the T1041 will pay $500 and the H0046 will pay $250, bringing the total monthly payment to the special population rate of $750.

Individuals meeting criteria 1 - 4 on the MIN list will remain on the list for 12 calendar months beginning the month of eligibility. For example, an individual who becomes eligible on April 15, will remain on the list until March 31st of the following year. In the event that a client is erroneously placed on the MIN list, e.g., an inpatient claim is voided, the individual will remain on the MN list through the end of the month. Individuals meeting criterion 5, will remain on the list for 3 months, including the month they were discharged from their inpatient episode.

The MIN list can be accessed through the PICIS website, under reports, under "Most in Need". The MIN list is updated weekly. Because there is a lag in claims, individuals may not be placed on the list as soon as they become eligible. For example, a second inpatient episode may occur in March, but the claims are not billed until June. Eligibility will be retroactive to inpatient discharge. Due to federal confidentiality laws, individuals on the MIN list due to substance abuse residential treatment episodes will not be displayed until the individual is admitted to the CCBHC. The facility may then bill the H0046 for intensive services for these individuals.

The Treat to Competency list can be accessed through the ODMHSAS Access Control.

- If a CCBHC bills the H0046 for the additional payment and the individual is admitted to psychiatric inpatient facility during the same month, the additional payment will be recouped once the inpatient claim is received.
- If a CCBHC bills the H0046 for a client who is not on the special population list for the date of service, payment will be recouped.

1.b.3 Other Claims Requirements for PPS Payments

Claims should include detailed HCPC/CPT coding, including modifiers, in order to bill the monthly payment.

- CCBHCs will need to have a charge master in order to implement the cost to charge ratio as demonstrated in the CMS cost report. The charges would be equal for all clients regardless of payer.
- Claims should include reasonable and customary charges or actual cost as the billed amount, not fee schedule amount. This will help facilitate claims adjustments and a means to associate costs of special populations.
- Each external provider to which services are referred is the billing provider for the services that it furnishes.
- CCBHCs must shadow report all CCBHC services provided including all care coordination activities that support CCBHC services.
- For Child SED and Special Population Clients receiving Targeted Case Management at an external entity, CW-TCM; OJA-TCM, only report T1016 if you have an established agreement (See also SAMHSA requirement 3.C.3) to prevent duplication, otherwise use special TCM reporting code, T2023
- For Adult SMI and Special Population clients receiving Advantage Waiver services, only report T1016 if you have an established agreement (See also SAMHSA requirement 3.C.3). to avoid duplication, with the Advantage Waiver provider, otherwise report T1017.

1.b.4 CCBHC Required Activities but Not Billable as a CCBHC Encounter

Certain activities within the Certified Community Behavioral Health Clinic (CCBHC) model are considered required activities but are not directly billable as CCBHC encounters. The following activities are identified as required but do not trigger a payment when billed individually:

- Preliminary triage and risk assessment
- Outreach
- Care coordination.

These activities are shadow reported using non-PPS service codes (CPT/HCPCS). This ensures that these required activities are documented and reported but does not result in a payment for each line item. The specific non-PPS service codes can be referred to in the non-PPS list.

1.b.5 Claims for Established Clients – Non-CCBHC Services

For the specified scope of Demonstration services, the provider is entitled to receive payment through the CCBHC PPS for applicable services. Furthermore, separate payment is granted for non-CCBHC services within the same month, utilizing rates specified in the Oklahoma Medicaid State Plan, as these services do not overlap. Non-CCBHC services must be invoiced using the non-CCBHC location and should include:

- Primary Care Services (Refer to note to criteria 4.g.3 on primary care services)
- Medications
- Unbundled prescribed drugs for individuals with OUD per a qualified OTP program (See

OAC 317:30-5-241.7 for requirements and prior authorization)
- Laboratory Services (See OAC 317:30-5-100 for guidelines)
- Shots and vaccines (Excludes VFC program)

1.b.6 Billing Guidelines for Crisis Behavioral Health Services

A "new" clinic user must receive a preliminary triage and risk assessment to determine acuity of needs directly from the CCBHC (not the DCO) prior to or concurrent with the receipt of additional demonstration services. (Criteria 2.b.1). The crisis continuum **(**Criteria 4.C) consists of the following:

- Emergency crisis intervention services
- 24-hour mobile crisis teams
- Crisis receiving/stabilization (includes Urgent Recovery Care)

Payment is made for crisis services in accordance with the Crisis Chart below. Facility-based crisis stabilization and urgent recovery care must be under the direction of a physician. Physician supervision/consultation is not reimbursable.

Billing Requirements CCBHC Crisis Services Effective 12/1/2022

Outpatient Crisis Service:

For an outpatient crisis service for a non-admitted individual that you have not done a transaction type 21 in the last 60 days, report H2011 without a CDC transaction type and bill fee-for-service (FFS).

For a non-admitted individual that you have done a transaction type 21 in the last 60 days, do a transaction type 21 and report H0007. It can be used to trigger the PPS payment. The H0007 procedure code will replace the H2011 crisis code for CCBHC clients.

Mobile Crisis Service:

For a mobile crisis service for a non-admitted individual that you have not done a transaction type 21 in the last 60 days, submit a transaction type 21 and a service focus 26. A prior authorization will be returned, and you will bill FFS.

For a mobile crisis service for a non-admitted individual that you have done a transaction type in the last 60 days, submit a transaction type 21 and a service focus 26. A quality initiative (QI) line will be returned, and the mobile crisis can be used to trigger the PPS payment.

Urgent Recovery Crisis (URC):

When an admitted client at your CCBHC goes to your URC, submit a transaction type 42 with a service focus of 32. A QI line will be returned, and the URC stay can be used to trigger the monthly rate.

When a non-admitted client goes to the URC, submit a transaction type 27 with a service focus of 32. A PA will be returned, and you can bill FFS, regardless of whether they are admitted at another CCBHC.

Crisis Center:

When an individual that is not admitted at your CCBHC or any other CCBHC, is admitted in your crisis center, submit a transaction type 23 with a level of care of SC and a PA will be returned. You will bill FFS for the crisis stay.

When your CCBHC client is admitted at your crisis center, submit a transaction type 40 and a level of care of SC. A QI line will be given, and you can use the crisis stay to trigger the monthly rate.

When a Medicaid-eligible individual admitted at another CCBHC, is admitted in your crisis center, you will bill the other CCBHC for the crisis stay. When an ODMHSAS only eligible individual admitted at another CCBHC, is admitted in your crisis center, submit a transaction type 23 and a level of care of SC. You can bill the crisis stay as FFS.

In the event that you submit a preadmission (21), and the client is then admitted to a crisis center on the same day, contact the PICIS Helpdesk and ask that the 21 be removed. Once this is removed, you will be able to get DH509 PA and bill the crisis stay as FFS.

Table 2: CCBHC CRISIS SERVICES

	(1) Non-admitted (Have not received a PPS payment) client	**(2) Client admitted at CCBHC where client is getting the crisis services**	**(3) Client admitted at CCBHC where client is getting the crisis service**	**(4) Admitted CCBHC client receiving crisis services at another CCBHC crisis center**	**(5) Admitted CCBHC client receiving crisis services at a non-CCBHC crisis center**
Crisis Center (CBSCC)	FFS	PPS	PPS*	Bill other CCBHC**	Bill other CCBHC**
URC	FFS	PPS	PPS*	FFS	FFS
Mobile Crisis/ Crisis Intervention	FFS	PPS	PPS*	FFS	FFS

- A client not established at any CCBHC who comes to a CCBHC for crisis services as the first point of contact.
- A client established at a CCBHC who is receiving crisis services at the CCBHC where he/she is established

- A client established at a CCBHC who is receiving crisis services at the CCBHC where he/she is established through the CCBHC's designated collaborating organization (DCO)
- A client established at a CCBHC who is receiving crisis services at another CCBHC where he/she is NOT established
- A client established at a CCBHC who is receiving crisis services at a non-CCBHC crisis facility (e.g., OCCIC)

*In these cases, the CCBHC is responsible to bill for the payment (PPS). The DCO should not bill OHCA/DMH for the services but may bill the CCBHC for the services provided.

**In order to get payment for services, the crisis provider/CBSCC must bill the CCBHC where the client is established if the client is a SoonerCare/Medicaid member. If the client is a DMH/indigent client, the crisis provider/CBSCC may bill fee-for-service for the crisis stay.

1. b.7 Claims for CCBHC Services - Dually Eligible Beneficiaries

The Protecting Access to Medicare Act, specified in section 223(d)(2)(B)(v), mandates that the state pays up to the PPS rate for all demonstration services provided to Medicaid beneficiaries. This requirement is applicable to services delivered to dual-eligible beneficiaries for whom the state shares the cost of direct services, extending beyond Medicare cost-sharing. Dually eligible beneficiaries vary in types, influencing the cost-sharing obligations imposed on states. However, the CCBHC PPS is not mandated for services provided to the following dual-eligible Medicaid beneficiaries due to potential absence of Medicare cost-sharing:

- Qualifying Individuals (QI)
- Qualified Disabled and Working Individuals (QDWI)
- Specified Low-Income Medicare Beneficiaries (SLMB)

For billing dual-eligible claims, the chart below provides guidance. When the sole service provided is Medicare compensable, it is acceptable to submit the claim to Medicaid using the same reporting code billed to Medicare as a detailed line item, in addition to the T1041 code, to receive PPS. The claim amount should be adjusted by the Medicare payment.

NOTE: As of January 1, 2024, Marriage, and Family Therapists (MFTs) and Mental Health Counselors (MHCs) have the capability to independently bill Medicare for services related to the diagnosis and treatment of mental illnesses. It is strongly encouraged for MFTs and MHCs to promptly enroll to ensure a seamless transition, preventing disruptions and enabling correct claims processing when the edit is removed to bypass Medicare due to staff credentials. Additional information can be found in Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries

Table 3: Claims for Dual Eligible Beneficiaries

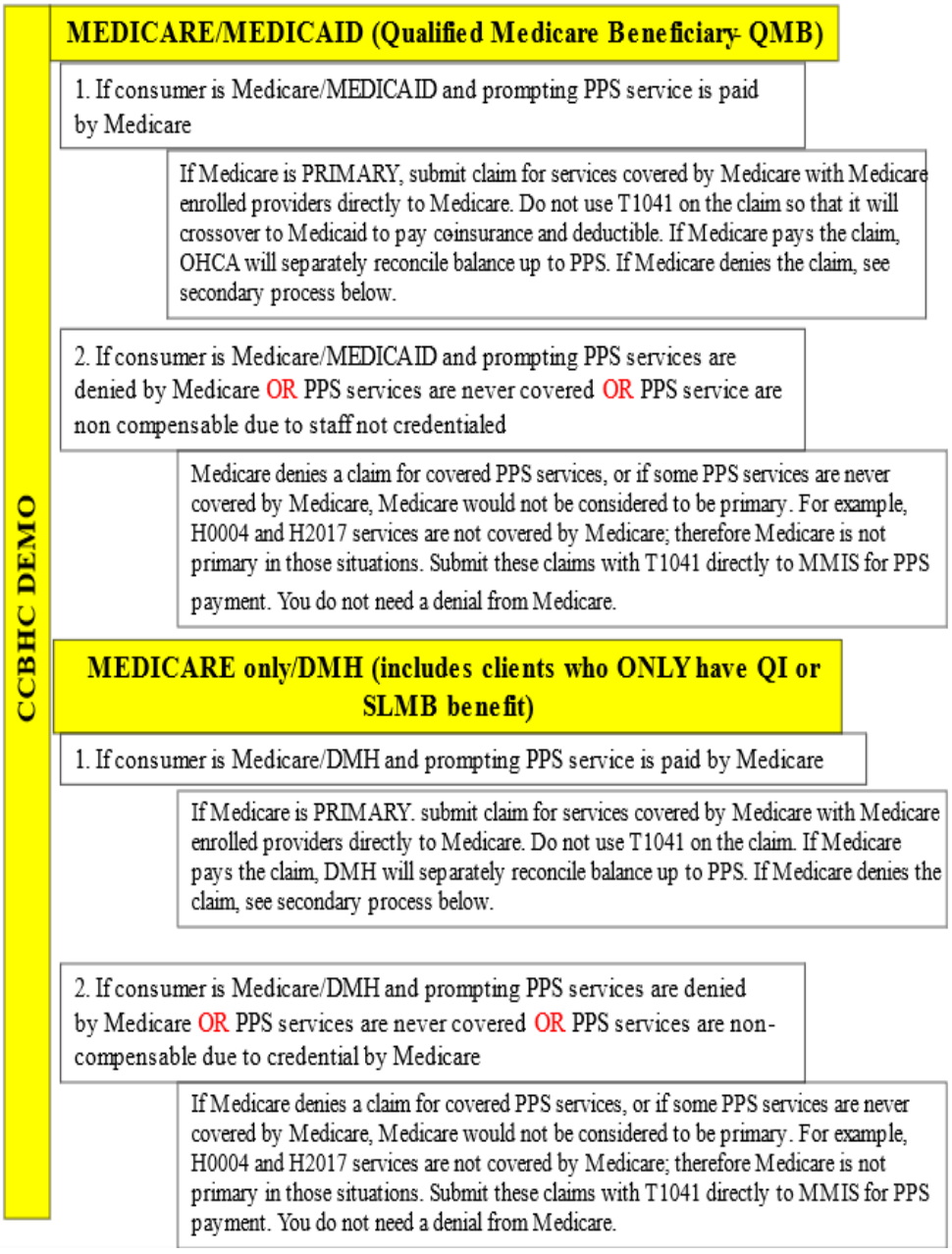
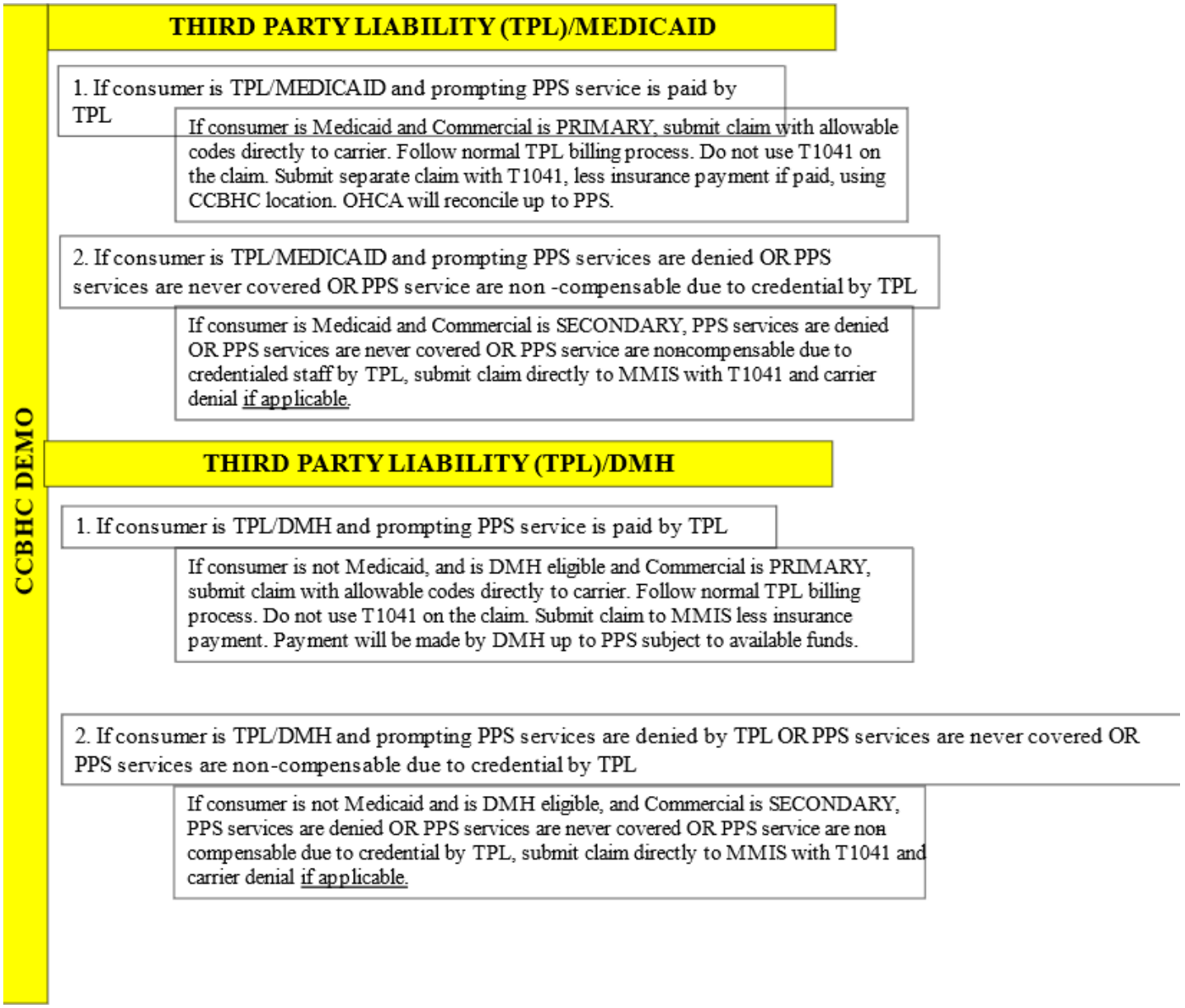


Table 3: Claims for Dual Eligible Beneficiaries, (Cont'd)



1.b.10 Prior Authorization

All outpatient CCBHC services must be provided following established medical necessity criteria. Some non-CCBHC services may require authorization. There is no prior authorization for CCBHC services. (See OAC 317:30-5-266 regarding CCBHC covered services). Occupational therapy services must be prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law.

1.b.11 DCO and Referred Services

In the context of the CCBHC (Certified Community Behavioral Health Clinic) model and associated services, the roles, and responsibilities of Designated Collaborating Organizations (DCOs) and referred services are outlined. Here are key points to understand:

1. DCO services within CCBHC PPS:
    - DCO services that fall within the scope of the CCBHC PPS are considered integral to the overall service model.
    - Encounters with DCOs are treated as CCBHC encounters for the purposes of the PPS. This implies that they are both clinically and financially integrated into the CCBHC model.
2. Distinction between DCO and referred services:
    - DCO services are distinct from referred services. The critical distinction lies in the financial and clinical responsibility associated with each.
    - The CCBHC assumes both financial and clinical responsibility for DCO services, considering them as part of its overall responsibilities and service provision.
3. Referrals to other providers:
    - If there are services needed by an individual or their family that cannot be directly provided by the CCBHC or a DCO, the CCBHC may make referrals to other providers or entities.
    - Importantly, the CCBHC remains responsible for care coordination, even for services to which it refers clients.
4. Payment Mechanisms:
    - Payment for DCO services within the CCBHC PPS framework is integrated into the prospective payment model.
    - However, payment for services to which clients are referred (referred services) is not part of the PPS. Instead, these services are paid through traditional mechanisms within Medicaid or other applicable funding sources.

In summary, the collaboration between CCBHCs, DCOs, and the referral system is structured to ensure comprehensive care, with clear delineation of responsibilities and payment mechanisms for different types of services within the broader behavioral health framework.

1.b.12 Exclusions and Limitations

The following expenses are excluded from coverage per PPS guidance:

- Inpatient care,
- Residential treatment,
- Room and Board

Service Limits

- Personal care, childcare, and respite services are not billable activities.
- Fee-for-service billing limitations for individual and group therapy do not apply. (See OAC 317:30-5-266) (4)(A)
- Eligibility requirements and billing limits for PSR services for adults do not apply. (See OAC 317:30-5-266) (6)(A)(i).
- For the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) population, services are furnished based on medical necessity.
- Clients living in an ICF/IID, nursing facility, or inmates of public correctional institutions are not eligible for CCBHC services. Individuals receiving services through a Program of All Inclusive Care for the Elderly (PACE) are also not eligible for CCBHC Services

Appendix B. SAMHSA Terms and Definitions

Terms and definitions included in this appendix are meant to guide states, territories, tribes, and existing/potential CCBHCs to understand the intent of the CCBHC certification criteria. The terms and definitions are not intended to replace state definitions that are more specific or are more broadly defined.

Agreement: As used in the context of care coordination, an agreement is an arrangement between the CCBHC and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.

Behavioral health: Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders.

Care coordination: CCBHCs establish activities within their organization and with care coordination partners that promote clear and timely communication, deliberate coordination, and seamless transition. This may include (but is not limited to):

- Establishing accountability and agreeing on responsibilities between care coordination partners.
- Engaging and supporting people receiving services in and, subject to appropriate consent, their family and caregivers, to participate in care planning and delivery and ensuring that the supports and services that the person receiving services and family receive are provided in the most seamless manner that is practical.
- Communicating and sharing knowledge and information, including the transfer of health records and prescriptions, within care teams and other care coordination partners, as allowable and agreed upon with the individual being served.
- Coordinating and supporting transitions of care that include tracking of admission and discharge and coordination of specific services if the person receiving services presents as a potential suicide or overdose risk.
- Assessment of the person receiving services needs and goals to create a proactive treatment plan and linkage to community resources.
- Monitoring and follow-up, including adapting supports and treatment plans as needed to respond to changes in the needs and preferences of individuals being served.
- Coordinating directly with external providers for appointment scheduling and follow up after appointment for any prescription changes or care needs, 'closing the loop.'
- Communicating and sharing knowledge and information to the full extent permissible under HIPAA, 42 CFR part 2, and ONC and CMS interoperability regulations on information blocking without additional requirements unless based on state law. As used here, care coordination applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each person receiving services as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

Case management: Case management may be defined in many ways and can encompass services ranging from basic to intensive. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as "a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery". See also the definition of "targeted case management."

Certified Community Behavioral Health Clinic (CCBHC) or Clinic: A CCBHC is a qualifying clinic that is responsible for providing all nine services in a manner that meets or exceeds CCBHC criteria described herein. The qualifying clinic may deliver the nine required services directly or through formal agreements with DCOs. The CCBHC must have the capacity to directly provide mental health and substance use services to people with serious mental illness and serious emotional disorders as well as developmentally appropriate mental health and substance use care for children and youth separate from any DCO relationship, unless substantially prohibited by their state because of their provider type.

