



Specialized Recovery Services Program

Recovery Management Guide

Effective July 1, 2018

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A. Purpose

As the single-state Medicaid agency, the Ohio Department of Medicaid (ODM) has administration and oversight responsibility for all Home and Community-Based Services (HCBS) programs that use Medicaid as their primary funding source. Through the Department of Administrative Services (DAS), ODM contracts with Recovery Management Agencies to assist with the implementation and management of ODM-administered HCBS programs throughout the state of Ohio. The Recovery Management Agencies perform both Independent Entity and Recovery Manager functions within the Specialized Recovery Services (SRS) program. ODM also contracts with a Provider Oversight Contractor to assist with provider compliance and operate a system for investigating and tracking incidents. The Recovery Management Contractor (or “Contractor”) and Provider Oversight Contractor must work closely and cooperatively with each other.

The federal government requires HCBS programs to ensure the health and welfare of each individual; this is also the fundamental goal of the relationship between ODM, the Recovery Management Contractors, and the Provider Oversight Contractor. This Recovery Management Guide details ODM’s standards and expectations related to daily operations to achieve that goal. As issues and/or potential inefficiencies are identified, ODM may modify the Recovery Management Guide during the term of the contract in order to clarify expectations, improve performance and to better meet the needs of individuals on the program. In the event there is a conflict between the terms and conditions of the contract and this guide, the contract is controlling.

B. Introduction

In order to better meet the needs of individuals with severe and persistent mental illness (SPMI) and diagnosed chronic conditions (DCC), Ohio amended the State Plan to create the Specialized Recovery Services (SRS) program. This program offers home and community-based services (HCBS) that are person-centered and aimed at supporting individuals in the community. The SRS program modernizes and improves the delivery of behavioral health and chronic condition services to better meet the needs of those currently eligible.

The SRS program is not a one size fits all program and is customized to each individual’s needs and goals. Individuals in the SRS program direct and plan service delivery, with support from a team of individuals they choose to be involved. Person-centered services are delivered pursuant to a written Person-Centered Care Plan that is developed through a process led by the individual, including people he or she has chosen to participate. SRS program services can be offered in community-based settings (e.g., individual’s own home), as well as residential, employment, and day settings to help individuals live in the most integrated setting possible. All residential services must have home-like characteristics and may not be institutional in nature.

C. Program Eligibility and Enrollment

C-1: Individual Screening and Assessment

The Recovery Management Contractor assesses an applicant for enrollment into the Specialized Recovery Services program. Individuals interested in requesting enrollment in the Specialized Recovery Services (SRS) program may request consideration through a Medicaid provider, a local County Department of Job and Family Services (CDJFS), the BCO@medicaid.ohio.gov mailbox, Community Behavioral Health Centers, Ohio Benefits Long-Term Services and supports (OBLTSS), or may self-refer.

1. Upon receipt of the referral, the Ohio Department of Medicaid (ODM) will randomly assign an Independent Entity (IE) within the region where the individual resides. Upon receipt of the referral, the IE will assign a Recovery Manager. The Recovery Manager shall conduct the initial assessment with the applicant and his/her authorized representative, legal guardian, or appropriate power of attorney, if applicable.
2. When appropriate, the Recovery Management Contractor refers and/or assists the applicant to access other community resources in order to obtain necessary services. This may include linking them to and/or making a referral to the County Department of Job and Family Services, the County Board of Developmental Disabilities, PASSPORT Administrative Agency, Adult Protective Services, Community Behavioral Health Center, and/or any other community resources that may be able to meet the applicant's immediate needs.
3. If the applicant is residing in an institution, the Recovery Management Contractor must discuss the HOME Choice program with the applicant. The HOME Choice program assists with transitioning individuals from the nursing facility to a home setting by providing goods and services. If the applicant is interested in HOME Choice, the Recovery Management Contractor must complete an Ohio Department of Medicaid 02361 form "HOME Choice Application." Information about the HOME Choice program can be found at <http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>.
4. At any time during the eligibility determination process, the Recovery Management Contractor may deny enrollment in the SRS program if the Recovery Management Contractor has not established contact with the applicant after at least three attempts to contact the applicant at varying times, and on at least three different days. The Recovery Management Contractor must maintain documentation of all attempts to reach the applicant. If the Recovery Management Contractor has knowledge of an individual's behavioral health provider, it is expected that attempts to engage the provider to help contact the individual will be made prior to denying enrollment in the SRS program.
5. If the applicant does not meet program eligibility criteria for the SRS program, the Recovery Management Contractor must, with the applicant's permission, refer the applicant to other

appropriate resources. The Recovery Management Contractor must provide the applicant with the contact information for the appropriate local agency.

6. Within three business days of the completion of the eligibility determination, the Recovery Management Contractor must enter the HCBS application status into the Ohio Department of Medicaid-approved financial eligibility system.

C-2: Eligibility and Enrollment

Prior to enrollment in the Specialized Recovery Services (SRS) program, the Recovery Manager will determine if the individual meets targeting and functional needs criteria for SRS using criteria described in OAC rule [5160-43-02](#). The individual conducting the eligibility assessment and developing a Person-Centered Care Plan cannot be a provider of other services available in the SRS program.

Information that may be used to determine eligibility for enrollment includes, but is not limited to:

- Assessment data;
- Reports from other professionals and team members;
- Ongoing monitoring; and
- Other information requested by or received from members of the individual's team.

The applicant or authorized representative must agree to participate in the Ohio Department of Medicaid-administered SRS program assessment and enrollment processes. This agreement is formally documented with the individual's signature on the Individual SRS Program Agreement and Responsibilities form and shall be obtained upon enrollment, but no later than, the Person-Centered Care Plan development date.

At the conclusion of the assessment process, the Recovery Manager must make a recommendation to the IE whether the applicant should be enrolled in or maintain enrollment in the program. The Recovery Manager must maintain documentation of each assessment and evidence gathered to make the determination. If, at any time during the assessment process or while enrolled in the SRS program, the applicant or individual fails to meet any of the eligibility or enrollment criteria, the Recovery Manager must recommend to the IE denial or disenrollment of the individual and inform him or her of hearing rights.

The Recovery Manager will provide to the individual, upon enrollment and as appropriate, the phone numbers of the Recovery Management Contractor, Recovery Manager, and the Medicaid Hotline. The Recovery Manager must also educate the individual enrolled in the SRS program about his or her right to contact any of these entities for assistance or to notify them of concerns.

The Recovery Manager will issue the individual a copy of the SRS Program Handbook and complete the Agreement and Responsibilities form (ODM 10178).

D. Assessments

The assessment process is designed to identify an applicant's needs, strengths and need for Specialized Recovery Services (SRS). Assessments are completed for SRS program applicants and at least once per year for enrolled individuals, in addition to ongoing, as-needed assessments performed as a part of the Recovery Management Contractor's day-to-day operations.

The assessment process collects data, evaluates for service need, and provides linkage to programs and services for applicants or individuals seeking access to SRS. This section outlines expectations and standards for conducting:

- **Initial assessments** when an applicant requests enrollment in the SRS program.
- **Annual assessments** to complete the individual's redetermination for SRS program eligibility.
- **Event-based assessments** for an individual enrolled in the SRS program when he or she experiences a significant change in condition.
- **Ongoing assessment** for an individual enrolled in the SRS program to identify any other changes and/or needs for support.

