MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
January 19, 2012
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the November 16, 2011 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Financial Report: Gloria Hudson-Hinkle, Director of General Accounting
   A. November Financial Summary
   B. November Financial Detail Report

V. SoonerCare Operations Update: Von Lawson, Director, Opportunities for Living Life
   A. SoonerCare Programs Report
   B. HCBS Waivers

VI Durable Medical Equipment (DME) Recycling Program: Stanley Ruffner, DME Director

VII. Electronic Access to SoonerCare Member Health Information: Adolph Maren, Planning Project Manager

VIII. Action Items: Traylor Rains, Policy Development Coordinator

OHCA Initiated

11-08 Date of Application Clarification - Eligibility rules are revised to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.
Budget Impact – Budget neutral.

11-13 My Life, My Choice Waiting List Clarification – OHCA rules for the My Life, My Choice Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

11-14 Sooner Seniors Waiver Waiting List Clarification – OHCA rules for the Sooner Seniors Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

11-29 Medically Fragile Waiver Waiting List Clarification – OHCA rules for the Medically Fragile Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

11-19 End Stage Renal Disease Payment Methodology – Policy, the State Plan, and reimbursement methodology will be updated to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type. **Budget Impact:** $959,000 total; $344,000 State Share.

11-25A&B SoonerRide Clarification - SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.
Budget Impact – Budget neutral.

11-26 Revocation of Enrollment and Billing Privileges - OHCA’s provider agreements policy is expanded to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS’s Medicare regulations on provider agreements.
Budget Impact – Budget neutral.

11-27 Outpatient Behavioral Health Rules - Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive requirements for providing covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Outpatient Behavioral Health, Psychologist and Licensed Behavioral Health Professional (LBHP) rules are being revised to remove the guidelines for obtaining authorizations to provide services. Authorization requirements will be placed in the Behavioral Health Provider Manual and the rule revisions will reference the Manual. The authorization requirements are procedural in nature and are more appropriate in the context of a billing manual rather than the Agency's administrative rules.
Budget Impact – Budget neutral.

11-30 School Based Services – School based services rules are revised to align policy with changes to Current Procedural Terminology (CPT) coding and guidelines. Revisions will correct references to units of service and include guidelines associated with the school based services. Additionally, rules are revised to remove "Dental Screenings" and "Psychological Services" in order to clarify that these services are included within the Child Health Encounter and Psychotherapy Services, respectively, and are not separately reimbursable.
Budget Impact – Budget neutral.

11-31 Purchasing - Purchasing rules are revised to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.
Budget Impact – Budget neutral.

11-33 Insure Oklahoma - Insure Oklahoma ESI rules are revised to clarify the definition of "in-network" as being the qualified health plan's highest percentage reimbursement network approved by OHCA. The rules are also revised to clarify that OHCA only reimburses members for their out of pocket expenses related to services obtained from providers in the highest percentage network.
Budget Impact – Budget neutral.

11-34 Catheter Type Limitations - Rules are revised to limit the number and type of catheters covered per member per month and bring policy in line with CMS regulations on catheter utilization. Current rules allow for 150 intermittent catheters per member per month. The change will allow a combined maximum of 200 intermittent catheters per member per month. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit. Finally, prior authorization for these catheters will no longer be required.
Budget Impact: Budget Savings of $548,500

11-35 Program of All-Inclusive Care for the Elderly (PACE) - PACE rules are revised to remove pilot specific requirements. Current language references Cherokee Nation as the PACE provider; revisions will replace specifics with general language that is applicable to any PACE provider. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.
Budget Impact – Budget neutral.

11-36 Cvek Pulpotomy and Crown Equalization - Agency dental policy is revised to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the type of crown that best serves the member's oral environment.
Budget Impact – Budget neutral.

11-38 PAP Certificates of Medical Necessity - Policy is revised to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.
Budget Impact – Budget neutral.

11-40 Eligibility Clean-Up - Eligibility policy is revised for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.

Budget Impact – Budget neutral.

11-41 Mental Illness Service Program Certification – Pursuant to 43A Okla. Stat. § 3-323A, Outpatient Behavioral Health Rules are revised to add Oklahoma Department of Mental Health Substance Abuse Service (ODMHSAS) Mental Health Service Program certification as an option for provider participation standards in lieu of national accreditation.
Budget Impact - Budget neutral.

11-42 Member Sanctions - Eligibility policy is revised to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspend for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.
Budget Impact – Budget neutral.

11-43 Pain Management During Anesthesia - Agency anesthesia coverage policy for children is revised to allow reimbursement for a pain management procedure when performed during an anesthesia session.
Budget Impact – Budget neutral.

OKDHS Initiated

11-32A&B OKDHS/DDSD Rule Changes - Permanent rule revisions are proposed by the OKDHS Developmental Disability Services Division (DDSD) pertaining to clarification of policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.
Budget Impact – Budget neutral.

IX. New Business

X. Adjourn

Next Meeting: Wednesday, March 7, 2012.

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
November 16, 2011

Members attending: Dr. Aulgur, Ms. Bellah, Dr. Bourdeau (via teleconference), Ms. Case (via teleconference), Dr. Cavallaro, Ms. Karen Bradford for Ms. Sherry Davis, Mr. Goforth, Ms. Thayer for Mr. Howard Hendrick, Ms. Holiman-James, Mr. McAdoo, Dr. McNeill, Dr. Ogle, Mr. Pilgrim, Dr. Post, Dr. Rhoades, Dr. Rhynes, Mr. Sczepanski, Ms. Slatton-Hodges for Ms. White, Dr. Wells, Dr. Woodward, Dr. Wright, Mr. Snyder for Ms. Patti Davis

Members absent: Ms. Brinkley, Dr. Crawford, Ms. Felty, Dr. Grogg, Dr. McCrory, Mr. Patterson, Dr. Simon, Mr. Tallent, Mr. Unruh

I. Welcome, Roll Call, and Public Comment Instructions
Dr. McNeill welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were no requests for public comment.

II. Approval of minutes of the September 15, 2011 Medical Advisory Committee Meeting
Ragina Holiman-James made the motion to approve the minutes as presented. Dr. Cavallaro seconded. Approved with Dr. Wells' changes regarding limiting the use of hygienists, which should be hygienists and assistants.

III. MAC Member Comments/Discussion
No discussion.

IV. Financial Report: Gloria Hudson-Hinkle, Director of General Accounting
Ms. Hudson-Hinkle reviewed the financial transactions through September 2011. There were no questions.

V. SoonerCare Operations Update: Carolyn Reconnu, Director, Health Management Program
Ms. Reconnu reviewed the SoonerCare Programs Report and the Health Management Program Update handouts.

Question - How do you determine who gets selected for the Practice Facilitation? Answer - Predictive Modeling software ranks providers according to risk guideline gaps. For example, diabetic measures might put somebody on the radar so we can offer assistance. We are working specifically on patients with co-morbidities, to see if we've missed anybody. We have served about 10% of our Patient Centered Medical Homes, and hundreds of providers.

Comment by MAC member this is wonderful. How does it compare to the projection for the first year, and has there been a percentage reduction on these patient days? Ms. Reconnu and Dr. Herndon responded that we really did not know what to expect. A lot of programs isolate it and only look, for example, at diabetics, others only look at people with congestive heart failure, and disease categories, where they know how they get a bang for their buck. We didn't opt out, we took on super hard patients. CMS helped us design this model. Lots of programs that do disease management target diabetes only or CHF only, not multiple conditions where you can make a real rapid return on investment. With time, disease management failed to save money in the long term. It's because they were not looking at the patient realistically. They were avoiding the "tough" patients, the charity patients, so to speak, We challenged ourselves to build long term, not short term results. Guided by AHRQ and CHCS and other authorities in health management, we built this program not knowing what the overall outcome would be. We did know how many years it would take to show the cost savings, if you take on the patient and not just the disease. We are just starting to break even now. It costs a lot of money to take care of patients and to teach them how to do the right things when they have multiple chronic conditions. Next year we anticipate showing cost savings. This is a program that was not done until Oklahoma did it. Now, Texas, Louisiana and several other states are building programs that are a lot like ours.

Dr. Keenan commented that this is an outstanding example of teamwork. As we go, we learn lessons and begin to take advantage of them. For example, in another year or so we are going to have to re-bid, and are in the process of: What have we learned? What is working/not working that we haven't been able to change so far? What kind of changes do we want to make next year? This is a small team to have accomplished as much as they have. Dr. Keenan thanked Dr. Herndon for taking this on. He is nationally known for his work on this. He came in as a medical reviewer, and Dr. Mitchell, our former Medicaid Director, wanted to start a Health Management Program. Dr. Herndon was soon on this special project, dealing with legislature, researching the project; he's brought it up from the ground.

VI. Dual Eligibles: Sarah Harding and David Ward, Policy, Planning and Integrity
Ms. Harding and Mr. Ward reviewed the handout. There were no questions.

Side note - We have new MAC members. Dr. Keenan mentioned the changes. The organizations have been contacted and most of the groups have responded with either their re-appointment, or new appointment. Some have responded with the alternates, others have not. Those that have not responded, we sent a second letter requesting a response.
A new member, under the Medical Equipment Suppliers, Mr. Randy McAdoo, present. His alternate is Mr. Dennis Teal. Under the Association of Health Care Providers, Mr. Scott Pilgrim, present, and his alternate is Ms. Rebecca Moore. For the Long-Term Care Association, Ms. Mary Brinkley, not present. We are still waiting on an alternate. Under Home Care, there are 2 home care associations. Mr. Bill Sczepanski is present, representing the Oklahoma Association of Home Care, and his alternate is Ms. Annette Mays. Mr. Steve Goforth is present, representing Home and Community Based Services. Ms. Tanya Case, who is present, is one of our At Large members.

VII. Waiver Development and Reporting: Cara Norris-Ramirez and Kimrey McGinnis, Policy, Planning & Integrity
Ms. Norris-Ramirez and Ms. McGinnis addressed the MAC and reviewed the handout.

Questions regarding the Breast and Cervical Cancer screening program: Is stereotactic biopsy included in the benefit? Answer: Is there indication for biopsy? Is there a suspicious finding that warrants biopsy? If there is a finding that is suspicious for malignant/pre-malignant condition, the patient would be eligible, and the biopsy whether stereotactic, open or needle, would be done after eligibility in this particular program. The issue is what is indicative of malignant/pre-malignant condition of the breast.

Mr. Rhoades – Funding is not unlimited, and there is a concern there may be delays in identifying or having sufficient funding to do all the diagnostic tests that would be needed for the population eligible. He hopes the OHCA can streamline getting the women into diagnosis and treatment. Let's be careful to not put up a barrier to obtaining the diagnostic testing.

Dr. Keenan mentioned that part of the issue is, they are eligible for all Medicaid services, as soon as they are determined eligible. They often get many services before they get their cancer diagnosis. It's the time for getting all the other ills and pains taken care of. We have found some issues there. The whole goal of our waiver is to get them diagnosed and into care. Some of our program dollars are being diverted into other services, as opposed to getting the diagnosis, and doing it in a timely manner so we can treat the patient as soon as possible. Getting them in and getting them diagnosed is our goal, but we also want to preserve the resources for what they are intended.

A question was asked about looking at a limited benefit package instead of the full package, and the likelihood if that's possible. We are investigating with our regional project manager, and whether it's most appropriate under the waiver amendment. Right now the way the program is set up, the group we are talking about is not in the waiver. A State Plan Amendment is also under discussion.

VIII. Action Items: Traylor Rains, Policy Development Coordinator

OHCA Initiated

11-03 Family Planning Waiver Population to State Plan – OHCA rules for the SoonerPlan Family Planning Program are revised to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan
Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.
Budget Impact – $171,887 state share; $1,246,000 federal share

11-24 Certified Alcohol and Drug Counselors – Rules are revised to reflect that behavioral health therapy services may only be provided by licensed professionals effective July 1, 2013. Currently, Certified Alcohol and Drug Counselors (CADCs) may perform therapy services in accordance with their Licensure Act. Revisions are made to comply with Oklahoma Statues.
Budget Impact – Budget Neutral
11-03 Ms. Bellah made the motion to approve 11-03 and 11-24. Dr. Post seconded. Passed.

11-27 Outpatient Behavioral Health Rules – Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive and procedural requirements for providing and billing for covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Partial Hospitalization Program (PHP) rules are revised in order to provide consistency with the Title XIX State Plan.
Budget Impact – Budget Neutral
Ms. Bellah motioned for roll call vote. Dr. Post seconded. Motion by Dr. Cavallaro to approve. Dr. Ogle seconded. One opposed. 13 votes for, 7 against, 1 abstain. Item 11-27 Approved.

Federally Initiated

11-04 "Rosa's Law" Revisions – OHCA rules are revised to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with Public Law 111-256 (Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.
Budget Impact –Budget Neutral

11-20 Provider Agreements Clarification– Provider agreement rules are revised to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise the contact information for the OHCA Provider Contracting Unit.
Budget Impact – Budget Neutral

OKDHS Initiated

11-15 Long-term Care Partnership Program– Oklahoma Health Care Authority long-term care eligibility rules are revised to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.
Budget Impact – Budget Neutral

Motion to approve by Ms. Holiman-James. Dr. Rhynes seconded. All approved.

IX. New Business – Dr. Rhynes mentioned optometry's attempt to become eligible through CMS for the EHR stimulus on the Medicaid side, as they currently are with Medicare. They think they have found a vehicle and have moved things forward significantly since the last MAC meeting. Illinois and Kentucky have already moved into approved status. The optometrists have been working with the OHCA and appreciate the support to where they may potentially be eligible. Things have moved forward in a positive way.