A qualifying clinic must be one of the following: a nonprofit organization; part of a local government behavioral health authority; an entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act; or an entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (PL 94-437). CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics. CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. State-certified clinics are designated as CCBHCs for a period determined by the state but not longer than three years. CCBHCs must be recertified or submit a new attestation every three years. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state.

CCBHC directly provides: When the term, "CCBHC directly provides" is used within these criteria, it means employees or contract employees within the management structure and, under the direct supervision of the CCBHC, deliver the service.

Community Needs Assessment: A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served. CCBHCs will conduct or collaborate with other community stakeholders to conduct a community needs assessment. The assessment should identify current conditions and desired services or outcomes in the community, based on data and input from key community stakeholders. Specific CCBHC criteria are tied to the community needs assessment including staffing, language and culture, services, locations, service hours and evidence- based practices. Therefore, the community needs assessment must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families. If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required components of the community needs assessment are collected. The community needs assessment is comprised of the following elements:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.
3. Economic factors and social determinants of health affecting the population's access to health

services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.

4. Cultures and languages of the populations residing in the service area.
5. The identification of the underserved population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every 3 years.
8. Input regarding:
   * cultural, linguistic, physical health, and behavioral health treatment needs;
   * evidence-based practices and behavioral health crisis services;
   * access and availability of CCBHC services including days, times, and locations, and telehealth options; and potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages, settings, crisis call centers and warmlines.
   * Specialty providers of medications for treatment of opioid and alcohol use disorders;
   * Peer-run and operated service providers;
   * Homeless shelters and housing agencies;
   * Employment services systems;
   * Services for older adults, such as Area Agencies on Aging;
   * Aging and Disability Resource Centers; and
   * Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food, and transportation programs).

Cultural and linguistic competence: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse clients.

Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required services as described in criteria 4. CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria. The formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. DCO agreements shall include provisions that assure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria. To this end, DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners.

From the perspective of the person receiving services and their family members, services received through a DCO should be part of a coordinated package with other CCBHC services and not simply accessing services through another provider organization. To this end, the DCO agreement shall take active steps to reduce administrative burden on people receiving services and their family members when accessing DCOs services through measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO. CCBHCs and their DCOs are further directed to

work towards inclusion of additional integrated care elements (e.g., including DCO providers on CCBHC treatment teams, collocating services). Regardless of DCO relationships entered into, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria.

In the Section 223 CCBHC Demonstration, payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. To the extent that services are needed by a person receiving services or their family that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers clients. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid or other funding sources.

Engagement: Engagement includes a set of activities connecting people receiving services with needed services and supporting their retention services. This involves the process of making sure people receiving services and families are informed about and are able to access needed services. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care also promote client person receiving services engagement.

Family: Involvement of families of both adults and children receiving services is important to treatment planning, treatment, and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual client's view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents, and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, extended family members, care givers, friends, and others as defined by the family. The CCBHC respects the view of what constitutes the family of the individual person receiving services.

Family-centered: The Health Resources and Services Administration defines family-centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves as developmentally appropriate. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's health care providers and recognize the family's customs and values". More recently, this concept was broadened to explicitly recognize that family-centered services should be both developmentally appropriate and youth guided. Family-centered care is family-driven and youth-driven.

Formal relationships: As used in the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and payment to be sought and utilized. This formal relationship does not extend to referrals for services outside either the CCBHC or DCO, which are not encompassed within the reimbursement provided by the PPS.

Limited English Proficiency (LEP): LEP describes a characteristic of individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

Lived Experience: People with lived experience are individuals directly impacted by a social issue or combination of issues who share similar experiences or backgrounds and can bring the insights of their experience to inform and enhance systems, research, policies, practices, and programs that aim to address the issue(s). Because CCBHCs are designed to serve people with mental disorders, adults with serious mental illness, children with serious emotional disturbance and their families, and individuals with substance use disorders, individuals with lived experiences provide valuable insight to improving the delivery of CCBHC services.

Measurement-Based Care: For purposes of these criteria, measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision-making among clinicians and patients and to individualize ongoing treatment plans.

Peer/Family/Caregiver Support: A peer support provider is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member/caregiver of such a person, plus skills learned in formal training, to deliver services to promote recovery and resiliency. Peer providers may have titles that may differ from state to state, e.g., certified peer specialist, peer support specialist, recovery coach, family partner, parent partner specialist. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers. Peer support may be provided in behavioral health, health, and community settings, e.g., mobile crisis outreach, psychiatric rehabilitation, outpatient mental health/substance use treatment, emergency rooms, wellness programs, peer-operated programs.

Person or People Receiving Services: Within this document, person or people receiving services refers to people of all ages (i.e., children, adolescents, transition age youth, adults, and older adults) who are receiving one of the nine required services from the CCBHC (including through any DCO arrangements). Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. In many places in the Certification Criteria, the person receiving services has a role in directing, expressing preferences, planning, and coordinating services. In these situations, when there is a legal guardian for the person receiving services, these roles shall also be filled by the legal guardian.

Person-centered care: Person-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.38 That guidance defines "person-centered planning" as a process directed by the person with service needs which identifies recovery goals, objectives and strategies. If the person receiving services wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the person receiving services to the maximum extent possible. Person-centered planning also involves self-direction, which means the person receiving services has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers.

Practitioner or Provider: Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).

Recovery: Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 guiding principles of recovery

are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes Health ("making informed healthy choices that support physical and emotional wellbeing"); Home (safe, stable housing); Purpose ("meaningful daily activities … and the independence, income and resources to participate in society"); and Community ("relationships and social networks that provide support, friendship, love, and hope").

Recovery-oriented care: Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual's assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community.

Required services: The nine service areas identified in PAMA, which CCBHCs must provide to people receiving services based on their needs (described in Program Requirement 4: Scope of Services), 1. Crisis Services; 2. Screening, Assessment, and Diagnosis; 3. Person-Centered and Family-Centered Treatment Planning; 4. Outpatient Mental Health and Substance Use Services; 5. Primary Care Screening and Monitoring; 6. Targeted Case Management Services; 7. Psychiatric Rehabilitation Services; 8. Peer Supports and Family/Caregiver Supports; and 9. Community Care for Uniformed Service Members and Veterans.

Satellite Facility: *A satellite facility of a CCBHC is a facility that was established by the CCBHC, operated under the governance and financial control of that CCBHC, and provides the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services as specified in CCBHC certification criteria Program Requirement 4. For CCBHCs participating in the Section 223 Demonstration only, the Protecting Access to Medicare Act of 2014 stipulates that "no payment shall be made to a satellite facility of a CCBHC established after April 1, 2014, under this Demonstration." This definition does not limit the provision of services in nonclinical settings such as shelters and schools or at other locations managed by the CCBHC that do not meet the definition of a satellite facility.*

Shared Decision-Making (SDM): Shared decision-making is a best practice in behavioral and physical health that aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their health care services. It involves tools and resources that offer objective information upon which people in treatment and recovery incorporate their personal preferences and values. Shared decision-making tools empower people who are seeking treatment or in recovery to work together with their service providers and be active in their own treatment.

Trauma-informed: A trauma-informed approach to care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in people receiving services, their families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical and gender issues.

Appendix C. Scope of Services and Activities Definitions

CCBHC SERVICES THAT TRIGGER PPS RATE

EMERGENCY CRISIS INTERVENTION

CRISIS INTERVENTION SERVICE
An unanticipated, unscheduled emergency intervention, face-to-face, to resolve immediate, overwhelming problems that severely impair the client's ability to function or maintain in the community. Must include but not limited to: 24-hour/7 day per week triage, evaluation, and stabilization; access to inpatient treatment, diagnosis, and evaluation in external settings, such as jails and general hospitals; and referral services. Services can be provided to clients in their residence or natural setting. The crisis situation and significant functional impairment must be clearly documented.

Note: This service must be reported with a unique Client ID to trigger a PPS payment. Crisis Intervention Services should not be billed during transportation time; the Home and Community Based Travel code should be billed for related travel.

Staff Requirement: LBHP or Licensure Candidate.

H0007	HE/HF			Crisis Intervention Services	15 min
H0007	HE/HF	GT		Crisis Intervention Services – Telehealth	15 min

ADULT MOBILE CRISIS SERVICES

Mobile Crisis Services are face-to-face services delivered in community setting where the client lives, works and/or socializes, for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. Mobile Crisis Services are provided by established mobile crisis teams certified by ODMHSAS as a part of Community-Based Structured Crisis Centers (CBSCC). Either a team consisting of an LBHP/Licensure Candidate and a Case Manager, or just an LBHP/Licensure Candidate can provide/bill for Mobile Crisis. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

Note: This service must be reported with a unique Client ID. It can be provided to both admitted and non-admitted clients. Mobile Crisis Services can be billed the same day as Urgent Recovery Center (URC), but only if it is provided prior to admission to URC. The LBHP is the mobile crisis team lead and is responsible for billing the service and writing the service note. Case Management cannot be separately billed when providing mobile crisis services. If Mobile Crisis is not billed and a Case Manager goes out to assist an client with a resource crisis, they would bill that as Case Management under their existing outpatient authorization or a PG038 if not an existing client.

If the service recipient is a child/youth, please use Children's Mobile Response and Stabilization (H2016).

Staff Requirement: LBHP or Licensure Candidate

90839	HE/HF			Mobile Crisis	First 60 minutes
90839	HE/HF	GT		Mobile Crisis - Telehealth	First 60 minutes
90840	HE/HF			Mobile Crisis	Additional 30 minutes
90840	HE/HF	GT		Mobile Crisis - Telehealth	Additional 30 minutes

URGENT RECOVERY CARE

Urgent Recovery Care services are face-to-face services provided within Urgent Recovery Centers (URCs) certified by the ODMHSAS. The services are for the purpose of crisis assessment and management with focus on preliminary assessment of risk, mental status, and the need for further evaluation or treatment, for up to 23 hours and 59 minutes. Services may include observation.

Note: This service must be reported with a unique Client ID. Clients who require this service may be using substances during the crisis. Nothing else is billable during the Urgent Recovery Care encounter except physician (E/M) services.

Staff Requirement: LBHP or Licensure Candidate

S9485	HE			Urgent Care Recovery (23 hour crisis chairs)	23-hour, 59 min
S9485	HE	GT		Urgent Care Recovery (23-hour crisis chairs) - Telehealth	23-hour, 59 min

COMMUNITY-BASED STRUCTURED CRISIS CARE

Crisis stabilization consists of emergency psychiatric and substance abuse services for the resolution of crisis situations provided in a behavioral health care setting. Crisis stabilization includes 1-hour increments of care with the ability to provide a protective environment, basic supportive care, pharmacological treatment, non-medical to medically supervised detoxification, medical assessment and treatment and referral services to appropriate level and type of service.

Staff Requirement: LBHP or Licensure Candidate

S9484	HE			Community-based Structured Crisis Care (16 beds or less)	1 hour

CHILDREN'S MOBILE RESPONSE AND STABILIZATION SYSTEM

MOBILE RESPONSE TEAM, In-Person Response for Any and All Children, Youth and Families (currently in services or not)

The mobile response team (MRT) for the defined crisis may consist of a trained Wraparound Facilitator/BHCMII paired with an FSP, PRSS, and has access to a LBHP. If a crisis rises to a level requiring clinical intervention, MRTs have access to a LBHP via telehealth or face-to-face to provide immediate and direct clinical intervention (in-person or telephonically). Response includes:

On-site face to face emergency response within one hour of receipt of referral in home and community-based settings.

Initial Response requires implementation of specific children's assessment, such as the Crisis Assessment Tool (CAT) or Ohio Scales.

Determination of Immediate needs; Assesses for risk to self and others.

Identifies crisis precipitants to assist in developing or revising of the child and family individualized crisis and/or safety plan.

Refers and links for evaluation and assessment for mental health and substance use services.

The Wraparound Facilitator/BHCMII will facilitate access to CCBHC (or free choice provider) follow-up appointment with LBHP within 24 hours of crisis response as needed.

- Ensures access to a comprehensive array of behavioral health treatment services and community supports.

Staff Requirement: BHCCII/Care Coordinator (CC)

H2016	HE			Mobile Response Team, In-Person	15 min

FAMILY DE-ESCALATION AND STABILIZATION

This is a face-to-face response to children and their families who are at risk for a mental health crisis or have experienced a mental health crisis. The goal is to help these children and youth stay in their homes by responding quickly, helping families navigate the system to make informed choices about services and supports that best fit their needs, and connecting with the resources needed to avert a clinical crisis. Includes education and advocacy to ensure families can obtain appropriate services and crisis de-escalation. Services include:

· Engagement;
· Assistance with developing crisis diversion plans or relapse prevention plans;
· Assistance with the identification of natural supports and access to community services during and after a crisis;
· Short-term behavioral health intervention provided in the setting of choice of family (often in home);
· Facilitate linkage to ongoing community services and supports;
· Monitor safety; and
· Review and update of safety plan.

Staff Requirement: FSP

T1027	HE	TG		Family De-escalation and Stabilization Services, Face-to-Face	15 min

THERAPEUTIC BEHAVIORAL SERVICES – IN HOME STABILIZATION

A short-term mental-health intervention, 30 to 90 days in duration, that may require daily contact with the youth and is associated with a specific circumstance or situation identified in the youth's Crisis Plan. Services are designed to aid in sustaining the youth safely in the community. Supervision assists youth who are unable to manage routine/daily responsibilities by providing services for the identified youth in areas such as: attending school, management of curfews, compliance with safety plan requirements identified in the POC, attendance at support or therapy sessions, taking prescribed medications or other tasks or events as specified in the youth's Crisis Plan.

Staff Requirement: BHA, BHCMI, BHCMII

H2019	HE	TG		Therapeutic Behavioral Services – In Home Stabilization Following Crisis or Inpatient Episode (Must be a referral from OK Children's Mobile Response and Stabilization)	15 min

ASSESSMENT & DIAGNOSIS

INITIAL EVALUATION

The initial evaluation (including what was gathered as part of the preliminary screening and risk assessment) include at a minimum: (1) preliminary diagnoses; (2) source of referral; (3) reason for seeking care, as stated by the client or other individuals who are significantly involved; (4) identification of the client's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of all current prescriptions and over-the-counter medications, herbal remedies, and dietary supplements and the indication for any medications; (6) A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful; (7) the use of any alcohol and/or drugs and indication for any current medications; (8) an assessment of whether the client is a risk to self or to others, including suicide risk factors; (9) an assessment of whether the client has other concerns for their safety, such as intimate partner violence; (10) assessment of need for medical care (with referral and follow-up as required); and (11) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services; (12) For children and youth, whether they have system involvement (such as child welfare and juvenile justice) and (13) one or two immediate goal(s).

Beginning 7/1/2024, additional elements will be required: a summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful; the use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications; and for children and youth, whether they have system involvement (such as child welfare and juvenile justice).

Staff Requirement: Various staff can complete parts of the Initial Assessment, but the preliminary diagnosis must be completed by an LBHP or Licensure Candidate

T1023	HE/HF			Initial Evaluation, new clients	Event
T1023	HE/HF	GT		Initial Evaluation, new clients - Telehealth	Event

BEHAVIORAL HEALTH ASSESSMENT

A face-to-face formal evaluation to establish problem identification, clinical diagnosis, or diagnostic impression. An evaluation shall include an interview with the client (and family, if deemed appropriate); may also include psychological testing; scaling of the severity of each problem identified for treatment; and /or pertinent collaborative information. This includes independent evaluations performed for children. The evaluation will determine an appropriate course of assistance which will be reflected in the service plan.

Note: Bill the "date of service" as the date when the assessment is fully completed, and it has been signed by the LBHP or Licensure Candidate.

Staff Requirement: LBHP or Licensure Candidate

H0031	HE/HF			Behavioral Health Assessment - new client	Event
H0031	HE/HF	GT		Behavioral Health Assessment - new client - Telehealth	Event

SOCIAL DETERMINANTS OF HEALTH RISK ASSESSMENT

Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months." The risk assessment is in relation to the patient's social risk factors that influence the diagnosis and treatment of medical conditions.

Staff Requirement: Any qualified staff per the assessment

G0136	HE/HF			Social Determinants of Health Risk Assessment	Event
G0136	HE/HF	GT		Social Determinants of Health Risk Assessment - Telehealth	Event

COMPREHENSIVE ASSESSMENT – CHILDREN 0 - 5 YEARS

COMPREHENSIVE ASSESSMENT AND PLANNING – INFANT AND EARLY CHILDHOOD MENTAL HEALTH – AGES 0 - 5 YEARS

Infant Mental Health (IMH) is defined as the developing skills of a young child to form positive relationships with adults and peers; express a range of emotions both positive and negative in healthy ways; and explore their environment and learn; all within the context of their family, culture, and community (Zero to Three). CCBHC service criteria (4.d.6) requires the use of standardized and validated and developmentally appropriate screening and assessment tools for persons receiving services. The Center for Medicare and Medicaid Services (CMS) recommends the use of age appropriate diagnostic criteria (such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5™)) to help clinicians more accurately identify diagnosis in young children who do not have language skills or exhibit the same symptoms as older children and adults (see also diagnostic requirements in ODMHSAS PA Manual for children 0-36 months). The DC: 0 – 5™ uses developmentally specific diagnostic criteria and reflects the relational nature of mental health in infancy and early childhood.

The comprehensive assessment for children 0-5 is an in-depth, detailed assessment of the child's emotional, social, behavioral, and developmental functioning, Service components include a diagnostic assessment and/or a functional assessment by an LBHP to objectively determine the service intensity needs of children with (or significant risk for) Severe Emotional Disturbance (SED). Methods for completing an assessment include clinical interviewing, observation of the infant/toddler and their caregiver in multiple settings (if possible), use of standardized assessment tools and interactive assessments that are usually recorded and shared with the parent/caregivers as part of the assessment process. The current version of the DC:0-5™ manual recommends a minimum of 3-5 sessions for the comprehensive assessment, including:

- An initial evaluation as intake that includes relationship history, presenting symptoms and behaviors, history of pregnancy and delivery, family functioning and cultural and community patterns, and family's current

environmental conditions and stressors. The intake should also include review of any previous assessments and developmental screenings or evaluations, assessment of systems involvement such as child welfare, as well as a review of health records from primary health provider. The initial evaluation may be conducted without the child present [**Use code T1023**].

- Three separate sessions follow the initial session; one session must include face-to-face contact with the child.
- Standardized tools validated for the young child can assist with screening and assessing young children and the relationships with their caregivers in a reliable way to provide adequate information necessary for the development of an appropriate treatment plan. Tools identified in the description below are only meant as examples of appropriate tools and do not represent an exhaustive list:

  Developmental Screening that addresses functioning in all 5 areas of development:

  gross & fine motor, speech & language, cognitive, social emotional and adaptive skills - Survey of the Well Being of the Young Child (SWYC); Ages & Stages Questionnaire 3 (ASQ 3) – appropriate for CC or FSP to complete with training on how to administer the tool.

  Relationship assessment, including Parent Child Interaction Procedures and Narrative Interviews – Crowell and Working Model of Child Interview (LBHP with training required)

  Behavioral Screening – Early Childhood Behavioral Inventory (ECBI)

  Trauma Screening - Young Child PTSD Checklist or Traumatic Events Screening Inventory – Parent Report Revised (TESI-PRR)

  Parental mental health: Edinburgh Postnatal Depression Screening (EPDS)

  Family functioning: Protective Factors screening, and informal observation - appropriate for CC or FSP to complete.

  Ohio Scales for ages 4 and 5 - appropriate for CC or FSP to complete.
- The screenings and assessment tools administered and completed following the initial session should be reported by the LBHP for each session (up to 3) per child per calendar year, using the functional assessment code **[99483**].
- For the final assessment session, providers must use the most appropriate diagnosis code available. A crosswalk has been published as a guide for clinicians which helps convert the DC: 0 – 5™ to the current edition of the DSM and ICD-10 for billing purposes.
- include the results of Ohio Scales in the child's assessment and incorporate into the comprehensive evaluation for it to be considered complete. The final session to complete the mental health assessment is coded with the [**H0031 HE TG]**

Notes:

1) It is allowable for CCBHC providers to gather information for each required assessment component from internal staff, existing documentation, or external providers from whom the CCBHC has obtained a release of information and if the documentation is less than one year old.
2) Brief phone calls used to gather information from collaterals (e.g., phone call to day care center) may be reported as case management (**T1017)** and does not require the use of one of the assessment sessions. Telephone calls do not trigger a payment. Can be reported by a certified case manager or Family Support Provider (FSP).
3) Wraparound planning tools including the Strengths, Needs, & Culture Discovery (SNCD) and Crisis Plan/Functional Assessment (CP/FA) should be completed by a Behavior Case Manager II (referred to as Care Coordinator (to support development of the Wraparound Plan). These portions of the planning process may be billed under Targeted Case Management (TCM) to ensure availability of adequate sessions for completing remaining elements of the Comprehensive Assessment if child meets TCM criteria (see service definition

billable activities of TCM; **use code T1016**). The FSP's role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the process **(use code T1027**). Review of Wraparound plan should include an update of appropriate developmental screener along with the relevant Ohio Scales based on the age of the identified child**.**

4) The comprehensive evaluation must be completed before recommending additional CCBHC services.

In the event patient or family participation stops before all sessions are completed, CCBHCs may bill for the sessions completed.

T1023	HE			Initial Assessment - Children 0 - 5 years, new clients	Event
T1023	HE	GT		Initial Assessment - Children 0 - 5 years, new clients, telehealth	Event
99483	HE	HN		Functional Assessment - Children 0 - 5 years	Session
99483	HE	TF	HN	Functional Assessment – Review/Update Children 0 - 5 years	Session

Staff Requirement & Training: LBHP or licensure candidate required for initial and comprehensive assessments. Clinicians conducting comprehensive assessments for children 0-5 must be trained to utilize the DC:0-5™ for diagnosis in order to appreciate developmentally appropriate stages and how to differentiate when these same behaviors may indicate a problem that would warrant therapeutic intervention. (Some assessment/screeners have specific qualification; it depends on which screeners are used for each piece whether they are qualified. Providers should follow the published guidelines based on the tool being used.