The following principles guide the assessment process:

- All assessments are conducted face-to-face with the SRS program applicant or individual enrolled in SRS program.
- The Recovery Manager will complete the assessment using the information gathered from the individual and, to the extent possible, the individual's informal caregivers and/or representative.
- With the individual's permission, the assessment will also include information from his or her current service providers and any other sources identified by the individual as having information that will be useful in determining his or her need for services.
- The assessment process must include evaluating the individual's current or intended community residence to verify the residence meets the home and community-based setting requirements outlined in OAC rule [5160-44-01](#).
- At the individual's request, the assessment may be terminated at any time and can be rescheduled at a later date and time, within prescribed timelines.

- Assessment components will be completed using information gathered from the individual and, to the extent possible, his or her informal caregivers and/or representative, as well as the individual's professional support team (physician, specialists, providers, etc.). Additionally, the assessment will include review of the individual's care needs, goals, strengths and preferences.
- The assessment is focused on the individual's current mental health, physical health, and functional needs.
- The assessment data is documented on the Ohio Department of Medicaid-approved assessment tool.
- The Recovery Manager will provide the individual with linkage to needed services identified during the assessment process through program enrollment, referral to other support systems, and/or enrollment in other service programs.
- If, at any time during the assessment process, the individual fails to meet any of the eligibility or enrollment criteria, the Recovery Manager will recommend the individual for denial or disenrollment and inform the individual of hearing rights.

D-1: Initial Assessment

Initial assessments are completed face-to-face using the ODM-approved assessment tool and are documented in the ODM-approved Recovery Management system. This assessment is used to determine the applicant's level of functioning, as well as identify the applicant's potential service needs for the SRS program. It also serves as the supporting documentation if the applicant is determined not to meet the eligibility requirements of the SRS program.

The Recovery Manager must complete all assessment activities and have a care plan in place 45 days from the date the individual is assigned to the Independent Entity.

D-2: Annual Assessment

Once enrolled in the SRS program, each individual is required to have an annual face-to-face assessment to determine his or her continued eligibility for the program. Annual assessments follow the same process as previously outlined for initial assessments.

The Recovery Manager must contact the individual to schedule the annual assessment at least 30 calendar days prior to the due date of the annual assessment. At that time, the Recovery Manager will also contact all individual-identified team members to invite them to participate in the annual assessment. Annual face-to-face assessments are conducted and an eligibility determination are made no more than 365 calendar days after the previous eligibility determination.

D-3: Event Based Assessments for a Significant Change of Condition

The Ohio Department of Medicaid requires the Recovery Management Contractor to conduct a face-to-face assessment for any reported, actual, or potential significant change of condition, or at the request of the individual. The Recovery Manager (RM) must make contact with the individual by the end of the next full calendar day following the Recovery Manager's knowledge of an actual or potential significant change of condition. If it is determined that a significant change in condition occurred, the Recovery Manager must complete a visit and an event based assessment, using the ODM-approved tool, by the end of the third full calendar day following the Recovery Manager's determination. For individuals who are in facilities located outside of the state of Ohio, or for individuals who are unable to be accessed in the treating facility, contact with the discharge planner to coordinate post-discharge care is expected. If the discharge planner is unable to be reached, the RM must document their attempts to connect with them, including documentation substantiating the RM's contact information was provided to the facility for follow up with the RM. A face-to-face visit and event based assessment by the RM, within three calendar days of learning the individual has been discharged from the facility, is required following identification of a significant change. Please note if a full comprehensive assessment is completed, it will change the annual reassessment date.

A significant change in condition may include, but is not limited to:

- An acute medical condition that results in institutionalization and/or the significant changes or deterioration of the individual's condition;
- Change of residence;
- Three reported incidents within 90 days; and
- Failure to use SRS for 30 days.

D-4: Ongoing Assessment

The Recovery Manager must assess the individual's changing care needs on an ongoing basis and address needs as they arise. The Recovery Manager is not required to complete the entire Ohio Department of Medicaid-approved eligibility comprehensive assessment tool when conducting ongoing assessment. The Recovery Manager shall maintain communication with the individual, authorized representative, providers, and other members of the team in order to promptly and appropriately address the individual's personal circumstances.

E. Recovery Management

All individuals enrolled in the Specialized Recovery Services (SRS) program receive Recovery Management services. Recovery Management assists individuals with linkage and authorization

for services and supports necessary to carry out the individualized Person-Centered Care Plan. Recovery Management is individual-focused and promotes and supports the individual's preferences, values, and right to self-determination. The Recovery Manager is essential to ensuring the individual's health and welfare.

Recovery Managers assist individuals in gaining access to approved SRS, Medicaid State Plan and community services, as well as medical, social, educational and other appropriate services, regardless of the funding source.

Recovery Management includes, but is not limited to, the following core functions:

- Monitoring the individual's health and welfare;
- Assessing the individual's needs, service goals and objectives;
- Annually assessing the individual's program eligibility;
- Scheduling, coordinating and facilitating meetings with the individual and his or her trans-disciplinary team;
- Authorizing services in the type, amount, scope, frequency and duration to meet the individual's needs;
- Linking and referring the individual to service providers;
- Developing and reviewing the Person-Centered Care Plan for SRS;
- Monitoring the delivery of all services identified in the individual's Person-Centered Care Plan;
- Transition planning for significant changes, including those changes that occur prior to enrollment on the SRS program and at significant life milestones such as entering or exiting school, work, etc.;
- Identifying and reporting incidents, as well as prevention planning to reduce the risk of reoccurrence;
- Assisting the individual with their annual Medicaid Redetermination.

E-1: Recovery Management Practice Standards

1. The maximum average staffing level for Recovery Management must be maintained in accordance with the contract.
2. The Recovery Manager must be an RN or possess a Bachelor's Degree in social work, counseling, psychology, or similar field and have a minimum of three years post-degree

experience working with individuals diagnosed with serious and persistent mental illness (SPMI) or have a minimum of one year post-graduate experience working with individuals with a diagnosed chronic condition (DCC).

3. The Recovery Manager maintains the minimum contact and visit schedule in accordance with the specifications outlined in this section and in the contract.
4. The Recovery Manager maintains the confidentiality of the individual's data in accordance with the Health Insurance Portability and Accountability Act regulations (HIPAA).
5. The Recovery Manager reports and documents incidents in accordance with OAC rule [5160-43-06](#) and the requirements of this Recovery Management Guide.
6. The Recovery Manager informs individuals of service alternatives and choice of qualified providers and assists individuals with linkage to providers and/or with the provider selection process, as needed.
7. The Recovery Manager revises or updates the individual's Person-Centered Care Plan as the individual's needs and resources change. The Recovery Manager must complete plan updates within 10 calendar days of a request or identified need.
8. The Recovery Manager must inform individuals of their rights and responsibilities while enrolled in the Specialized Recovery Services program.

E-2: Recovery Management Process Requirements

The following principles and responsibilities underline Recovery Management services for individuals enrolled in the Specialized Recovery Services (SRS) program.