X. Adjourn – 2:47 p.m.

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Five Months Ended November 30, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 439,410,943	$ 439,410,943	$ -	0.0%
Federal Funds	914,487,297	893,831,325	(20,655,972)	(2.3)%
Tobacco Tax Collections	23,801,704	25,685,571	1,883,867	7.9%
Quality of Care Collections	21,740,079	21,378,394	(361,685)	(1.7)%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	135,358	135,358	-	0.0%
Drug Rebates	72,000,019	80,571,910	8,571,891	11.9%
Medical Refunds	16,812,864	20,429,058	3,616,194	21.5%
Other Revenues	8,146,756	8,521,137	374,381	4.6%
TOTAL REVENUES	**$ 1,551,538,510**	**$ 1,544,967,185**	**$ (6,571,324)**	**(0.4)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 18,278,203**	**$ 16,122,273**	**$ 2,155,930**	**11.8%**
ADMINISTRATION - CONTRACTS	**$ 49,998,043**	**$ 42,360,844**	**$ 7,637,199**	**15.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	13,780,426	12,739,832	1,040,594	7.6%
Acute Fee for Service Payments:				
Hospital Services	388,423,722	371,906,646	16,517,076	4.3%
Behavioral Health	131,204,059	134,571,328	(3,367,269)	(2.6)%
Physicians	184,591,812	187,241,742	(2,649,929)	(1.4)%
Dentists	65,407,381	63,382,175	2,025,206	3.1%
Other Practitioners	31,219,627	31,930,710	(711,083)	(2.3)%
Home Health Care	9,580,689	8,976,683	604,007	6.3%
Lab & Radiology	22,620,572	22,244,200	376,372	1.7%
Medical Supplies	20,272,152	19,945,574	326,578	1.6%
Ambulatory Clinics	36,228,966	35,835,830	393,136	1.1%
Prescription Drugs	151,785,694	155,985,529	(4,199,835)	(2.8)%
Miscellaneous Medical Payments	13,329,834	14,293,969	(964,136)	(7.2)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	209,435,613	206,787,320	2,648,294	1.3%
ICF-MR Private	24,586,203	23,973,244	612,959	2.5%
Medicare Buy-In	60,287,863	59,875,742	412,121	0.7%
Transportation	11,679,481	11,456,852	222,630	1.9%
EHR-Incentive Payments	30,480,602	30,480,602	-	0.0%
Part D Phase-In Contribution	30,720,617	30,413,912	306,705	1.0%
Total OHCA Medical Programs	**1,435,635,315**	**1,422,041,888**	**13,593,426**	**0.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,504,000,943**	**$ 1,480,525,005**	**$ 23,475,937**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 47,537,567**	**$ 64,442,180**	**$ 16,904,613**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Five Months Ended November 30, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 12,927,590	$ 12,731,050	$ -	$ 187,758	$ -	$ 8,782	$ -
Inpatient Acute Care	277,594,063	247,589,815	202,786	5,771,582	20,964,844	1,298,868	1,766,167
Outpatient Acute Care	106,349,143	99,626,409	17,335	4,498,810	-	2,206,589	
Behavioral Health - Inpatient	51,066,089	49,531,210	-	-	-	2,658	1,532,221
Behavioral Health - Outpatient	8,245,050	8,235,528	-	-	-	-	9,522
Behavioral Health Facility- Rehab	94,420,960	75,416,524	-	206,317	-	53,101	18,745,018
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	6,899,825	-	-	-	-	-	6,899,825
Targeted Case Management	24,244,136	-	-	-	-	-	24,244,136
Therapeutic Foster Care	1,332,307	1,332,307	-	-	-	-	-
Physicians	209,570,236	157,555,708	24,209	6,804,047	25,549,945	4,111,880	15,524,448
Dentists	63,413,768	59,851,371	-	31,593	3,495,091	35,713	-
Other Practitioners	32,183,371	31,322,245	185,985	252,660	407,641	14,840	-
Home Health Care	8,976,689	8,958,239	-	6	-	18,444	-
Lab & Radiology	23,626,034	21,645,731	-	1,381,834	-	598,469	-
Medical Supplies	20,275,050	18,882,719	1,031,645	329,476	-	31,210	-
Ambulatory Clinics	40,409,306	35,669,941	-	797,845	-	165,888	3,775,631
Personal Care Services	5,305,125	-	-	-	-	-	5,305,125
Nursing Facilities	206,787,320	132,499,379	57,465,394	-	16,806,231	16,317	-
Transportation	11,456,852	10,318,045	1,078,190	-	57,954	2,662	-
GME/IME/DME	57,304,588	-	-	-	-	-	57,304,588
ICF/MR Private	23,973,244	19,717,952	3,901,587	-	353,704	-	-
ICF/MR Public	24,178,058	-	-	-	-	-	24,178,058
CMS Payments	90,289,653	89,216,815	1,072,839	-	-	-	-
Prescription Drugs	163,747,012	137,230,936	-	7,761,483	17,924,123	830,470	-
Miscellaneous Medical Payments	14,294,155	13,663,827	-	186	593,125	37,017	-
Home and Community Based Waiver	66,858,525	-	-	-	-	-	66,858,525
Homeward Bound Waiver	37,702,714	-	-	-	-	-	37,702,714
Money Follows the Person	1,256,209	-	-	-	-	-	1,256,209
In-Home Support Waiver	10,272,158	-	-	-	-	-	10,272,158
ADvantage Waiver	73,873,337	-	-	-	-	-	73,873,337
Family Planning/Family Planning Waiver	3,150,317	-	-	-	-	-	3,150,317
Premium Assistance*	24,817,693	-	-	24,817,693	-	-	-
EHR Incentive Payments	30,480,602	30,480,602					
Total Medicaid Expenditures	**$ 1,827,281,178**	**$1,261,476,353**	**$ 64,979,970**	**$ 52,841,292**	**$ 86,152,658**	**$ 9,432,907**	**$ 352,397,998**

* Includes $24,674,880.27 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Five Months Ended November 30, 2011

		FY12
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	131,232,339
Federal Funds		228,615,732
TOTAL REVENUES	**$**	**359,848,071**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 66,858,525
Money Follows the Person	1,256,209
Homeward Bound Waiver	37,702,714
In-Home Support Waivers	10,272,158
ADvantage Waiver	73,873,337
ICF/MR Public	24,178,058
Personal Care	5,305,125
Residential Behavioral Management	5,551,964
Targeted Case Management	17,816,074
Total Department of Human Services	**242,814,164**
State Employees Physician Payment	
Physician Payments	15,524,448
Total State Employees Physician Payment	**15,524,448**
Education Payments	
Graduate Medical Education	18,150,000
Graduate Medical Education - PMTC	1,355,971
Indirect Medical Education	29,677,651
Direct Medical Education	8,120,966
Total Education Payments	**57,304,588**
Office of Juvenile Affairs	
Targeted Case Management	1,131,883
Residential Behavioral Management - Foster Care	19,367
Residential Behavioral Management	1,328,494
Multi-Systemic Therapy	9,522
Total Office of Juvenile Affairs	**2,489,266**
Department of Mental Health	
Targeted Case Management	-
Hospital	1,532,221
Mental Health Clinics	18,745,018
Total Department of Mental Health	**20,277,239**
State Department of Health	
Children's First	891,130
Sooner Start	935,768
Early Intervention	2,694,994
EPSDT Clinic	898,643
Family Planning	33,527
Family Planning Waiver	3,094,206
Maternity Clinic	54,549
Total Department of Health	**8,602,818**
County Health Departments	
EPSDT Clinic	355,397
Family Planning Waiver	22,583
Total County Health Departments	**377,980**
State Department of Education	**58,515**
Public Schools	**1,651,539**
Medicare DRG Limit	**-**
Native American Tribal Agreements	**1,531,273**
Department of Corrections	**128,825**
JD McCarty	**1,637,343**
Total OSA Medicaid Programs	**$ 352,397,998**
OSA Non-Medicaid Programs	**$ 35,245,294**
Accounts Receivable from OSA	**$ 27,795,221**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Five Months Ended November 30, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 21,363,269	$ 21,363,269
Interest Earned	15,126	15,126
TOTAL REVENUES	**$ 21,378,394**	**$ 21,378,394**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 55,884,887	$ 20,034,732	
Eyeglasses and Dentures	121,926	43,711	
Personal Allowance Increase	1,458,580	522,901	
Coverage for DME and supplies	1,031,645	369,845	
Coverage of QMB's	430,315	154,268	
Part D Phase-In	1,072,839	1,072,839	
ICF/MR Rate Adjustment	2,056,318	737,190	
Acute/MR Adjustments	1,845,270	661,529	
NET - Soonerride	1,078,190	386,531	
Total Program Costs	**$ 64,979,970**	**$ 23,983,545**	**$ 23,983,545**
Administration			
OHCA Administration Costs	$ 226,379	$ 113,189	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 226,379**	**$ 113,189**	**$ 113,189**
Total Quality of Care Fee Costs	**$ 65,206,349**	**$ 24,096,735**	
TOTAL STATE SHARE OF COSTS			**$ 24,096,735**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Five Months Ended November 30, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 21,470,039	$ -	$ 18,184,739
State Appropriations			
Tobacco Tax Collections	-	21,125,580	21,125,580
Interest Income	-	212,554	212,554
Federal Draws	4,432,268	15,793,265	15,793,265
All Kids Act	(7,418,508)	124,123	124,123
TOTAL REVENUES	$ 18,483,799	$ 37,255,521	$ 55,316,138

EXPENDITURES	FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 24,379,752	$ 24,379,752
College Students		142,813	142,813
All Kids Act		295,128	295,128
Individual Plan			
SoonerCare Choice	$ 182,673	$ 65,488	
Inpatient Hospital	5,750,853	2,061,681	
Outpatient Hospital	4,442,593	1,592,670	
BH - Inpatient Services	-	-	
BH Facility - Rehabilitation Services	205,282	73,594	
Physicians	6,751,551	2,420,431	
Dentists	26,047	9,338	
Other Practitioners	246,103	88,228	
Home Health	6	2	
Lab and Radiology	1,363,009	488,639	
Medical Supplies	321,717	115,336	
Ambulatory Clinics	789,954	283,199	
Prescription Drugs	7,662,128	2,746,873	
Miscellaneous Medical	-	-	
Premiums Collected	-	(972,534)	
Total Individual Plan	**$ 27,741,917**	**$ 8,972,943**	
College Students-Service Costs	**$ 230,582**	**$ 82,664**	
All Kids Act- Service Costs	**$ 51,100**	**$ 18,319**	
Total Program Costs	**$ 52,841,292**	**$ 33,891,619**	
Administrative Costs			
Salaries	$ 13,534	$ 651,421	$ 664,954
Operating Costs	29,081	56,405	85,486
Health Dept-Postponing	-	-	-
Contract - HP	256,445	984,964	1,241,409
Total Administrative Costs	**$ 299,059**	**$ 1,692,789**	**$ 1,991,848**
Total Expenditures			**$ 35,883,467**
NET CASH BALANCE	**$ 18,184,739**		**$ 19,432,671**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

Fiscal Year 2012, For the Five Months Ended November 30, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	$ 421,601	$ 421,601
TOTAL REVENUES	**$ 421,601**	**$ 421,601**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 8,782	$ 2,204	
Inpatient Hospital	1,298,868	326,016	
Outpatient Hospital	2,206,589	553,854	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	53,101	13,328	
Case Mangement	0	-	
Nursing Facility	16,317	4,096	
Physicians	4,111,880	1,032,082	
Dentists	35,713	8,964	
Other Practitioners	14,840	3,725	
Home Health	18,444	4,629	
Lab & Radiology	598,469	150,216	
Medical Supplies	31,210	7,834	
Ambulatory Clinics	165,888	41,638	
Prescription Drugs	830,470	208,448	
Transportation	2,662	668	
Miscellaneous Medical	37,017	9,291	
Total Program Costs	$ 9,432,907	$ 2,367,660	**$ 2,367,660**
TOTAL STATE SHARE OF COSTS			**$ 2,367,660**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

FINANCIAL REPORT

For the Five Months Ended November 30, 2011
Submitted to the CEO & Board
January 12, 2012

- Revenues for OHCA through November, accounting for receivables, were **$1,544,967,185** or **(.4%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,480,525,005** or **1.6% under** budget.

- The state dollar budget variance through November is **$16,904,613 positive.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		8.0
Administration		2.9
Revenues:		
Taxes and Fees		1.5
Drug Rebate		3.1
Overpayments/Settlements		1.4
Total FY 12 Variance	**$**	**16.9**

ATTACHMENTS

SoonerCare Programs

November 2011 Data for January 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment November 2011	Total Expenditures November 2011	Average Dollars Per Member Per Month November 2011
SoonerCare Choice Patient-Centered Medical Home			449,392	**470,390**	**$147,085,267**	
	Lower Cost	*(Children/Parents; Other)*		425,106	$101,822,353	$240
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,284	$45,262,914	$1,000
SoonerCare Traditional			239,274	**238,411**	**$212,143,795**	
	Lower Cost	*(Children/Parents; Other)*		131,574	$60,765,394	$462
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		106,837	$151,378,401	$1,417
SoonerPlan			31,082	**40,768**	**$652,883**	$16
Insure Oklahoma			32,181	**31,834**	**$11,576,013**	
	Employer-Sponsored Insurance		19,095	17,831	$4,735,412	$266
	Individual Plan		13,085	14,003	$6,840,601	$489
TOTAL			**751,928**	**781,403**	**$371,457,958**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $18,833,861 are excluded.

Net Enrollee Count Change from Previous Month Total	6,154

New Enrollees	19,515

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,486
Aged/Blind/Disabled	*Adult*	130,747
Other	*Child*	167
Other	*Adult*	20,425
PACE	*Adult*	86
TEFRA	*Child*	405
Living Choice	*Adult*	96
OLL Enrollment		**171,412**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled November 2011
Dual Enrollees	**103,906**	**107,552**

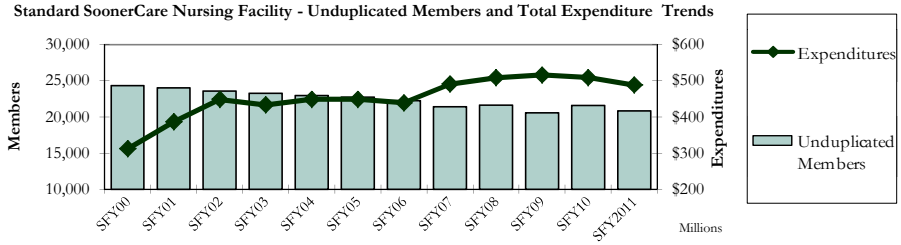
		Monthly Average SFY2011	Enrolled November 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,857**	**$3,744**
	Child	92	87	
	Adult	15,641	15,770	

SFY2011 Long-Term Care

Statewide LTC Occupancy Rate - 71.0%
SoonerCare funded LTC Bed Days 68.2%

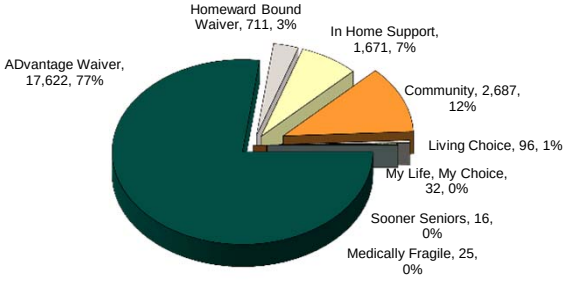
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled November 2011
Total Providers		**29,026**	**37,640**
	In-State	20,585	27,838
	Out-of-State	8,442	9,802