Staff Requirement: LBHP or Licensure Candidate

H0031	HE	TG		Comprehensive Evaluation – Children 0 - 5 years	Event

Functional Assessment Component: - CHILDREN 0 - 5 YEARS

Standardized tools validated for the young child can assist with screening and assessing young children and the relationships with their caregivers in a reliable way. Following is a list of tools designed to screen the developmental performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. Tools identified in the description are only meant as examples of appropriate tools and do not represent an exhaustive list:

- Developmental Screening that addresses functioning in all 5 areas of development: gross & fine motor, speech & language, cognitive, social emotional and adaptive skills – Survey of the Well Being of the Young Child (SWYC), Ages & Stages Questionnaire 3 (ASQ 3)
- Relationship assessment, including Parent Child Interaction Procedures and Narrative Interviews – Crowell and Working Model of Child Interview
- Behavioral Screening – Early Childhood Behavioral Inventory (ECBI)
- Trauma Screening - Young Child PTSD Checklist or Traumatic Events Screening Inventory – Parent Report Revised (TESI-PRR)

Staff Requirement: LBHP, BHCMII/CC for initial assessment; BHCMII/CC, FSP for updates

99483	HE	HN			Functional Assessment (Ages 0-5)	Event
99483	HE	TF	HN		Functional Assessment Updates/Review (Ages 0-5)	Event

FUNCTIONAL ASSESSMENT (FA) Ages 6-20

All CCBHC children/youth are eligible to have a functional assessment completed. Children/Youth enrolled in Wraparound are required to have at least one Functional Assessment and subsequent Crisis Plan completed. The Functional Assessment may be performed prior to admission to SOC, especially when there is a safety concern to the youth, family or community, or a pending change of placement, i.e., a youth being returned home from foster care, inpatient treatment, or detention. The Functional Assessment is a process of gathering and organizing descriptive information about a child/youth's behaviors of concern to understand the underlying unmet needs the child/youth is experiencing which are driving the concerning behaviors. This information is gathered from the child/youth, their caregivers, their natural supports, and any professionals working with family, through a combination of observation and conversation with those relevant individuals who know the child/youth and family best and have knowledge of the concerning behaviors. A Functional Assessment is a necessary component in Crisis and Safety Planning and should be developed for each identified behavior or situation of concern in collaboration with the child/youth, their caregivers, and any necessary supports, i.e., Child and Family Team for youth enrolled in Wraparound. The Functional Assessment process takes into consideration any unmet needs across life domains. A Functional Assessment can be used as a tool in any phase of Wraparound, with any member of the family, whenever a problem arises, for as many behaviors or situations as need to be addressed. Functional Assessments should be revised whenever new information arises, as should the related Crisis or Safety Plans.

Note: This assessment can include up to six hours of non-face-to-face time of the qualified staff for report preparation. The Functional Assessment process should be completed within 30 days of the first meeting, so that Crisis and Safety Planning are completed proactively. Further assessments (review/update) will be provided and reported as medically necessary as determined by the CFT, hut no less frequently than every 90 days. All independent assessments/evaluations performed for children/youth should be added to the comprehensive care plan to be considered complete.

Staff Requirement: BHCCII/CC, FSP or BHA

99483	HE	HM				Functional Assessment (Ages 6-20)	Event
99483	HE	TF	HM			Functional Assessment Updates/Review (Ages 6-20)	Event
99483	HE	HM	TG			Functional Assessment (Ages 6-20) – Telehealth*	Event
99483	HE	TF	HM	GT		Functional Assessment Updates/Review (Ages 6-20) – Telehealth*	Event

*This service may be provided through telehealth only if requested by the family.

COMPREHENSIVE ASSESSMENT – PACT

The client's psychiatrist or APN, primary PACT case manager, and individual treatment team members shall prepare the written comprehensive assessment(s) within six (6) weeks of admission. The comprehensive assessment components are a psychiatric diagnosis examination, a comprehensive nursing assessment, and a functional assessment.

PSYCHIATRIC DIAGNOSTIC EXAMINATION: PACT

Biopsychosocial assessment which may include discussion with family or other sources in addition to the patient. The diagnostic interview is indicated for initial or periodic diagnostic evaluation of a patient for suspected or diagnosed psychiatric illness.

Staff Requirement: MD and DO OR APRN and PA with psychiatric certification.

90791	HE			Psychiatric Diagnostic Examination (no medical services)	Event
90791	HE	GT		Psychiatric Diagnostic Examination (no medical services) - Telehealth	Event
90792	HE			Psychiatric Diagnostic Examination (with medical services)	Event
90792	HE	GT		Psychiatric Diagnostic Examination (with medical services) - Telehealth	Event

COMPREHENSIVE NURSING ASSESSMENT: PACT

A nursing assessment is a comprehensive assessment of medical, dental, and other health needs. If there is a gap in care of more than one year, or if the team cannot obtain a history and physical that identifies the medical, dental, and other health needs completed within the last 12 months, an RN must complete the nursing assessment, or a referral must be made to a PCP for a wellness visit. A nursing assessment must be conducted by a Registered Nurse, per Oklahoma Board of Nursing. Patient Assessment Guidelines can be located at https://www.ok.gov/nursing/ptassessgl.pdf.
For adults, either obtain annual physical records from primary care or update nursing assessment annually.

Staff Requirement: Registered Nurse

T1001	HE			Comprehensive Nursing Assessment	Event

FUNCTIONAL ASSESSMENT (FA), PACT

The functional assessment for clients who have been admitted to a PACT program shall include the following areas:

- Extent and effect of any violence within the client's living situation(s) or personal relationships;
- The current version of the Alcohol Severity Index (ASI) within the first 6 weeks of admission and as clinically indicated thereafter;
- Education and employment;

- o Social development and functioning by a team professional as approved by the team leader;
- o Activities of daily living, to be completed by the team professional or Recovery Support specialist under the supervision of the team leader;
- o Family structure and relationships by a team professional as approved by the team leader
- o Historical timeline by all team members under the supervision of the team leader.

Staff Requirement: Member of the PACT team

99483	HE	TG			Functional Assessment (PACT)	Event

PSYCHIATRIC DIAGNOSTIC EXAMINATION

Biopsychosocial assessment which may include discussion with family or other sources in addition to the patient. The diagnostic interview is indicated for initial or periodic diagnostic evaluation of a patient for suspected or diagnosed psychiatric illness.

Staff Requirement: MD and DO OR APRN and PA with psychiatric certification.

90791	HE			Psychiatric Diagnostic Examination (no medical services)	Event
90791	HE	GT		Psychiatric Diagnostic Examination (no medical services) - Telehealth	Event
90792	HE			Psychiatric Diagnostic Examination (with medical services)	Event
90792	HE	GT		Psychiatric Diagnostic Examination (with medical services) - Telehealth	Event

MEDICATION EVALUATION AND MANAGEMENT FOR BEHAVIORAL HEALTH, NEW PATIENT

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Staff Requirement: Psychiatrist, APRN with psychiatric credentials, PA who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

99202-99205	HE/HF			Medication Evaluation and Management for **Behavioral Health**, New Patient	Refer to code for time
99202-99205	HE/HF	GT		Medication Evaluation and Management for **Behavioral Health**, New Patient – Telehealth	Refer to code for time

MEDICATION EVALUATION AND MANAGEMENT FOR BEHAVIORAL HEALTH, ESTABLISHED PATIENT

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history, a problem-focused examination, and straightforward medical decision-making. Counseling nature of the problem(s) and the patient's and /or family's needs. Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem history, a problem-focused examination, and medical decision-making of low complexity. Counseling nature of the problem(s) and the patient's and /or family's needs. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity. Counseling nature of the problem(s) and the patient's and /or family's needs. Usually the presenting problem(s) are moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive, and medical decision-making of high complexity. Counseling nature of the problem(s) and the patient's and /or family's needs. Usually the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Staff Requirement: Psychiatrist, APRN with psychiatric credentials, PA who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

99212-99215	HE/HF			Medication Evaluation and Management for **Behavioral Health**, Established Patient	Refer to code for time

99212-99215	HE/HF	GT		Medication Evaluation and Management for **Behavioral Health**, Established Patient – Telehealth	Refer to code for time

NEW PATIENT HOME SERVICES

99341 Home visit for evaluation and management of a new patient. Presenting problem(s) of low severity; typically, 20 minutes spent face-to-face.

99342 Home visit for evaluation and management of a new patient. Presenting problem(s) of moderate severity; typically, 30 minutes spent face-to-face.

99343 Home visit for evaluation and management of a new patient. Presenting problem(s) of moderate to high severity; typically, 45 minutes spent face-to-face.

99344 Home visit for evaluation and management of a new patient. Presenting problem(s) of high severity; typically, 60 minutes spent face-to-face.

99345 Home visit for evaluation and management of a new patient. Usually, patient is unstable or developed significant new problem requiring immediate physician attention; typically, 75 minutes spent face-to-face.

Staff Requirement: MD or DO

99341-99345	HE/HF			New Patient Home Services **Behavioral Health**	Refer to code for time

ESTABLISHED PATIENT HOME SERVICES

99347 Home visit for evaluation and management of an established patient. Presenting problem(s) are self-limited or minor; typically, 15 minutes spent face-to-face.

99348 Home visit for evaluation and management of an established patient. Presenting problem(s) of low to moderate severity; typically, 25 minutes spent face-to-face.

99349 Home visit for evaluation and management of an established patient. Presenting problem(s) of moderate to high severity; typically, 40 minutes spent face-to-face.

99350 Home visit for evaluation and management of an established patient. Presenting problem(s) of moderate to high severity; patient may be unstable or developed significant new problem requiring immediate physician attention; typically, 60 minutes spent face-to-face.

Staff Requirement: MD or DO

99347-99350	HE/HF			Established Patient Home Services for **Behavioral Health**	Refer to code for time

COMPREHENSIVE NURSING ASSESSMENT

A nursing assessment is a comprehensive assessment of medical, dental, and other health needs. If there is a gap in care of more than one year, or if the team cannot obtain a history and physical that identifies the medical

dental and other health needs completed within the last 12 months, an RN must complete the nursing assessment, or a referral must be made to a PCP for a physical assessment. A nursing assessment must be conducted by a Registered Nurse, per Oklahoma Board of Nursing.

Staff Requirement: Registered Nurse

T1001	HE/HF				Comprehensive Nursing Assessment	Event

PATIENT-CENTERED TREATMENT PLANNNG OR SIMILAR PROCESSES INCLUDING RISK ASSESSMENT

COMPREHENSIVE CARE PLAN, NEW CLIENT

The process of developing a written plan based on the assessments (conducted by LBHP or Licensure Candidate) that identify the clinical needs/problems necessitating treatment. This process includes establishing goals and objectives; planning appropriate interventions; identifying treatment modalities, responsible staff, and discharge criteria. Client involvement must be clearly documented if the client is 14 years of age or older. If the client is under 18 years of age, the parent or guardian must also be involved as allowed by law.

Note: Treatment team members can assist with writing the service plan, with oversight from LBHP or Licensure Candidate. The LBHP or Licensure Candidate must complete the assessment, review, and sign the service plan.

Required: Face-to-face; written documentation which must include client participation and signature.
Staff Requirement: LBHP or Licensure Candidate

H0032	HE/HF			Comprehensive Care Plan, new client	Event
H0032	HE/HF	GT		Comprehensive Care Plan, new client - Telehealth	Event

COMPREHENSIVE CARE PLAN UPDATE

A comprehensive review and evaluation of the current treatment of the customer. This includes a review of the service plan with the customer and the update of the plan as required. For mental health it includes the CAR evaluation, and for substance abuse it includes the ASI or TASI. This review may be in the form of a multi-disciplinary staffing or at times only the clinician and customer. All compensable service plan reviews must include an update to the individual service plan. Customer involvement must be clearly documented if the customer is 14 years of age or older, if the customer is under 18 years of age, the parent or guardian must also be involved; as allowed by law.

Note: Treatment team members can assist with writing the service plan, with oversight from LBHP or Licensure Candidate. The LBHP or Licensure Candidate must complete the assessment, review, and sign the service plan. Service plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the clinician and the customer; however, they can only be billed/reimbursed once every six months.

Required: Face-to-face; written documentation which must include customer participation and signature.

Staff Requirement: LBHP or Licensure Candidate

H0032	HE/HF	TF		Comprehensive Care Plan Update	Event
H0032	HE/HF	TF	GT	Comprehensive Care Plan Update - Telehealth	Event

INDIVIDUAL, FAMILY, GROUP COUNSELING & PSYCHOTHERAPY (Use for non-Dual Eligible clients)

*Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of age) criteria as set forth in the Prior Authorization Manual.

BEHAVIORAL HEALTH COUNSELING AND THERAPY, INDIVIDUAL

A face-to-face therapeutic session with one-on-one interaction between a clinician and a client to promote emotional or psychological change to alleviate disorders. Psychotherapy must be goal directed and use a generally accepted approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment, in accordance with an individualized service plan.

Staff Requirement: LBHP or Licensure Candidate

H0004	HE/HF			Behavioral Health Counseling and Therapy, per 15 min, Individual	15 min
H0004	HE/HF	GT		Behavioral Health Counseling and Therapy, per 15 min, Individual - Telehealth	15 min

BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MIN, FAMILY WITH OR WITHOUT PATIENT PRESENT

A face-to-face therapeutic session conducted by a clinician with family members/couples conducted in accordance with a documented service plan focusing on treating family/marital problems and goals. The service must be provided to specifically benefit a ODMHSAS eligible individual as identified in a service plan and use generally accepted treatment methods for this modality of treatment.

Note: This service is typically inclusive of the identified client but may be performed if indicated without the client's presence. When the client is an adult, his/her permission must be obtained in writing.

Staff Requirement: LBHP or Licensure Candidate

H0004	HE/HF	HR		Behavioral Health Counseling and Therapy, per 15 min, Family with patient present	15 min
H0004	HE/HF	HR	GT	Behavioral Health Counseling and Therapy, per 15 min, Family with patient present - Telehealth	15 min
H0004	HE/HF	HS		Behavioral Health Counseling and Therapy, per 15 min, Family without patient present	15 min
H0004	HE/HF	HS	GT	Behavioral Health Counseling and Therapy, per 15 min, Family without patient present - Telehealth	15 min

BEHAVIORAL HEALTH COUNSELING AND THERAPY – GROUP

A face-to-face therapeutic session with a group of individuals using the interaction of the clinician and two or more clients to promote positive emotional or behavioral change. The focus of the group must be directly related to goals and objectives of the individual client service plan and use a generally accepted framework for this modality of treatment. This service does not include social skill development or daily living skill activities. Group Psychotherapy for adults is limited to eight total clients, except for the residents of nursing and ICF/MR facilities where the limit is six total residents. Group size is limited to a total of six clients for all children. A group may not consist solely of related individuals. Group Psychotherapy is not reimbursable for children under the age of three (3).

Note: This service can also be provided as Multi-Family Group Psychotherapy, where designated clients and their families meet regarding similar issues. The service is billed once per family unit present and is billed under the designated client. Sessions are limited to a maximum of eight families.

Staff Requirement: LBHP or Licensure Candidate

H0004	HE/HF	HQ		Behavioral Health Counseling and Therapy, per 15 min, Group	15 min
H0004	HE/HF	HQ	GT	Behavioral Health Counseling and Therapy, per 15 min, Group - Telehealth	15 min

SUBSTANCE ABUSE EARLY INTERVENTION COUNSELING

A school based/sanctioned service provided by substance abuse treatment and prevention professionals. Interactive, preventive counseling that may include training in life skills, such as problem-solving, responsibility, communication, and decision-making skills, which enable clients to successfully resist social and other pressures to engage in activities that are destructive to their health and future. This service must be recommended by a physician or other licensed practitioner. OHCA rules for requirements related to subcontracting with a school - 317:30-5-1021 Eligible providers.

Staff Requirement: LBHP or Licensure Candidate

H0022	HF				Substance Abuse Early Intervention Counseling (	15 min
H0022	HF	GT			Substance Abuse Early Intervention Counseling (	15 min
H0022	HF	HQ			Substance Abuse Early Intervention Counseling - Group	15 min

PARENTING SKILLS TRAINING, GROUP (FAMILIES WITH CHILDREN 0-17) EBP

This is community-based intensive behavioral health intervention delivered to treat emotional disturbances or co-occurring substance use disorders. Services are designed to correct or ameliorate symptoms of mental health and/or substance abuse problems and to reduce the likelihood of the need for more intensive/restrictive services. Services include approved curriculum-based skills training and education with the client and the family directed specifically towards the identified youth and his or her behavioral health needs and goals as identified in the individualized plan of care. Treatment may include trauma-informed and evidence-based practices (EBP) related to adverse childhood experiences. Services may be provided individually in the office, home, or

community, or in single or multi-family group sessions. Group sessions may not be provided in the home. If appropriate, client may not be present.

Note: Curriculum should be age appropriate for the child.

Staff Requirement: LBHP or Licensed Candidate, BHA, or CC in under supervision of LBHP

S9444	HE/HF				Parenting Skills Training, Group (Families with Children 0-17) EBP	15 min

GROUP BEHAVIORAL HEALTH INTERVENTIONS, ages 6-17 (child is present)

Group behavioral health interventions specifically target children and adolescents identified through systematic and equitable screening as experiencing mild distress, functional impairment, or being at risk for particular problems. Examples of these small group interventions encompass social skills groups, and groups addressing challenges such as stress related to traumatic events.

Access to Support Services:
Students have access to support services available in both community and in-school treatment settings, emphasizing the need for clear goals and purposes in each setting. Collaboration agreements, such as a Memorandum of Understanding (MOU), between CCBHCs and school districts are expected, aligning with state law, HB4106. Targeted supports involve team meetings for processing behavioral health referrals, increasing reinforcement for positive behavior, restoring positive relationships, analyzing root causes of behavior for supportive interventions, using restorative interventions for conflict resolution, and providing small-group and structured interventions for specific needs.

Exclusions/Limitations:
Settings: Group interventions are not provided in the home.

Recreation-Oriented Services: Billing does not cover services primarily recreation-oriented or provided in non-medically supervised settings, including sports activities, exercise groups, craft hours, leisure and social hours, meals, community trips, and tours.

Personal Care Services: Exclusions encompass personal care services assisting in daily activities, safety maintenance, and activities provided without professional skills or training.

Transportation: Behavioral health interventions related to transportation to and from school are not billable.

Group size: Group size should not exceed ten (10) participants,

This framework ensures that interventions are purposeful, clinically sound, and aligned with the specific needs of children and adolescents in both community and school settings.

Staff Requirement: LBHP, BHCMII (CC), BHA

S9446	HE/HF				Group Behavioral Health Interventions, ages 6-17 (child	15 min

					is present)	

MULTIPLE-FAMILY GROUP PSYCHOTHERAPY (AGES 0-3)

Multiple Family Group Psychotherapy treatment will allow beneficiaries and their families with similar issues to meet face-to-face in a group with a clinician. The group's focus is to assist the beneficiary and their family members in resolving emotional difficulties, encourage personal development and ways to improve and manage their functioning skills.

Multiple Family Group Psychotherapy requires one professional and a minimum of 2 family units (a minimum of 4 individuals) and a maximum of up to eight individuals which includes the beneficiaries and their families.

Staff Requirement: LBHP or Licensure Candidate

90849	HE				Multiple-family group psychotherapy (ages 0-3)	45+ min

FAMILY PSYCHOTHERAPY, CONJOINT PSYCHOTHERAPY WITH THE PATIENT PRESENT (AGES 0-3)

Family psychotherapy which entails family participation in the treatment process of a child in that family. For the child being treated, it is with the expectation that intervention in their family interactions will improve their emotional or behavioral disturbances.

Staff Requirement: LBHP or Licensure Candidate

90847	HE				Family Psychotherapy with Patient Present (ages 0-3)	26+ min

OUTPATIENT CLINIC PRIMARY CARE SCREENING AND MONITORING

SELF-MANAGEMENT EDUCATION AND TRAINING, FACE-TO-FACE

A nurse uses a standard curriculum to educate a patient about his or her disease or disorder, for example, asthma or diabetes. The nurse also provides training on how to manage it more effectively. This education and training service enables the patient and or the caregiver or family to effectively manage the disease. The healthcare professional spends 30 minutes with an individual patient.

Staff Requirement: LPN under RN supervision

98960	HE/HF				Self-management education and training, face-to-face, 1 patient	Event
98961	HE/HF				Self-management education and training, face-to-face, 2-4 patients	Event

PREVENTIVE HEALTH SCREENING

INFECTIOUS AGENT ANTIBODY, DETECTION BY ENZYME IMMUNOASSAY
Infectious agent antibody detection by enzyme immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening.

Staff Requirement: Refer to screening requirements

G0432	HE/HF				Infectious Agent Antibody, detection by enzyme immune assay	Event

INFECTIOUS AGENT ANTIBODY DETECTION BY ENZYME
Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV2, screening.

Staff Requirement: Refer to screening requirements

G0433	HE/HF				Infectious Agent Antibody, detection by enzyme immunosorbent assay	Event

INFECTIOUS AGENT ANTIBODY, RAPID
Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.

Staff Requirement: Refer to screening requirements

G0435	HE/HF				Infectious Agent Antibody, rapid	Event

DIABETES SCREENING TEST GLUCOSE; QUANTITATIVE, BLOOD (EXCEPT REAGENT STRIP)
The lab analyst performs a test to measure the amount of glucose in a patient's blood using a method other than a reagent strip.

Staff Requirement: Refer to screening requirements

82947	HE/HF				Diabetes Screening Test Glucose; quantitative, blood (except reagent strip)	Event

DIABETES SCREENING TEST GLUCOSE; POST GLUCOSE DOSE (INCLUDES GLUCOSE)
The lab analyst tests a sample, typically blood, for glucose, also known as blood sugar. The collecting provider takes the sample at a set time after the patient has ingested an amount of liquid or a meal with a high glucose content.

Staff Requirement: Refer to screening requirements

82950	HE/HF				Diabetes Screening Test Glucose; quantitative, blood (except reagent strip)	Event

DIABETES SCREENING TEST GLUCOSE; TOLERANCE TEST (GTT)

The lab analyst performs a test to measure the amount of glucose in a patient's blood at three different times: initially while fasting, and two more times, each at a specific time after the patient takes an oral dose of glucose.