1. The Recovery Manager must explain the role and responsibilities of the RM to the individual and, if applicable, the authorized representative both verbally and in writing. This must include an explanation of the Recovery Management Contractor's role related to the Ohio Department of Medicaid in the operations of this program.
2. The Recovery Manager must provide current contact information to the individual. The Recovery Manager must also ensure the individual has the Recovery Management Contractor's information accessible to family members and emergency personnel.
3. The Recovery Manager must obtain permission in writing from the individual prior to contact with any members of the individual's team to request information about care and treatment plans in effect, and to request notification of any changes in plans of care and treatment to reduce duplication of services. At the time permission is obtained, the individual must be informed of the right to revoke permission to any person at any time within the rules and requirements of the SRS program. Permission must be renewed annually. The Recovery Manager must provide his or her contact information to all members of the individual's team.

4. For all service additions and changes, the Recovery Manager must contact the individual no longer than 24 hours after the service addition or change was to be initiated to confirm that it is in place and that the individual is satisfied with the service addition or change and document the contact in the clinical record.

5. The Recovery Manager must contact service providers to verify delivery of services in the type, amount, frequency, scope, and duration as identified on the individual’s Person-Centered Care Plan no later than three business days after the scheduled service start date and document the verification in the clinical record.

6. The Recovery Manager must maintain ongoing communication with the individual and members of the team, including all service providers listed on the Person-Centered Care Plan. Ongoing communication will enable the Recovery Manager to identify any problems in service delivery, validate the current Person-Centered Care Plan, ensure supports are being provided in accordance with the Person-Centered Care Plan, and identify/monitor any potential/known risks to the individual’s health and welfare. The Recovery Manager will request notification of any changes in the individual’s condition or needs.

7. The Recovery Manager must monitor the quality of the service delivery and care provided by all authorized SRS providers. This includes review of service delivery records, incident reports, and other documentation of service delivery.

E-3: Acuity Level

All individuals enrolled on the SRS program will be designated as Acuity Level 3. The Recovery Management Contractor will conduct visits and contacts according to the Acuity Level 3 contact schedule described below. More frequent monitoring and contacts may occur depending on the individuals’ situation. Recovery Manager contact is defined as a face-to-face visit, phone conversation, email exchange or other electronic communication with the individual that ensure the exchange of information between the Recovery Manager and the individual. Electronic communications without response are not considered as a Recovery Manager contact with the individual. The first contact/visit should be based 30 days from the date of enrollment into the SRS program. The RM must document all contacts or visits with the individual, authorized representative, providers, or other team members in the case record within one business day of the contact and/or visit.

Length of Individual’s Enrollment on SRS Program	Frequency of Contact with Individual	Timing of In-Person Visit
0-6 month	Monthly	Once, maximum of 180 calendar days between enrollment and visit
7 - 12 months	Monthly	Once, maximum of 180 calendar days between visits

Longer than 12 months	Monthly	Annually, maximum of 365 calendar days between visits
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E-4: Additional Recovery Management Monitoring Requirements

- Monitor the individual’s progress with respect to the identified goals, objectives and outcomes;
- Re-evaluate the individual’s goals, objectives, services, and all program eligibility requirements when applicable and at least once every 12 months;
- Complete the HCBS Settings Verification Checklist annually and with each change in residence to verify the residence meets the home and community-based setting requirements outline in OAC rule [5160-44-01](#);
- Maintain documentation in accordance with Ohio Department of Medicaid rules, regulations, policies and procedures;
- Upon enrollment and annually, the RM will have the individual sign the Agreement and Responsibilities form (ODM 10178 and the RM will provide the individual with a copy.

If, at any time, the individual is no longer eligible for the Specialized Recovery Services program, the Recovery Management Contractor shall recommend him or her for disenrollment, advise the individual of this determination, and inform the individual of state hearing rights.

F. Person Centered Service Planning and Care Coordination

The assessment provides information for the initial steps of person-centered service planning. The Recovery Management Contractor develops the Person-Centered Care Plan, as outlined in OAC [5160-44-02](#), and in collaboration with a team. The team members, at a minimum, include the individual, informal caregiver(s), authorized representative, physical and behavioral health providers, and the Recovery Manager. The Recovery Manager documents communication records and/or team meeting minutes as part of the planning process.

Person-centered planning is intended to:

1. Identify the strengths and needs of the individual including risk areas to be addressed to ensure the individual’s health and welfare;
2. Develop goals to address needs;
3. Set desired outcomes for each need;

4. Identify available supports and determine the type of informal support and provider(s) to address unmet needs; and
5. Set a pattern of delivery for each provider.

The Person-Centered Care Plan should:

- Reflect the individual's strengths and preferences;
- Reflect clinical and support needs as identified through assessment;
- Include individually identified goals and desired outcomes;
- Reflect the services and supports (paid or unpaid) that will assist the individual to achieve goals, including providers of those services and supports, including natural supports;
- Reflect the setting in which the individual resides was chosen by the individual from among setting options which included non-disability specific settings and the option for a private unit in a residential setting;
- Be understandable to the individual receiving services and supports. The written plan must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all persons and providers responsible for its implementation;
- Be distributed to the individual and other people involved in the plan; and
- Prevent the provision of unnecessary or inappropriate services and supports.

The Recovery Management Contractor will use these components to inform and develop a comprehensive Person-Centered Care Plan for the individual. Person-centered service planning and care coordination address the individual's changing circumstances and needs over time. The Plan must be revised as often as necessary to meet the individual's needs.

The Person-Centered Care Plan is a written outline of the individual's SRS. The Person-Centered Care Plan identifies goals, objectives and outcomes related to their SRS.

The Recovery Manager coordinates and initiates services. This includes communicating and collaborating with the individual, physical and behavioral health provider(s), SRS providers and informal caregivers.

The Recovery Manager coordinates activities between all providers and agencies that are, or will, participate in meeting the individual's needs. This includes, but is not limited to, scheduling meetings, disseminating information, planning updates, maintaining documentation, as well as facilitating collaboration among team members.

F-1: Person-Centered Care Plan Contents

The Person-Centered Care Plan must include, at minimum:

- The name, phone number and service responsibilities of all SRS providers;
- The total number of approved units of each service and the total projected monthly cost for SRS for 12 months beginning with the enrollment and/or annual date;
- The start and stop dates of service delivery; and
- Any modifications to the additional conditions required for provider owned or controlled residential settings outlined in OAC [5160-44-01](#) paragraph (C). The plan must include all of the required elements outlined in OAC [5160-44-02](#) paragraph (B).

Upon completion of the care plan the Recovery Manager will forward the draft plan and the results of the HCBS Settings Verification Checklist to its Independent Entity contact for final review and approval. The plan must be approved within 10 days of the request.

F-2: Disaster Planning

The Recovery Management Contractor must ensure every individual has a disaster plan in place and that it is documented in the Person-Centered Care Plan. This plan must address fire, tornado, electrical outage and other potential risks that would prevent an individual from receiving services in his or her residence.

F-3: Recovery Management Services

Recovery Management services must be outlined in the Person-Centered Care Plan. The Person-Centered Care Plan must indicate an Acuity Level 3 and related contact schedule, as well as specify the Recovery Management service involves monitoring of services, needs, and coordination of interventions related to assessed needs.