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled November 2011***	Total Monthly Average SFY2011	Total Enrolled November 2011
Physician	*6,489*	*7,515*	*11,777*	13,492
Pharmacy	*901*	*871*	*1,230*	1,147
Mental Health Provider***	*935*	*3,754*	*982*	3,809
Dentist	*798*	*977*	*901*	1,111
Hospital	*187*	*192*	*739*	915
Licensed Behavioral Health Practitioner***	*503*	*3,290*	*524*	3,322
Extended Care Facility	*392*	*377*	392	377

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

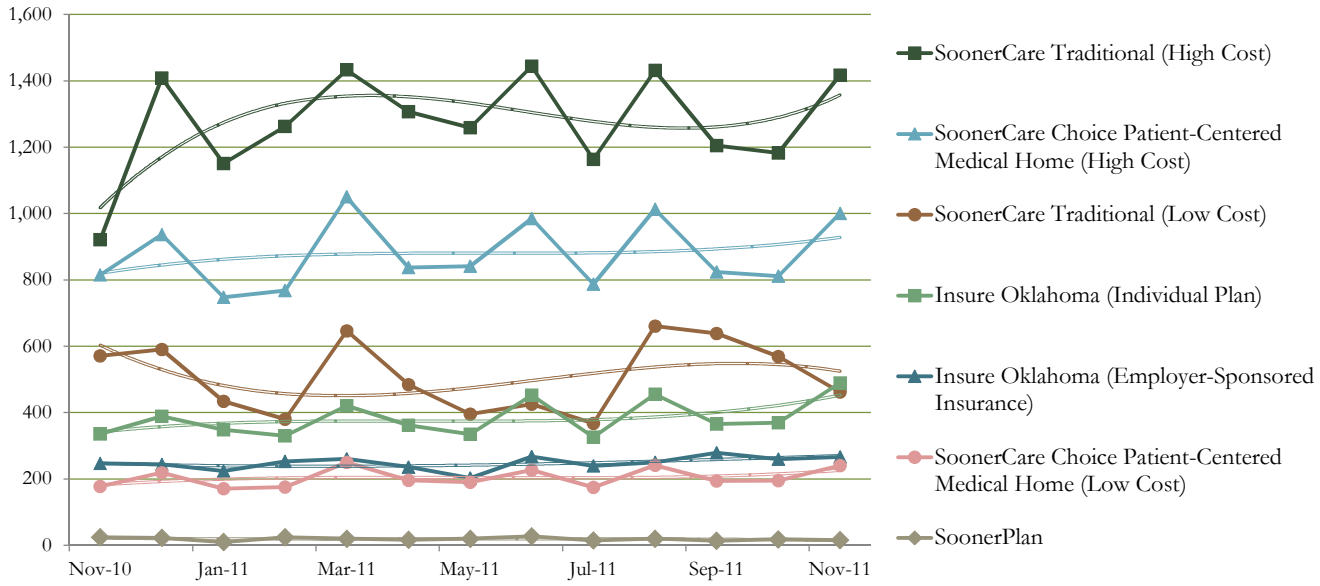
Total Primary Care Providers	*4,461*	*5,283*	6,467	7,566
Patient-Centered Medical Home	*1,476*	*1,728*	1,502	1,755

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

***Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Licensed Behavioral Health Practitioners and Mental Health Providers.

SOONERCARE PER MEMBER PER MONTH (PMPM) TRENDS



ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

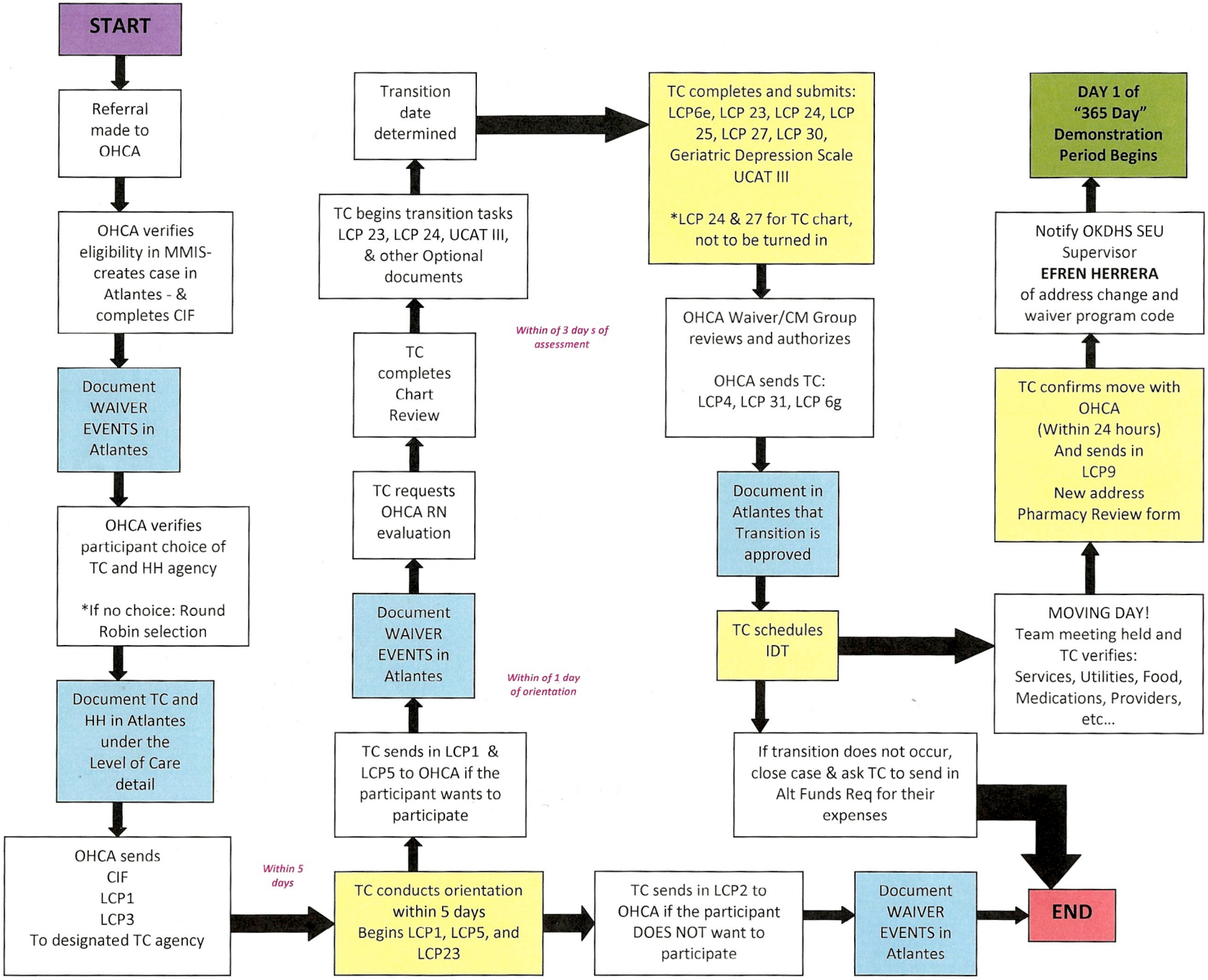
The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As Of 1/3/2012	December 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	46	$977,500	1,035	$22,007,917
Eligible Hospitals	5*	$2,658,211	65	$48,169,868
Totals	51	$3,635,711	1,100	$70,177,785

*Current Eligible Hospitals Paid
PAULS VALLEY GEN HSP
ST JOHN MED CTR
ST JOHN OWASSO
ST JOHN SAPULPA INC
ST MARY'S REGIONAL CTR

Oklahoma Living Choice Waiver Program Transition Process Overview

2/25/2011



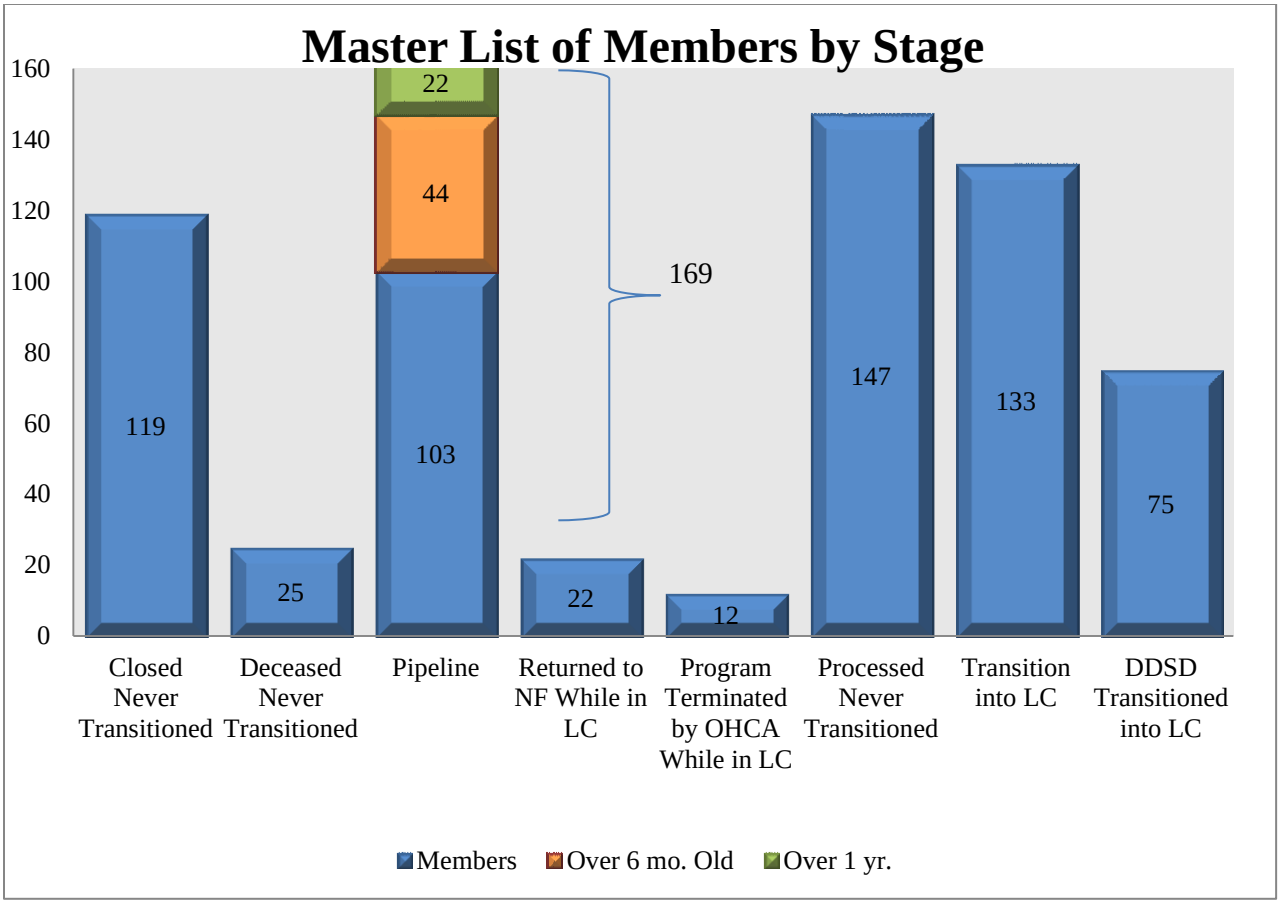


Figure 1 *7 of deceased members did not transitioned into the LC program.
** The following numbers together constitute the total transitions members transitioned for the Elderly and Physically Disabled populations: 18 deceased members, 22 members that returned to NF, 12 members that were terminated, and the 133 transitions and are currently in the LC program or one of the Waivers.

All members included on the "Master List" by stage currently in as of January 3, 2012 are included in the above graph. An exact breakdown of this list is below.

Current Stage	Member Count
Closed/Withdrawals Never Transitioned to LC	**119**
Death Total	**25**
Pipe Line	**169**
Returned to NF While in LC	**22**
Program Terminated by OHCA While in LC	**12**
Alternative Funds Processed Never Transitioned into LC	**147**
Transitioned in to LC	**133**
DDSD Transitioned into LC	**75**
TOTAL	**702**

Figure 2

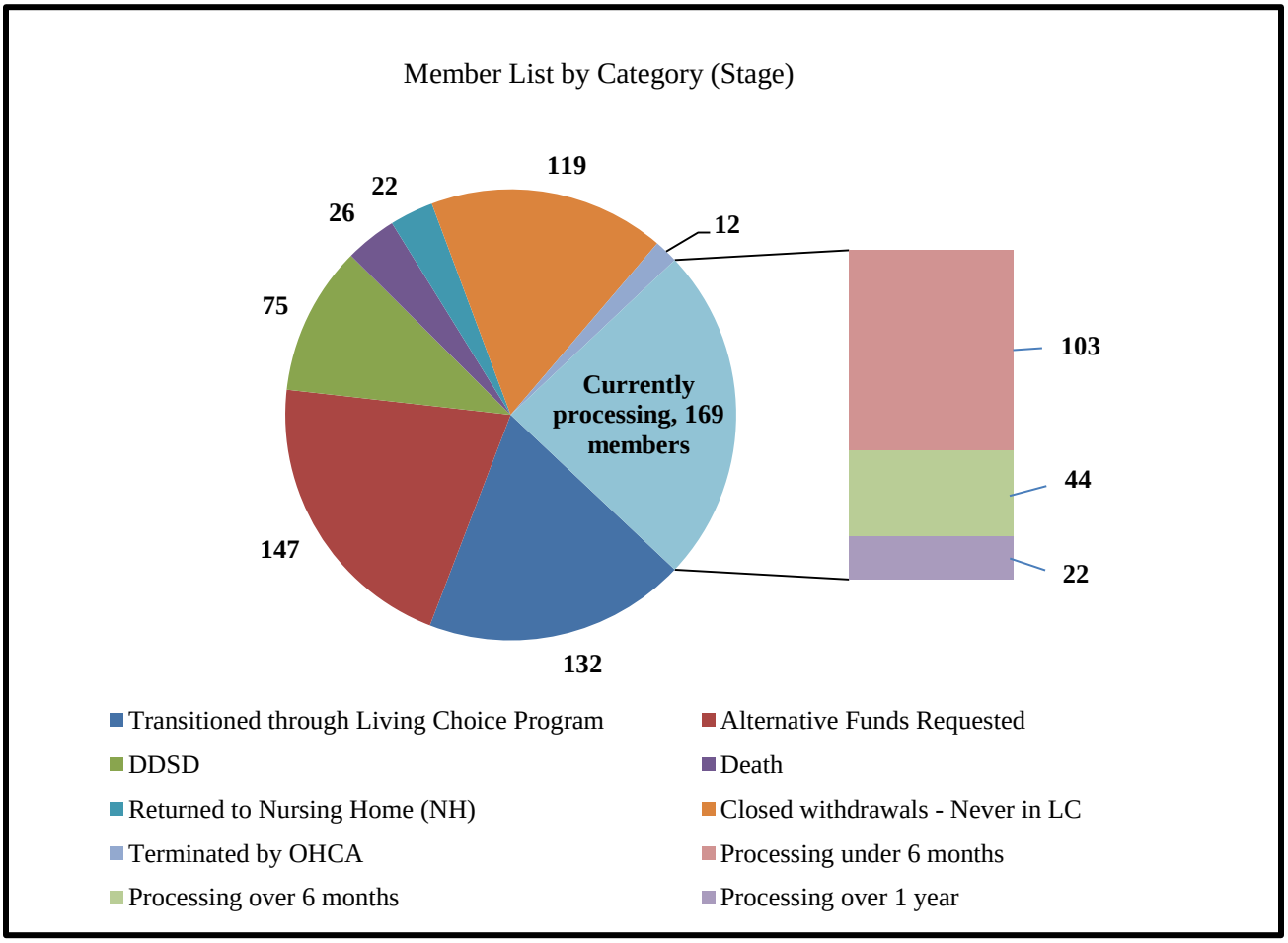


Figure 3

Overall there are 627 total members (excluding DDSD) listed on the "Master List" as of January 3, 2012:

- 132 members have (21. %) transitioned through the Living Choice Program.
- 147 members have (23.4 %) requested or received alternative transition funds as they were unable to be successfully transitioned out of a managed care facility.
- 26 members have (3.9 %) have died during the transition process.
- 22 members have (3.5 %) returned to the nursing home after being.
- 119 members have (18.97 %) are no longer in the program.
- 12 members have (1.9 %) terminated by OHCA.
- 75 members are Developmental Disability Services Division (DDSD) members

Of the 627 total members, 169 members (28.4 %) going through the process of transition. This number does however change daily. Figure 3 above is simply a breakdown of the three respective categories that constitute members that are currently in the transition pipeline as of Monday January 3, 2011. 103 members (60.9%) have been in process for less than 6 months 44 members (26%) have been in process for over 6 months22 members (13%) have been in process for over a year.