Staff Requirement: Refer to screening requirements

82951	HE/HF				Diabetes Screening Test Glucose; quantitative, blood (except reagent strip)	Event

PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL

At an encounter separate from a preventive medicine visit, the provider offers counseling related to subjects appropriate for the patient's age, family history, and areas of concern. The subjects covered relate to prevention and risk factor reduction. Use this code for a session lasting roughly 15 minutes.

Staff Requirement: Refer to screening requirements

99402	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	30 min
99403	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	45 min
99404	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	60 min

COUNSELING THERAPY FOR OBESITY

For persons with BMI equal to or greater than 30, face-to-face behavioral counseling for obesity for qualified beneficiaries. The services must be delivered either one-on-one (patient and counselor), or for groups of up to 10 individuals.

Staff Requirement: Refer to screening requirements

G0447	HE/HF				Counseling Therapy for Obesity – Individual	15 min
G0473	HE/HF				Counseling Therapy for Obesity - Group	30 min

TARGETED CASE MANAGEMENT

Planned referral, linkage, monitoring and support, and advocacy provided in partnership with a client to support that client in self-sufficiency and community tenure. Case management actions may take place in the client's home, in the community, or in the facility. A DMHSAS Certified Behavioral Health Case Manager, in accordance with a service plan developed with and approved by the client and qualified staff, must provide the services. The plan must demonstrate the client's need for specific services provided. Billable activities include: completion of a strengths based assessment; development of case management care plan; referral, linkage and advocacy to assist with gaining access to appropriate community resources; monitoring and support related to the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress; follow-up contact with the client if they miss any scheduled appointments (including physician/medication, therapy, rehabilitation, or other supportive service appointments as delineated on the service plan); and crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist client(s) from progression to a higher level of care. Targeted Case Management is only available to persons with SMI, SED, or on the ODMHSAS Most in Need List.

Transitional Case management services can also be provided in an inpatient setting to assist with transition and discharge planning. For children ages 0-21 that are transitioning out of inpatient facilities only, these services should be reported under the Transitional Case Management codes below (following specialized guidelines for prior authorization and billing). Assistance with transition and discharge planning for clients who do not meet criteria for "Transitional Case Management" (e.g., over the age of 21), these services should be reported under the Outpatient in Inpatient Setting codes listed below.

Staff Requirement: BHCM II, LBHP, Licensed Candidate

T1016	HE/HF	HO			Targeted Case Management - Clients with SMI/SED, or on the Most in Need list only	15 min
T1016	HE/HF	HO	GT		Targeted Case Management - Clients with SMI/SED, or on the Most in Need list only - Telehealth	15 min
T1016	HE/HF	HN			Targeted Case Management - Clients with SMI/SED, or on the Most in Need list only	15 min
T1016	HE/HF	HN	GT		Targeted Case Management - Clients with SMI/SED, or on the Most in Need list only - Telehealth	15 min
T1016	HE/HF	HO	HY		Targeted Case Management - Clients with SMI/SED, or on the Most in Need list in custody of OJA	15 min
T1016	HE/HF	HO	HY	GT	Targeted Case Management - Clients with SMI/SED, or on the Most in Need custody of OJA - Telehealth	15 min
T1016	HE/HF	HO	HU		Targeted Case Management - Clients with SMI/SED on the Most in Need list in custody of DHS	15 min
T1016	HE/HF	HO	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need custody of DHS - Telehealth	15 min
T1016	HE/HF	HN	HY		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA	15 min
T1016	HE/HF	HN	HY	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA – Telehealth	15 min
T1016	HE/HF	HN	HU		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS	15 min
T1016	HE/HF	HN	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS - Telehealth	15 min

PSYCHIATRIC REHABILITATIVE SERVICES

INDIVIDUAL PSYCHOSOCIAL REHABILITATIVE TREATMENT

A face-to-face service provided one on one by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. This service includes educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum-based education and skills practice and should be goal specific in accordance with an individualized service plan. Travel time to and from treatment sessions is not included.

In order to receive PSR services the client must meet medical necessity requirements but there are no limits and documentation required in the outpatient PA manual is not required.

Note: This service is generally performed with only customers but may include the customer and the customer's family/support system during a service that focuses on the customer's diagnosis, symptom/behavior management, and recovery-based curriculum.

Staff Requirement: BHCM II (Certification issued July 1, 2013, or after), CADC, LBHP, or Licensure Candidate

H2017	HE/HF			PSR (individual) 6 years and older	15 min
H2017	HE/HF	GT		PSR (individual) 6 years and older - Telehealth	15 min

GROUP PSYCHOSOCIAL REHABILITATIVE TREATMENT

A face-to-face, group service provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. This service includes educational and supportive services regarding independent living, self- care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum-based education and skills practice and should be goal specific in accordance with an individualized service plan. Travel time to and from activities is not included. The maximum staffing ratio is fourteen customers to one qualified staff for adults aged 18 and older.

Note: This service is generally performed with only customers but may include the customer and the customer's family/support system in a group that focuses on the customer's diagnosis, symptom/behavior management, and recovery-based curriculum.

Staff Requirement: BHCM II (Certification issued July 1, 2013, or after) or CADC or LBHP or Licensure Candidate

H2017	HE/HF	HQ	HW		PSR (group) 18 years and older	15 min
H2017	HE/HF	HQ	HW	GT	PSR (group) 18 years and older – Telehealth	15 min

ENHANCED ILLNESS MANAGEMENT AND RECOVERY (EIMR)

Program staff who have received ODMHSAS facilitated training on Enhanced Illness Management and Recovery (EIMR) for PSR Programs, and who are providing curriculum-based life skills training through IMR should utilize the following code/modifier to report time spent doing IMR.

Staff Requirement: BHCM II (Certification issued July 1, 2013, or after), or CADC, LBHP or Licensure Candidate, and Completion of ODMHSAS facilitated training on Illness Management and Recovery (IMR) for PSR Programs.

H2017	HE	TF	TG	Enhanced Illness Management & Recovery	15 min

PSYCHOEDUCATION AND COUNSELING

Services are designed to restore, rehabilitate, and support the client's overall health and wellness. Services are intended for clients to provide purposeful and ongoing psychoeducation and counseling that are specified in the client's person-centered, individualized plan of care. Components include delivery of manualized wellness management interventions such as:

a. Wellness Recovery Action Plans (or WRAP®) is a self-management and recovery system designed to decrease intrusive or troubling feelings and behaviors; increase personal empowerment; improve quality of life; and assist people in achieving their own life goals and dreams.

b. Illness Management and Recovery/Wellness Management and Recovery (IMR/WMR) are evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives. WMR is an essential part of recovery in that it improves the client's ability to manage one's illness, avoids relapses and hospitalizations by giving people greater control over their lives, allows clients more time to pursue goals by lessening the time spent dealing with their mental illness, and leads to better quality of life by lessening the client's distress from symptoms.

c. Components for either model include practitioner use of motivational, educational, and cognitive behavioral techniques such as:

- Psychoeducation about mental illness;
- Cognitive behavioral approaches to medication;
- Planning for relapse prevention;
- Social skills training to strengthen social support; and
- Coping skills to manage symptoms of mental illness.

Psychoeducation and Counseling can be weekly sessions, individual or group format, and generally last between three (3) to six (6) months. WRAP and IMR/WMR components are psychoeducation and counseling services, which are based on a client's specific medical needs in accordance with the client's individual treatment plan. Education does not take place in a classroom setting.

Staff Requirement: RN, LPN

H2027	HE/HF				Psychoeducation and Counseling, Individual	15 min
H2027	HE/HF	GT			Psychoeducation and Counseling, Individual - Telehealth	15 min
H2027	HE/HF	HQ			Psychoeducation and Counseling, Group	15 min

CHILDREN'S PSYCHOSOCIAL REHAB (CPSR)

GROUP PSYCHOSOCIAL REHABILITATIVE TREATMENT, 12 - 17

A face-to-face, group service provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. This service includes educational and supportive services regarding independent living, self- care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum-based education and skills practice and should be goal specific in accordance with an individualized service plan. Travel time to and from activities is not included. The maximum staffing ratio is eight customers to one qualified staff for children under the age of 18.

Note: This service is generally performed with only customers but may include the customer and the customer's family/support system in a group that focuses on the customer's diagnosis, symptom/behavior management, and recovery-based curriculum.

Staff Requirement: BHCM II (Certification issued July 1, 2013, or after) or CADC or LBHP or Licensure Candidate

H2017	HE/HF	HQ			PSR (group) 12 - 17 years	15 min
H2017	HE/HF	HQ	GT		PSR (group) 12 - 17 years – Telehealth	15 min

THERAPEUTIC BEHAVIORAL SERVICES

Therapeutic Behavioral Services, (TBS) - Services are goal directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components:

(1) Basic living and self-help skills: Clients are given the skills to manage their daily lives which have been affected by mental health and/or substance use disorder issues; Clients' lives are restored by learning safe and appropriate behaviors to use, which may include stress and anger management, behavior redirection and self-esteem enhancement.

(2) Social skills: Through rehabilitative interventions, clients are able to identify and comprehend the physical, emotional, and interpersonal needs of others which enables them to interact with others.

(3) Communication skills: Clients are able to overcome the disabling effects that mental health and/or substance use disorder issues have on their everyday lives by learning how to appropriately. communicate their physical, emotional, and interpersonal needs to others.

(4) Organization and time-management skills: Clients are enabled to manage and prioritize their daily activities which have been diminished by their mental health and/or substance use disorder issues.

(5) Transitional living skills: Clients are enabled through rehabilitative interventions to begin partial-independent and/or fully independent lives.

The activities listed above are provided one-on-one and may be provided by a QBHA or higher under the supervision of, or direction of a LBHP. All services may be provided in the home, residential or school settings, or in the community. (Must be a referral from OK Children's Mobile Response and Stabilization)

Staff Requirement: LBHP or Under Supervision, CADC, BHCMII, BHA

H2019	HE			Therapeutic Behavioral Services	15 min

CHILDREN'S FAMILY/CAREGIVER PSYCHOEDUCATION, GROUP (0-5 years)

Treatment Services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship. IMH Treatment Services are grounded in attachment theory, are relationship focused, developmentally appropriate and trauma informed, and address the interplay between the infant and parent or other significant caregivers. IMH Treatment Services focus on the parent-child dyad and are designed to improve infant and family functioning in order to reduce the risk for more severe behavioral, social, emotional and relationship disturbances as the infant gets older.

Qualified professionals. LBHP or Licensure Candidate

H2027	HE	HQ	HS		Children's Family Psychoeducation (ages 0-5)	15 min

INTENSIVE IN-HOME SUPPORTS, SKILLS TRAINING

These intensive services are provided in a supportive and interactive manner and directed toward maintaining or restoring a positive family relationship. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multi-systemic approach to treatment and have a goal of keeping families together. The services may include wraparound and family preservation programs. Services may also be directed toward family restoration when a child has been in an out-of-home placement. IIH support services are characterized by small caseloads, short duration of services, 24-hour availability of staff, and the provision of services primarily in the family's home or in another environment familiar to the family. This service is provided by BHCMII, with LBHP supervision. Other intensive service components such as crisis intervention, counseling, therapeutic behavior services, parent training and targeted case management services should be reported separately.

Note: for children 6 – 17 years of age.

Staff Requirement: BHCMII

S5110	HE			Intensive in-home supports, Skills Training	15 min

SELF MANAGEMENT

MEDICATION TRAINING AND SUPPORT

The medication training and support service is a documented review and educational session by a licensed registered nurse, or physician assistant focusing on the customer's response to medication and compliance with the medication regimen. The customer must be present at the time of the service. The review will include current medications and vital signs. A physician is not required to be present, but must be available for consult, if necessary. The service is designed to maintain the customer on the lowest level of the least intrusive medications, encourage normalization and prevent hospitalization.

Note: The billing system will not allow for Medication Training and Support and Evaluation & Management (E&M)

codes to be billed on the same day.

Ambulatory Detox: An agency must have Chapter 24 certification in order to provide this service under Ambulatory Detox.

Staff Requirement: Licensed Registered Nurse, Advanced Practice Nurse, or Physician Assistant under the supervision of a physician

H0034	HE/HF			Medication training and support	15 min
H0034	HE/HF	GT		Medication training and support – Telehealth	15 min

OCCUPATIONAL THERAPY (OT) EVALUATION, LOW

Occupational therapy evaluations include an occupational profile, medical and therapy history, relevant assessments, and development of a plan of care, which reflects the therapist's clinical reasoning and interpretation of the data. Coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and the needs of the patient, family and/or other caregivers. At a minimum, each of the following components noted in the code descriptors must be documented, in order to report the selected level of occupational therapy evaluation.

Occupational therapy evaluation, low complexity, requiring these components:
● An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;
● An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
● Clinical decision making of **low complexity**, which includes an analysis of the occupational profile, analysis of data from problem focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Occupational therapy evaluation, **moderate complexity,** requiring these components:

- An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;
- An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Occupational therapy evaluation, **high complexity**, requiring these components:

- An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance;
- An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Staff Requirement: Occupational Therapist

97165	HE/HF			OT Evaluation, Low	Refer to code for time
97165	HE/HF	GT		OT Evaluation, Low - Telehealth	Refer to code for time
97166	HE/HF			OT Evaluation, Medium	Refer to code for time
97166	HE/HF	GT		OT Evaluation, Medium – Telehealth	Refer to code for time
97167	HE/HF			OT Evaluation, High	Refer to code for time
97167	HE/HF	GT		OT Evaluation, High – Telehealth	Refer to code for time

Occupational Therapy Re-evaluation
Reevaluation of occupational therapy established plan of care, requiring these components:

- An assessment of changes in patient functional or medical status with revised plan of care;
- An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
- A revised plan of care.

A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.

Typically, 30 minutes are spent face-to-face with the patient and/or family.

Staff Requirement: Occupational Therapist

97168	HE/HF			Occupational Therapy Reevaluation	30 min
97168	HE/HF	GT		Occupational Therapy Reevaluation – Telehealth	30 min

THERAPEUTIC EXERCISE

Therapeutic exercises are performed in either an active, active-assisted or passive (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening) approach. The exercises may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity, or mobility that has resulted from a specific disease or injury. 15 minutes.

Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance). Therapeutic exercise includes activities related to strengthening, endurance training, range of motion, and flexibility. These activities can include use of free weights, exercise machines such as treadmills and range of motion exercises (passive and active). Therapeutic exercises describe services aimed at improving a parameter, such as vocational services. The process of developing or creating appropriate employment situations for clients with a serious mental illness who desire employment to include, but not limited to: the identification of employment positions, conducting job analysis, matching clients to specific jobs, facilitating job expansion or advancement and communicating with employers about training needs.

Staff Requirement: Occupational Therapist

97110	HE/HF			Therapeutic Exercise	15 min
97110	HE/HF	GT		Therapeutic Exercise - Telehealth	15 min

NUTRITION SERVICES INITIAL ASSESSMENT AND INTERVENTION

Medical nutrition therapy: initial assessment and intervention, individual, face-to-face with the client, each 15 minutes.

Staff Requirement: Registered Dietitian Nutritionist

97802	HE/HF			Nutrition Services Initial Assessment And Intervention	15 min
97802	HE/HF	GT		Nutrition Services Initial Assessment And Intervention - Telehealth	15 min

SUBSEQUENT NUTRITION SERVICES AND REASSESSMENT AND INTERVENTION

It consists of a nutritional assessment, the assignment of a specific diet, counseling services, and/or specialized therapies to treat an illness or condition. Nutritional counseling/MNT is covered when ordered by a physician and provided by a Registered Dietitian/Nutritionist to treat an illness or medical condition in which MNT is proven to be effective for treatment.

Staff Requirement: Registered Dietitian Nutritionist

97803	HE/HF			Subsequent Nutrition Services and Reassessment And Intervention	15 min
97803	HE/HF	GT		Subsequent Nutrition Services and Reassessment And Intervention - Telehealth	15 min

HEALTH AND WELLNESS EDUCATION

WELLNESS SELF-MANAGEMENT PLAN DEVELOPMENT

Adults: Individual physical wellness plan development is a systematic approach to collecting information from clients that identifies risk factors, provides individualized feedback, and links the client with at least one intervention to promote health, sustain function and/or prevent disease. (The Wellness Plan should address the 8 dimensions of Health).

Children: Wellness goals for children may be set around: physical health and development, behavioral/emotional functioning, and social functioning. These goals may be identified in the Wraparound Plan. Wellness Resource Skills Development, Individual (Must have completed Wellness Coaching).

Required: Face-to-face; individual or group activity. Group size should not exceed ten (10) participants, and this service has a limit of 2 ½ hours per day.

Staff Requirement: Wellness Coach

S5190	HE/HF			Wellness Self-Management Plan Development (with HRA)	15 min
S5190	HE/HF	GT		Wellness Self-Management Plan Development (with HRA) - Telehealth	15 min

WELLNESS FOCUSED APPRAISAL

A wellness focused appraisal is conducted by a Licensed Practical Nurse and is an appraisal of an client's status and situation at hand, contributing to comprehensive assessment by the RN, supporting initial and ongoing data collection and deciding who needs to be informed of the information and when to inform.

Staff Requirement: LPN

S5190	HE/HF	TG		Wellness Focuses Appraisal	15 min

WELLNESS RESOURCE SKILLS DEVELOPMENT

The process of providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support. Services can also include the provision of the Live Longer, Live Stronger program.

Note: When providing services related to tobacco cessation, the tobacco specific codes listed below should be used.

Required: Face-to-face; individual or group activity. Group size should not exceed ten (10) participants, and this service has a limit of 2 ½ hours per day.

Staff Requirement: Wellness Coach

T1012	HE			Wellness Resource Skills Development,	15 min

				Individual	
T1012	HE	GT		Wellness Resource Skills Development, Individual - Telehealth	15 min
T1012	HE	HQ		Wellness Resource Skills Development, Group	15 min
T1012	HE	HQ	GT	Wellness Resource Skills Development, Group - Telehealth	15 min

TOBACCO CESSATION SUPPORT

When providing wellness services related to tobacco cessation, the tobacco specific codes listed below should be used.

Staff Requirement: Wellness Coach

T1012	HE/HF	SE		Tobacco Cessation Support, Individual	15 min
T1012	HE/HF	SE	GT	Tobacco Cessation Support, Individual	15 min
T1012	HE/HF	SE	HQ	Tobacco Cessation Support, Group	15 min

ORAL/INJECTION/MEDICATION ADMINISTRATION (RN)

Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit.

Staff Requirement: Registered Nurse or Licensed Practical Nurse within scope of practice

T1502	HE			Oral/Injection/Medication Administration-	Event

SUPPORTED EMPLOYMENT

PRE-VOCATIONAL SERVICES

Services that focus on development of general work behavior. The purpose of prevocational services is to utilize individual and group work- related activities to assist clients with developing positive work attitudes, personal characteristics, and work behaviors; to develop functional capacities; and to obtain optimum levels of vocational development.

IPS: When utilizing the IPS Model of Employment, the function of IPS Engagement and IPS Assessment shall be reported under this service.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service (Employment Consultants are preferred). To provider IPS services, staff has to be IPS credentialed.

H2014	HE/HF	TF		Prevocational Services
H2014	HE/HF	TF	HB	Prevocational Services - IPS

VOCATIONAL SERVICES

The process of developing or creating appropriate employment situations for clients with a serious mental illness who desire employment to include, but not limited to: the identification of employment positions, conducting job analysis, matching clients to specific jobs, facilitating job expansion or advancement and communicating with employers about training needs.

Note: This service can be reported with a unique Client ID. A generic Client ID (999999992) can be reported if utilizing the IPS Model of Employment but cannot be used to trigger a PPS rate.

IPS: When utilizing the IPS Model of Employment, the function of IPS Job Development and Job Placement shall be reported under this service.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service. (Employment Consultants are preferred). To provider IPS services, staff has to be IPS credentialed.

H2014	HE/HF			Vocational Services	15 min
H2014	HE/HF	HB		Vocational Services - IPS	15 min

EMPLOYMENT TRAINING

Time actually spent, on-the-jobsite, working with the client, managers, supervisors, co-workers, business clients, and including active observation. Includes anything that is done on-the-jobsite to assist the client.

Required: Face-to-face; individual or group activity.

IPS: When utilizing the IPS Model of Employment, the function of IPS Job Coaching shall be reported under this service.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service (Employment Consultants are preferred). To provider IPS services, staff has to be IPS credentialed.

H2025	HE/HF			Employment Training	15 min
H2025	HE/HF	HB		Employment Training - IPS	15 min

JOB RETENTION SUPPORT

A minimum of two contacts per month for a 3-month period with the focus of each contact being job retention and related support. Each contact must be documented in the clinical record and describe one or more of the following direct services: work adjustment counseling, job accommodation negotiation, after work support group, or other specifically described work related supports. Contacts can be in an individual or group setting.

Note: The “Per Diem” code can only be billed once every 3 months.

IPS: When utilizing the IPS Model of Employment, the function of IPS Follow-Along Supports shall be reported under this service.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service (Employment Consultants are preferred). To provider IPS services, staff has to be IPS credentialed.

H2026	HE/HF			Job Retention Support	Once every 3 months
H2026	HE/HF	HB		Job Retention Support - IPS	Once every 3 months

PEER SUPPORT AND COUNSELING SERVICES AND FAMILY/CAREGIVER SUPPORTS

COMMUNITY RECOVERY SUPPORT/RECOVERY SUPPORT SPECIALIST

This service provides the training and support necessary to ensure active participation of the customer (and family when applicable) in the service plan development process and with the on-going implementation, support, and reinforcement of skills learned throughout the treatment process. Training may be provided to the customer to assist with their recovery process. This may involve assisting the customer in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to their mental illness and treatment; development and enhancement of problem-solving skills, coping mechanisms, and strategies for symptom/behavior management; assistance in understanding crisis plans and plan of care process; training on medications or diagnoses; development and enhancement of communication and socialization skills; interpreting choice offered by service providers; and assisting with understanding policies, procedures, and regulations that impact those with mental illness while living in the community.

Note: Individual activity. Provided to children aged 16 or over with SED and/or substance use disorder(s) and adults age 18 and over with SMI and/or substance use disorder(s). This service can be provided in an inpatient setting to assist with transition/discharge planning (specific code for inpatient setting should be used).