F-4: Maintaining the Person-Centered Care Plan

The Person-Centered Care Plan is updated at the individual's annual assessment, and throughout the course of ongoing Recovery Management activities.

The Recovery Manager must respond to requests for changes to the Person-Centered Care Plan in writing and within 10 calendar days of a request from the individual. Approvals must be updated in the Person-Centered Care Plan. Termination, reduction, or denial of Medicaid-funded services must be accompanied by information on how to exercise hearing rights.

- The Recovery Manager must review and/or modify the Person-Centered Care Plan within 24 hours of receipt of a notification of a significant change, including but not limited to changes in the individual's physical or mental condition.
- The Recovery Manager must notify the individual and the individual's providers of all changes in the Person-Centered Care Plan.

- The Recovery Manager must provide written documentation prior to the expected date of service change; or verbal notification prior to the change, if provision of written documentation is not possible, prior to the updated date of expected service delivery.
 - The Recovery Manager must provide an updated Person-Centered Care Plan no later than 48 hours after the date of service change if verbal notification was given.
- The Person-Centered Care Plan is not complete until it is signed by the individual, or the individual's authorized representative or legal guardian.
 - The Recovery Manager must contact the individual no later than 24 hours after the initiation of, or change to, services to assess the individual's satisfaction with the services and/or change.

G. Participant Rights

G-1: Choice of Providers

G-1(a): Recovery Management Agency Choice

- Individuals have the right to choose and change their Recovery Management Agency annually, or on a case-by-case basis as determined by the Ohio Department of Medicaid.

G-1(b): Recovery Manager Choice

- The individual will be able to change their Recovery Manager within the Recovery Management Agency every quarter.

G-1(c): Provider Choice

- Individuals enrolled in an HCBS program have the right to select an eligible provider of their choice for any Medicaid service, within the authorized service plan. The Recovery Management Contractor is responsible for ensuring that individuals are afforded this right to select the provider of his or her choice and to assist, to the extent needed, in the selection process.
- The Recovery Management Contractor is responsible for ensuring the individual has selected an adequate number of providers to secure full coverage of services authorized in the Person-Centered Care Plan. This includes, but is not limited to, assisting individuals with identifying potential providers, contacting the providers to determine interest, and linking individuals to interested providers.

G-2: Due Process Rights

The Recovery Management Contractor must issue hearing rights for all changes to Person-Centered Care Plans that result in a reduction, denial, or suspension of Specialized Recovery Services (SRS). The Recovery Management Contractor must notify applicants of their appeal

rights in the event of an SRS program enrollment denial, termination, or for denial of the provider of their choice, including the reason for the denial or termination. The Recovery Management Contractor must be prepared to defend the action in a state hearing, if the individual requests one. More information on the state hearings process can be found in Chapter [5101:6](#) of the Ohio Administrative Code. All actions must include an explanation of the decision, as well as rule citations and language to support the action.

The Independent Entity (IE) Contractor will lead all hearings in which it recommended the service denial or modification to requested services and for which the Ohio Department of Medicaid (ODM) concurred with the Recovery Management Contractor's recommendation. In addition, the IE contractor will lead all program denial hearings and ODM will lead all proposed disenrollment hearings.

The Recovery Management Contractor must produce and provide copies of an appeal summary to the hearing officer and to the individual and his or her authorized representative(s) at least three business days prior to the hearing date.

G-2(a): Requesting an Assistant Attorney General for a Hearing

When the Recovery Management Contractor is notified an individual will have legal representation, the Recovery Management Contractor must request an Assistant Attorney General to represent the Recovery Management Contractor at the hearing. However, the Attorney General's office will provide an Assistant Attorney General only if the Recovery Management Contractor can confirm that the appellant has legal representation.

- All requests for Attorney General representation must be made as directed by the Ohio Department of Medicaid. If the request is received fewer than 24 hours before the hearing is scheduled, but at least 30 minutes before the hearing, the Recovery Management Contractor can e-mail a request for an Assistant Attorney General to attend the hearing. An Assistant Attorney General cannot be requested with a phone call.
- The Recovery Management Contractor will be notified of the name of the Assistant Attorney General assigned to the hearing.
- If the Assistant Attorney General is requested fewer than 30 minutes prior to the start of a hearing, or if the request for an Assistant Attorney General is denied or otherwise cannot be fulfilled, the Recovery Management Contractor must proceed without Assistant Attorney General representation.

G-2(b): Hearings Process

If an Assistant Attorney General is attending the hearing, the Ohio Department of Medicaid or Recovery Management Contractor, depending upon who is leading the hearing, must forward all documents pertaining to the hearing to the assigned Assistant Attorney General. If a hearing has been canceled, the Ohio Department of Medicaid or Recovery Management

Contractor, as appropriate, must notify the Attorney General's office by e-mail as soon as it learns of the cancellation.

If an appellant appears at the hearing with legal representation without advance notice and their legal representation admits new written information or presents testimony not previously seen or heard by the Ohio Department of Medicaid, the Recovery Management Contractor or the Assistant Attorney General, and the preceding parties need time to review and consider the new information, they can request that the hearing be reconvened or the record left open for the submission of additional documentation. State hearing officers will make the final ruling on whether the hearing will be reconvened or the record left open.

If an appellant has no legal representation and submits new evidence or documentation, not previously reviewed or considered, the Ohio Department of Medicaid or Recovery Management Contractor may request that the hearing officer reconvene the hearing or leave the record open to allow them to review and respond to the new evidence or documentation.

If an appellant has requested a state hearing within 15 days of the Recovery Management Contractor having issued an adverse notice containing hearing rights, the Recovery Management Contractor must continue the appellant's services at his or her current level until the outcome of the state hearing. When the hearing decision is rendered, the Recovery Management Contractor must follow the decision as directed and submit a compliance form to the Bureau of State Hearings validating compliance.

When the Ohio Department of Medicaid receives a hearing decision, the decision will be forwarded to the Recovery Management Contractor. The Recovery Management Contractor is responsible for reading the hearing decision and adhering to the compliance ordered in the decision. The Recovery Management Contractor must complete the State Hearing Compliance Form #4068 to the ODM designee and provide a complete description of the compliance action, including the exact dates the action occurred.

All compliance, in accordance with Rule 5101:6-7-03 of the Ohio Administrative Code, must be achieved within 15 calendar days of the decision and no later than 90 days from the date of the hearing request. The Ohio Department of Medicaid will review the compliance and, if accepted, forward it to the Bureau of State Hearings. If not accepted, the compliance will be returned to the CMA for further action.

If the appellant disagrees with the state hearing decision, he or she may make a written request for an administrative appeal to the Ohio Department of Job and Family Services, Bureau of State Hearings, PO Box 182825, Columbus OH 43218-2825 or fax (614) 728-0874. Their written request must be received by the Bureau of State Hearings within 15 calendar days of the date the hearing decision was issued.

During the administrative appeal process, the Recovery Management Contractor must proceed with enacting the state hearing decision unless instructed by the Bureau of State Hearings to do otherwise.

