Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
November 2nd, 2023
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_jbKcBtGvSSK9CNU-AxoQFg
Telephone: 1-669-254-5252 **Webinar ID: 161 133 6420Z**

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the September 7th, 2023: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. 2023 Post Award Forum: Oklahoma's Institution for Mental Disease (IMD) Section 1115(a) Medicaid Demonstration Project Waiver: **Melissa Miller Senior Director, Behavioral Health Policy, and Planning**

VI. State Readiness- MAC Implications: **Christina Foss, Deputy Chief of Staff**

VII. Medicaid Directors Update: **Traylor Rains, State Medicaid Director**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

A. **APA WF # 23-16A&B Minimum Age for Enrollment into ADvantage Waiver**
B. **APA WF # 23-19 Adult Day Health Services Revisions**
C. **APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations**
D. **APA WF # 23-21 Quarterly Payments for Orthodontic Services**

IX. Election of Chairman and Vice-**Chairman: Chairman, Jason Rhynes, O.D.**

X. New Business: **Chairman, Jason Rhynes, O.D.**

XI. Future Meeting: **Chairman, Jason Rhynes, O.D.**

January 4, 2024

March 7, 2024
May 2, 2024
July 4, 2024 or July 11, 2023
September 5, 2024
November 7, 2024

XII. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the September 7, 2023, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble, Dr. Steven Crawford, Ms. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Tina Johnson, Ms. Jennifer King, Ms. Melissa Miller, Dr. Jason Rhynes, and Dr. Marny Dunlap providing a quorum.

Alternates present were:

Delegates absent without an alternate were**:** Mr. J. Daniel Post, Dr. Raymond Smith, and Dr. Whitney Yeates.

II. Approval of the July 13th, 2023 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passed unanimously.

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. Financial Reports: Josh Richards, Senior Director of Financial Services

Josh Richards presented the financial report ending in June 2023. OHCA is 0.1% over budget in revenues and 0.6% under budget in expenditures with the result that our budget variance is a negative $47,410,064. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 6.8 million state dollars, and administration is a positive 3.4 million state dollars. For more detailed information, see item 5 in the MAC agenda.

VI. Medicaid Directors Update: Traylor Rains, State Medicaid Director

Mr. Rains stated that OHCA is still in middle of unwinding PHE, just hit the halfway mark. 150,000 members have unenrolled now. We expect that number to be around 300,000 in December. We are in good shape, taken new strategies, such as in June and July was paused procedural termination for 30 days, to allow more time for outreach. On average we got about 12,500 members re-enrolled just by taking that break in June and July. Our procedural rates are going down, which is good and

expected. We are working with our partner Unite Us to help coordinate the members who have lost eligibility during the unwinding process. Unite Us will help connect members who are no longer eligible with treatment services provided by community based organizations, free & charitable clinics and safety net clinics like FQHCs.

Ms. Foss gave an update regarding marketing materials from the SoonerSelect Contracted Entities and an overview of how marketing materials will be brought to the MAC in future meetings for review and approval. We are currently in the process of reviewing all the plans marketing materials which includes everything from social media posts, to what their website looks like. We want to make sure we are all using clear language. The plans will be asked to submit a yearly marketing plans 90 days before they are due, allowing the MAC to be able to review those materials.

Ms. Puebla discussed the federal authorities needed in order to implement SoonerSelect one of which is the 1915b waiver and the other is the readiness review process to be conducted, reported, and approved by CMS. The contracts between OHCA and the CEs as well as the capitated rates must also be approved by CMS. The quality strategy must be conducted, published, and submitted to CMS. We are currently in our dental desk review about to be completed, and moving to on-site, which will take place the two weeks following. We are also in conjunction working on the medical and children specialty desk review process. Out of the 5 phases, we are in the 3rd. After the 5 phases are completed, we will be moving on to the on-site reviews. Lastly, Quality members were announced this week and posted on our website in the press release.

Mr. Miller discussed HIE Strategic planning such as the RFP development, new emergency rules, opt-out policy changes, exemption approvals, statistics, participants, and outreach. For more detailed information, see items 6C in the MAC agenda.