Face-to-face group community recovery support services conducted by trained clients who have experienced similar behavioral health problems. This service can include the facilitation of Wellness Recovery Action Plans (WRAP).

Note: Group activity. Provided to children aged 16 or over with SED and/or substance use disorder(s) and adults age 18 and over with SMI and/or substance use disorder(s).

Staff Requirement: Peer Recovery Support Specialist

H2015	HE/HF			Community Recovery Support/Recovery Support Specialist	15 min
H2015	HE/HF	GT		Community Recovery Support/Recovery Support Specialist - Telehealth	15 min
H2015	HE/HF	HQ		Community Recovery Support/Recovery Support Specialist - Group	15 min

FAMILY SUPPORT SERVICES

GROUP CAREGIVER BEHAVIORAL MANAGEMENT TRAINING (FAMILY/CAREGIVER)

Multiple-family group behavior management/ modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/ caregiver(s);

initial 60 minutes, additional 15 minutes.

Staff Requirement: LBHP/Candidate, BHCMII under supervision of LBHP

96202	HE/HF			Group Caregiver Behavioral Management Training (family/caregiver)	60 min
96203	HE/HF			Group Caregiver Behavioral Management Training (family/caregiver)	Additional 15 min

FAMILY TRAINING AND SUPPORT

This service provides the training and support necessary to ensure active participation of the family or client in the treatment planning process and with the ongoing implementation, support, and reinforcement of skills learned throughout the treatment process. Training may be provided to family members to increase their ability to provide a safe and supportive environment in the home and community. This may involve assisting the client or family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management; assistance in understanding crisis plans and plan of care process; training on medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures, and regulations that impact those with mental illness while living in the community.

Note: Individual activity. Provided to children or youth under the age of 25. This service can be provided in an inpatient setting to assist with transition/discharge planning (specific code for inpatient setting should be used).

Staff Requirement: Family Support Provider

T1027	HE/HF			Family Training & Support	15 min
T1027	HE/HF	GT		Family Training & Support – Telehealth	15 min
T1027	HE/HF	HQ		Family Training & Support – Group	15 min

CCBHC ACTIVITIES THAT DO NOT TRIGGER PPS RATE

PRELIMINARY SCREENING AND RISK ASSESSMENT

A formal process of evaluation of the presenting problems of a client which results in the referral of the client to relevant service resources. The evaluation process is to determine the likelihood that an client may be experiencing mental health, substance abuse, trauma, or gambling related disorders. The purpose is not to establish the presence or specific type of such disorder but to establish the need for referral for more in-depth clinical evaluation and assessment and/or referral to relevant service resources. Services can include the time spent on screening (face to face and by telephone), time spent on assisting with intake documentation, and time spent on referral to external agencies at the time of screening and admission only. This includes mental health, substance abuse, co-occurring, drug court, gambling, and residential screening.

Suicide Screening: Must use evidence-based suicide screening tools, such as the Columbia Suicide Severity Rating Scale (C-SSRS), Ask Suicide-Screening Questions (ASQ), or Suicide Cognitions Scale (SCS)

Note: When utilizing screening instruments, will need to adhere to requirements of the screening tool, such as level of staffing allowed to administer and whether or not the tool can be administered over the phone or must

be face-to-face.

Staff Requirement: Staff requirements are based on what is required to administer the specific screening tool(s) used. The following are eligible to provide this service, as allowed by the screening tool(s) used: BHA, or FSP, or PRSS, or BHCM I, or BHCM II (Certification issued July 1, 2013, or after), or CADC, or LBHP or Licensure Candidate. Urgent Recovery Center: LPN and RN can do health screenings.

H0002	HE	HN			MH Screening & Referral, new clients	Event
H0002	HF	HN			SUD Screening & Referral, new clients	Event
H0002	HE	HH			Co-occurring Screening & Referral, new clients	Event
H0002	HE	HN	GT		MH Screening & Referral, new clients - Telehealth	Event
H0002	HF	HN	GT		SUD Screening & Referral, new clients – Telehealth	Event
H0002	HE	HH	GT		Co-occurring Screening & Referral, new clients - Telehealth	Event
H0002	HE/HF/HV	TG	U1		Suicide Screening	Event
H0002	HE/HF/HV	TG	U1	GT	Suicide Screening - Telehealth	Event
H0002	HE	HN	HB		Ambulatory Detox Screening & Referral, new clients	Event
H0002	HE	HN	HB	GT	Ambulatory Detox Screening & Referral, new clients - Telehealth	Event
H0001	HV	HN			Gambling Screening & Referral, new clients	Event
H0001	HV	HN	GT		Gambling Screening & Referral, new clients	Event
H0002	HV	TF			Gambling Pre-screen, new clients	Event
H0002	HV	TF	GT		Gambling Pre-screen, new clients - Telehealth	Event
H0001	HF	TG	U1		Complex Screening & Referral	Event
H0001	HF	TG	U1	GT	Complex Screening & Referral – Telehealth	Event

DUI ADSAC ASSESSMENT

A face-to-face clinical interview evaluating an client's need and receptivity to substance abuse treatment and his or her prognosis.

Staff Requirement: An individual certified to conduct alcohol and other drug assessments related to driver's license revocations.

H0001	HF	U5		DUI Assessment	Event

DRUG SCREEN

A drug screen is a method of testing for the use of drugs by clients in substance abuse treatment. It must be qualitative and test for multiple drug classes and will include Urine Analysis (U.A.s). U.A.s should be administered if indicated by the clinical interview or assessments administered to the clients. Appropriate documentation is

required.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

H0003	HF			Urine Screen	15 min

INITIAL EVALUATION

The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, includes at a minimum:

1. Preliminary diagnoses
2. The source of referral
3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful
7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence.
10. Assessment of need for medical care (with referral and follow-up as required)
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.
13. At least one immediate treatment goal. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)

Staff Requirement: While many staff may complete parts of the initial evaluation, the preliminary diagnosis must be completed by an LBHP or Licensure Candidate.

T1023	HE/HF	FQ			Initial Evaluation - New Client – Telephone	Event

CRISIS INTERVENTION SERVICE – Telephone

An unanticipated, unscheduled emergency intervention to resolve immediate, overwhelming problems that severely impair the client's ability to function or maintain in the community. Must include but not limited to: 24-hour/7 day per week triage, evaluation, and stabilization; access to inpatient treatment, diagnosis, and evaluation

in external settings, such as jails and general hospitals; and referral services. Services can be provided to clients in their residence or natural setting. The crisis situation and significant functional impairment must be clearly documented.

Note: This service must be reported with a unique Client ID to trigger a PPS payment. Crisis Intervention Services should not be billed during transportation time; the Home and Community Based Travel code should be billed for related travel.

Staff Requirement: LBHP or Licensure Candidate.

H0030	HE/HF			Crisis Intervention Services – Telephone*	15 min

CARE COORDINATION

FAMILY CONFERENCE INTERPRETATION OR EXPLANATION OF RESULTS OF PSYCHIATRIC, OTHER MEDICAL EXAMINATIONS AND PROCEDURES TO FAMILY OR OTHER RESPONSIBLE PERSONS, OR ADVISING THEM HOW TO ASSIST PATIENT

Family conference is used when the treatment of the patient may require explanations to the family, employers, or other involved persons for their support in the therapy process. This may include reporting of examinations, procedures, and other accumulated data. The service must be face-to-face.

Staff Requirement: PA, APRN, RN, MD, DO

90887	HE/HF/HV			Family Conference Interpretation	15 min
90887	HE/HF/HV	GT		Family Conference Interpretation - Telehealth	15 min

TREATMENT TEAM MEETING

A formal and structured process of interaction among staff from the same agency for the purpose of evaluating and updating the treatment plan based on the customer's documented progress when the customer is not present.

99368	HE/HF	HB			Treatment Team Meeting – IPS Intra-agency Clinical Consultation for Field Monitoring	15 min
99368	HE/HF	HB	GT		Treatment Team Meeting – IPS Intra-agency Clinical Consultation for Field Monitoring – Telehealth	15 min
99368	HE/HF	TF	HB		Treatment Team Meeting – IPS	15 min
99368	HE/HF	TF	HB	GT	Treatment Team Meeting – IPS - Telehealth	15 min

MEDICATION RECONCILIATION

Medication reconciliation is the process of comparing a client's medication orders to all of the medications that the client has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. This service may be provided by an RN. This should be documented in the EMR within 30 days of discharge from an inpatient facility. Client follow-up must occur within 72 hours after discharge.

The physician needs to order any changes, additions, or deletions to the medication.

Staff Requirement: RN/LPN

1111F	HE	TG		Medication reconciliation

SCHEDULED TEAM CONFERENCE

A formal, structured process of interaction among three (3) or more staff from the same HH agency for discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision will be used. It will be used to identify additional resources needed, to discuss the transition of the client to a different level within the complex care program, and to modify the ICP as necessary.

Note: No more than one staff present will shadow report the team conference.

G9007	HE/HFHV			Scheduled Team Conference	15 min
G9007	HE/HF/HV	GT		Scheduled Team Conference – Telehealth	15 min

PSYCHIATRIST, PCP ADMINISTRATIVE TIME

This includes direction and general supervision of care management services that are provided for behavioral health conditions and medical conditions, which are generally provided by clinical staff. Management and/or coordination of services are provided and overseen, as needed, psychosocial needs, and activities of daily living. Monitor usage of psychotropic medications through report analysis and follow up with outliers; collaboration with OKDHS, OHCA, other care partners and stakeholders to share information and to ensure state protocols are in place to improve the use of psychotropic medications among children in foster care, in accordance with Federal guidance and best practice guidelines. This service may also include inter-professional consultations which are services requested by telephone or internet by a physician or other qualified healthcare professional seeking a consultant's expert opinion for a client without a face-to-face client encounter with the consultant.

Staff Requirement: Physician/PCP Consultant

G9012	HE/HF			Psychiatrist, PCP Administration Time	Event

INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTANT (IECMHC)

IECMHC is a prevention-based service that pairs a mental health consultant with families and adults who work with infants and young children in the different settings where they learn and grow, such as childcare, preschool, and their home. The aim is to build adults' capacity to strengthen and support the healthy social and emotional development of children—early and before intervention is needed. IECMHC involves expanding the competence of staff to understand and respond to challenging behaviors, emphasizes the importance of early relationships, promotes positive social and emotional development in young children and empowers staff to link families with community resources. IECMHC should practice in a trauma-responsive and culturally sensitive manner.

Staff Requirement: IECMHCs are highly trained LBHPs/candidates with specialized skill/ training in utilizing/taking a consultative stance and knowledge in childhood development, the effects of stress and trauma on families, the importance of attachment, and the impacts of adult mental illness on developing children.

Staff Requirement: LBHP or Licensure Candidate

S9482	HE			IECMH CONSULTANT	15 min

MEDICATION REMINDER SERVICES, NON-FACE-TO-FACE

Medication reminders may include telephone prompts, electronic alerts, and medication deliveries, as well as pill box organization and packing.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

S5185	HE/HF			Medication Reminder Services, Non-Face-to-Face; Per Month

PARTICIPATING IN AN APPOINTMENT

CCBHC team member may accompany a client to a medical appointment while the client is receiving treatment to assist the client in meeting their needs. An CCBHC intervention must be provided to report this code, i.e., client education, reinforcing self-management skills, and modeling or assisting with questions to healthcare providers regarding health concerns.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

T2001	HE/HF/HV			Sitting in an appointment	15 min

NURSE CARE MANAGEMENT SERVICES INCLUDES QUALITY REPORTING

T2022	HE/HF	TD		Nurse Care Management Services includes quality reporting, RN	15 min
T2022	HE/HF	TE		Nurse Care Management Services includes quality reporting, LPN	15 min

CARE COORDINATION

Care coordination is the implementation of the plans of care with active client involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

Care coordination is the deliberate organization of client care which includes sharing information among all the participants concerned to achieve safer and more effective care. This means the client's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the client. (AHRQ). These primarily non-face to face services must be documented in the client's medical record and are primarily driven by protocols and guidelines developed by the PCP consultant or RN in collaboration with the client's behavioral health practitioners.

Staff Requirement: Any level of staff

T2022	HE/HF			Care Coordination	15 min
T2022	HE/HF	TF		Care Coordination – Review data sources, HIE, Population Performance	15 min

OUTPATIENT IN INPATIENT SETTING TRANSISTIONAL

H2015	HE/HF	HK			Community Recovery Support/Recovery Supp Specialist - Outpatient in Inpatient Setting Transitional*	PRSS
T1027	HE/HF	HK			Family Training & Support - Transition from a higher level of care. *	FSP

*Transitional services cannot be used to trigger a payment. An outpatient service must be provided in the month to trigger a bundled payment.

COMMUNITY RECOVERY SUPPORT/RECOVERY SUPPORT SPECIALIST - TELEPHONE

H2015	HE/HF	FQ		Community Recovery Support/Recovery Support Specialist – Telephone	15 min

FAMILY TRAINING AND SUPPORT - TELEPHONE

T1027	HE/HF	TF*		Family Training & Support - Telephone	15 min

**Please note the telephonic modifier was not changed.*

CASE MANAGEMENT SERVICES

Staff Requirement: BHCMI, BHCM II, CADC, LBHP or License Candidate

T1017	HE/HF/HV	HO			Case Management	15 min
T1017	HE/HF/HV	HN			Case Management	15 min
T1017	HE/HF/HV	HM			Case Management	15 min
T1017	HE/HF/HV	HO	GT		Case Management - Telehealth	15 min
T1017	HE/HF/HV	HN	GT		Case Management - Telehealth	15 min
T1017	HE/HF/HV	HM	GT		Case Management - Telehealth	15 min
T1017	HE/HF/HV	HO	93		Case Management - Telephone	15 min
T1017	HE/HF/HV	HN	93		Case Management - Telephone	15 min
T1017	HE/HF/HV	HM	93		Case Management - Telephone	15 min
T2023	HE/HF	HO	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	15 min
T2023	HE/HF	HN	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	15 min
T2023	HE/HF	HM	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	15 min
T2023	HE/HF	HO	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	15 min
T2023	HE/HF	HN	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	15 min
T2023	HE/HF	HM	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	15 min

T2023	HE/HF	HO	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC) - Telehealth	15 min
T2023	HE/HF	HN	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC) – Telehealth	15 min
T2023	HE/HF	HM	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC) – Telehealth	15 min
T2023	HE/HF	HO	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC) - Telehealth	15 min
T2023	HE/HF	HN	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC) – Telehealth	15 min
T2023	HE/HF	HM	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC) - Telehealth	15 min
T2023	HE/HF	HO	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC) - Telephone	15 min
T2023	HE/HF	HN	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC) – Telephone	15 min
T2023	HE/HF	HM	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC) – Telephone	15 min
T2023	HE/HF	HO	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC) – Telephone	15 min
T2023	HE/HF	HN	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC) – Telephone	15 min
T2023	HE/HF	HM	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC) - Telephone	15 min

TARGETED CASE MANAGEMENT – TELEPHONE OR TRANSITIONING

T1016	HE/HF	HO	93		Targeted Case Management - Clients with SMI/SED, or on the Most in Need list – Telephone	15 min
T1016	HE/HF	HN	93		Targeted Case Management - Clients with SMI/SED, or on the Most in Need list – Telephone	15 min
T1016	HE/HF	HO	HY	93	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA- Telephone	15 min
T1016	HE/HF	HN	HU	93	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS - Telephone	15 min
T1016	HE/HF	HO	HY	93	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA- Telephone	15 min
T1016	HE/HF	HN	HU	93	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS - Telephone	15 min
T1016	HE/HF	HO	TG		Transitional Targeted Case Management –	15 min

					Clients with SMI/SED, or on the Most in Need list	
T1016	HE/HF	HN	TG		Transitional Targeted Case Management - Clients with SMI/SED, or on the Most in Need list	15 min
T1016	HE/HF	HO	HY	TG	Transitional Targeted Case Management - Clients with SMI/SED, or on the Most in Need list custody of OJA	15 min
T1016	HE/HF	HO	HU	TG	Transitional Targeted Case Management - Clients with SMI/SED, or on the Most in Need list custody of DHS	15 min
T1016	HE/HF	HN	HY	TG	Transitional Targeted Case Management - Clients with SMI/SED, or on the Most in Need list custody of OJA	15 min
T1016	HE/HF	HN	HU	TG	Transitional Targeted Case Management - Clients with SMI/SED, or on the Most in Need list custody of DHS	15 min

INDIVIDUAL AND FAMILY COUNSELING & PSYCHOTHERAPY - TELEPHONE

H0004	HE/HF	FQ			Behavioral Health Counseling and Therapy, per 15 min, Individual – Telephone	15 min
H0004	HE/HF	HR	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family with patient present - Telephone	15 min
H0004	HE/HF	HS	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family without patient present - Telephone	15 min
H0022	HF	FQ			Substance Abuse Early Intervention Counseling (if school-based, must be pursuant to IEP) - Telephone	15 min

PSYCHOSOCIAL REHAB SERVICES – TELEPHONE

H2017	HE/HF	FQ			Individual Rehabilitative Treatment, 6 years and older – Telephone	15 min

QUALITY MEASURE REPORTING
ADULT BODY MASS INDEX

G8417	HE			BMI is documented above normal parameters and a follow-up plan is documented
G8418	HE			BMI is documented below normal parameters and a follow-up plan is documented

G8419	HE			BMI documented outside normal parameters, no follow-up plan documented, no reason given
G8420	HE			BMI is documented within normal parameters and no follow up plan is required
G8421	HE			BMI not documented and no reason is given
G8422	HE			BMI not documented; with documentation the client is not eligible for BMI calculation

TOBACCO SCREENING

1036F	HE			Current tobacco non-user OR Tobacco Screening not Performed for Medical Reasons
4004F	HE			Patient screened for tobacco use AND received tobacco cessation intervention if identified as a tobacco user OR Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco
4004F	HE	1P		Documentation of medical reason(s) for not screening for tobacco use
4004F	HE	8P		Tobacco screening OR tobacco cessation intervention not performed; reason not otherwise specified

UNHEALTHY ALCOHOL SCREENING

G9621	HE			Client identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling
G9622	HE			Client not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method
G9623	HE			Documentation of medical reason(s) for not screening for unhealthy alcohol use in the measurement year or the year prior
G9624	HE			Client not screened for unhealthy alcohol screening using a systematic screening method OR client did not receive brief counseling, reason not given

DEPRESSION SCREENING

G8431	HE			Screening for clinical depression is documented as being positive AND a follow-up plan is documented
G8432	HE			Clinical depression screening not documented; reason not given
G8433	HE			Screening for clinical depression not documented documentation stating the patient is not eligible
G8510	HE			Screening for clinical depression is documented as negative, a follow-up plan is not required
G8511	HE			Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

G8940	HE			Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible

DEPRESSION REMISSION

G9509	HE			Depression remission at twelve months as demonstrated by a twelve-month (+/-30 days) PHQ-9 score of less than 5
G9510	HE			Depression remission at twelve months not demonstrated by a twelve-month (+/-30 days) PHQ-9 score of less than five. Either PHQ-9 score was not assessed during the allowed time period or is greater than or equal to 5
G9717	HE			Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

SOCIAL DETERMINANTS OF HEALTH SCREENING

M1207	HE			Screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
M1208	HE			Not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety

OUTREACH, STAFF EDUCATION, TRAINING, & TRAVEL
COMMUNITY OUTREACH AND ENGAGEMENT

Through outreach and engagement, the client is informed about CCBHC enrollment; the benefits of CCBHC enrollment to the client; privacy; and selecting a PCP, if needed.

Note: This service is to be used for clients who are not already admitted for services, and can be provided either face to face, or through telephone contact. Face to face outreach takes place outside of behavioral health facilities, in the community. This service can only be reported with a generic Customer ID (999999992).

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

H0023	HE/HF/HV			Community Outreach and Engagement	20 min

INTENSIVE OUTREACH

Activities directed toward potential customer or persons who are at risk, with the purpose of establishing trust and rapport, explaining services available, and dispelling likely or actual resistance to services on the part of the potential customer.

Note: This service is to be used for clients who are not already admitted for services, and can be provided either

face to face, or through telephone contact. Face to face outreach takes place outside of behavioral health facilities, in the community. This service can be reported with either a unique Customer ID or a generic Customer ID (999999992).

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

H0023	HE/HF/HV	TF		Intensive Outreach (unique or generic ID)	15 min
H0023	HE/HF/HV	TF	FQ	Intensive Outreach (unique or generic ID) – Telephone	15 min

CUSTOMER FOLLOW-UP SERVICES This service includes:

1) Follow-up contact with a customer to re-engage them in treatment, support continued stability in the community, and/or offer assistance related to recovery.
2) Contact with a customer to assist with transition/discharge planning for clients in residential treatment (except for psychiatric residential treatment which should be provided under case management), halfway house, detox, jail or prison, nursing home, and follow-up after crisis intervention;
3) Case management follow-up contact with the customer of less than eight (8) minutes related to missed appointments (including physician/medication, therapy, rehabilitation, or other supportive service appointments as delineated on the service plan). When the case management follow-up service duration is eight (8) or more minutes, the service provided must be billed as case management;
4) RN/LPN follow-up with a customer after an appointment to address chronic medical conditions.

Required: Face-to-face; telephone contacts (written documentation is required for all telephone contacts); and written follow-up correspondence. Customer does not need to be present. Leaving voice or text messages for clients and other failed communication attempts are not compensable

Staff Requirement: [MH, SA, and GA] Any level of ODMHSAS outpatient service provider can provide service functions 1) & 2). Service function 3) must be provided by: BHCM I, or BHCM II (Certification issued July 1, 2013, or after), or CADC, or LBHP or Licensure Candidate Service function 4) must be provided by an RN/LPN.

H0006	HE/HF			Customer Follow-Up Services #1 & 2	15 min
H0006	HE/HF	FQ		Customer Follow-Up Services #1 & 2 - Telephone	15 min
H0006	HE/HF	TG		Customer Follow-Up Services #3	15 min
H0006	HE/HF	TG	FQ	Customer Follow-Up Services #3 - Telephone	15 min
H0006	HF	TD		Customer Follow-Up Services #4	15 min
H0006	HF	TD	FQ	Customer Follow-Up Services #4 - Telephone	15 min

TRAVEL

Travel can be to the clients' home, to various locations within the community or to facilities where the client is receiving other related services.