G-3: Complaint Process

The Specialized Recovery Services (SRS) program enrolled individuals, service providers, family members, individual advocates, or others involved in the care of the individual have the right to make complaints to, or about, the Recovery Management Contractor. Complaints can be made to the Recovery Management Contractor, Provider Oversight Contractor, or to ODM, and they can originate from a face-to-face conversation, phone call, email, ODM inquiry, or regular mail. If the Recovery Management Contractor receives a complaint about a provider, the complaint must be forwarded to the provider oversight contractor. The Recovery Management Contractor must maintain records of all complaints.

The Recovery Management Contractor must use the following protocol for complaints:

1. Categorize complaints, reference a department, and determine a resolution type.
2. Send a complaint acknowledgment letter to the complainant within one business day of the complaint. A copy of this letter is sent to the ODM contract manager.
3. Investigate all complaints within three business days of the date of receiving the complaint and maintain a record of all investigatory notes.
4. Submit an action plan to ODM contract manager via email within seven days of receiving the complaint.
5. Address and attempt to resolve all complaints within 15 calendar days and record the resolution.
6. The Recovery Management Contractor must send a follow-up letter to each complainant to confirm that resolution has taken place. A copy of this letter is sent to the contract manager.
7. If a complainant indicates to ODM that a satisfactory resolution was not obtained, and ODM agrees, the complaint will be re-opened and returned to the Recovery Management Contractor for further investigation. (Return to Step 3 of this process)

H. Participant Safeguards

H-1: Risk Assessment and Mitigation

Participant risk and safety considerations are assessed throughout the course of recovery management activities, and with the informed involvement of the individual, potential interventions that promote independence and safety are considered. During assessments, reassessments, and anytime thereafter, any known or perceived risk and/or safety considerations are documented on the person-centered care plan and in clinical documentation.

When the Recovery Management Contractor identifies risk factors it must work with the individual's team to put services and supports in place to mitigate the risk. An emergency response plan should be activated for, but not limited to, severe weather alerts issued by the

National Weather Service or County Sheriff Department, power outages, fires, drinking water advisory, etc. Risks can be identified through formal and ongoing assessment, incident reports, reports from providers, documentation reviews, and other means.

The Recovery Manager may initiate risk and safety planning via the implementation of an "Acknowledgement of Responsibility" form, or explore development of a behavior support plan by appropriate personnel.

H-2: Acknowledgement of Responsibility

When the individual poses or continues to pose a risk to his or her health and welfare, the Recovery Manager must develop and implement an Acknowledgment of Responsibility (AR). The AR is created between the Recovery Management Contractor and the individual and/or the legal guardian, as applicable, identifying the risks and setting forth interventions recommended by the Recovery Manager to remedy risks to the individual's health and welfare.

H-2(a): How to Develop an Acknowledgement of Responsibility Plan

- Identify the potential risk to the individual's health and welfare and what behaviors or concerns are putting the individual at risk.
- Identify the goal – what needs to change in order to reduce risk(s) to the health and safety of the individual?
- Develop objectives that are specific, measurable, realistic and timely to reduce the identified behavior or concern that is impacting health and safety.
- Develop action steps (interventions) with the individual's input, and in collaboration with the Recovery Manager, to implement in order to mitigate against the risks.

The individual and/or the legal guardian, as applicable, must sign the AR. If she or he does not, the Recovery manager must document the refusal to sign.

The Acknowledgement of Responsibility must be identified in the Person-Centered Care Plan. The Acknowledgement of Responsibility form must be used when developing the plan and it must be monitored monthly to ensure the individual is adhering to the proposed interventions, as well as to ensure there is follow up on recommendations for service linkage, etc. Case file documentation must address how the individual is progressing with the agreed-upon interventions, progress toward goals (positive and negative), and modifications to interventions based on assessment of progress. If the individual has followed the plan and is no longer considered a risk, then the plan can be discontinued. Discontinuation of the plan must be clearly documented in the clinical record.

The Acknowledgement of Responsibility must:

- Be in writing and uploaded into the individual's record in the recovery management system
- Be documented in the Person-Centered Care Plan
- Be reviewed monthly and as needed with the individual and updated accordingly

- Be monitored during visits, team meetings, and plan updates to determine progress toward achieving the desired outcomes. Monitoring must be documented monthly in the communication notes in the case management system.

Action must be taken if the identified risks continue and/or cannot be mitigated. The Recovery Management Contractor must document all monitoring, including interventions that prove successful, as well as action steps that are not successful and do not mitigate identified risks.

H-2(b): Disenrollment Due to Inability to Assure Health and Welfare

If the individual does not adhere to the agreed-upon interventions, and the Recovery Manager advises that the individual's health and welfare cannot be assured, the Recovery Management Contractor may submit a recommendation to ODM's SRS Clinical Manager, or their designee, to disenroll the individual from the SRS program due to the inability to ensure his or her health and welfare. This may be done as soon as continued risks without any resolution are identified or after intervention attempts have failed. The AR must be in place at least one month before a recommendation to disenroll is submitted to the SRS Clinical Manager or their designee.

The clinical record must show a progression of how the individual failed to adhere to the Acknowledgment of Responsibility Agreement (AR) and actions the case manager has taken to support the individual in following the Agreement. The AR must be attached to the recommendation at the time of the request. Any incidents and communication notes documenting the individual's nonadherence must also be addressed in the AR. If a concern expressed in the recommendation is not addressed in the AR, it will be returned to the Recovery Management Contractor and asked that it be added and monitored for at least one month. The request must also include documentation reflecting interdisciplinary team collaboration has occurred to review the identified safety concern(s), discuss interventions, progress or lack thereof, and determine whether all relevant interventions have been attempted and deemed unsuccessful. Finally, the submission must include a transition plan for ODM review and a statement indicating the recommendation for disenrollment has been reviewed and approved by the Recovery Management Contractor's Clinical Director. Requests received by ODM will undergo review by the interdisciplinary clinical team and a written response will be issued to the Recovery Management Contractor. ODM responses may include request for additional follow up action(s) or a recommendation to proceed with notice of disenrollment due to inability to assure health and welfare.

H-3: Behavioral Interventions: Restraint, Restrictive Interventions, and Seclusion

Restraint, Restrictive Interventions, and Seclusion are used for behaviors that pose a serious risk of harm to the individual or to others. They include aggression to others, objects, or self.

If such behaviors occur, the Recovery Management Contractor must identify and engage an authorizing entity. The use of restraint or restrictive intervention is permitted only if authorized by a physician, County Board of Developmental Disabilities, a licensed psychologist, or other behavioral health professional. Only physicians can authorize chemical restraints. Only a County Board of Developmental Disabilities can authorize the use of seclusion.

H-3(a): Restraint

Restraint is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Allowable restraints include:

- Physical restraint, i.e., the use of any hands-on or physical method to restrict the movement or function of the individual's head, neck, torso, one or more limbs or the entire body; or
- Chemical restraint, i.e., the use of any sedative psychotropic drug exclusively to manage or control behavior; or
- Mechanical restraint, i.e., the use of any device to restrict an individual's movement or function for any purpose other than positioning and/or alignment.

Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restraints. They will always be explored and encouraged by the Recovery Management Contractor and the individual's team.

Restraints may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. The only restraint that may be used in an emergency is a protective hold, which is the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement. Any other use of prone restraints is prohibited.