VIII. <u>Proposed Rule Change: Presentation, Discussions, and Vote:</u>
Kasie McCarty, Senior Director of Federal and State Authorities

APA WF # 23-08 Non-Payment of Provider Preventable Conditions – The proposed rules update non-payment policies for provider preventable conditions (PPCs), including health care-acquired conditions (HCACs), and other provider-preventable conditions (OPPCs), for inpatient, outpatient, and long-term care services as required by Section 2702 of the Affordable Care Act of 2010. The rules will delineate the conditions that will be identified for non-payment and the requirements for provider to report the PPCs regardless of whether the provider seeks SoonerCare reimbursement for services to treat the conditions consistent with federal regulation.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

APA WF # 22-13 Secure Mental Health Transportation — The proposed additions implement secure mental health transportation as a covered benefit for SoonerCare members. Policy will define the service as secure transportation to a facility arranged by a Qualified Transportation Service Provider (QTSP) for the appropriate, medically necessary services to treat members experiencing a behavioral health crisis. Rules will include the specific contracted with the Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS) requirements including for eligible providers (driver/contractor), member program eligibility, covered services, and the distance that will be taken into consideration when transporting members. Finally, additions will state that reimbursement for secure mental health transportation is outlined in the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact, for SFY2024, will be an increase in the total amount of $6,153,652; with $1,939,170 in state share. The estimated budget impact, for SFY2025 will be an increase in the total amount of $6,153,652; with $1,939,170 in state share.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

APA WF # 23-15 Biosimilar Reimbursement — The proposed additions align reimbursement for certain biosimilar products with the Medicare Part B fee schedule. The Inflation Reduction Act (2022) included a provision directing Medicare Part B to increase reimbursement for certain biosimilar products from Average Sales Price (ASP) + 6% to ASP + 8%. Based on CMS guidance, policy will be amended to replace specific references to ASP + 6% with language indicating payment will match the Medicare Part B fee schedule.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $200,320; with $45,353 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $600,691; with $189,378 in state share.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

APA WF # 23-18 Twelve-months Continuous Eligibility for Children in Medicaid and CHIP – The proposed revisions update eligibility policy for SoonerCare to implement 12-months continuous eligibility for children under age 19 receiving services through Medicaid and the Children's Health Insurance Plan (CHIP), effective January 1, 2024, in compliance with the Consolidated Appropriations Act of 2023.

Budget Impact: The estimated total cost for SFY 2024 is $4,463,262 ($3,056,776 in federal share and $1,406,485 in state share). The estimated total cost for SFY 2025 is $54,941,044 ($37,353,042 in federal share and $17,588,002 in state share).

The rule change motion to approve as by Ms. Wanda Felty and seconded by Dr. Arlen Foulks and passes unanimously.

IX. MAC Meeting Dates for Calendar 2023:

Chairman, Jason Rhynes, O.D.

November 2, 2023

X. **New Business:**

Chairman, Jason Rhynes, O.D.

XI. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Arlen Foulks and seconded by Dr. Steven Crawford, there was no dissent and the meeting adjourned at 2:21pm.

SECTION 1115 INSTITUTIONS FOR MENTAL DISEASE (IMD) WAIVER

YEAR 3 POST-AWARD FORUM

Melissa Miller, MSW, Sr. Director of Behavioral Health Policy and Planning

Oklahoma Department of Mental Health and Substance Abuse Services

OVERVIEW OF OKLAHOMA'S IMD WAIVER

- States can pursue an IMD waiver for mental health or substance use disorder treatment services.
- Oklahoma's IMD waiver application includes both categories of services through a joint Serious Mental Illness (SMI) and Substance Use Disorder (SUD) waiver.
- The waiver will be effective for five years from the date of approval, with a potential for renewal.
- Oklahoma's approval date is December 22, 2020, with each year of the demonstration running on a calendar year basis.