Staff Requirement: Any level of service provider

S0215	HE/HF			Travel	15 min
S0215	HE/HF	HB		Travel – IPS	15 min

STAFF EDUCATION & TRAINING

Systematic presentation of selected information to impart knowledge or instructions, to increase understanding of specific issues or programs, and to examine attitudes and/or behaviors.

Note: This service can only be reported with a generic Customer ID (999999992).
Required: Written documentation.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

97537	HE/HF/HV			Staff Education & Training (generic (ID)	15 min
97537	HE/HF/HV	GT		Staff Education & Training (generic (ID) – Telehealth	15 min

MISCELLANEOUS SERVICES

DIVORCE ARBITRATION

Services to include but not be limited to: Arbitration and mediation in contested child custody matters; court-order visitation supervision; educational services for divorce and related issues; provision of individual and/or group counseling to children/families regarding divorce and related issues; and crisis diversion. Services may also include screening and referral.

Note: This service can be reported with either a unique Client ID or a generic Client ID (999999992).
Staff Requirement: BHCM I BHCM II (Certification issued July 1, 2013, or after), or CADC, or LBHP or Licensure Candidate

H0022	HE			Divorce Arbitration (unique or generic ID)	15 min

Gambling services can be reported but do not trigger the monthly rate.

Appendix D. Procedure codes

CCBHC SERVICES THAT TRIGGER THE PPS RATE						
HCPCS /CPT	Mod 1	Mod 2	Mod 3	Mod 4	Description of Service	Provider Type
1		CRISIS BEHAVIORAL HEALTH SERVICES (Established /Existing)				
					EMERGENCY CRISIS INTERVENTION, 24 HOUR MOBILE	
H0007	HE/HF				Crisis intervention services	LBHP/candidate
H0007	HE/HF	GT			Crisis intervention services - Telehealth	LBHP/candidate
90839	HE/HF				Mobile Crisis - first 60 minutes	LBHP/candidate
90839	HE/HF	GT			Mobile Crisis - first 60 minutes - Telehealth	LBHP/candidate
90840	HE/HF				Mobile Crisis - additional 30 minutes	LBHP/candidate
90840	HE/HF	GT			Mobile Crisis - additional 30 minutes - Telehealth	LBHP/candidate
	URGENT CARE RECOVERY AND CRISIS STABILIZATION					
S9485	HE				Urgent Care Recovery (23-hour crisis chairs)	LBHP/candidate
S9485	HE	GT			Urgent Care Recovery (23-hour crisis chairs) - Telehealth	LBHP/candidate
S9484	HE				Community Based Structured Crisis Care (16 beds or less) beginning 1/1/2022	LBHP/candidate
	CHILDREN'S MOBILE RESPONSE AND STABILIZATION SYSTEM					
H2016	HE				Mobile Response Team (In Person)	BHCMII/CC
T1027	HE	TG			Family De-escalation and Stabilization, In-Person	FSP
H2019	HE	TG			Therapeutic Behavioral Services - In-home community stabilization following crisis or inpatient episode, In-Person.	BHA/BHCMI/ BHCMII
2					ASSESSMENT AND DIAGNOSIS	
T1023	HE/HF				Initial Evaluation - new client	LBHP/candidate
T1023	HE/HF	GT			Initial Evaluation - new client - Telehealth	LBHP/candidate
H0031	HE/HF				Behavioral Health Assessment	LBHP/candidate
H0031	HE/HF	GT			Behavioral Health Assessment - Telehealth	LBHP/candidate
G0136	HE/HF				Social Determinants of Health Risk Assessment	any qualified staff per assessment.
G0136	HE/HF	GT			Social Determinants of Health Risk Assessment - Telehealth	any qualified staff per assessment.
H0031	HE	TG			Comprehensive Evaluation – Children 0 - 5 years	LBHP/candidate
99483	HE	HN			Functional Assessment (Ages 0-5)	LBHP/BHCMII/CC
99483	HE	TF	HN		Functional Assessment Updates/Review (Ages 0-5)	BHCMII/CC
99483	HE	HM			Functional Assessment (Ages 6-20)	BHCMII/CC, FSP, BHA
99483	HE	TF	HM		Functional Assessment Updates/Review (Ages 6-20)	BHCMII/CC, FSP, BHA
99483	HE	HM	GT		Functional Assessment (Ages 6-20) - Telehealth*	BHCCII/CC, FSP, BHA
99483	HE	TF	HM	GT	Functional Assessment Updates/Review (Ages 6-20) - Telehealth*	BHCMII/CC, FSP, BHA
99483	HE	TG			Functional Assessment (PACT)	PACT Team
96130	HE	HP			Psychological Testing	Psychologist
96130	HE	HO			Psychological Testing	LBHP
96131	HE	HP			Psychological Testing	Psychologist

96131	HE	HO			Psychological Testing	LBHP
96136	HE	HP			Neuropsychological Testing	Psychologist
96136	HE	HO			Neuropsychological Testing	LBHP
96137	HE	HP			Neuropsychological Testing	Psychologist
96137	HE	HO			Neuropsychological Testing	LBHP
96138	HE				Neuropsychological Testing	Tech
96139	HE				Neuropsychological Testing	Tech
96146	HE				Neuropsychological Testing	Computer
96132	HE	HP			Neuropsychological Testing	Psychologist
96133	HE	HP			Neuropsychological Testing	Psychologist
96112	HE	HP			Developmental Testing	Psychologist
96112	HE	HO			Developmental Testing	LBHP
96113	HE	HP			Developmental Testing	Psychologist
96113	HE	HO			Developmental Testing	LBHP

ASSESSMENT AND DIAGNOSIS (CONT'D) (Physician medical services for Medicaid clients are billed outside the CCBHC bundle)						
96116	HE	HP			Neurological Testing, Hour	Psychologist
96116	HE	HO			Neurological Testing, Hour	LBHP
90791	HE/HF				Psychiatric Diagnostic Examination (no medical services)	refer to manual
90791	HE/HF	GT			Psychiatric Diagnostic Examination (no medical services) - Telehealth	refer to manual
90792	HE/HF				Psychiatric Diagnostic Examination (with medical services)	refer to manual
90792	HE/HF	GT			Psychiatric Diagnostic Examination (with medical services) - Telehealth	refer to manual
99202-99205	HE/HF				Medication Evaluation and Management for **Behavioral Health**, New Patient,	refer to manual
99202-99205	HE/HF	GT			Medication Evaluation and Management for **Behavioral Health**, New Patient - Telehealth	refer to manual
99211-99215	HE/HF				Medication Evaluation and Management for **Behavioral Health**, Established Patient	refer to manual
99211-99215	HE/HF	GT			Medication Evaluation and Management for **Behavioral Health**, Established Patient - Telehealth	refer to manual
99341-99342, 99344-99345	HE/HF				Medication Evaluation and Management for **Behavioral Health**, New Patient Home Services	refer to manual
99347-99350	HE/HF				Medication Evaluation and Management for **Behavioral Health**, Established Patient Home Services	refer to manual
T1001	HE/HF				Comprehensive Nursing Assessment	RN
3	**PATIENT - CENTERED TREATMENT PLANNING PROCESSES INCLUDING RISK ASSESSMENT**					
					TX PLANNING	
H0032	HE/HF				Comprehensive Care Plan, new client	LBHP/candidate
H0032	HE/HF	GT			Comprehensive Care Plan, new client - Telehealth	LBHP/candidate
H0032	HE/HF	TF			Comprehensive Care Plan Update, new client	LBHP/candidate
H0032	HE/HF	TF	GT		Comprehensive Care Plan Update, new client - Telehealth	LBHP/candidate
4	**OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE SERVICES**					
a	**INDIVIDUAL, FAMILY, GROUP COUNSELING & PSYCHOTHERAPY**					
H0004	HE/HF				Behavioral Health Counseling and Therapy, per 15 min, Individual	LBHP/candidate

H0004	HE/HF	GT			Behavioral Health Counseling and Therapy, per 15 min, Individual - Telehealth	LBHP/candidate
H0004	HE/HF	HR			Behavioral Health Counseling and Therapy, per 15 min, Family with patient present	LBHP/candidate
H0004	HE/HF	HR	GT		Behavioral Health Counseling and Therapy, per 15 min, Family with patient present - Telehealth	LBHP/candidate
H0004	HE/HF	HS			Behavioral Health Counseling and Therapy, per 15 min, Family without patient present	LBHP/candidate
H0004	HE/HF	HS	GT		Behavioral Health Counseling and Therapy, per 15 min, Family without patient present - Telehealth	LBHP/candidate
H0004	HE/HF	HQ			Behavioral Health Counseling and Therapy, per 15 min, Group	LBHP/candidate
H0004	HE/HF	HQ	GT		Behavioral Health Counseling and Therapy, per 15 min, Group - Telehealth	LBHP/candidate
H0022	HF				Substance Abuse Early Intervention Counseling	LBHP/candidate
H0022	HF	GT			Substance Abuse Early Intervention Counseling - Telehealth	LBHP/candidate
H0022	HF	HQ			Substance Abuse Early Intervention Counseling - Group	LBHP/candidate
S9444	HE/HF				Parenting Skills Training, Group (Families with Children 0-17) EBP	LBHP/candidate, BHA, CC
S9446	HE/HF				Group Behavioral Health Interventions, ages 6-17 (child is present)	LBHP, BHA, CC
90849	HE				Multiple-family group psychotherapy (ages 0-3)	LBHP/candidate
90847	HE				Family psychotherapy, conjoint psychotherapy with the patient present (ages 0-3)	LBHP/candidate
5		**OUTPATIENT CLINIC PRIMARY CARE SCREENING AND MONITORING**				
a						
98960	HE/HF				Self-management education and training, face-to-face, 1 patient (Promoting a Healthy Lifestyle)	LPN under RN direction
98961	HE/HF				Self-management education and training, face-to-face, 2–4 patients (Promoting a Healthy Lifestyle)	LPN under RN direction
b		**PRIMARY CARE SCREENING AS RECOMMENDED BY USPSTF for HIV AND HEPATITIS**				
G0432	HE/HF				Infectious Agent Antibody, detection by enzyme immunoassay	Per screening requirements
G0433	HE/HF				Infectious Agent Antibody detection by enzyme	Per screening requirements
G0435	HE/HF				Infectious agent antibody, rapid	Per screening requirements

c					**PRIMARY CARE SCREENING PURSUANT TO CCBHC PRORAM REQUIREMENT 5**	
82947	HE/HF				Diabetes Screening Test Glucose; quantitative, blood (except reagent strip)	Per screening requirements
82950	HE/HF				Diabetes Screening Test Glucose; post glucose dose (includes glucose)	Per screening requirements
82951	HE/HF				Diabetes Screening Test Glucose; tolerance test (GTT), 3 specimens (includes glucose)	Per screening requirements
d					**PREVENTIVE COUNSELING**	
99402	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual, 30 min	Per screening requirements
99403	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual, 45 min	Per screening requirements
99404	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual, 60 min	Per screening requirements

G0447	HE/HF				Counseling Therapy for Obesity	Per screening requirements
G0473	HE/HF				Counseling Therapy for Obesity Group 2-10	Per screening requirements

6		**TARGETED CASE MANAGEMENT (Billing criteria for non-F2F TCM is discussed in case management guidance on the ARC website.)**				
T1016	HE/HF	HO			Targeted Case Management - Clients with SMI/SED or on the Most in Need list only	LBHP/candidate
T1016	HE/HF	HO	GT		Targeted Case Management - Clients with SMI/SED or on the Most in Need list only - Telehealth	LBHP/candidate
T1016	HE/HF	HN			Targeted Case Management - Clients with SMI/SED or on the Most in Need list only	BHCMII/CADC
T1016	HE/HF	HN	GT		Targeted Case Management - Clients with SMI/SED or on the Most in Need list only - Telehealth	BHCMII/CADC
T1016	HE/HF	HO	HY		Targeted Case Management - Clients with SMI/SED or on the Most in Need list in custody of OJA	LBHP/candidate
T1016	HE/HF	HO	HY	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need custody of OJA - Telehealth	LBHP/candidate
T1016	HE/HF	HO	HU		Targeted Case Management - Clients with SMI/SED or on the Most in Need list in custody of DHS	LBHP/candidate
T1016	HE/HF	HO	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need custody of DHS - Telehealth	LBHP/candidate
T1016	HE/HF	HN	HY		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA	BHCMII/CADC
T1016	HE/HF	HN	HY	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA - Telehealth	BHCMII/CADC
T1016	HE/HF	HN	HU		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS	BHCMII/CADC
T1016	HE/HF	HN	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS - Telehealth	BHCMII/CADC
7					**PSYCHIATRIC REHABILITATIVE SERVICES**	
a					**PSYCHOSOCIAL REHAB SERVICES**	
H2017	HE/HF				Individual Rehabilitative Treatment, 6 years and older	LBHP, candidate, BHCMII, CADC
H2017	HE/HF	GT			Individual Rehabilitative Treatment, 6 years and older - Telehealth	LBHP, candidate, BHCMII, CADC
H2017	HE/HF	HQ	HW		Group Rehabilitative Treatment - Clients 18 years and older	LBHP, candidate, BHCMII, CADC
H2017	HE/HF	HQ	HW	GT	Group Rehabilitative Treatment - Clients 18 years and older - Telehealth	LBHP, candidate, BHCMII, CADC
H2017	HE/HF	TF	TG		Enhanced Illness Management & Recovery	refer to manual
H2027	HE/HF				Psychoeducation and Counseling	LPN/RN
H2027	HE/HF	GT			Psychoeducation and Counseling - Telehealth	LPN/RN
H2027	HE/HF	HQ			Psychoeducation and Counseling, Group	Nurse, BHCMII

b					**CHILDREN'S PSYCHOSOCIAL REHAB (CPSR)**	
H2017	HE/HF	HQ			Group Rehabilitative Treatment - Clients 12 - 17 years	LBHP, candidate, BHCMII, CADC
H2017	HE/HF	HQ	GT		Group Rehabilitative Treatment - Clients 12 - 17 years - Telehealth	LBHP, candidate, BHCMII, CADC
H2019	HE				Therapeutic Behavioral Services	LBHP, candidate, BHCMII, CADC, BHA
H2027	HE	HQ	HS		Children's Family/Caregiver Psychoeducation - Group (ages 0-5)	LBHP/candidate
S5110	HE				Intensive In-home Supports, Skills Training, Individual 6 - 17 years	BHCMII
c					**SELF MANAGEMENT**	
H0034	HE/HF				Medication Training and Support	refer to manual
H0034	HE/HF	GT			Medication Training and Support - Telehealth	refer to manual
97165	HE/HF				Occupational Therapy Evaluation, Low	Occ. Therapist
97165	HE/HF	GT			Occupational Therapy Evaluation, Low - Telehealth	Occ. Therapist
97166	HE/HF				Occupational Therapy Evaluation, Medium	Occ. Therapist
97166	HE/HF	GT			Occupational Therapy Evaluation, Medium - Telehealth	Occ. Therapist
97167	HE/HF				Occupational Therapy Evaluation, High	Occ. Therapist
97167	HE/HF	GT			Occupational Therapy Evaluation, High - Telehealth	Occ. Therapist
97168	HE/HF				Occupational Therapy Re-evaluation	Occ. Therapist
97168	HE/HF	GT			Occupational Therapy Re-evaluation - Telehealth	Occ. Therapist
97110	HE/HF				Therapeutic Exercise	Occ. Therapist
97110	HE/HF	GT			Therapeutic Exercise - Telehealth	Occ. Therapist
97802	HE/HF				Nutrition Services Initial Assessment and Intervention	RDN (licensed Dietitians)
97802	HE/HF	GT			Nutrition Services Initial Assessment and Intervention – Telehealth	RDN (licensed Dietitians)
97803	HE/HF				Subsequent Nutrition Services and Reassessment and Intervention	RDN (licensed Dietitians)
97803	HE/HF	GT			Subsequent Nutrition Services and Reassessment and Intervention - Telehealth	RDN (licensed Dietitians)
8	**HEALTH AND WELLNESS EDUCATION (Prevention)**					
S5190	HE/HF				Wellness Self-Management Plan Development	Wellness Coach
S5190	HE/HF	GT			Wellness Self-Management Plan Development - Telehealth	Wellness Coach
S5190	HE/HF	TG			Wellness Focused Appraisal	LPN
T1012	HE/HF				Wellness Resource Skills Development, Individual	Wellness Coach
T1012	HE/HF	GT			Wellness Resource Skills Development, Individual - Telehealth	Wellness Coach
T1012	HE/HF	HQ			Wellness Resource Skills Development, Group	Wellness Coach
T1012	HE/HF	HQ	GT		Wellness Resource Skills Development, Group - Telehealth	Wellness Coach
T1012	HE/HF	SE			Tobacco Cessation Support	Wellness Coach
T1012	HE/HF	SE	GT		Tobacco Cessation Support - Telehealth	Wellness Coach
T1012	HE/HF	SE	HQ		Tobacco Cessation Support, Group	Wellness Coach
T1502	HE				Oral/Injection/Medication Administration	refer to manual
9	**SUPPORTED EMPLOYMENT**					
H2014	HE/HF	TF			Pre-Vocational Services	any qualified staff
H2014	HE/HF	TF	HB		Pre-Vocational Services - IPS	IPS Specialist
H2014	HE/HF				Vocational Services	any qualified staff
H2014	HE/HF	HB			Vocational Services - IPS	IPS Specialist
H2025	HE/HF				Employment Training	any qualified staff
H2025	HE/HF	HB			Employment Training - IPS	IPS Specialist
H2026	HE/HF				Job Retention Support	any qualified staff
H2026	HE/HF	HB			Job Retention Support - IPS	IPS Specialist

T2022	HE/HF/HV	TF			Care Coordination - Reviewing data sources, e.g., HIE, Population Performance	any qualified staff
H2015	HE/HF/HV	HK			Community Recovery Support/Recovery Supp Specialist - Outpatient in Inpatient Setting Transitional (Transitional services cannot be used to trigger a payment. An outpatient service must be provided in the month to trigger a	PRSS

10	PEER SUPPORTS & COUNSELOR SERVICES AND FAMILY /CAREGIVER SUPPORTS					
a					PEER SUPPORT AND COUNSELOR SERVICES	
H2015	HE/HF				Community Recovery Support/Recovery Supp Specialist	PRSS
H2015	HE/HF	HQ			Community Recovery Support/Recovery Supp Specialist - Group	PRSS
H2015	HE/HF	GT			Community Recovery Support/Recovery Supp Specialist - Telehealth	PRSS
b					FAMILY SUPPORT SERVICES	
96202	HE/HF				Group Caregiver Behavioral Management Training (family/caregiver) 18 and over, initial 60 min	LBHP, Candidate, BHCMII under LBHP supervision
96203	HE/HF				Group Caregiver Behavioral Management Training (family/caregiver) 18 and over, each additional 15 min	LBHP, Candidate, BHCMII under LBHP supervision
T1027	HE/HF				Family Training & Support	FSP
T1027	HE/HF	GT			Family Training & Support -Telehealth	FSP

SERVICES THAT DO NOT TRIGGER THE PPS RATE

Must be reported for tracking

HCPCS/CPT	Mod 1	Mod 2	Mod 3	Mod 4	Description of Service	Provider Type
PRELIMINARY SCREENING AND RISK ASSESSMENT*						
H0002	HE	HN			MH Screening & Referral, new clients	refer to manual
H0002	HF	HN			SUD Screening & Referral, new clients	refer to manual
H0002	HE	HH			Co-occurring Screening & Referral, new clients	refer to manual
H0002	HE	HN	GT		MH Screening & Referral, new clients - Telehealth	refer to manual
H0002	HF	HN	GT		SUD Screening & Referral, new clients - Telehealth	refer to manual
H0002	HE	HH	GT		Co-occurring Screening & Referral, new clients - Telehealth	refer to manual
H0002	HE/HF/HH	TG	U1		Suicide Screening	refer to manual
H0002	HE/HF/HH	TG	U1	GT	Suicide Screening - Telehealth	refer to manual
H0002	HE	HN	HB		Ambulatory Detox Screening & Referral, new clients	refer to manual
H0002	HE	HN	HB	GT	Ambulatory Detox Screening & Referral, new clients	refer to manual
H0001	HV	HN			Gambling Screening & Referral, new clients	refer to manual
H0002	HV	TF			Gambling Pre-screen, new clients	refer to manual
H0001	HV	HN	GT		Gambling Screening & Referral, new clients - Telehealth	refer to manual
H0002	HV	TF	GT		Gambling Pre-screen, new clients - Telehealth	refer to manual
H0001	HF	TG	U1		Complex Screening & Referral	refer to manual
H0001	HF	TG	U1	GT	Complex Screening & Referral - Telehealth	refer to manual
H0002	HF	TF	U1		Screening and Referral – Residential Initial Screening (TCUDSII)	refer to manual
H0001	HF	TF	U1	GQ	Screening and Referral – Residential Initial Screening (TCUDSII) - telephone	refer to manual
H0001	HF	U5			DUI Assessment	refer to manual
H0003	HF				Drug Screen	refer to manual
T1023	HE/HF	FQ			Initial Evaluation - new client - Telephone	LBHP/candidate
EMERGENCY CRISIS INTERVENTION						
H0030	HE/HF				Crisis intervention services - Telephone	LBHP/candidate
CARE COORDINATION						
90887	HE/HF/HV				Family Conference Interpretation or explanation of results of psychiatric, other medical examinations and procedures to family or other responsible persons, or advising them how to assist patient	PA, APRN, MD/DO
90887	HE/HF/HV	GT			Family Conference Interpretation - Telehealth	PA, APRN, MD/DO
99368	HEHF	HB			Treatment Team Meeting – IPS Intra-agency Clinical Consultation for Field Monitoring	any staff
99368	HEHF	HB	GT		Treatment Team Meeting – IPS Intra-agency Clinical Consultation for Field Monitoring - Telehealth	any staff
99368	HE/HF	TF	HB		Treatment Team Meeting – IPS	IPS Specialist
99368	HE/HF	TF	HB	GT	Treatment Team Meeting – IPS -Telehealth	IPS Specialist
1111F	HE	TG			Medication reconciliation after discharge from a higher level of care	RN/LPN
G9007	HE/HF/HV				Scheduled Team Conference	any staff
G9007	HE/HF/HV	GT			Scheduled Team Conference - Telehealth	any staff