The following are not considered restraints:

- Any device that an individual can remove or is used for positioning and/or alignment
- Physical guidance or assistance to complete Activities of Daily Living or medical procedures, or for safety, such as holding hands when crossing the street
- Medication ordered to be used in preparation for a medically necessary medical procedure.

H-3(b): Restrictive Interventions

Restrictive interventions are used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restrictive interventions. They will always be explored and encouraged by the Recovery Management Contractor and the individual's team.

Restrictive interventions may be appropriate to address issues such as wandering in unsafe environments, risk of ingesting unsafe or unhealthy items or failing to complete necessary medical/personal care tasks. Interventions may include, but are not limited to manipulation of the environment or denying access to a wanted item or activity until completion of a certain task.

Restrictive intervention may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience.

Time away is a restrictive intervention during which the individual is directed away from a location or an activity using verbal prompting, only to address a specific behavior. The individual is able to return to the location or activity at his/her choosing. Time away shall never include the use of a physical prompt or an escort. Time away is considered a restrictive intervention as long as the intervention does not meet the definition of seclusion/time-out. The use of any physical prompt or required timeline for re-engaging in an activity shall elevate the restrictive intervention to "seclusion."

H-3(c): Seclusion

Seclusion is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of seclusion. They will always be explored and encouraged by the Recovery Management Contractor and the individual's team.

Seclusion or Time Out is any restriction that is used to address a specified behavior that prevents the individual from leaving a location for any period of time. Seclusion may include preventing the individual from leaving an area until he or she is calm. Seclusion shall never include the use of locked doors and must always include constant visual supervision of the individual. It must only be used for behaviors that are physically harmful to the individual or other persons.

Seclusion may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. Time-out or seclusion will only be permitted if approved as a part of a behavior support plan. The use of seclusion that is not a part of a plan authorized and overseen by a County Board of Developmental Disabilities is prohibited.

The Recovery Management Contractor must identify and develop a plan that addresses behaviors that include the use of restraint, seclusion and restrictive interventions. Recovery Managers must ensure the following are addressed for the use of restraint, restrictive interventions, and seclusion:

- Agreement from the team that the use of use of restraint, seclusion, and/or restrictive intervention is appropriate.
- Obtain consent from the individual enrolled in the program or authorized representative for the plan and the interventions.
- Safety and well-being measures are built into the Person-Centered Care Plan as well as measures to mitigate or prevent risk
- Written verification of authorization of the use of restraint, restrictive interventions, and/or seclusion by the authorizing entity is obtained.

- An oversight entity for ongoing monitoring the use of the restraint, restrictive interventions, and/or seclusion is identified. The person implementing the restraint, restrictive interventions, and/or seclusion cannot be person responsible for monitoring the use of the restraint, restrictive intervention, and/or seclusion.
- The party responsible is identified and directed to train staff that implement the restraint, restrictive interventions, and/or seclusion.
- The planned use of restraint, restrictive interventions, and/or seclusion is documented in the Person- Centered Care Plan, and communication record.

Individuals with developmental disabilities that are served by a County Board of Developmental Disabilities are eligible to access support with behavior plan development. This includes the County Board of Developmental Disabilities oversight committees and processes. Recovery Managers must collaborate with local County Boards of Developmental Disabilities staff to access this service on behalf of the individual.

H-3(d): Reporting expectations

Any use of an approved restraint, restrictive intervention and seclusion must be documented by the provider and reviewed by the Recovery Manager during routine visits and team meetings. Any use of a restraint, restrictive intervention, or seclusion that is not approved, or is implemented contrary to the plan, must be reported as an incident via the ODM-approved system. Additionally, the use of any prohibited restraint or seclusion or any unauthorized use of a restrictive intervention must be reported as an incident. The Recovery Management Contractor must review reporting requirements with all persons authorizing or implementing a restraint, restrictive intervention, or seclusion.

The Recovery Management Contractor must develop and send an annual report to the physician who certified the restraint, seclusion plan or restrictive intervention plan. The report must include identification of the restraint, seclusion or restrictive intervention used frequency of use per month, and information on the outcome or response to the use of the restraint, seclusion, or restrictive intervention. The Recovery Management Contractor must ensure the physician evaluates the need for, and re-authorizes if necessary, the use of the restraint, seclusion, or restrictive intervention at least annually.

H-3(e): Review

The Recovery Management Contractor must review and discuss the use of restraint, seclusion, or restrictive intervention with the team at least every 90 days. Additionally, the Recovery Management Contractor must review all incident reports related to the use of restraint, seclusion, or restrictive intervention. The Recovery Management Contractor is required to review the use of restrictive interventions to ensure the use was appropriate and within prescribed guidelines.

H-4: Service Monitoring

The Recovery Management Contractor must monitor service delivery, at minimum, in conjunction with scheduled regular contacts. Monitoring services is not a compliance review process, but rather a quality check to ensure the health and welfare of the individual, as well as to ensure all needs are being met. At any time, if there are concerns about the individual's well-being, including incident identification, or about the performance of the provider, the Recovery Management Contractor must follow incident reporting guidelines.

Service Monitoring includes:

- Confirming the start of services within one business day of a new service or a new provider being added to a Person-Centered Care Plan.
- Monitoring provider service delivery by reviewing notes and other documentation. Any changes that were not previously reported to the Recovery Management Contractor must be assessed to determine the need for an event-based assessment and/or incident report, as applicable.

H-5: Incident Management

Incidents are described in Ohio Administrative Code rule [5160-43-06](#). The Recovery Management Contractor must comply with that rule and follow the protocol below when an incident occurs.

1. Take Immediate Action

- Upon discovery of an incident or allegation, the Recovery Management Contractor must take immediate action(s) to ensure the health and welfare of the individual.

In the event of a death of an individual, the Recovery Management Contractor must notify and provide relevant details to the local county coroner when the Recovery Management Contractor is aware that the:

- Individual's death was a result of an accident, injury, or trauma
- Individual's death was potentially accidental, suicidal or homicidal;
- Individual has a history of drug or alcohol abuse and/or misuse of medications including controlled substances
- Individual has been a victim, or has a history, of alleged abuse, neglect, or exploitation
- Individual's death is questionable, potentially suspicious, and/or under unknown circumstances.

2. Report to Protective Agencies

- Immediately after securing the individual’s safety, the Recovery Management Contractor must notify law enforcement, adult protective services, county board of developmental disabilities or other entity, as appropriate. The Ohio Department of Medicaid also requires the Recovery Management Contractor to cooperate with these entities, as needed, in investigations.

3. Report Incident(s) to Provider Oversight Contractor:

- The Recovery Management Contractor must report incidents in the Ohio Department of Medicaid-approved system within 24 hours of discovery.

H-5(a): Incidents Alerts

Incident alerts are described in OAC [5160-43-06](#) and must be reported *within 24 hours of discovery* to both the Provider Oversight Contractor and ODM due to the severity and/or impact of the incident on the individual or the need for ODM involvement. The Ohio Department of Medicaid monitors each incident alert to ensure that the investigation, remediation, and prevention planning are timely and effective.