INCLUDED POPULATIONS AND SERVICES

Inpatient stays in psychiatric hospitals (with more than 16 beds)

- Adults ages 21-64

Crisis stabilization services in crisis units (with more than 16 beds)

- Adults ages 18-64

Substance use disorder treatment in residential settings (with more than 16 beds)

- Adults ages 18-64
- Individuals under 18 years old

UPDATES/ ACHIEVEMENTS FOR CY 2023

- Preliminary mid point assessment was completed, outlining important performance metrics.

Name	Description	Goal	2021
SUD provider availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Increase	373
SUD provider availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Increase	429

	Description	Goal	2021
Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period (annual)	Increase	6,493
Average Length of Stay in IMDs	The average length of stay (days) for beneficiaries discharged from IMD inpatient or residential treatment for SUD	Stabilize	20.58

UPDATES/ ACHIEVEMENTS FOR CY 2023

Metric	Demo Goal	2021
Average Length of Stay in IMDs for all IMDs and populations	≤ 30 days	9.43
Average Length of Stay in IMDs for all IMDs and populations among short-term stays (≤ 60 days)		9.29
Average Length of Stay in IMDs for all IMDs and populations among long-term stays (≥ 60 days)		73.25
Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Consistent	3,231

UPDATES/ACHIEVEMENTS FOR CY 2023

- ODMHSAS has expanded (and is continuing to expand) a statewide crisis continuum of care, including:
  - Urgent Recovery Clinics
  - Crisis units
  - Mobile crisis teams
  - 988 call center

- Visit **oklahoma.gov/odmhsas** for more information on the state's Comprehensive Crisis Response.

Questions?

November 2023 MAC
Proposed Rule Amendment Summaries

These proposed ***EMERGENCY*** rules were presented for Tribal Consultation and were subject to at least a 15-day public comment period. The Agency is requesting the effective date to be immediately upon Governor's approval (no later than January 19).

APA WF # 23-16A&B Minimum Age for Enrollment into ADvantage Waiver — The Oklahoma Health Care Authority (OHCA) seeks to align rules with the 1915(c) HCBS ADvantage Waiver which was recently amended to lower the eligibility age that an individual can enter the program from 21 to 19 years of age to better facilitate their transition into the ADvantage Program.

Budget Impact: Budget neutral

APA WF # 23-19 Adult Day Health Services Revisions — These emergency revisions are necessary to maintain the level of support for individuals who are eligible to receive HCBS 1915(c) waiver services by providing the same amount of adult day health they were receiving while on the DDS Aging state-funded services wait list. The maximum number of adult day health units that can be provided in a day will increase from six (6) to eight (8) hours. Additionally, policy revisions will change the name from adult day services to adult day health.

Budget Impact: The estimated budget impact for SFYs 2024 and 2025 is a savings in state funds of $1,020,564 for SFY 2024 and a savings in state funds of $2,041,128 for SFY 2025. Adult Day Health is paid 100% from state funds when eligible individuals need eight hours of services per day but receive fewer than eight. Increasing the cap to eight hours per day allows use of federal dollars.

APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations — The proposed rule changes will help alleviate wait times for TEFRA approval by adding additional provider types to conduct psychological evaluations for TEFRA applicants. In addition to licensed psychologists or school psychologists as currently outlined in policy, certified psychometrists, psychological technicians of a psychologist, and licensed behavioral health professionals will be added to policy. Further revisions will reflect a new business process of conducting ICF/IID level of care reevaluations biennially rather than annually.

Budget Impact: The estimated budget impact for SFY 2024 is $83,395, of which $27,078 is state share. The estimated budget impact for SFY 2025 is $166,790, of which $53,390 is state share.

APA WF # 23-21 Quarterly Payments for Orthodontic Services — The Agency proposes to transition the current orthodontic payment protocol from a bulk payment to a quarterly payment system. The new payment protocol will be based on twenty-four (24) months with built in progress reports. Proposed revisions will remove outdated language and add new language to delineate the new payment criteria and billing instructions.

Budget Impact: Budget neutral

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-41. Home and Community Based Services Waivers for persons with physical disabilities

(a) **ADvantage Waiver**. The ADvantage Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for elderly and disabled individuals in specific waiver areas. To receive ADvantage Program services, individuals must meet the nursing facility level of care criteria, be age ~~65~~sixty-five (65) years or older, or age ~~21~~nineteen (19) or older if disabled. ADvantage Program members must be SoonerCare eligible and reside in the designated service area. The number of members in the ADvantage Waiver is limited.