G9012	HE/HF				Psychiatrist, PCP Administrative time	Psychiatrist/PCP
S9482	HE				Infant and Early Childhood Mental Health (IECMH) Consultant	LBHP/candidate
S5185	HE/HF				Medication Reminder Services, Non-Face-to-Face; Per Month	any qualified staff
T2001	HE/HF/HV				Participating in an Appointment	any qualified staff
T2022	HE/HF/HV	TD			Nurse Care Management Services includes quality reporting, RN	RN
T2022	HE/HF/HV	TE			Nurse Care Management Services includes quality reporting, LPN	LPN
T2022	HE/HF/HV				Care Coordination	any qualified staff
T2022	HE/HF/HV	TF			Care Coordination - Reviewing data sources, e.g., HIE, Population Performance	any qualified staff
H2015	HE/HF/HV	HK			Community Recovery Support/Recovery Supp Specialist - Outpatient in Inpatient Setting Transitional (Transitional services cannot be used to trigger a payment. An outpatient service must be provided in the month to trigger a bundled payment.)	PRSS
T1027	HE/HF	HK			Family Training & Support - Transition from a higher level of care. (Transitional services cannot be used to trigger a payment. An outpatient service must be provided in the month to trigger a bundled payment.)	FSP
H2015	HE/HF	FQ			Community Recovery Support/Recovery Support Specialist – Telephone	PRSS
T1027	HE/HF	TF			Family Training & Support - Telephone*	FSP
CASE MANAGEMENT SERVICES						
T1017	HE/HF/HV	HO			Case Management	LBHP/candidate
T1017	HE/HF/HV	HN			Case Management	BHCMII/CADC
T1017	HE/HF/HV	HM			Case Management	BHCMI
T1017	HE/HF/HV	HO	GT		Case Management - Telehealth	LBHP/candidate
T1017	HE/HF/HV	HN	GT		Case Management - Telehealth	BHCMII/CADC
T1017	HE/HF/HV	HM	GT		Case Management - Telehealth	BHCMI
T1017	HE/HF/HV	HO	93		Case Management - Telephone	LBHP/candidate
T1017	HE/HF/HV	HN	93		Case Management - Telephone	BHCMII/CADC
T1017	HE/HF/HV	HM	93		Case Management - Telephone	BHCMI
T2023	HE/HF	HO	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	LBHP/candidate
T2023	HE/HF	HN	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HU		Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMI
T2023	HE/HF	HO	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	LBHP/candidate
T2023	HE/HF	HN	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HY		Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMI
T2023	HE/HF	HO	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	LBHP/candidate

T2023	HE/HF	HN	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HU	GT	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMI
T2023	HE/HF	HO	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC)	LBHP/candidate
T2023	HE/HF	HN	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HY	GT	Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMI
T2023	HE/HF	HO	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	LBHP/candidate
T2023	HE/HF	HN	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)	BHCMI
T2023	HE/HF	HO	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC)	LBHP/candidate
T2023	HE/HF	HN	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMII/CADC
T2023	HE/HF	HM	HY	93	Case Management for custody kids (OJA) in Systems of Care (SOC)	BHCMI
TARGETED CASE MANAGEMENT SERVICES						
T1016	HE/HF	HO	93		Targeted Case Management - Clients with SMI, SED, or on the Most in Need list - Telephone	LBHP/candidate
T1016	HE/HF	HN	93		Targeted Case Management - Clients with SMI, SED, or on the Most in Need list - Telephone	BHCMII/CADC
T1016	HE/HF	HO	HY	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of OJA- Telephone	LBHP/candidate
T1016	HE/HF	HO	HU	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of DHS - Telephone	LBHP/candidate
T1016	HE/HF	HN	HY	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of OJA- Telephone	BHCMII/CADC
T1016	HE/HF	HN	HU	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of DHS - Telephone	BHCMII/CADC
T1016	HE/HF	HO	TG		Transitional Targeted Case Management – Clients with SMI, SED, or on the Most in Need list	BHCMII/CADC
T1016	HE/HF	HN	TG		Transitional Targeted Case Management - Clients with SMI, SED, or on the Most in Need list	BHCMII/CADC
T1016	HE/HF	HO	HY	TG	Transitional Targeted Case Management - Clients with SMI, SED, or on the Most in Need list custody of OJA	BHCMII/CADC
T1016	HE/HF	HO	HU	TG	Transitional Targeted Case Management - Clients with SMI, SED, or on the Most in Need list custody of DHS	BHCMII/CADC
T1016	HE/HF	HN	HY	TG	Transitional Targeted Case Management - Clients with SMI, SED, or on the Most in Need list custody of OJA	BHCMII/CADC
T1016	HE/HF	HN	HU	TG	Transitional Targeted Case Management - Clients with SMI, SED, or on the Most in Need list custody of DHS	BHCMII/CADC
					OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE SERVICES	
					INDIVIDUAL AND FAMILY COUNSELING & PSYCHOTHERAPY (H0004 may be used as Medicaid primary and trigger PPS for individuals with dual eligibility if there is no LCSW.)	
H0004	HE/HF	FQ			Behavioral Health Counseling and Therapy, per 15 min, Individual - Telephone	LBHP/candidate
H0004	HE/HF	HR	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family with patient present - Telephone	LBHP/candidate

H0004	HE/HF	HS	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family without patient present - Telephone	LBHP/candidate
H0022	HF	FQ			Substance Abuse Early Intervention Counseling (if school-based, must be pursuant to IEP) - Telehealth	LBHP/candidate
					PSYCHIATRIC REHABILITATIVE SERVICES	
					PSYCHOSOCIAL REHAB SERVICES	
H2017	HE/HF	FQ		-	Individual Rehabilitative Treatment, 6 years and older - Telephone	LBHP, candidate, BHCMII, CADC
					QUALITY MEASURE REPORTING	
G8417	HE				BMI is documented above normal parameters and a follow-up plan is documented	
G8418	HE				BMI is documented below normal parameters and a follow-up plan is documented	
G8419	HE				BMI documented outside normal parameters, no follow-up plan documented, no reason given	
G8420	HE				BMI is documented within normal parameters and no follow up plan is required	
G8421	HE				BMI not documented and no reason is given	
G8422	HE				BMI not documented, with documentation the client is not eligible for BMI calculation	
1036F	HE				Current tobacco non-user OR Tobacco Screening not Performed for Medical Reasons	
4004F	HE				Patient screened for tobacco use AND received tobacco cessation intervention if identified as a tobacco user OR Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco	
4004F	HE	1P			Documentation of medical reason(s) for not screening for tobacco use	
4004F	HE	8P			Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified	
G9621	HE				Client identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling	
G9622	HE				Client not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	
G9623	HE				Documentation of medical reason(s) for not screening for unhealthy alcohol use in the measurement year or the year prior	
G9624	HE				Client not screened for unhealthy alcohol screening using a systematic screening method OR client did not receive brief counseling, reason not given	
G8431	HE				Screening for clinical depression is documented as being positive AND a follow-up plan is documented	
G8432	HE				Clinical depression screening not documented, reason not given	
G8433	HE				Screening for clinical depression not documented, documentation stating the patient is not eligible	
G8510	HE				Screening for clinical depression is documented as negative, a follow-up plan is not required	
G8511	HE				Screening for clinical depression documented as positive, follow-up plan not documented, reason not given	
G9717	HE				Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder	

G8940	HE				Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible	
G9509	HE				Depression remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than 5	
G9510	HE				Depression remission at twelve months not demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five. Either PHQ-9 score was not assessed during the allowed time period or is greater than or equal to 5	
M1207	HE				Screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	
M1208	HE				Not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	
Administrative						
H0023	HE/HF/HV				Community Outreach and Engagement	any qualified staff
H0023	HE/HF/HV	TF			Intensive Outreach (unique or generic ID)	any qualified staff
H0023	HE/HF/HV	TF	FQ		Intensive Outreach (unique or generic ID) - Telephone	any qualified staff
H0006	HE/HF				Customer Follow-Up Services #1 & 2	any qualified staff
H0006	HE/HF	FQ			Customer Follow-Up Services #1 & 2 - **telephone**	any qualified staff
H0006	HE/HF	TG			Customer Follow-Up Services #3	BH CM, CADC, LBHP/candidate
H0006	HE/HF	TG	FQ		Customer Follow-Up Services #3 - **telephone**	BH CM, CADC, LBHP/candidate
H0006	HF	TD			Customer Follow-Up Services #4	RN/LPN
H0006	HF	TD	FQ		Customer Follow-Up Services #4 - **telephone**	RN/LPN
S0215	HE/HF/HV				Travel	any qualified staff
S0215	HE/HF/HV	HB			Travel - IPS	any qualified staff
97537	HE/HF/HV				Staff Education & Training (generic (ID)	any qualified staff
97537	HE/HF/HV	GT			Staff Education & Training (generic (ID) - Telehealth	any qualified staff
MISCELLANEOUS SERVICES						
H0022	HE				Divorce Arbitration (unique or generic ID)	BHCM I, BHCM II, LBHP/candidate
GAMBLING SERVICES						

Gambling services can be reported but do not trigger the monthly rate.

Appendix E. Changes from FY2023 to FY2024

CHANGES FROM FY2023 TO FY2024

ADDITIONS:

Added new outpatient crisis intervention code (H0007) for CCBHC clients. Removed the H2011 code from the PPS bundle.

H0007	HE/HF				Crisis intervention services	LBHP/candidate
H0007	HE/HF	GT			Crisis intervention services - Telehealth	LBHP/candidate

Added PACT Comprehensive Assessment description as required in Chapter 55 (OAC 450-55-5-5) to the Expanded Service Definitions.

The client's psychiatrist or APN, primary PACT case manager, and individual treatment team members shall prepare the written comprehensive assessment(s) within six (6) weeks of admission. The comprehensive assessments shall include a written narrative report on ODMHSAS approved forms for each of the following areas: psychiatric diagnostic examination, comprehensive nursing assessment, and functional assessment.

Revised

99483	HE	TG			Functional Assessment (PACT)

Old

G0505	HE	HM			Functional Assessment (PACT, SOC: Ages 6-17)

Added Customer Follow-Up Services.

H0006	HE/HF			Customer Follow-Up Services #1 & 2
H0006	HE/HF	FQ		Customer Follow-Up Services #1 & 2 - Telephone
H0006	HE/HF	TG		Customer Follow-Up Services #3
H0006	HE/HF	TG	FQ	Customer Follow-Up Services #3 - Telephone
H0006	HF	TD		Customer Follow-Up Services #4
H0006	HF	TD	FQ	Customer Follow-Up Services #4 - Telephone

The definition of Customer Follow-Up Services has been broadened to allow LPNs to perform the service and includes follow-up for chronic medical services.

Added SMI and SED to Targeted Case Management. T1016 can be used for adults with SMI and children with SED and used as a trigger service.

T1016	HE/HF	HO			Targeted Case Management - Clients with SMI/SED or on the Most in Need list only
T1016	HE/HF	HO	GT		Targeted Case Management - Clients with SMI/SED or on the Most in Need list only - Telehealth
T1016	HE/HF	HN			Targeted Case Management - Clients with SMI/SED or on the Most in Need list only
T1016	HE/HF	HN	GT		Targeted Case Management - Clients with SMI/SED or on the Most in Need list only - Telehealth
T1016	HE/HF	HO	HY		Targeted Case Management - Clients with SMI/SED or on the Most in Need list in custody of OJA
T1016	HE/HF	HO	HY	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need custody of OJA - Telehealth
T1016	HE/HF	HO	HU		Targeted Case Management - Clients with SMI/SED or on the Most in Need list in custody of DHS

T1016	HE/HF	HO	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need custody of DHS - Telehealth
T1016	HE/HF	HN	HY		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA
T1016	HE/HF	HN	HY	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of OJA - Telehealth
T1016	HE/HF	HN	HU		Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS
T1016	HE/HF	HN	HU	GT	Targeted Case Management - Clients with SMI/SED or on the Most in Need list custody of DHS - Telehealth
T1016	HE/HF	HO	TG		Transitional Targeted Case Management - Clients with SMI/SED or < 21 years on the Most in Need list
T1016	HE/HF	HN	TG		Transitional Targeted Case Management - Clients with SMI/SED or < 21 years on the Most in Need list
T1016	HE/HF	HO	HY	TG	Transitional Targeted Case Management - Clients with SMI/SED or < 21 years on the Most in Need list custody of OJA
T1016	HE/HF	HO	HU	TG	Transitional Targeted Case Management - Clients with SMI/SED or < 21 years on the Most in Need list custody of DHS
T1016	HE/HF	HN	HY	TG	Transitional Targeted Case Management - Clients with SED or < 21 years on the Most in Need list custody of OJA
T1016	HE/HF	HN	HU	TG	Transitional Targeted Case Management - Clients with SED or < 21 years on the Most in Need list custody of DHS
T1016	HE/HF	HO	HK		Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list
T1016	HE/HF	HN	HK		Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list
T1016	HE/HF	HO	HY	HK	Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list custody of OJA
T1016	HE/HF	HO	HU	HK	Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list custody of DHS
T1016	HE/HF	HN	HY	HK	Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list custody of OJA
T1016	HE/HF	HN	HU	HK	Transitional Targeted Case Management - Clients with SMI or > 20 years on the Most in Need list custody of DHS

Added Social Determinants of Health Risk Assessment. Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months." The risk assessment is in relation to the patient's social risk factors that influence the diagnosis and treatment of medical conditions.

G0136	HE/HF				Social Determinants of Health Risk Assessment	LPN

Added Self-measurement Education and Training. A nonphysician healthcare professional uses a standard curriculum to educate a patient about his or her disease or disorder, for example, asthma or diabetes. She also provides training on how to manage it more effectively. This education and training service enables the patient and or the caregiver or family to effectively manage the disease.

98960	HE/HF				Self-management education and training, face-to-face, 1 patient (Promoting a Healthy Lifestyle)	LPN under RN direction

98961	HE/HF				Self-management education and training, face-to-face, 2–4 patients (Promoting a Healthy Lifestyle)	LPN under RN direction

Added codes for preventive health screenings.

G0432	HE/HF				Infectious Agent Antibody, detection by enzyme immunoassay
G0433	HE/HF				Infectious Agent Antibody detection by enzyme
G0435	HE/HF				Infectious agent antibody, rapid
82947	HE/HF				Diabetes Screening Test Glucose; quantitative, blood (except reagent strip)
82950	HE/HF				Diabetes Screening Test Glucose: post glucose dose (includes glucose)
82951	HE/HF				Diabetes Screening Test Glucose: tolerance test (GTT), 3 specimens (includes glucose)
99402	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
99403	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
99404	HE/HF				Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
G0447	HE/HF				Counseling Therapy for Obesity
G0473	HE/HF				Counseling Therapy for Obesity Group 2-10

Added Group Behavioral Health Interventions, ages 6-17 (child is present) and changed code for Parenting Skills Training, Group.

NEW

S9444	HE/HF				Parenting Skills Training, Group (Families with Children 0-17) EBP	LBHP/candidate, BHA, CC
S9446	HE/HF				Group Behavioral Health Interventions, ages 6-17 (child is present)	LBHP, BHA, CC

OLD

S9446	HE/HF	HQ			Parenting Skills Training, Group (Families with Children 0-17) EBP	LBHP/candidate

Added telehealth modifier to Evaluation and Management codes.

90791	HE/HF	GT			Psychiatric Diagnostic Examination (no medical services) - Telehealth
90792	HE/HF	GT			Psychiatric Diagnostic Examination (with medical services) - Telehealth
99202-99205	HE/HF	GT			Medication Evaluation and Management for **Behavioral Health**, New Patient – Telehealth
99211-99215	HE/HF	GT			Medication Evaluation and Management for **Behavioral Health**, Established Patient – Telehealth

Added Group Caregiver Behavioral Management Training for family/caregivers.

96202	HE/HF				Group Caregiver Behavioral Management Training (family/caregiver) 1 and over, initial 60 minutes	LBHP/candidate
96203	HE/HF				Group Caregiver Behavioral Management Training (family/caregiver) 1 and over, each additional 15 minutes	LBHP/candidate

Added 93 as telephone modifier for T1017, T1016 and T2023. The GT modifier was added to case management for custody kids.

T1017	HE/HF/HV	HN	93		Case Management - Telephone
T1017	HE/HF/HV	HM	93		Case Management - Telephone
T1016	HE/HF	HO	93		Targeted Case Management - Clients with SMI, SED, or on the Most in Need list - Telephone
T1016	HE/HF	HN	93		Targeted Case Management - Clients with SMI, SED, or on the Most in Need list - Telephone
T1016	HE/HF	HO	HY	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of OJA- Telephone
T1016	HE/HF	HO	HU	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of DHS - Telephone
T1016	HE/HF	HN	HY	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of OJA- Telephone
T1016	HE/HF	HN	HU	93	Targeted Case Management - Clients with SED or on the Most in Need list custody of DHS - Telephone
T2023	HE/HF	HO	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)
T2023	HE/HF	HN	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)
T2023	HE/HF	HM	HU	93	Case Management for custody kids (OKDHS) in Systems of Care (SOC)
T2023	HE/HF	HO	HK	93	Case Management for custody kids (OJA) in Systems of Care (SOC)
T2023	HE/HF	HN	HK	93	Case Management for custody kids (OJA) in Systems of Care (SOC)
T2023	HE/HF	HM	HK	93	Case Management for custody kids (OJA) in Systems of Care (SOC)

Added FQ as telephone modifier for H2017.

H2017	HE/HF	FQ			Individual Rehabilitative Treatment, 6 years and older - Telephone	LBHP, candidate, BHCMII, CADC

Added GT as telehealth modifier for nutritional services.

97802	HE/HF	GT			Nutrition Services Initial Assessment and Intervention - Telehealth
97803	HE/HF	GT			Subsequent Nutrition Services and Reassessment and Intervention - Telehealth

Added GT as telehealth modifier and HQ group modifier for wellness resource skills development and tobacco cessation.

T1012	HE/HF/HV	GT			Wellness Resource Skills Development, Individual - Telehealth
T1012	HE/HF/HV	HQ			Wellness Resource Skills Development, Group
T1012	HE/HF/HV	SE	GT		Tobacco Cessation Support - Telehealth
T1012	HE/HF/HV	SE	HQ		Tobacco Cessation Support, Group

Add HQ as group modifier for family training and support.

T1027	HE/HF	HQ			Family Training & Support - Group

The FQ telephone modifier was added to Community Recovery Support/Recovery Supp Specialist.

H2015	HE/HF	FQ			Community Recovery Support/Recovery Supp Specialist - Telehealth

Added GT as telehealth modifier for + add on - interactive complexity

90785	HE	GT			+ add on - interactive complexity (never reported alone)

Added GT telehealth modifier to several screenings and FQ telephone for Initial Evaluation.

H0002	HE	HN	GT		MH Screening & Referral, new clients - Telehealth
H0002	HF	HN	GT		SUD Screening & Referral, new clients - Telehealth
H0002	HE	HH	GT		Co-occurring Screening & Referral, new clients - Telehealth
H0002	HE/HF/HH	TG	U1	GT	Suicide Screening - Telehealth
H0002	HE	HN	HB	GT	Ambulatory Detox Screening & Referral, new clients
H0001	HV	HN	GT		Gambling Screening & Referral, new clients - Telehealth
H0002	HV	TF	GT		Gambling Pre-screen, new clients - Telehealth
T1023	HE/HF	FQ			Initial Evaluation - new client - Telephone

Added GT modifier to IPS treatment team meetings.

99368	HEHF	HB	GT		Treatment Team Meeting – IPS Intra-agency Clinical Consultation for Field Monitoring - Telehealth
99368	HE/HF	TF	HB	GT	Treatment Team Meeting – IPS -Telehealth

The FQ telephone modifier was added to therapy.

H0004	HE/HF	FQ			Behavioral Health Counseling and Therapy, per 15 min, Individual - Telephone
H0004	HE/HF	HR	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family with patient present - Telephone
H0004	HE/HF	HS	FQ		Behavioral Health Counseling and Therapy, per 15 min, Family without patient present - Telephone
H0022	HF	FQ			Substance Abuse Early Intervention Counseling (if school-based, must be pursuant to IEP) - Telehealth

Added permanent telehealth to several services.

G0505	HE	HM	GT		Functional Assessment (Ages 6-20) - Telehealth*
G0505	HE	TF	HM	GT	Functional Assessment Updates/Review (Ages 6-20) - Telehealth*
H0022	HF	GT			Substance Abuse Early Intervention Counseling (if school-based, must be pursuant to IEP) - Telehealth
H2027	HE/HF	GT			Psychoeducation and Counseling - Telehealth
97802	HE/HF	GT			Nutrition Services initial Assessment and Intervention
97803	HE/HF	GT			Subsequent Nutrition Services and Reassessment and Intervention - Telehealth
H2015	HE/HF	GT			Community Recovery Support/Recovery Supp Specialist - Telehealth
T1012	HE/HF/HV	GT			Wellness Resource Skills Development, Individual - Telehealth
T1012	HE/HF/HV	HQ	GT		Wellness Resource Skills Development, Group - Telehealth
T1012	HE/HF/HV	SE	GT		Tobacco Cessation Support – Telehealth

Telehealth was added to Functional Assessment, Ages 6 – 20.

99483	HE	HN			Functional Assessment (Ages 0-5)	LBHP/BHCMII/CC

99483	HE	TF	HN		Functional Assessment Updates/Review (Ages 0-5)	BHCMII/CC
99483	HE	H M			Functional Assessment (Ages 6-20)	BHCCII/CC, FSP, BHA
99483	HE	TF	H M		Functional Assessment Updates/Review (Ages 6-20)	BHCCII/CC, FSP, BHA
99483	HE	H M	GT		Functional Assessment (Ages 6-20) - Telehealth*	BHCCII/CC, FSP, BHA
99483	HE	TF	H M	GT	Functional Assessment Updates/Review (Ages 6-20) - Telehealth*	BHCCII/CC, FSP, BHA

Added Psychological, Neuropsychic, Developmental, and Neurological Testing.