Notification must include the following information in the subject line: INCIDENT ALERT, alert type, incident number assigned by the incident database. ODM reviews all pertinent information, including investigation outcomes, recommendations, final reports, approved prevention plans and verification of implementation of the approved prevention plans. ODM does not close the incident alert until after the health and safety of the individual has been ensured.

When the individual is a MyCare Ohio member, OAC rule 5160-43-06 is not applicable. Refer to OAC rule [5160-58-05.3](#) for incident management responsibilities.

At its discretion, ODM may request further review of any incident under investigation, and/or conduct a separate, independent review or investigation of any incident.

ODM shall ensure the health and welfare of individuals enrolled in the program. ODM and providers are responsible for ensuring individuals in the specialized recovery services program are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a Medicaid provider agreement, and annually thereafter, all providers, including all employees who have direct contact with individuals enrolled in the program, must acknowledge in writing they have reviewed this rule and related procedures.

H-5(b): Potential Recovery Management Contractor Involvement/Conflict of Interest

If, at any time, during the discovery or investigation stages, information surfaces that indicates that a Recovery Management Contractor employee is directly or indirectly responsible for the death, abuse, exploitation, misappropriation, or neglect of an individual, the Recovery Management Contractor must immediately notify ODM, which will assume the investigation. When the ODM is conducting an investigation and requires interviews with the Recovery

Managers, Recovery Management supervisors may be present, but not interfere, during the interview.

H-5(c): Incident Prevention Planning

After the investigation concludes, the Recovery Management Contractor must create a prevention plan to prevent the same or similar incident from reoccurring and submit it to the Provider Oversight Contractor for review and approval.

Prevention planning must include an evaluation to determine how to mitigate the effects of the occurrence, how to eliminate the risk to the individual from the cause(s) and contributing factors, and/or how to eradicate those cause(s) and contributing factors that pose a continued risk to the individual and others.

The prevention plan must:

- Be objective, measurable, attainable, reasonable (include timelines), realistic, enforceable, verifiable, and sustainable
- Consider and address all cause(s) and contributing factors and effects of the occurrence
- Be comprehensive and meet appropriate, legal, ethical, industry and profession standards, and be an acceptable practice

Some prevention plan elements may require multiple actions including, but not limited, to:

- Training for other provider and agency staff members
- Revising Person-Centered Services Plans
- Disciplining employees
- Taking administrative actions (i.e., changing policy or procedures, reassigning staff, increasing staff ratios)

The recovery manager must discuss the prevention plan with the individual prior to adding to the Person-Centered Care Plan and assure that the individual permits the addition of the prevention plan being added to the Person-Centered Care Plan.

➤ Prevention Plans Escalation timelines

- a. Provider Oversight Contractor will email the Recovery Manager and cc Supervisor with a request to develop the Prevention Plan.
- b. The Recovery Manager/Supervisor will have 3 business days to submit the Prevention Plan to the Provider Oversight Contractor for approval.
- c. If not received, Provider Oversight Contractor will escalate to the Clinical Manager

d. The Clinical Manager will have 2 days to have it submitted the Provider Oversight Contractor

e. If not submitted in 2 days, the Provider Oversight Contractor will escalate to the Recovery Management Contract Manager with the required documentation. The Recovery Management Contract Manager will remedy the situation within 3 days.

1. Correspondence sent to Recovery Manager and Supervisor
2. Correspondence sent to Clinical Manager if no response was received

- The Provider Oversight Contractor will review the prevention plan within 5 days of submission.
- Once reviewed, the Provider Oversight Contractor will either approve the prevention plan or ask for changes. If the case management agency fails to respond to request for additional changes, the Provider Oversight Contractor will escalate to the Recovery Management Contract Manager within 2 days. If the Recovery Management Contractor fails to place the prevention plan in the Person Centered Plan within 10 days, the Provider Oversight Contractor will escalate to the Recovery Management Contract Manager on day twelve after the approval.
 - a. All correspondence to the Recovery Management Contractor will be forwarded to the Recovery Management Contract Manager
- The Recovery Management Contract Manager will remedy the situation within 3 days.
- If not, resolved, Provider Oversight Contractor will reach out to Provider Oversight Contract Manager for a resolution.

H-6: Recovery Management Contractor Supervision of Recovery Managers

The Recovery Management Contractor must maintain a Recovery Manager-to-Supervisor ratio of not more than 12:1. Supervisors must meet with each Recovery Manager at least once per month to review caseloads, current case assignments, critical issues, etc. The Contractor must maintain documentation of the monthly Recovery Manager case load reviews including date, cases reviewed, and follow up actions required by the Recovery Manager. This documentation must be available at the request of ODM. Supervisors must also hold monthly team meetings with their Recovery Managers for peer review, reviewing practice standards, etc.

I. Accessing Ohio Department of Medicaid's Information Management Systems

In order to fulfill Recovery Management functions, the Recovery Management Contractor must have access to state data systems, which require it to implement a secure virtual private network connection. This must be done in cooperation with Ohio Department of Medicaid.

The Ohio Department of Medicaid will provide the Recovery Management Contractor access to Ohio Department of Medicaid data systems:

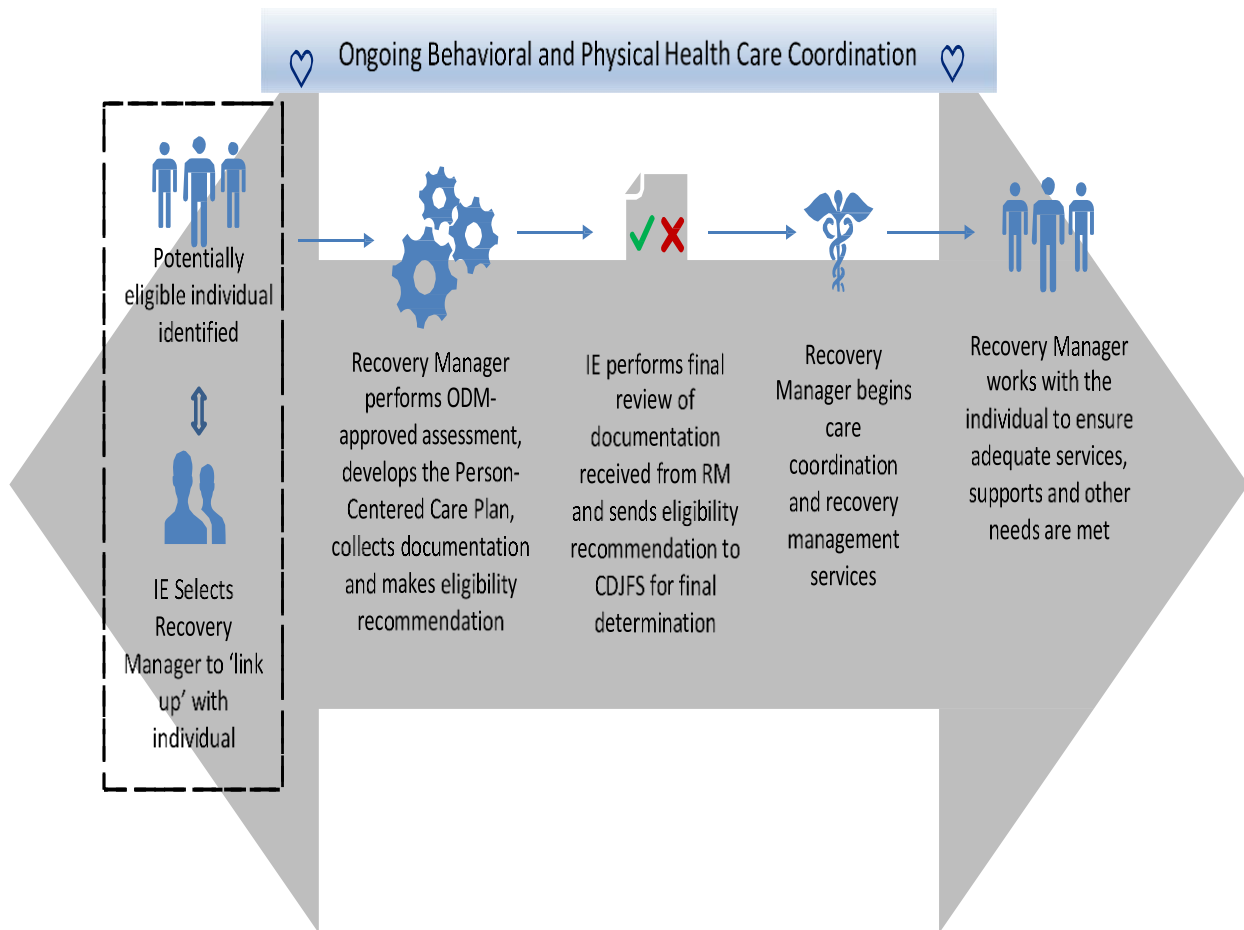
1. Medicaid Information Technology System (MITS)
2. Ohio Benefits used by Ohio Department of Medicaid and county departments of job and family services
3. The Ohio Department of Medicaid-approved Recovery Management System