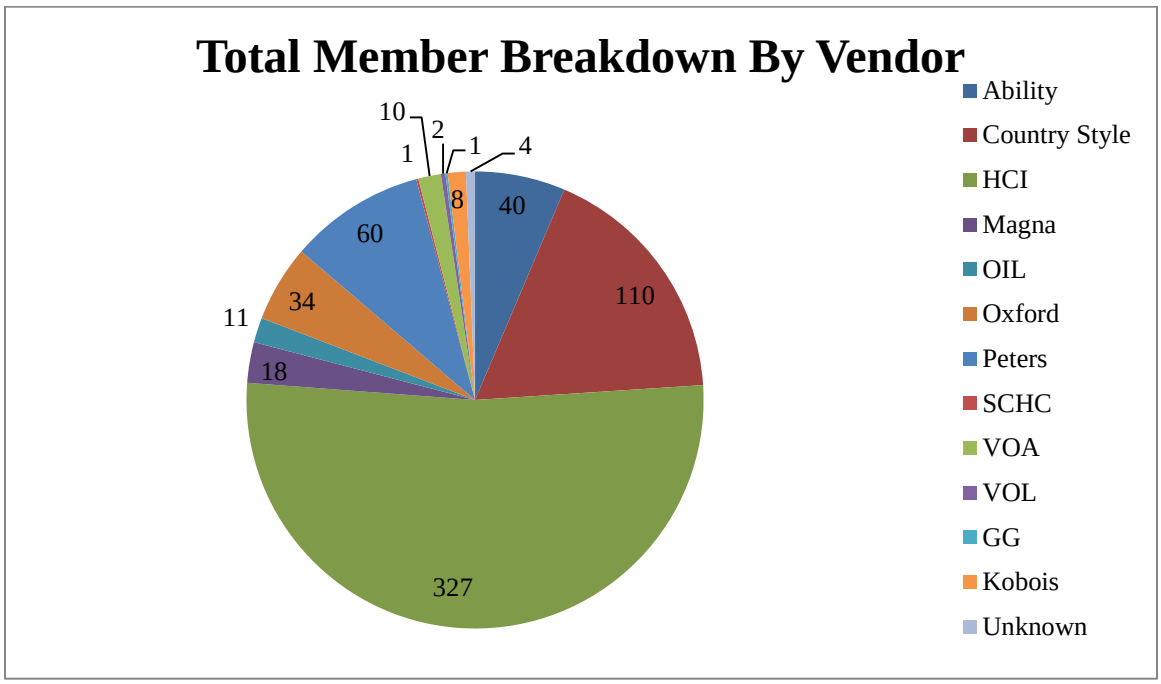


Figure 4

This figure represents the breakdown of all members present on the "Master List" by vendor.

- Ability represents 40 members (4 % of all cases on the Master List).
- Country Style represents110 members (17.5% of all cases).
- HCI represents 327 members (52 % of all cases).
- Magma represents 18 members (2.8 percent of all cases).
- OIL represents 11 members (1.7 % of all cases).
- Oxford represents 34 members (5.4 % of all cases).
- Peters represents 60 members (9.5 % of all cases).
- SCHC represents 1 members (less than 1% of all cases).
- VOA represents 10 members (1.5 % of all cases).
- VOL represents 2 members (.3 % of all cases).
- GG represents 1 members (2.8 % of all cases).
- KOBOIS represents 8 members (1.2 % of all cases).
- "Unknown" as used here likely refers to cases in which members voluntarily quit or never fully qualified for the program. Therefore no vendor was ever chosen to attempt to transition them from the nursing facility. There were 4 members in this category (less than 1%)