96130	HE	HP			Psychological Testing	Psychologist
96130	HE	HO			Psychological Testing	LBHP
96131	HE	HP			Psychological Testing	Psychologist
96131	HE	HO			Psychological Testing	LBHP
96136	HE	HP			Neuropsych Testing	Psychologist
96136	HE	HO			Neuropsych Testing	LBHP
96137	HE	HP			Neuropsych Testing	Psychologist
96137	HE	HO			Neuropsych Testing	LBHP
96138	HE				Neuropsych Testing	Tech
96139	HE				Neuropsych Testing	Tech
96146	HE				Neuropsych Testing	Computer
96132	HE	HP			Neuropsych Testing	Psychologist
96133	HE	HP			Neuropsych Testing	Psychologist
96112	HE	HP			Developmental Testing	Psychologist
96112	HE	HO			Developmental Testing	LBHP
96113	HE	HP			Developmental Testing	Psychologist
96113	HE	HO			Developmental Testing	LBHP
96116	HE	HP			Neurological Testing, Hour	Psychologist
96116	HE	HO			Neurological Testing, Hour	LBHP
96110	HE	HP			Developmental Screening	Psychologist
96110	HE	HO			Developmental Screening	LBHP

CLARIFICATIONS/CHANGES:

Clarified the requirements for psychosocial rehab services*: to receive PSR services the client must meet medical necessity requirements, but there are no limits, and documentation required in the outpatient PA manual is not required.*

Replaced G0505 with 99483 due to G0505 being end dated.

On services 90833, 90836, 90838, the staff level was corrected to reflect MD, DO, PA, or APRN.

90833	HE				+ add on - Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	MD, DO, APRN, PA
90836	HE				Individual Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	MD, DO, APRN, PA

90838	HE				+ add on - Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	MD, DO, APRN, PA

Updated the staff requirements for Functional Assessment (G0505) for children.

Functional Assessment (Ages 0-5)	LBHP, **BHCMI/CC**
Functional Assessment Updates/Review (Ages 0-5)	**BHCMII/ CC**
Functional Assessment (Ages 6-20)	BHCCII/CC, **FSP, BHA**
Functional Assessment Updates/Review (Ages 6-20)	BHCCII/CC, FSP, **BHA**
Functional Assessment (Ages 6-20) - Telehealth*	BHCCII/CC**, FSP, BHA**
Functional Assessment Updates/Review (Ages 6-20) - Telehealth*	BHCCII/CC, FSP, **BHA**

Changed the definition of Medication Reminder Services (S5185) to include pill box organization and packing.

MEDICATION REMINDER SERVICES, NON-FACE-TO-FACE

Medication reminders may include telephone prompts, electronic alerts, and medication deliveries, as well as pill box organization and packing.

Staff Requirement: Any level of ODMHSAS outpatient service provider can provide this service.

S5185	HE/HF			Medication Reminder Services, Non-Face-to-Face; Per Month

Crisis Diversion (H2016) was renamed to Systems of Care: Mobile Crisis Team and language was updated.

CHILDREN'S MOBILE RESPONSE AND STABILIZATION SYSTEM

MOBILE RESPONSE TEAM, In-Person Response for Any and All Children, Youth and Families (currently in services or not)

The mobile response team (MRT) for the defined crisis may consist of a trained Wraparound Facilitator/BHCMII paired with an FSP, PRSS, and has access to a LBHP. If a crisis rises to a level requiring clinical intervention, MRTs have access to a LBHP via telehealth or face-to-face to provide immediate and direct clinical intervention (in-person or telephonically). Response includes:

- On-site face to face emergency response within one hour of receipt of referral in home and community-based settings.
- Initial Response requires implementation of specific children's assessment, such as the Crisis Assessment Tool (CAT) or Ohio Scales.
- Determination of Immediate needs; Assesses for risk to self and others.
- Identifies crisis precipitants to assist in developing or revising of the child and family individualized crisis and/or safety plan.
- Refers and links for evaluation and assessment for mental health and substance use services.
- The Wraparound Facilitator/BHCMII will facilitate access to CCBHC (or free choice provider) follow-up appointment with LBHP within 24 hours of crisis response as needed.
- Ensures access to a comprehensive array of behavioral health treatment services and community supports.

Staff Requirement: BHCCII/CC

H2016	HE			Mobile Response Team, In-Person	15 min
H2016	HE			Mobile Response and Stabilization Team, In-Person	15 min

S9446 has been changed from Parenting Skills Training to Group Behavioral Health interventions. S9444 is now Parenting Skills Training.

S9444	HE/HF				Parenting Skills Training, Group (Families with Children 0-17) EBP	LBHP/candidate, BHA, CC
S9446	HE/HF				Group Behavioral Health Interventions, ages 6-17 (child is present)	LBHP, BHA, CC

DELETIONS:

Ended CBSCC service *greater than 16 beds*.

S9484	HE	TG			Community Based Structured Crisis Care (greater than 16 beds)	LBHP/candidate

Terminated 99354 due it being end dated.

99354	HE				+ add on Prolonged service 80+ minutes (add-ons from 99354-99359) (ages 0-3)	LBHP/candidate

Deleted the comprehensive care plan review due to SAMHSA no longer requiring it.

S0281	HE/HF			Comprehensive Care Plan Review	Event
S0281	HE/HF	GT		Comprehensive Care Plan Review - Telehealth	Event

Appendix F. Care Coordination Guidance

Policy Guidance: Coordination with Certified Community Behavioral Health Clinics (CCBHCs), Children and Youth, 0-17

Effective Date:
September 1, 2021

EXTERNAL PROVIDER TYPES AFFECTED
Qualified Schools; School-based Case Management (SB-CM)
Early Intervention Targeted Case Management (EI-TCM; SoonerStart)
Child Welfare Targeted Case Management (CW-TCM)
Developmental Disabilities Services Division, Targeted Case Management (DDSD-TCM)
Office of Juvenile Affairs, Targeted Case Management (OJA-TCM)
Individually contracted LBHPs/Psychologists
Outpatient Behavioral Health (OPBH) Agencies

BACKGROUND`
Certified Community Behavioral Health Clinics (CCBHCs) are required to provide a broad array of services directly. They may also provide services through referral or formal relationships with other providers, in order to meet the needs of the population served. This integrated clinic and service delivery model uses a monthly prospective payment system (PPS) reimbursement structure. Originally a federal demonstration project from 2017-2019 (extended by law to September 2023) this new service delivery model aims to integrate mental health and substance use disorder service provision; coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services; increase consistent use of evidence-based practices; and increase access to high-quality care. In a nutshell, CCBHCs provide outreach, increase access, improve services, improve, and expand crisis response services, and serve as a 'one-stop shop' to those who are currently underserved.

In addition, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to expand CCBHC services in the state. This policy guidance will apply to State Plan CCBHCs as well.

PURPOSE

The purpose of this guidance is to define the CCBHCs care coordination activities for:

1. Children referred to them by external providers listed above that are already receiving a service from another mental health and/or substance use disorder provider; or
2. Children that are currently being served at the CCBHC when it is discovered they are also receiving services with an external service provider.

POLICY/PROCESS

The current CCBHCs will provide a primary care coordinator (CC) to work with the child/youth in the CCBHC. This CCBHC CC (this function will be performed by the CCBHC's integrated team lead. Job titles may vary between agencies) will be working closely with the child/youth to coordinate care across settings as well as with providers to ensure seamless transitions for individuals across the full spectrum of health and social services. The goal of the CCBHC CC is to increase consistent use of evidence-based practices and improve access to integrated high-

quality care. The CCBHC CC does not replace the CW or OJA case manager but is seen as someone the CW or OJA case manager will collaborate with to best serve the child/youth. CCBHC CCs who are made aware that they are working with a child/youth who is eligible for CW-TCM or OJA TCM or who has an existing clinical provider, will be required to reach out to the assigned CW or OJA case manager and/or clinical provider as appropriate. During this initial contact, the CCBHC CC and external providers will discuss the following:

- How to contact each other with child/youth related updates
- Share information related to the child/youth's care plan
- Discuss what the preferred method of communication will be between the external providers and the CCBHC CC.

AGREEMENTS

CCBHCs and external providers are to work cooperatively and collaboratively. As a participant in the Demonstration or in the approved state plan, CCBHCs are required to provide care coordination and to establish agreements with a variety of community or regional services, supports, and providers. (See Demonstration criteria 3.c.3 and ODMHSAS rules in OAC 450:17-5-183). A care coordination agreement describes the parties' mutual expectations and responsibilities related to care coordination in enough detail so that it leaves no question about the need for services from each provider, (or it is the child/youth's choice) in order to avoid duplication. The agreement must be completed and signed by all within 60 days.

The communication between coordinators will include conversations on how to best support the child/youth for the best outcomes possible.

EXAMPLES OF NEEDED CONTACTS

- Child/youth starts with a CCBHC
- Child/youth starts with a Child Welfare Targeted Case Manager (CW-TCM)
- Referral for new service provider
- Change in living situation/address
- Change in symptoms, decompensation requiring additional intervention
- Hospital admission/discharge
- Emergency Department (ED) admission/discharge
- Detoxification services admission/discharge
- Detoxification step-down services admission/discharge
- Residential treatment admission/discharge
- Home and Community Based Service (HCBS) referral/intake

Notes:

- CCHBC child/youth may also be receiving TCM. These services may be delivered by the CCBHC provider (BH-TCM), or different providers (CW, OJA, DDSD). Regardless of the provider of these services, the CCBHC CC **will remain the primary contact.**
- Proper release of information should be on file.
- CCBHC CCs are to include external providers as part of a child/youth's care team on the child/youth's care plan/service agreement and document all contacts with the external providers in the child/youth's record.

CONSIDERATIONS FOR A CCBHC DELIVERY SYSTEM: AVOIDING DUPLICATION AND PAYMENT

All OPBH services must be provided following established medical necessity criteria (MNC). Some services require prior authorization. Medicaid children/youth are allowed free choice of providers as indicated in §1902(a)(23) of the Social Security Act. As such, they can receive health services at their choice of CCBHC or non-CCBHC. Duplication of services is prohibited. The use of care coordination and TCM should minimize duplication.

PRO**VTYPE**	**COLLABORATION ACROSS PROVIDERS**

Policy Guidance: Coordination with Certified Community Behavioral Health Clinics (CCBHCs), Adults ages 18 and over

Effective Date:
September 1, 2021

EXTERNAL PROVIDER TYPES AFFECTED
ADvantage Home and Community Based Services (HCBS) Waivers Case Management
Developmental Disabilities Services Division, Targeted Case Management (DDSD-TCM) Individually contracted LBHPs/Psychologists
Outpatient Behavioral Health (OPBH) Agencies
Drug and Specialty Court OP Agency

BACKGROUND`
Certified Community Behavioral Health Clinics (CCBHCs) are required to provide a broad array of services directly. They may also provide services through referral or formal relationships with other providers, in order to meet the needs of the population served. This integrated clinic and service delivery model uses a monthly prospective payment system (PPS) reimbursement structure. Originally a federal demonstration project from 2017-2019 (extended by law to September 2023) this new service delivery model aims to integrate mental health and substance use disorder service provision; coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services; increase consistent use of evidence-based practices; and increase access to high-quality care. In a nutshell, CCBHCs provide outreach, increase access, improve services, improve, and expand crisis response services, and serve as a 'one-stop shop' to those who are currently underserved.

In addition, Oklahoma was able to obtain a State Plan Amendment (SPA) through CMS in 2019 to continue to expand CCBHC services in the state. This policy guidance will apply to State Plan CCBHCs as well.

PURPOSE
The purpose of this guidance is to define the CCBHCs care coordination activities for:

1. Adults referred to them by external providers listed above that are already receiving a service from another mental health and/or substance use disorder provider; or
2. Adults that are currently being served at the CCBHC when it is discovered they are also receiving services with an external service provider.

POLICY/PROCESS
The current CCBHCs will provide a primary care coordinator (CC) to work with the adult in the CCBHC. This CCBHC CC (this function will be performed by the CCBHC's integrated team lead. Job titles may vary between agencies) will be working closely with the adult to coordinate care across settings as well as with providers to ensure seamless transitions for individuals across the full spectrum of health and social services. The goal of CCBHC CC is to increase consistent use of evidence-based practices and improve access to integrated high-quality care. The CCBHC CC does not replace the ADvantage or DDSD case manager but is seen as someone the Advantage or DDSD case manager will collaborate with to best serve the adult. CCBHC CCs who are made aware that they are working with an adult who is eligible for Advantage CM or DDSD TCM or who has an existing clinical provider, will be required to reach out to the assigned ADvantage or DDSD case manager and/or clinical provider as appropriate. During this initial contact, the CCBHC CC and external providers will discuss the following:

- How to contact each other with adult related updates
- Share information related to the adult's care plan
- Discuss what the preferred method of communication will be between the external providers and the CCBHC CC.

AGREEMENTS

CCBHCs and external providers are to work cooperatively and collaboratively. As a participant in the Demonstration or in the approved state plan, CCBHCs are required to provide care coordination and to establish agreements with a variety of community or regional services, supports, and providers. (See Demonstration criteria 3.c.3 and ODMHSAS rules in OAC 450:17-5-183). A care coordination agreement describes the parties' mutual expectations and responsibilities related to care coordination in enough detail so that it leaves no question about the need for services from each provider, (or it is the adult/caregiver's choice) in order to avoid duplication. The agreement must be completed and signed by all within 60 days.

The communication between coordinators will include conversations on how to best support the adult for the best outcomes possible.

EXAMPLES OF NEEDED CONTACTS

- Adult starts with a CCBHC
- Referral for new service provider
- Change in living situation/address
- Change in symptoms, decompensation requiring additional intervention
- Hospital admission/discharge
- Emergency Department (ED) admission/discharge
- Detoxification services admission/discharge
- Detoxification step-down services admission/discharge
- Residential treatment admission/discharge
- Home and Community Based Service (HCBS) referral/intake

Notes:

- CCHBC adult may also be receiving TCM. These services may be delivered by the CCBHC provider (BH-TCM), or different providers (ADvantage, DDSD). Regardless of the provider of these services, the CCBHC CC **will remain the primary contact.**
- Proper release of information should be on file.
- CCBHC CCs are to include external providers as part of an adult's care team on the adult's care plan/service agreement and document all contacts with the external providers in the adult's record.

CONSIDERATIONS FOR A CCBHC DELIVERY SYSTEM: AVOIDING DUPLICATION AND PAYMENT

All OPBH services must be provided following established medical necessity criteria (MNC). Some services require prior authorization. Medicaid recipients are allowed free choice of providers as indicated in §1902(a)(23) of the Social Security Act. As such, they can receive health services at their choice of CCBHC or non-CCBHC. Duplication of services is prohibited. The use of care coordination and TCM should minimize duplication.

PROVTYPE	COLLABORATION ACROSS PROVIDERS
CCBHCs	When a CCBHC is working with an **established/existing** adult who is also eligible for ADvantage CM or DDSD-TCM (who meet CCBHC eligibility criteria), the CCBHC ensures that case management activities are coordinated through initiation of a care coordination agreement to avoid unnecessary duplication. Providers should have the adult/caregiver sign the agreement and insert the information in the individual's record. Bill PPS code T1041 Service reports the appropriate case management code.
ADvantage CM	If a **non-established/new** adult is referred from the ADvantage nurse, the member must have a preliminary screening and risk assessment to determine acuity of needs. The CCBHC and Waiver both offer a package of services. The CCBHC model is generally better suited for those with higher behavioral health needs, while ADvantage Waiver is better suited for those individuals with higher physical health needs. The CCBHC will initiate a CC agreement that describes the role of each case manager in enough detail so that it leaves no question for the need for dual case management. For example, the ADvantage nurse may assume primary responsibility for physical health care coordination while the CCBHC role is for behavioral health coordination. This must be documented in the CC agreement and also added to the waiver plan of care. This differentiation is vital since both providers may service report and use the same billing code T1016. which may appear to be concurrent billing of the same service. Billing for ADvantage CM is through traditional waiver methods as usual.
DDSD-TCM	If a **non-established/new** adult is referred from DDSD, the adult must have a preliminary screening and risk assessment. If it is determined that the adult has a co-morbid behavioral health/IDD condition, the adult would then be eligible for the behavioral health services that are provided. IDD services are not part of the CCBHC certified services and are not to be included in the PPS. The CCBHC will initiate a CC agreement with the HCBS waiver case manager. The need for dual case management and services must be documented in the CC agreement and also added to the waiver plan of care. (See OAC 317:30-5-1011(1)(B)). Billing for DDSD-TCM is FFS as usual. No PA is required.
Independent LBHPs/ Psychologists	When an independently contracted LBHP/Psychologist requests an authorization for an assessment for a medical operation or testing and the adult is **also an established/existing CCBHC adult,** a Customer Data Core (CDC) is required for the assessment, testing. must meet MNC. A CC agreement initiated by the CCBHC is also required. The agreement describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service; testing; adult/caregiver's choice). *The CC agreement must be signed by the adult/caregiver and a copy documented in the adult's record.* Payment is FFS and billing should align with the OPBH services provided in collaboration with the CCBHC and endorsed by the adult/caregiver.
OPBH Agency	When an OPBH Agency requests a Level 1/2/3/4 authorization for treatment or testing, services are approved with the submission of a CDC and additional PA

	related data elements (including diagnostic information), which must meet MNC. If the adult is also an **established/existing CCBHC adult** that has been receiving services from the CCBHC within the last six (6) months, providers will be required to complete the appropriate CDC. The *diagnostic information (including the identified OP level of care) directly provided by the CCBHC* can be used to satisfy the additional PA related information for this request*. PA requests for testing must meet MNC. A CC agreement or Letter of Collaboration (LOC) initiated by the CCBHC is also required. The agreement/LOC describes each parties' mutual expectations, including the need for services from each provider (e.g., specialty service, testing, adult/caregiver's choice*). *The CC agreement must be signed by the adult/caregiver, and a copy documented in the adult/caregiver's record*. Payment is FFS and billing should align with the OPBH services provided in collaboration with the CCBHC and endorsed by the adult/caregiver. Billing for case management services is not allowed per OAC 317:30-5-241.6(G). Billing is not allowed for adults receiving PACT services.
Drug and Specialty Court Provider	In addition to the psychiatric assessment, if a **non-established/new adult** is referred from a drug and specialty court provider for medication clinic only, payment may be made for principal care management (G2065) in addition to the psychiatric assessment. The CCBHC will initiate a CC agreement. Payment is FFS from non-CCBHC location. External provider bills FFS for case management as usual.

Notes*:*

*Per Demonstration criteria 4. d.1and 4.e.1 and ODMHSAS rules in OAC 450:17-5-178 and 450:17-5-180, the CCBHC directly provides Assessment, diagnosis, and treatment planning.

PROVIDER RESOURCES

CCBHC Federal Demonstration Criteria
CCBHC Federal Demonstration Guidance– When is a Person a CCBHC client?
CCBHC Manual
Prior Authorization Manual

LEGAL REFERENCES

Medicaid Rules OAC 317:30-5-241(d) (Medical Necessity and Prior Authorization) Medicaid Rules OAC 317:30-5-241.1(2) (Assessments)
Medicaid Rules OAC 317:30-5-241.1(3) (Service Plans)
Medicaid Rules OAC 317:30-5-241.6 (BH-TCM)
Medicaid Rules OAC 317:30-5-266(2) (CCBHCs)
Medicaid Rules OAC 317:30-5-281(b) (LBHP)
Medicaid Rules OAC 317:30-5-1011(1)(B)) (DDSD-TCM)
Medicaid Rules OAC **317:35-17-14** (ADvantage Case Management)
ODMHSAS Rules OAC 450:17-5-178 (CCBHC Assessment Dx)
ODMHSAS Rules OAC 450:17-5-183 (CCBHC Care Coordination)
ODMHSAS Rules OAC 450:17-5-186 (CCBHC Case Management)

Appendix G. Quality Measures

The Behavioral Health Clinic (BHC) quality measures that CCBHCs will use were updated in 2023 and will be implemented January 1, 2025. Below is a list, divided into clinic-collected and state-collected measures, required and optional.

For Section 223 Demonstration or other state-certified CCBHCs, it is a state decision as to whether to require reporting of measures designated as optional.

Color Key: ✓ = SAMHSA Required measures **Clinic-Collected Measures**

Color Key: ✓✓ = State Required measures **Clinic-Collected Measures**

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)[1]	Notes
✓ Time to Services (I-SERV)	SAMHSA	n/a	Will include sub-measures of average time to: Initial Evaluation, Initial Clinical Services, Crisis Services
✓ Depression Remission at Six Months (DEP-REM-6)	MN Community Measurement	n/a	Changed from the Twelve-Month version of the measure
✓ Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	n/a	n/a
✓ Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	CMS	Adult and Child	Child was added to the Medicaid Child Core Measure Set
✓ Screening for Social Drivers of Health (SDOH)	CMS	n/a	Using the 2023 Merit-Based Incentive Payment System (MIPS) version
✓✓ Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	n/a	n/a
✓✓ Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)	Mathematica	n/a	n/a

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)[1]	Notes
✓✓ Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)	Mathematica	n/a	n/a
✓✓ Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	NCQA	Child	Measure modified to coincide with change in Medicaid Child Core Measure Set
Controlling High Blood Pressure (CBP-AD)	NCQA	Adult	n/a

State-Collected Measures

Measure Name and Designated Abbreviation	Steward	CMS Medicaid Core Set (2023)	Notes
✓ Patient Experience of Care Survey	SAMHSA	n/a	n/a
✓ Youth/Family Experience of Care Survey	SAMHSA	n/a	n/a
✓ Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	CMS	Adult	n/a
✓ Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	NCQA	Adult	n/a
✓ Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	NCQA	Child	n/a

✓ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	NCQA	Adult	n/a
✓ Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
✓ Plan All-Cause Readmissions Rate (PCR-AD)	NCQA	Adult	n/a
✓ Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	Child	n/a
✓ Antidepressant Medication Management (AMM-BH)	NCQA	Adult	n/a
✓ Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	Adult	n/a
✓ Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	NCQA	Adult	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Child	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Child	n/a