The Recovery Management Contractor must request new user staff access through Ohio Department of Medicaid by submitting the appropriate access request documentation. The request is made by completing a Code of Responsibility Form (Ohio Department of Medicaid #07078), which can be requested by e-mail to the Ohio Department of Medicaid contract manager(s). Completed forms must be submitted through the Recovery Management Contractor's ODM contract manager.

Conversely, the Recovery Management Contractor must request termination of the Ohio Department of Medicaid system access within one business day of the last date of employment for any user with access to any Ohio Department of Medicaid system. Requests for terminations may be made in advance, and all requests for termination of system access must be submitted through the Recovery Management Contractor's ODM contract manager.

Appendix A

Care Coordination Flow



Appendix B

Qualifying Diagnoses for Specialized Recovery Services Program Eligibility

ODM Rule 5160-43-02

Diagnosis Category Description for Severe and Persistent Mental Illness (SPMI)

ICD-10 CODES

F06.0	Psychotic disorders with hallucinations or delusions
F06.2	Psychotic disorder with delusions
F06.30-F06.34	Mood disorders
F06.4	Anxiety disorders
F07.0	Personality change
F20.0-F29 disorder	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorder
F30.10-F30.9	Manic episodes
F31.0-F31.9	Bipolar disorder
F32.0-F39	Major depressive and mood disorders
F40.00-F40.11	Phobic and other anxiety disorders
F40.240	Claustrophobia
F40.241	Acrophobia
F40.8	Other phobic anxiety disorders
F41.0	Panic disorder without agoraphobia
F41.1	Generalized anxiety disorder
F42.2-F42.9	Obsessive-compulsive disorder
F43.10-F43.12	Post-traumatic stress disorder
F43.20-F43.25	Adjustment disorders
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.4-F44.9	Dissociative and conversion disorders
F45.0-F45.9	Somatoform disorders
F48.1- F48.9	Other nonpsychotic mental disorders
F50.00-F50.9	Eating disorders
F53	Postpartum depression
F60.3	Borderline Personality Disorder

F633-F63.9	Impulse disorders
F64.1- F64.9	Gender identity disorders
F68.10-F68.8	Disorders of adult personality and behavior
F90.0-F90.9	Attention-deficit hyperactivity disorders
F91.0-F91.9	Conduct disorders
F93.0-F93.9	Emotional disorders with onset specific to childhood
F94.0- F94.9	Disorders of social functioning with onset specific to childhood and adolescence

Diagnosis Category Description for Diagnosed Chronic Conditions (DCC)

ICD-10 CODE

B20 Human immunodeficiency virus [HIV] disease

B91 Sequelae of poliomyelitis

C15 Malignant neoplasm of esophagus C16 Malignant neoplasm of stomach

C20 Malignant neoplasm of rectum

C21 Malignant neoplasm of anus and anal canal

C22 Malignant neoplasm of liver and intrahepatic bile ducts

C23 Malignant neoplasm of gallbladder

C24 Malignant neoplasm of other and unspecified parts of biliary tract

C25 Malignant neoplasm of pancreas

C26 Malignant neoplasm of other and ill-defined digestive organs

C30 Malignant neoplasm of nasal cavity and middle ear

C31 Malignant neoplasm of accessory sinuses

C32 Malignant neoplasm of larynx

C33 Malignant neoplasm of trachea

C34 Malignant neoplasm of bronchus and lung

C38 Malignant neoplasm of heart, mediastinum and pleura

ODM BCO 7.1.18

C45 Mesothelioma

C46 Kaposi's sarcoma

C47 Malignant neoplasm of peripheral nerves and autonomic nervous system

C48 Malignant neoplasm of retroperitoneum and peritoneum

C51 Malignant neoplasm of vulva

C52 Malignant neoplasm of vagina

C56 Malignant neoplasm of ovary

C58 Malignant neoplasm of placenta

C64 Malignant neoplasm of kidney, except renal pelvis

C65 Malignant neoplasm of renal pelvis

C66 Malignant neoplasm of ureter

C67 Malignant neoplasm of bladder

C68 Malignant neoplasm of other and unspecified urinary organs

C70 Malignant neoplasm of meninges

C71 Malignant neoplasm of brain

C72 Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system

C74 Malignant neoplasm of adrenal gland

C7A Malignant neuroendocrine tumors

C7B Secondary neuroendocrine tumors

C81 Hodgkin lymphoma

C82 Follicular lymphoma

C83 Non-follicular lymphoma

C84 Mature T/NK-cell lymphomas

C85 Other specified and unspecified types of non-Hodgkin lymphoma

C86 Other specified types of T/NK-cell lymphoma

C88 Malignant immunoproliferative diseases and certain other B-cell lymphomas

C90 Multiple myeloma and malignant plasma cell neoplasms

C91 Lymphoid leukemia

C92 Myeloid leukemia

C93 Monocytic leukemia

C94 Other leukemias of specified cell type

C95 Leukemia of unspecified cell type

C96 Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue

D57 Sickle-cell disorders

D58 Other hereditary hemolytic anemias

D65 Disseminated intravascular coagulation [defibrination syndrome]

D66 Hereditary factor VIII deficiency

D67 Hereditary factor IX deficiency

E84 Cystic fibrosis

N18.6 End Stage Renal Disease (ESRD)

Q85 Phakomatoses, not elsewhere classified

Z94 Transplanted organ and tissue status

Z21 Asymptomatic human immunodeficiency virus [HIV] infection status