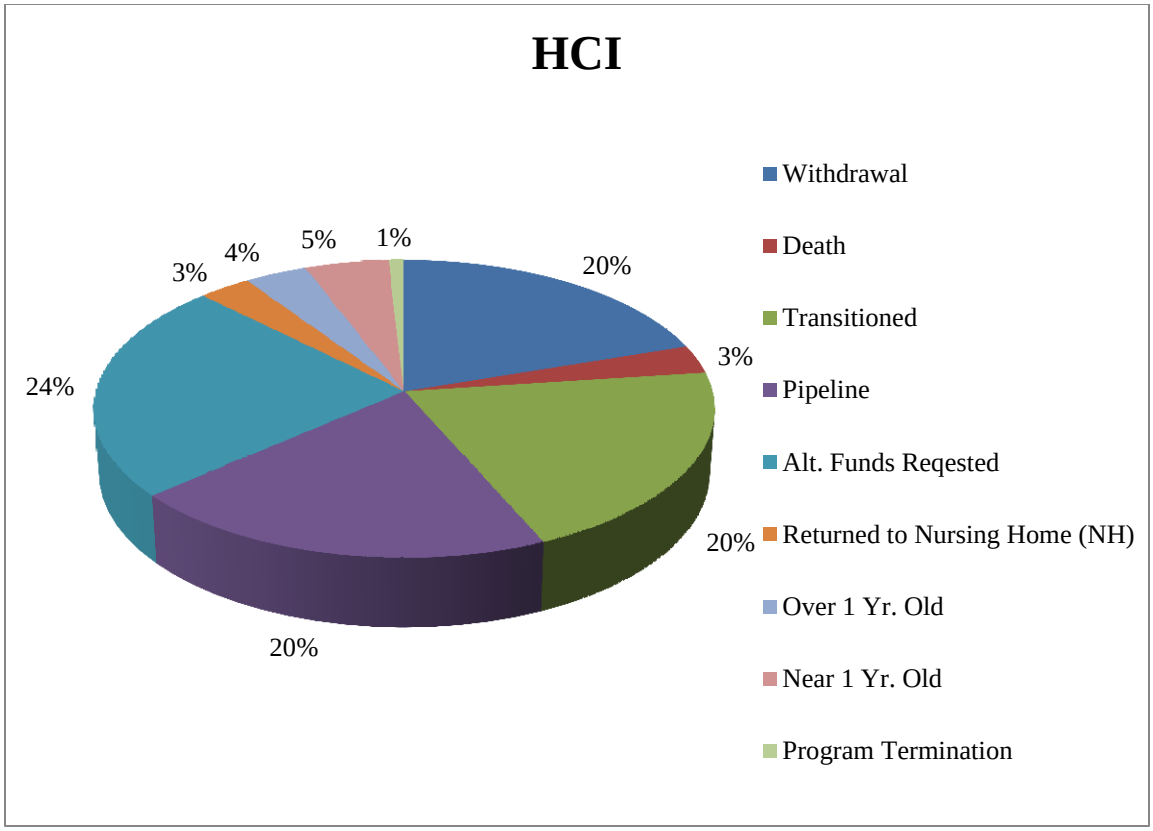


Figure 5

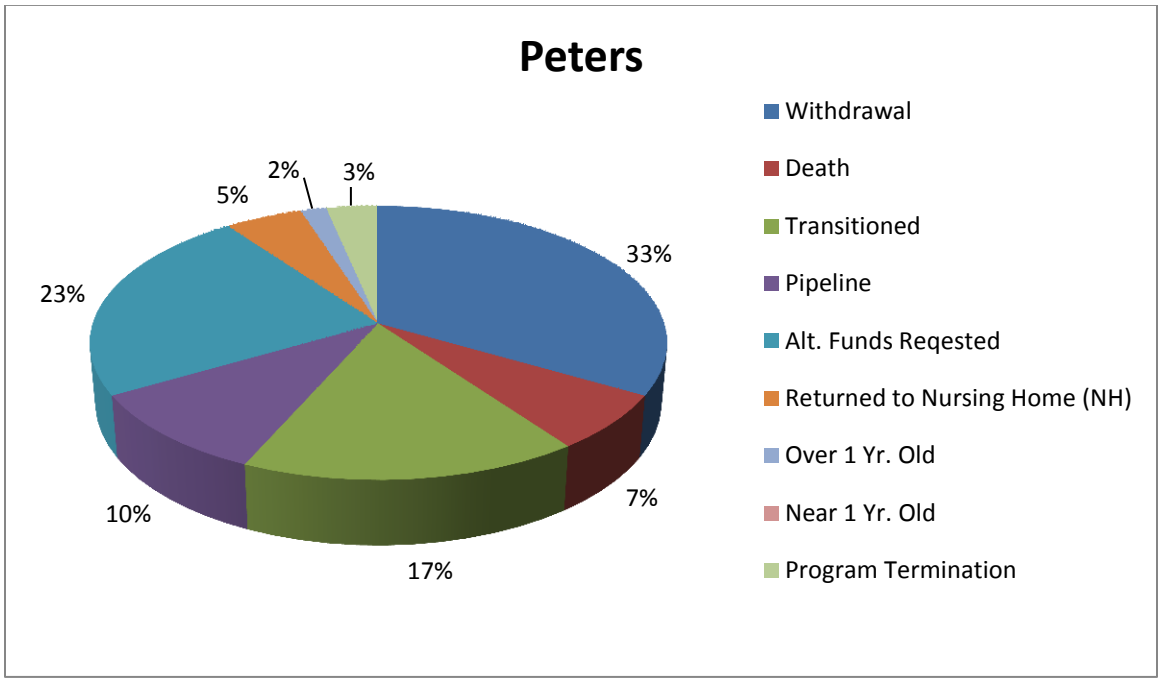


Figure 6

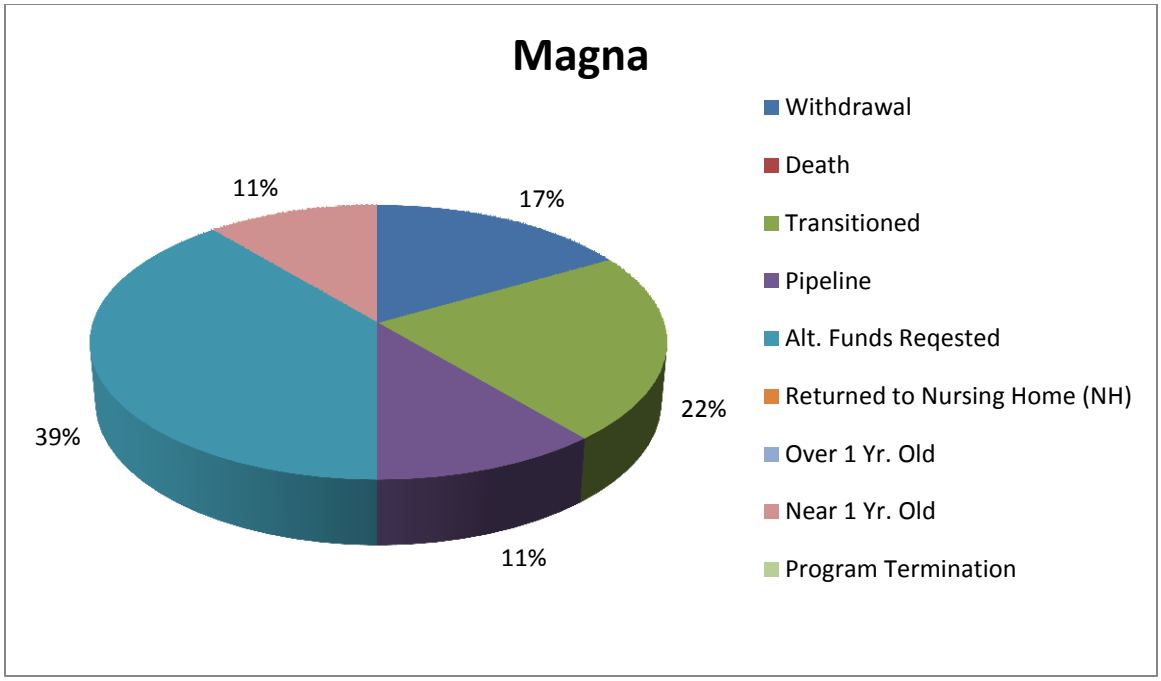


Figure 7

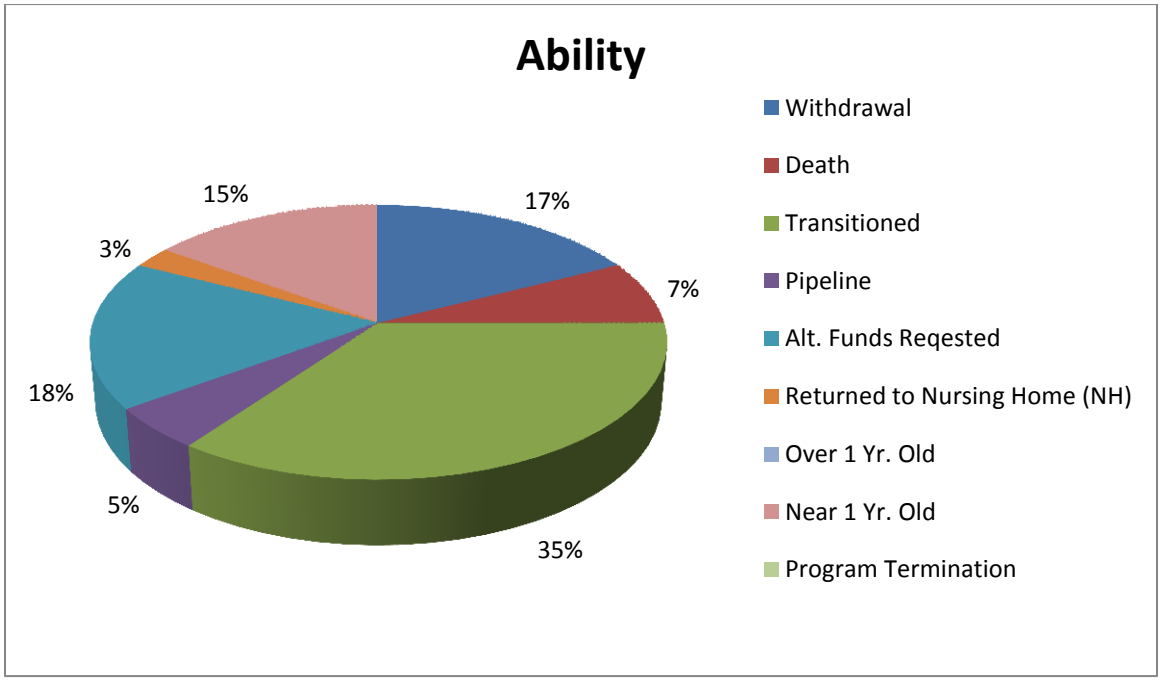


Figure 8

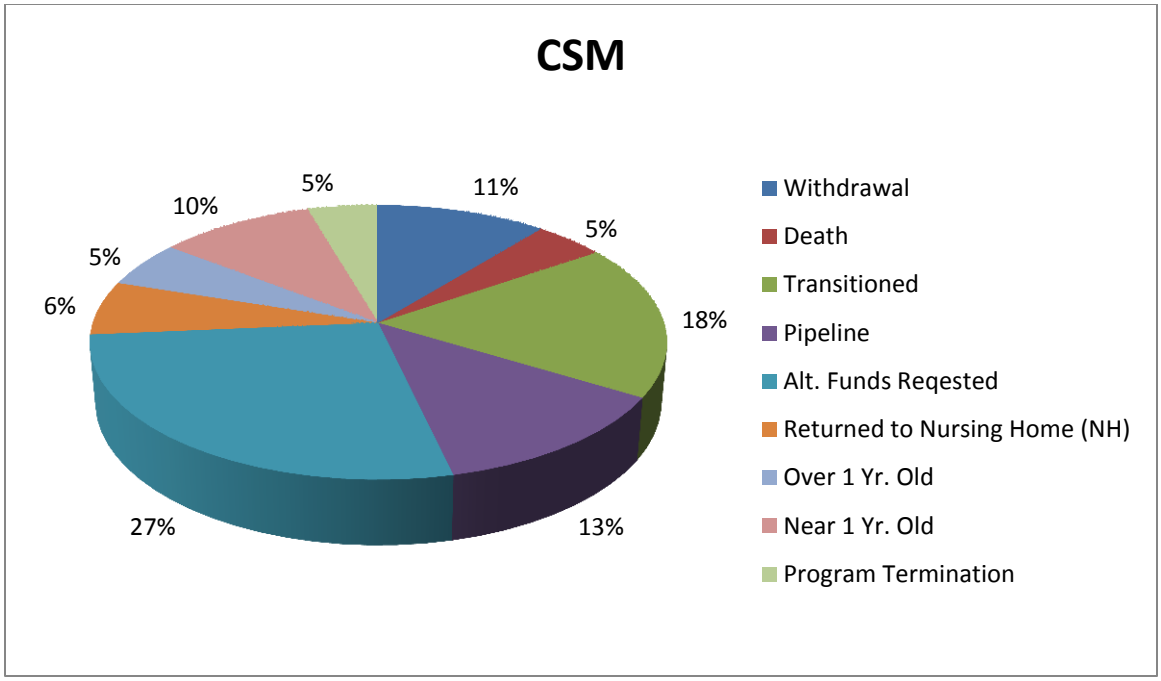


Figure 9

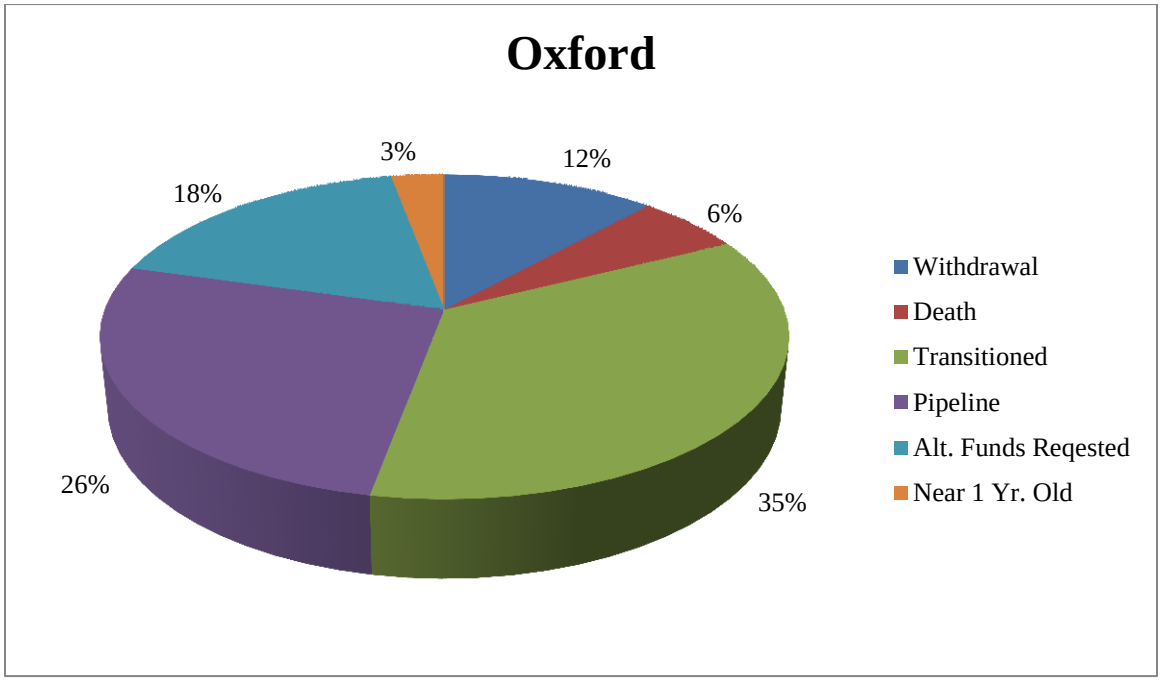


Figure 10

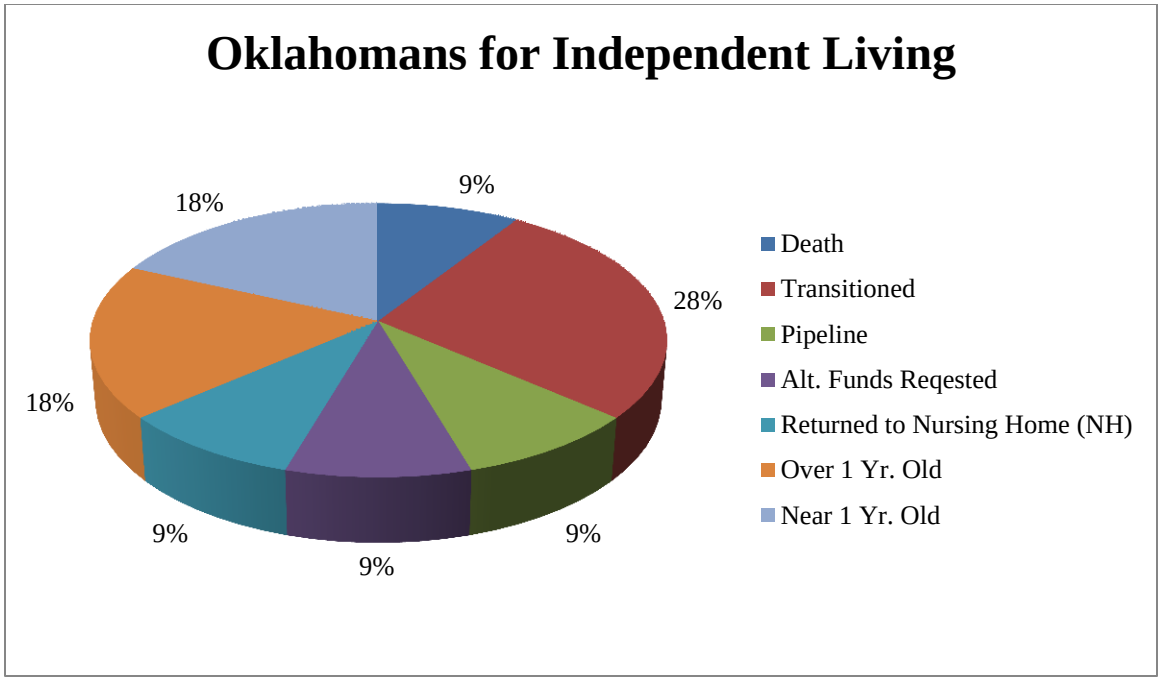


Figure 11

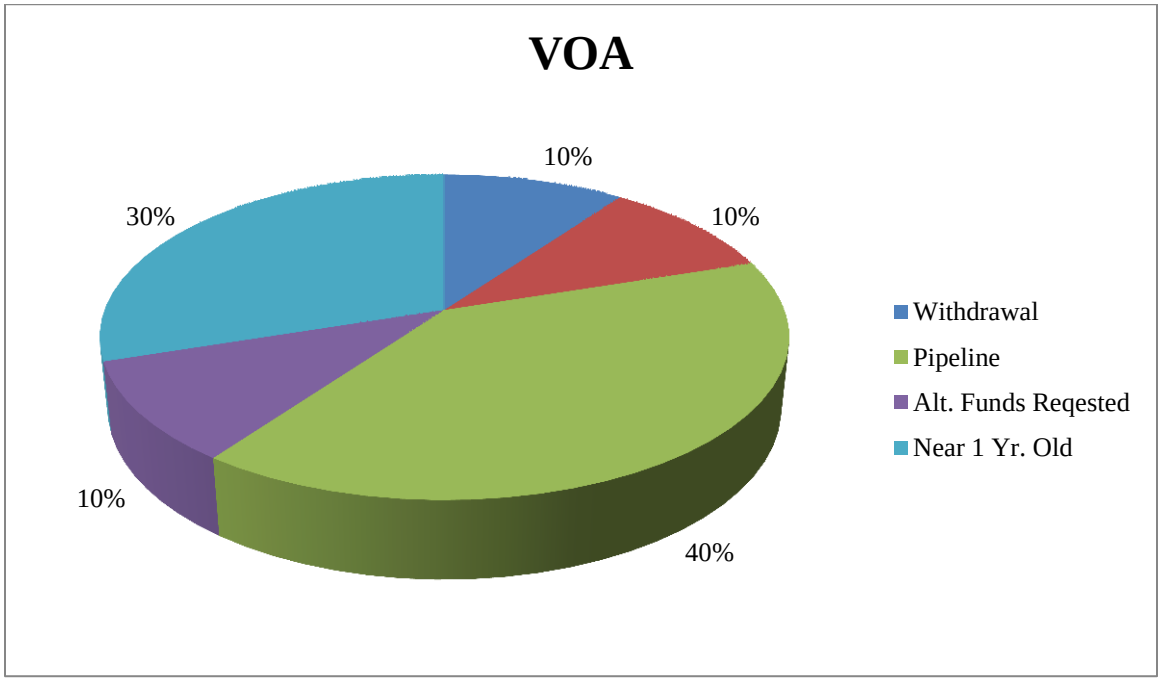


Figure 12

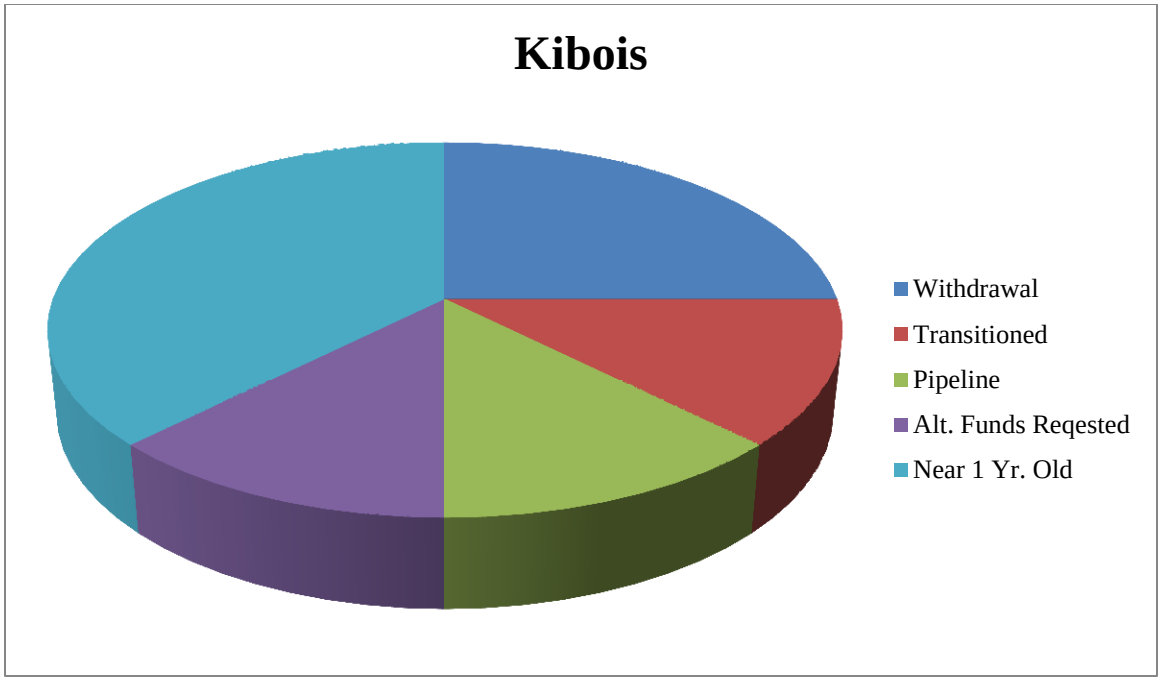


Figure 13

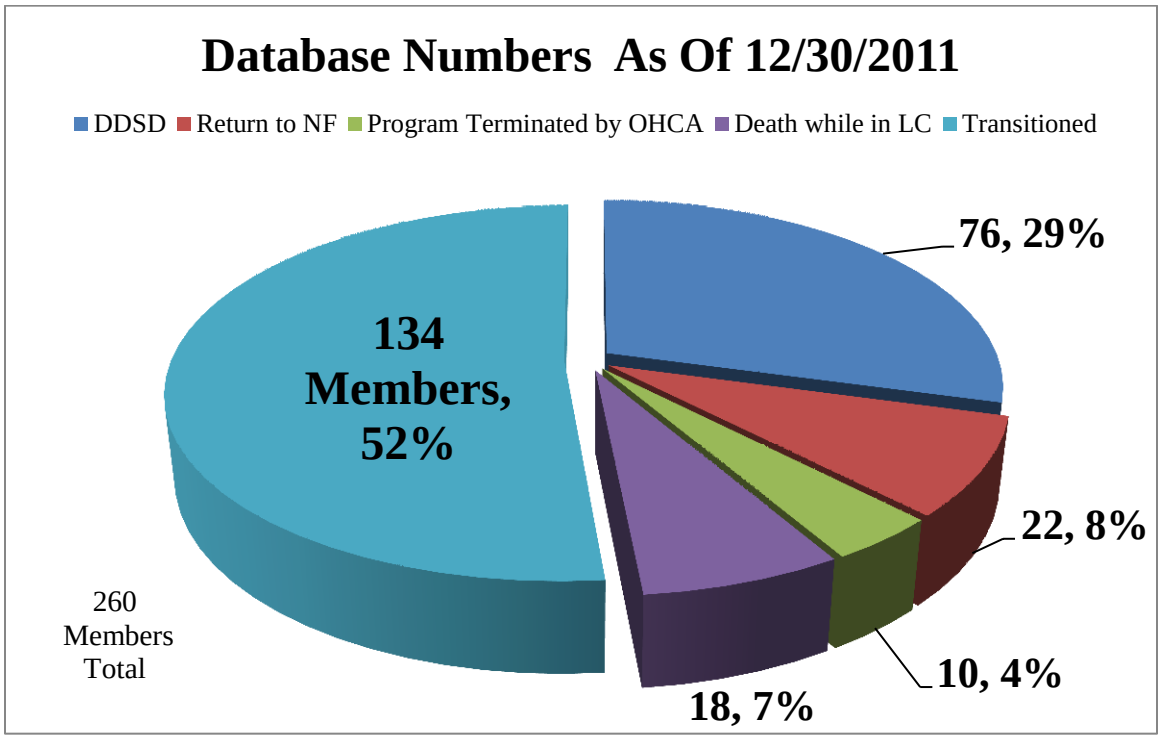


Figure 14

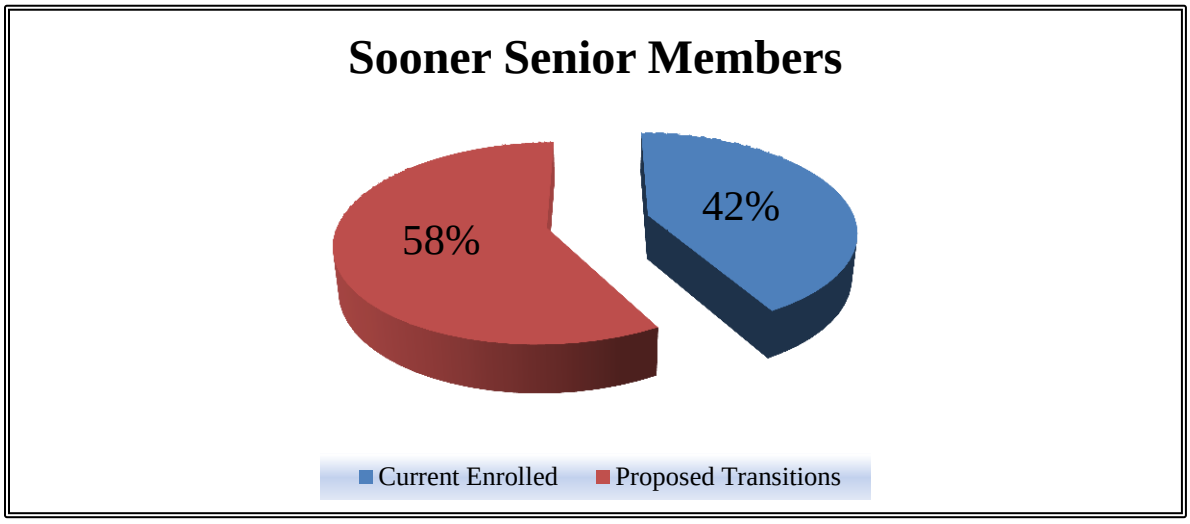
Sooner Seniors

This program offers Medicaid qualified older persons with long term illnesses who meet nursing facility level of care criteria, the same services received through the Living Choice demonstration in a residential setting of their choosing.

Some of the services offered include the following:

- Advanced supportive/restorative assistance
- Dental services (up to $1,000 per person annually)
- Environmental modifications
- Prescription drug
- Personal emergency response system (PERS)
- Skilled nursing
- Private duty nursing
- Specialized medical equipment and supplies
- Therapy services: Physical
- Therapy services: Occupational
- Transportation
- Vision services to include eye exam and glasses

Members Currently Enrollment	**18**
Proposed Transitions	**25**



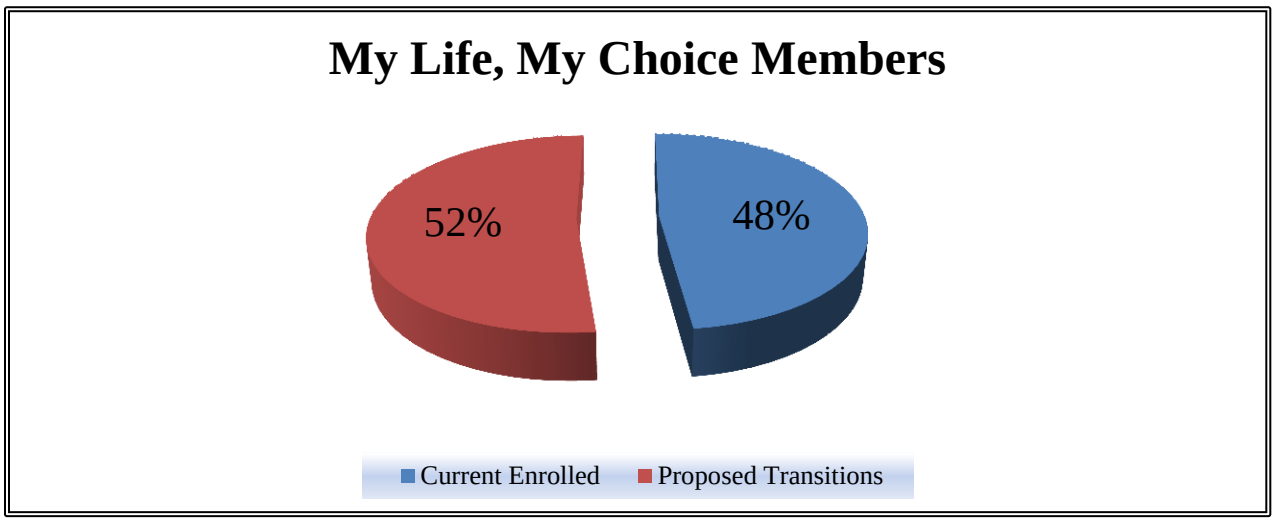
My Life, My Choice

This program will offer Medicaid qualified persons with physical disabilities who meet nursing facility level of care criteria, the same services received through the Living Choice demonstration in a residential setting of their choosing.

Some of the services offered include the following:

- Adult day health care
- Assistive technology
- Audiology treatment and evaluation
- Case management
- Family counseling
- Family training
- Home delivered meals
- Hospice care
- Independent living skills training
- Nutritional educational services
- Personal care
- Psychiatry

Members Currently Enrollment	**38**
Proposed Transitions	**41**



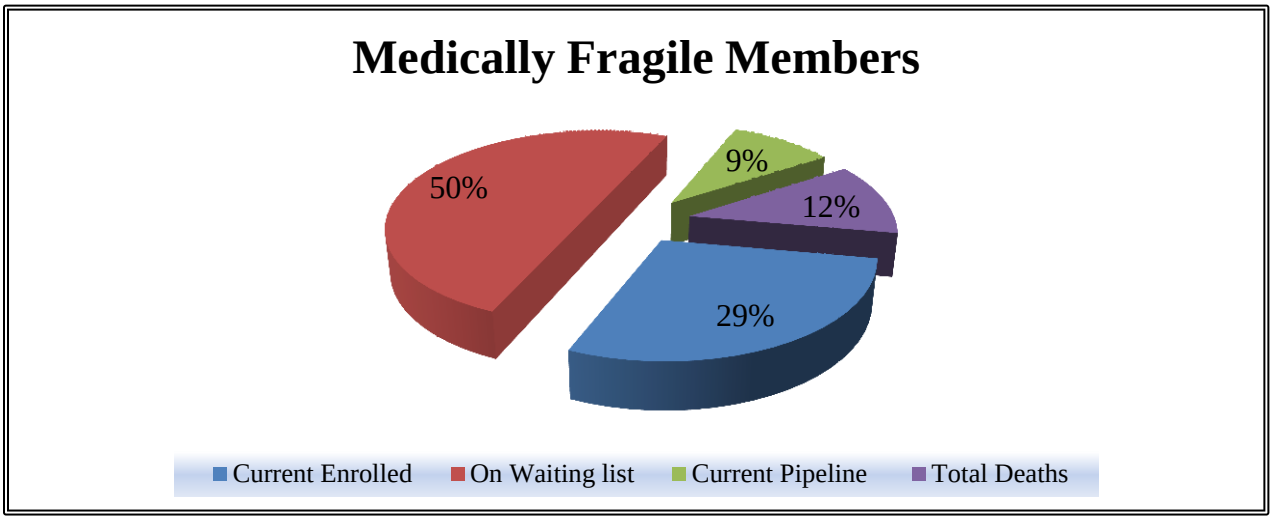
Medically Fragile

The Medically Fragile program is a home and community-based alternative to placement in a hospital and/or skilled nursing unit of a nursing facility to receive Medicaid-funded assistance for care. The goal of this program is to provide services which allow Medicaid eligible persons who meet hospital and/or skilled nursing level of care to remain at home or in the residential setting of their choosing while receiving the necessary care.