(b) **Medically Fragile Waiver**. The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the ~~OHCA~~Oklahoma Health Care Authority (OHCA) skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid (SoonerCare) services eligibility

(a) Long-term medical care for the categorically needy includes:

(1) Care in a long-term care facility per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Care in a public or private intermediate care facility for the intellectually disabled (ICF/IID), per OAC 317:35-9;

(3) Care of persons sixty-five (65) years of age and older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community-Based waiver services for persons with intellectual disabilities, per OAC 317:35-9;

(5) Personal Care services, per OAC 317:35-15; and

(6) Home and Community-Based waiver services (ADvantage waiver) for frail elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and older, who do not have an intellectual disability or a cognitive impairment related to a developmental disability per OAC 317:35-17-3.

(b) When an individual is certified as eligible for SoonerCare coverage of long-term care, he or she is also eligible for other SoonerCare services. ADvantage waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage assisted living center, any income beyond one-hundred and fifty percent (150%) of the federal benefit rate is available to defray the cost of the assisted living services received. The member is responsible for payment to the assisted living services center provider for days of service, from the first day of each full-month in which services were received, until the vendor pay obligation is met. When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for QMBP or SLMB benefits. An ADvantage program member may reside in a licensed assisted living services center only when the assisted living services center is a certified ADvantage assisted living services center provider from whom the member is receiving ADvantage assisted living services.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a thirty (30) calendar day period, the person's health, due to disease process or disability, would without appropriate services, deteriorate and require long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the waiver, at least monthly, to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the categories in (A) though (D) of this paragraph. He or she must:

(A) Be sixty-five (65) years of age and older; or

(B) Be ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age, physically disabled and not developmentally disabled; or

(C) When developmentally disabled, and ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability;

(D) Be ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age, not physically disabled but has clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C) of this paragraph. He or she must:

(A) Require long-term care facility level of care, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) Meet service eligibility criteria, per OAC 317:35-17-3(f); and

(C) Meet program eligibility criteria, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth in (1) though (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home and/or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage assisted living center.

(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment, or independent-living apartment, or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage and/or preparation amenities in addition to bedroom and/or living space.

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of home and/or apartment in emergency situations, for a period not to exceed sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services while the member is a student.

(5) Members may receive ADvantage respite services in an LTC facility for a continuous period not to exceed thirty (30) calendar days.

(d) Home and Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid waiver allows the Oklahoma Health Care Authority (OHCA) to offer certain Home and Community-Based services to an annually capped number of persons, who are categorically needy, per Oklahoma Department of Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside the LTC facility cannot exceed the annual cost of caring for that individual in an LTC facility. When determining the ADvantage service plan cost cap for an

individual, the comparable SoonerCare cost to serve that individual in an LTC facility is estimated.
(e) Services provided through the ADvantage waiver are:
(1) Case management;
(2) Respite;
(3) Adult day health care;
(4) Environmental modifications;
(5) Specialized medical equipment and supplies;
(6) Physical, occupational, or speech therapy or consultation;
(7) Advanced supportive and/or restorative assistance;
(8) Nursing
(9) Skilled nursing;
(10) Home-delivered meals;
(11) Hospice care;
(12) Medically necessary prescription drugs, within the limits of the ADvantage waiver;
(13) Personal care, State Plan, or ADvantage personal care;
(14) A Personal Emergency Response System (PERS);
(15) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(16) Institution;
(17) Assisted living; and
(18) SoonerCare medical services for individuals, twenty-one (21) years of age and over, within the State Plan scope.
(f) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for long-term care facility level of care. The criteria in (1) through (5) of this subsection are used to make the service eligibility determination, which includes:
(1) An open ADvantage program waiver slot, as authorized by the Centers for Medicare and Medicaid Services (CMS), which is available to ensure federal participation in payment for services to the individual. When the Oklahoma Department of Human Services/Aging Services (OKDHS/AS) determines all slots are filled, the individual cannot be certified by OKDHS as eligible for ADvantage services and his or her name is placed on a waiting list for entry when an open slot becomes available;
(2) The ADvantage waiver-targeted service group. The target group is individuals, who:
(A) Are frail and sixty-five (65) years of age and older; or
(B) are ~~Twenty-one~~nineteen (19) to sixty-four (64) years of age and physically disabled; or
(C) When developmentally disabled, and are ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or
(D) Are ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age, not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-174-3(b)(2)(A through C).
(3) An ineligible individual because he or she poses a physical threat to himself or herself or others as supported by professional documentation.
(4) Members of the household or persons who routinely visit the household, as supported by