Some of the services offered include the following:

- Advanced Supportive/Restorative Care
- Case Management Services
- Environmental Modifications
- Home-Delivered Meals
- Hospice Care
- Occupational Therapy
- Prescription Drugs
- PERS (Personal Emergency Response System)
- Respiratory Therapy
- Respite Care
- Specialized Medical Equipment and Supplies
- Speech Therapy

Currently Enrolled Members	**24**
Members On Waiting List	**42**
Current Pipeline	**8**
Total Deaths	**10**



OHCA DME REUSE PROGRAM

January 2012

SOONERCARE

House Bill 2777

Retrieve and donate DME to individuals who are disabled or elderly

* Voluntary Donations
* Donations Dedicated to SoonerCare for 60 Days after Donation

Contractor


Oklahoma's Assistive
Technology Program
ABLE Tech
Oklahoma ABLE Tech

Overview

* Retrieve
* Refurbish
* Reassign

Quality Indicators

* Access for elderly and disabled Oklahomans
* Delivering Clean Equipment
* Training of Staff to Set-up Equipment properly
* Involving Professionals in Reassignment

Products

Augmentative Communication Devices	Bath Benches
CPAP	Commodes
Gait Trainers	Hospital Beds
Nebulizers	Standers
Manual Wheelchairs	Power Wheelchairs (non-custom)

How does it work?

* SoonerCare purchased DME when no longer needed may be donated
* DME purchased through Medicare and Private Insurance may be donated
* DME is sanitized and refurbished to a reusable condition

oklahoma health care authority

OKLAHOMA'S ASSISTIVE TECHNOLOGY PROGRAM

ABLE Tech

OKLAHOMA ABLE TECH

* Customers access Website to see what is available

* Customers contact an 800 # to donate or request equipment – Pilot location – Oklahoma County

* Equipment is matched to a customer's needs and delivered free of charge

Electronic Access to SoonerCare Member Health Information

Adolph Maren Jr.
Oklahoma Health Care Authority
Planning Project Manager
MAC 1-19-2012

Background

* A more robust dynamic information retrieval architecture is part of the MMIS reprocurement effort.
* Clarification of high-level requirements is ongoing.
* Hewett Packard Enterprise Systems (HPES) solution requires validation of programmatic topics which impact the technical solution.
* Clarification and validation will produce the OHCA/HPES statement of work.

Electronic Access to SoonerCare Member Health Information

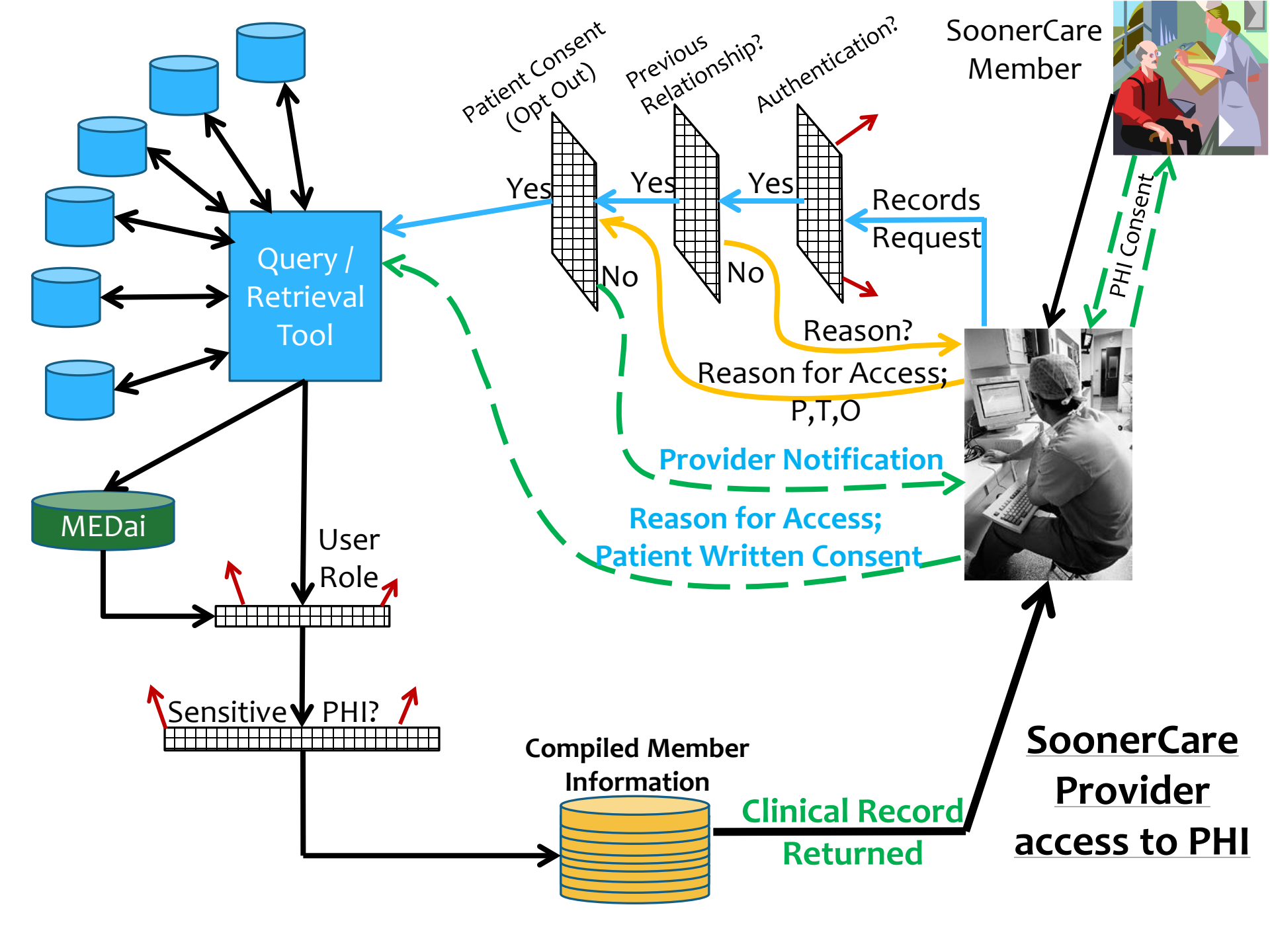
* Controlling Access to PHI:
  * Authentication – identify the user
  * Authorization – the user's role will assist with determining the level of access
  * Patient Consent Model – how does the HIE allow access to PHI?

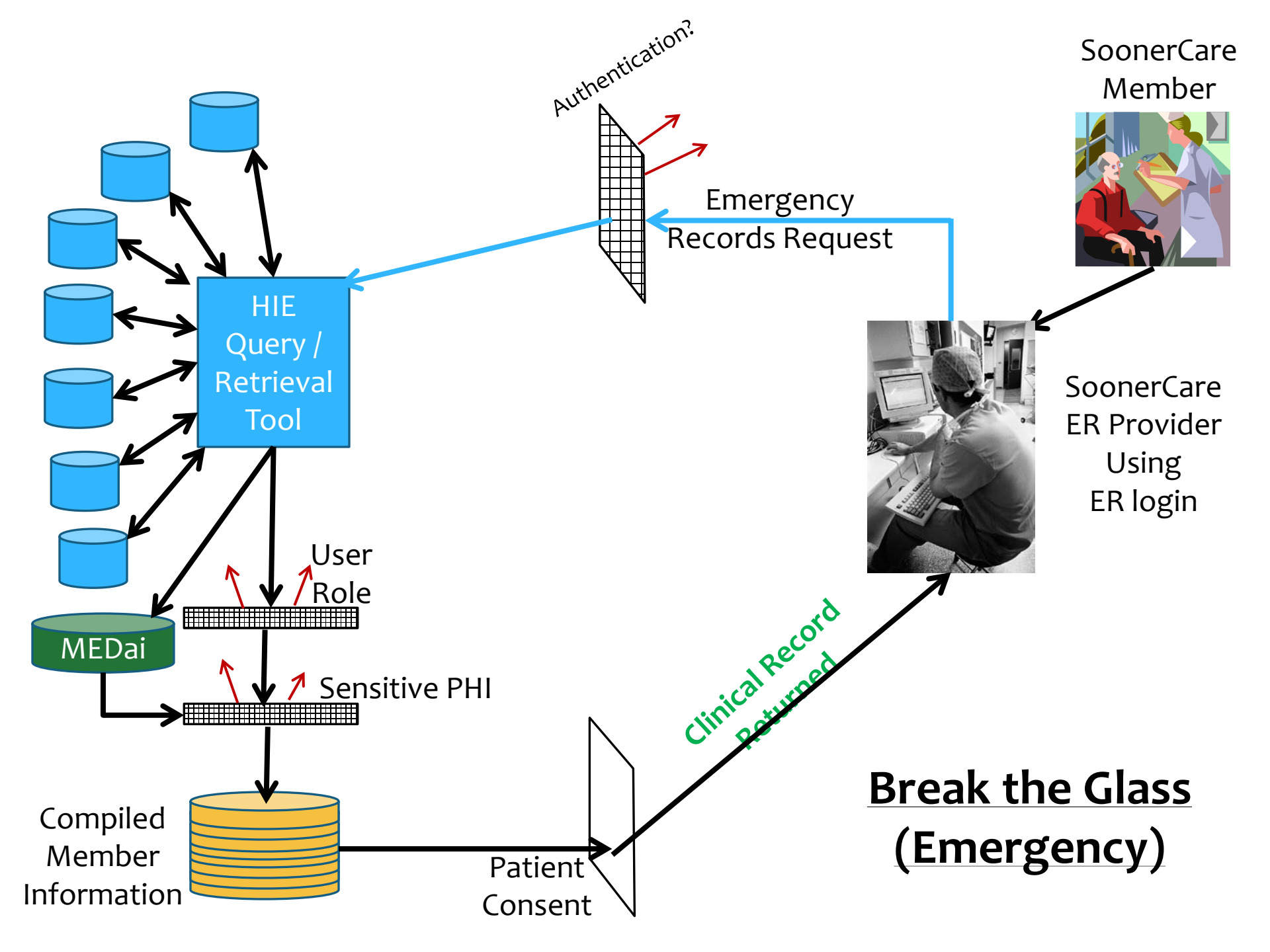
Consent Model Comparisons

Consent Model	Key Benefits	Key Limitations
No Consent (PHI is automatically included – members cannot Opt Out)	Immediately maximizes availability of PHI for HIE goals; minimizes administrative burden	No accommodation of individual preference; does not build trust
Opt Out (All lawful PHI is accessible until member Opts Out)	Provides patient choice/control; Rapidly achieves higher levels of participation- more data available for HIE goals; decreases administrative burden; procedurally simpler to implement.	Requires action on the part of patients to deny consent; No granularity of patient preference; may discourage participation by those w/sensitive PHI.
Opt In (No PHI is accessible until member Opts In; then only lawful PHI is disclosed)	Allows for explicit, affirmative consent for participation; Procedurally simpler to implement.	Requires intensive outreach efforts; lower levels of participation; increases administrative time/resources; No granularity of patient preference; may discourage participation by those w/sensitive PHI.

Other State Consent Model Comparisons

Consent Policy	State
Opt In	New Mexico, Utah, Louisiana, Massachusetts
Opt In (except for one-to-one exchanges)	New York
Opt In w/restrictions (granularity by provider)	Rhode Island
Opt Out	Maryland, Colorado, New Hampshire, Ohio, Nebraska, Idaho, Maine, Tennessee,
Opt Out for general PHI; Opt In for sensitive PHI	Pennsylvania
Opt Out of Record Locator Service (w/exceptions-by provider); Opt In to query	Minnesota
No consent	Indiana, Wisconsin
No consent for lab data, etc.; Opt Out of the query function	Delaware
Medicaid No consent; private Opt Out	Illinois


Patient Consent (Opt Out)
Previous Relationship?
Authentication?
SoonerCare Member
Yes
Yes
Yes
No
No
Records Request
Reason?
Reason for Access; P,T,O
PHI Consent
Query / Retrieval Tool
Provider Notification
Reason for Access; Patient Written Consent
MEDai
User Role
Sensitive PHI?
Compiled Member Information
Clinical Record Returned
SoonerCare Provider access to PHI


Authentication?
SoonerCare Member
Emergency Records Request
HIE Query / Retrieval Tool
SoonerCare ER Provider Using ER login
User Role
MEDai
Sensitive PHI
Clinical Record Returned
Compiled Member Information
Patient Consent
Break the Glass (Emergency)

Conclusion

* Inclination to use the Opt-Out model for initial architecture implementation.
* The consent model will be reviewed periodically to determine if changes are needed.

* Comments?

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children; forms

(a) **Application.** An application for categorically needy pregnant women and families with children consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, in the county OKDHS office, or online. A face to face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five days from the date services are rendered. The hospital, applicant, or someone acting on the applicant’s behalf has fifteen days from the date the NODOS form was received by OHCA to submit a completed

SoonerCare application. Filing a Notification of Date of Service does not guarantee coverage and if a completed application is not submitted within fifteen days, the NODOS is void.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped with the date the application was received into the OHCA Eligibility Unit. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the applicant signed the application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

SUBCHAPTER 7. MEDICAL SERVICES
PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms

(a) **Application.** An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent,

spouse, guardian or someone else acting on the individual's behalf. A individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the~~

~~county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped into the OHCA Eligibility Unit. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the county office or the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office or the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the member signed the application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-4. Application for My Life, My Choice Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for My Life, My Choice Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month

the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 5. SOONER SENIORS

317:50-5-4. Application for Sooner Seniors Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Sooner Seniors Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and

community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-4. Application for Medically Fragile Waiver services

(a) If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application.** The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.6. Dialysis

Payment for dialysis is made at the ~~all-inclusive~~ Medicare ~~allowable composite~~ prospective payment system wage adjusted base rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure~~, such as routine medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen)~~. The physician is reimbursed separately.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 29. RENAL DIALYSIS FACILITIES

317:30-5-306. Coverage by category

Payment is made to renal dialysis facilities as set forth in this Section.

(1) **Adults.** Payment is made for outpatient renal dialysis for adults at the ~~composite~~ PPS rate.

(2) **Children.** Coverage for children is the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable service.

317:30-5-307. Payment methodology

Payment of in-facility dialysis treatments and home dialysis treatment is made under the ~~composite~~ PPS rate reimbursement system ~~as established by Medicare~~.

(1) All items and services included under the ~~composite~~ PPS rate must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients. If the facility fails to furnish (either directly or under arrangements) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish. These items and services include:

(A) medically necessary dialysis equipment and dialysis support equipment;

(B) home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;

(C) purchase and delivery of all necessary dialysis supplies;

(D) routine ESRD related laboratory tests~~,~~; and

(E) all dialysis services furnished by the facility's staff.

(2) Some examples (but not an all-inclusive list) of items and services that are included in the ~~composite~~ PPS rate and may not be billed separately when furnished by a dialysis facility are:

(A) staff time used to administer blood;

(B) declotting of shunts and any supplies used to declot shunts;

(C) oxygen and the administration of oxygen; and

(D) staff time used to administer nonroutine peritoneal items.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-326.1. Definitions

The following words and terms, when used in this subchapter ~~have~~ shall have the following meaning, unless context clearly indicates otherwise.

"Attendant" means an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.

"Emergency" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"~~Escort~~Medical escort" means a family member, ~~or~~ legal guardian, or volunteer whose presence is required and medically necessary to assist a member during transport and while at the place of treatment. ~~An~~ A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. ~~An~~ A medical escort must be of an age of legal majority recognized under State law.

"Member/eligible member" means any person eligible for SoonerCare ~~with the exception of~~ and individuals considered to be Medicare/SoonerCare full dually eligible. This does not include those individuals who are categorized only as Qualified Medicare Beneficiaries ~~Plus (QMBP)~~ (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals-1 (QI-1), individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children ~~and~~, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved hospital services, it also means that a physician or physician specialist is available to provide the necessary care required to treat the

member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, non-emergency transportation service to a more distant hospital, clinic, or physicians' office solely to avail a member of the service of a specific physician or physician specialist does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

"Non-ambulance" means a carrier that is not an ambulance.

"Non-emergency" means all reasons for transportation that are not an emergency as defined above.

"SoonerRide Non-Emergency Transportation (NET)" means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

317:30-5-327. Eligibility for SoonerRide ~~non-emergency non-ambulance transportation eligibility~~ NET

Transportation ~~must be for medically necessary treatment~~ is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility in accordance with 42 CFR 441.170. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus (QMBP)~~ (QMB);

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);

(4) inpatient;

(5) institutionalized (i.e. long-term care facility);

(6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children ~~and~~, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

317:30-5-327.1. ~~Access to non-emergency non-ambulance transportation through SoonerRide~~ SoonerRide NET Coverage

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic

services, clinic services, pharmacy services, eye care and dental care under the following conditions:

(1) Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services.

(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(B) The nearest appropriate facility is not considered appropriate if no bed or provider is available. However, the medical records must be properly documented.

(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.

(i) Members seeking self-referred services are limited to the 45 mile radius.

(ii) Native Americans seeking services at a tribal or I.H.S facility may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(iii) Veterans may be transported to the nearest Veterans Affairs (VA) facility equipped for their medical needs. Trips to out-of-state VA facilities require prior approval.

(iv) Duals may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(2) The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program; and

(3) Services requiring prior authorization must have been authorized (e.g. travel that exceeds the 45 mile radius, out-of-state travel, meals and lodging services).

~~(a)~~(b) ~~Non-emergency, non-ambulance transportation services are available through the state's SoonerRide Non-Emergency Transportation (NET) program.~~ SoonerRide NET is available on a statewide basis to all eligible members.

~~(b)~~(c) ~~SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. Eligible providers are providers who have valid OHCA contracts. The NET must be to access medically necessary covered services for which a member has available benefits. Additionally,~~ SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.

~~(c)~~(d) ~~The use of SoonerCare funded transportation for any other purpose is fraudulent activity and subject to criminal prosecution and civil and administrative sanctions.~~ SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.

~~(d) The SoonerRide broker assures that NET transportation services are provided:~~

~~(1) in a manner consistent with the best interest of the member;~~

~~(2) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;~~

~~(3) appropriate to available services; and~~

~~(4) appropriate for the limitations of the member.~~

(e) In documented medically necessary instances, a medical escort may accompany the member.

(1) SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.

(2) A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

317:30-5-327.2. Service availability [REVOKED]

~~(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, pharmacy services, eye care and dental care.~~

~~(b) SoonerRide NET is available if a member is being discharged from a facility to home. The facility is responsible for scheduling the transportation.~~

~~(c) In documented medically necessary instances, may wish to accompany the member for health care services. In such~~

~~instances, the family member or legal guardian may accompany the member.~~

~~(1) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.~~

~~(2) A escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.~~

317:30-5-328. Subsistence (sleeping accommodations and meals)

(a) Lodging and meals assistance for eligible members is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.