professional documentation that do not pose a threat of harm or injury to the individual or other household visitors.

(5) An ineligible individual when his or her living environment poses a physical threat to himself or herself or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the individual move are unsuccessful or not feasible.

(g) The State, as part of the ADvantage waiver program approval authorization, ensures CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on criteria (1) through (8) of this subsection.

(1) The individual's needs, as identified by UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, or other formal or informal services.

(2) One (1) or more members of the individual's household pose a physical threat to themselves or others as supported by professional documentation.

(3) The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) The individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) The individual's living environment poses a physical threat to self or others as supported by professional documentation and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) The individual does not require at least one ADvantage service monthly.

(8) The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in his or her living environment produces evidence of illegal drug activity or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor;

(C) The use of substances, such as inhalants including, but not limited to:

(i) Typewriter correction fluid;

(ii) Air conditioning coolant;

(iii) Gasoline;

(iv) Propane;

(v) Felt-tip markers;

(vi) Spray paint;

(vii) Air freshener;
(viii) Butane;
(ix) Cooking spray;
(x) Paint; and
(xi) Glue;

(D) The observed intoxication, consumption or sensory indicators, such as smell of the use of any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(i) Smoking pipes used to consume substances other than tobacco;
(ii) Roach clips containing marijuana cigarettes;
(iii) Needles and other implements used for injecting drugs into the body;
(iv) Plastic bags or other containers used to package drugs;
(v) Miniature spoons used to prepare drugs; or
(vi) Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use.

(F) Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) The typical use of such items in the community; and/or

(H) Testimony of an expert witness regarding use of the item.

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, OKDHS AS provides technical assistance to the provider for transitioning the individual to other services.

(i) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS AS of the determination and of the right to appeal the decision.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) Oral examinations;

(ii) Medically necessary images;

(iii) Prophylaxis;

(iv) Flouride application;

(v) Development of a sequenced treatment plan that prioritizes:

(I) Pain elimination;

(II) Adequate oral hygiene; and

(III) Restoring or improving ability to chew;

(vi) Routine training of member or primary caregiver regarding oral hygiene; and

(vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.

(2) **Nutrition services**. Nutrition Services are provided, per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) Intended to help the member achieve greater independence to reside and

participate in the community; and

(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.

(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is made to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within the occupational therapist's employment. Payment is made in fifteen-minute (15-minute) units, with a limit of four hundred and eighty (480) units per Plan of Care (POC) year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises

the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) Intended to maximize a member's psychological and behavioral well-being; and

(II) Provided in individual and group formats, with a six-person maximum.

(ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Service description.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in the community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and

may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

(iii) Have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2) unless a waiver is granted, per 56 O.S. §1025.2; and

(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for:

(I) Routine care and supervision family normally provides; or

(II) Services furnished to a member by a person who is legally responsible, per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP clearly specifies the role of the HTS and person providing IPS to ensure there is no service duplication.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS

services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent

experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) Center-based prevocational services, per OAC 317:40-7-6;

(II) Community-based prevocational services per, OAC 317:40-7-5;

(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) IPS;

(iii) ~~Adult Day Services~~Adult Day Health;

(iv) Daily Living Supports (DLS);

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(14) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete the OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent

experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:

(I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and

(II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) Job coaching per OAC 317:40-7-7;

(II) Enhanced job coaching per OAC 317:40-7-12;

(III) Employment training specialist services per OAC 317:40-7-8; and

(IV) Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.

(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) Payments passed through to users of supported-employment programs; or

(III) Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) IPS;

(iii) ~~Adult Day Services~~Adult Day Health;

(iv) DLS;

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(15) **IPS.**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Service description.**

(i) IPS:

(I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.

(iii) The DDS POC reviewer is required to review and approve services.

(C) **Coverage limitations.** IPS are limited to twenty-four (24) hours per day and are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(16) **~~Adult day services~~Adult day health.**

(A) **Minimum qualifications.** ~~Adult day service~~Adult day health provider agencies:

(i) Meet licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and

(ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for ~~adult day services~~adult day health.

(B) **Service description.** ~~Adult day services~~Adult day health provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** ~~Adult day services are~~adult day health is furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of ~~six (6)~~eight (8) hours daily~~, at which point a unit is one (1) day~~. All services are authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care ~~annually~~, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1. Determining ICF/IID institutional level of care for TEFRA children

In order to determine ~~ICF/IID~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA) children:

(1) The child must be age ~~18~~eighteen (18) years or younger and expected to meet the following criteria for at least ~~30~~thirty (30) days.

(A) Applicants under age three (3) must:

(i) ~~have~~Have a diagnosis of a developmental disability; and

(ii) ~~have~~Have been evaluated by the SoonerStart Early Intervention Program or other appropriate healthcare provider, and found to have severe dysfunctional deficiencies with findings of at least two (2) standard deviations in at least two (2) total domain areas.

(B) Applicants age three (3) years and older must:

(i) ~~have~~Have a diagnosis of intellectual disability or a developmental disability; and

(ii) ~~have~~Have received a psychological evaluation by a licensed psychologist, ~~or~~ school psychologist certified by the Oklahoma Department of Education (ODE) within the last ~~12~~twelve (12) months, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP). The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/IID level of institutional care requires an IQ of ~~70~~seventy (70) or less, or a full-scale functional assessment indicating a functional age composite that does not exceed fifty (50) percent of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight (8) years.

(2) Psychological evaluations are required for children who are approved for TEFRA under ICF/IID level of care. Children under evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist, ~~or~~ school psychologist certified by the ODE, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP) at ~~age three, age six,~~application, at two (2) years (but no later than three (3) years) after the initial psychological evaluation, and at two (2) years (but no later than three (3) years) after the second psychological evaluation and, if medically necessary, thereafter, to ascertain continued eligibility for TEFRA under the ICF/IID level of institutional care. ~~The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third (3rd) and sixth (6th) birthday, and, if medically necessary, thereafter.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 1. GENERAL PROVISIONS

PART 79. DENTISTS

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be electronically submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

(1) Completed prior authorization requesting all needed treatments;

(2) Complete and scored Handicapping Labio-Lingual Deviation (HDL) Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) Completed OHCA caries risk assessment form;

(8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and

(9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of thirty (30) on the HDL Index may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);

(4) Objective evidence must be submitted with the HLD;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and

(6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights [see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) ~~Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.~~Adjustments after the initial treatment will be authorized at the end of the first year and then quarterly in the second and third years. The treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval. An additional progress report must be submitted to the OHCA before receiving the final quarterly payment.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond ~~thirty-six (36)~~twenty-four (24) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the ~~yearly~~ first year payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received ~~yearly~~the first year payment does not agree to be financially responsible, then the OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. Providers will be reimbursed for either the study model or images when

obtained for orthodontic evaluation and/or therapy.

(1) Documentation of casts and/or photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic claim.

(2) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(3) 3-D model images or photographic images not in compliance with the diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

317:30-5-704. Billing instructions

(a) **HCPCS Codes.** The Oklahoma Health Care Authority (OHCA) utilizes the Medicare Level II Healthcare Common Procedure Coding System (HCPCS) codes. All claim submissions must be in compliance with this coding system.

(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in ~~box 34 of the current American Dental Association (ADA) dental claim form. For mailed prior authorizations, a completed HCA-13D form is required.~~ the appropriate field when submitting prior authorizations on the provider portal.

(c) **Images.** Any type of film or prints submitted will not be returned. All images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.