(1) Lodging and/or meals are reimbursable with prior authorization if the trip cannot be completed during SoonerRide operating hours, the trip is more than 100 miles from the member's city of residence, and travel is to obtain specialty care or the treatment requires an overnight stay.

(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(5) During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(b) A member who needs lodging and/or meals assistance must first seek services with a contracted lodging provider. If the lodging provider provides meals the member may not be reimbursed for services billable by the contracted lodging provider. If lodging and/or meals assistance with contracted lodging providers are not available, the member may request

reimbursement assistance by submitting a travel reimbursement form. The travel reimbursement form may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement form must be documented with receipts, and reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. SoonerCare transportation and subsistence

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. ~~Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month.~~ As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus~~ ~~(QMBP)~~ (QMB) when SoonerCare pays only the Medicare premium, deductible, and co-pay;

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1;

(4) individuals who are in an institution for mental disease (IMD), ~~inpatient;~~

(5) inpatient;

~~(5)~~ (6) institutionalized (i.e. long-term care facility);

~~(6)~~ (7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children ~~and~~, the ADvantage Waiver, the Living Choice demonstration, the Sooner

Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) **Subsistence (sleeping accommodations and meals).** ~~An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from SoonerCare funds. If the individual needs assistance~~

~~with necessary expenses of lodging and meals, the member may pay for the lodging and meals and then submit a travel reimbursement form for reimbursement; if the member does not have the funds for the necessary subsistence, authorization is made by the local office on the Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA or the local OKDHS office. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot state per diem amounts. Payment for meals is only provided for overnight stays that are more than 50 miles from the home and are based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.~~ Lodging and meals assistance for eligible members is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.

(A) Lodging and/or meals are reimbursable with prior authorization if the trip cannot be completed during SoonerRide operating hours, the trip is more than 100 miles from the member's city of residence, and travel is to obtain specialty care or the treatment requires an overnight stay.

(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(C) Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria.

(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(E) During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(F) A member who needs lodging and/or meal assistance must first seek services with an OHCA contracted lodging provider. If the lodging provider provides meals the member is not eligible for separate reimbursement and may

not seek assistance for meals obtained outside of the contracted lodging facility. If lodging and/or meal assistance with contracted lodging providers is not available, the member may request reimbursement assistance by submitting a travel reimbursement form. The travel reimbursement form may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement form must be documented with receipts, and reimbursement will not exceed established state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.

(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program.

OHCA and providers have the right to terminate or suspend contracts with each other. Remedies are provided in this Section that may be used by the agency in addition to a formal contract action against the provider. When the use of these remedies results in a contract action, appropriate due process protections will be afforded to the provider for that contract action. Subsections (1) through (10) are additional remedies under which OHCA may revoke a currently enrolled provider or supplier's SoonerCare billing privileges and any corresponding provider agreement or supplier agreement.

(1) **Noncompliance.** The provider or supplier is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, or in the enrollment application applicable for its provider or supplier type. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under subsections (2), (3), (5), or (7) of this Section.

(A) OHCA may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(B) Requested additional documentation must be submitted within 60 calendar days of request.

(2) **Provider or supplier conduct.** The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR 1001.2; or

(B) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Felonies.** The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted

of a Federal or State felony offense that OHCA has determined to be detrimental to the best interests of the program and its beneficiaries. Denials based on felony convictions are for a period to be determined by the OHCA, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses. Offenses include but are not limited to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(C) Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and

(D) Any felonies that would result in mandatory exclusion under 42 U.S.C. § 1320a-7a of the Social Security Act.

(4) **False or misleading information.** The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the SoonerCare program. Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider or supplier is no longer operational to furnish SoonerCare covered items or services, or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for, SoonerCare members.

(6) **Provider and supplier screening requirements.**

(A) A provider does not submit an application fee that meets the requirements set forth in 42 CFR 455.460.

(B) Either of the following occurs:

(i) OHCA is not able to deposit the full application amount.

(ii) The funds are not able to be credited to the State of Oklahoma.

(C) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(D) There is any other reason why OHCA is unable to deposit the application fee.

(7) **Misuse of billing number.** The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a (a)(32) or a change of ownership as outlined in 42 CFR 455.104(c) (within 35 days of a change in ownership).

(8) **Abuse of billing privileges.** The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(9) **Failure to report.** The provider or supplier did not comply with the reporting requirements specified in the SoonerCare provider agreement or regulations.

(10) **Failure to document or provide OHCA access to documentation.**

(A) The provider or supplier did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) A provider or supplier that meets the revocation criteria specified in (10)(A) of this subsection is subject to revocation for a period of not more than 1 year for each act of noncompliance.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.24. ~~Pre-authorization~~ Prior Authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. Residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(b) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during awake hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger

but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

(c) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity

criteria described in ~~in the OHCA Behavioral Health Provider Manual~~ OAC 317:30-5-95.25 through 317:30-5-95.31.
(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for ~~insuring~~ ensuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.
(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria ~~and following the current OHCA Behavioral Health Provider Manual~~ as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System ~~(CALOCUS)~~ (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children

~~All acute psychiatric admissions for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual~~.

Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (1), (2), (3), (4) and two of the terms and conditions in (5)(A) to (6)(C) of this subsection. Acute psychiatric admissions for children 12 or younger must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the

diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.

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

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

(4) Child must be medically stable.

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

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

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

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

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

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

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

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

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

~~All acute psychiatric continued stay authorizations for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual~~.

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis,

children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

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

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

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

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

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

317:30-5-95.27. Medical necessity criteria for admission - inpatient chemical dependency detoxification for children

~~All admissions for inpatient chemical dependency detoxification for children must meet the medical necessity criteria for a detoxification admission as identified in the OHCA Behavioral Health Provider Manual.~~

Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

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

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

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

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

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

317:30-5-95.28. Medical necessity criteria for continued stay - inpatient chemical dependency detoxification program for children

Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to ~~seven to~~ eight days based on a case-by-case review, per medical necessity criteria ~~as identified in the OHCA Behavioral Health Provider Manual~~ as described in OAC 317:30-5-95.27.

317:30-5-95.29. Medical necessity criteria for admission - psychiatric residential treatment for children

~~All psychiatric residential treatment admissions for children must meet the medical necessity criteria for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.~~

Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4) and one of the (5)(A) through (5)(D), and one of (6)(A) through (6)(C) of this subsection.

(1) An Axis I primary diagnosis form the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

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

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

(4) Child must be medically stable.

(5) Patient demonstrates escalating pattern of self injurious or assaultive behaviors as evidenced by:

(A) Suicidal ideation and/or threat.

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

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

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

(A) Intensive behavioral management.

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

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

317:30-5-95.30. Medical necessity criteria for continued stay - psychiatric residential treatment center for children

~~All psychiatric residential treatment continued stay authorizations for children must meet the medical necessity criteria for continued stay for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.~~

For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.

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

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

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

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

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

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

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

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

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

interventions.

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

(A) Intensive behavioral management.

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

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

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

317:30-5-95.31. ~~Pre-authorization~~ Prior Authorization and extension procedures for children

(a) ~~Pre-admission~~ Prior authorization for inpatient psychiatric services for children must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within 24 hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension ~~following the guidelines in the OHCA Behavioral Health Provider Manual~~. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 15 days and in a psychiatric residential treatment facility for 3 months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.2 Provider participation standards

(a) **Accreditation and certification status.** Any agency may participate as an OPBH provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) ~~Evidenced~~ Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and

(C) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation will supply the documentation from the

accrediting body, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) Effective 07/01/10, all behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in ~~the OHCA BH Provider Manual~~ OAC 317:30-3-2 and OAC 317:30-5-280.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A BHRS, if individual or group rehabilitative services for behavioral health disorders are provided;

(C) An AODTP, if treatment of alcohol and other drug disorders is provided;

(D) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support ~~service~~ Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Treatment Plans;
(B) Psychotherapies;
(C) Behavioral Health Rehabilitation services;
(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.
(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.
(6) Comply with all applicable Federal and State Regulations.
(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.
(8) Demonstrate the ability to keep appropriate records and documentation of services performed.
(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.
(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual,~~ unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).
(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

~~(c) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.~~

~~(d) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.~~

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(d) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in ~~the OHCA BH Provider Manual~~ this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population.** This service is compensable only on behalf of a member who is under a PACT program.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified professional.** This service is performed by an LBHP. CADCs are permitted to provide Drug and Alcohol assessments through June 30, 2010. Effective July 1, 2010 all assessments must be provided by LBHPs.

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.

(D) **Target population and limitations.** This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(E) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include a DSM multi-axial diagnosis completed for all five axes from the most recent DSM edition. The assessment must contain but is not limited to the following:

(i) Date, to include month, day and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial and last name;

(iv) Gender;

(v) Birth Date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Signature of parent of guardian participating in face-to-face assessment. Signature required for members over the age of 14;

(xiv) Bio-Psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (i.e. attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and
(IV) Full Five Axes DSM diagnosis.

(xvi) Pharmaceutical information to include the following for both current and past medications;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;
(xviii) Signature and credentials of LBHP who performed the face-to-face behavioral assessment;
(xix) Client Data Core Elements reported into designated OHCA representative.

A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

(B) **Qualified professional.** This service is performed by an LBHP.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the ~~provider~~ LBHP and member.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);
(ii) identified presenting challenges, problems, needs and diagnosis;
(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present (signatures are required from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP; and
(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity).
(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.
(xiii) Service plan updates must address the following:
(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian

(if younger than 18 or otherwise applicable), and the primary LBHP.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member. The date of service is when the treatment plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified professionals.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements.** All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) Service Limitations. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of two, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either an therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.2. Psychotherapy

(a) **Individual/Interactive Psychotherapy.**

(1) **Definition.** Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances,

in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(3) **Qualified professionals.** With the exception of a qualified interpreter if needed, only the member and the Licensed Behavioral Health Professional (LBHP) or Certified Alcohol and Drug Counselor (CADC), for substance abuse (SA) only, should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only.

(4) **Limitations.** A maximum of 6 units per day per member is compensable.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP or the CADC when treating alcohol and other drug disorders only, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does

not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only. Group Psychotherapy must take place in a confidential setting limited to the LBHP or CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or CADC and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic,

aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve ~~or maintain~~ the member's condition and functional level and to prevent relapse or hospitalization and (3) ~~Are provided in accordance with services outlined in 42 CFR 410.43.~~ Include the following:

(A) Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs.

(C) Substance abuse specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation training and education services to the extent the training and educational activities are closely and clearly related to the member's care and treatment, provided by a Behavioral Health Rehabilitation Specialist (BHRS), Certified Alcohol and Drug Counselor (CADC)or LBHP who meets the professional requirements listed in 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified case managers.

(2) **Qualified professionals.** ~~All services in the PHP are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider Manual for further requirements. The treatment plan is directed under the supervision of a physician.~~

All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(1) A licensed physician;

(2) Registered nurse; and

(3) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

The clinical team may also include any of the following paraprofessionals:

(1) Masters or bachelors level Behavioral Health Rehabilitation Specialist;

(2) Certified Case Manager; or

(3) Certified Alcohol and Drug Counselor (CADC).

The treatment plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day ~~and must be prior authorized~~. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. ~~Refer to OHCA BH Provider Billing Manual for further definition.~~ Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD).

~~(5) **Reporting.** Reporting requirements must be followed as outlined in the OHCA BH Provider Billing Manual~~

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy – a minimum of 1 session per week;

(ii) Family therapy – a minimum of 1 session per week; and

(iii) Group therapy – a minimum of 2 sessions per week;

(C) Interchangeable therapies which include the following:

(i) Case Management (face-to-face);

(ii) BHRS/ alcohol and other drug abuse education;

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. ~~Refer to OHCA BH Provider Billing~~

~~Manual for further requirements.~~ Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. ~~Refer to OHCA BH Provider Billing Manual for further requirements.~~ Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services;

(ii) Group therapy at least two hours per week; and

(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) BHRS to include alcohol and other drug education if clinically necessary and appropriate

(iii) Case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** BHR are behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the

skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.

(1) **Clinical restrictions.** This service is generally performed with only the members and the BHRS, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum.

(2) **Qualified providers.** A BHRS, CADC, or LBHP may perform BHR, following a treatment curriculum approved by a LBHP. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

(3) **Group sizes.** The minimum staffing ratio is fourteen members for each BHRS, CADC, or LBHP for adults and eight to one for children under the age of eighteen.

(4) **Limitations.**

(A) **Transportation.** Travel time to and from BHR treatment is not compensable. Group psychosocial rehabilitation services do not qualify for the OHCA transportation program, but they will arrange for transportation for those who require specialized transportation equipment. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the outpatient behavioral health agency site. When this occurs, the BHRS, CADC, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Billing.** Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless allowed by OHCA or its designated agent.

(i) **Group.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual.** The maximum is six units per day. Children under an ODMHSAS Systems of Care program may

be prior authorized additional units as part of an intensive transition period.

(E) **Documentation requirements.** Progress notes for intensive outpatient mental health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

(i) Curriculum sessions attended each day and/or dates attending during the week;

(ii) Start and stop times for each day attended and the physical location in which the service was rendered;

(iii) Specific goal(s) and objectives addressed during the week;

(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;

(v) Member satisfaction with staff intervention(s);

(vi) Progress, or barrier to, made towards goals, objectives;

(vii) New goal(s) or objective(s) identified;

(viii) Signature of the lead BHRS; and

(ix) Credentials of the lead BHRS.

(b) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.

(B) One unit is allowed per month per patient ~~without prior authorization~~.

(C) Medication Training & Support is not allowed to be billed on the same day as pharmacological management.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements** - Medication Training and Support documented review must focus on:

(A) a member's response to medication;
(B) compliance with the medication regimen;
(C) medication benefits and side effects;
(D) vital signs, which include pulse, blood pressure and respiration; and
(E) documented within the progress notes/medication record.

317:30-5-241.4 Crisis Intervention

(a) **Onsite and Mobile Crisis Intervention Services (CIS).**

(1) **Definition.** Crisis Intervention Services are face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

(2) **Limitations.** Crisis Intervention Services are not compensable for SoonerCare members who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster Home. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. The maximum is eight units per month; established mobile crisis response teams can bill a maximum of sixteen units per month, and 40 units each 12 months per member.

(3) **Qualified professionals.** Services must be provided by a LBHP.

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

(1) **Qualified professionals.** FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

(2) **Limitations.** The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Documentation of records must comply with OAC 317:30-5-248.

317:30-5-241.5 Support services

(a) **Program of Assertive Community Treatment (PACT) Services.**

(1) **Definition.** PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

(2) **Target population.** Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders. PACT services are those services delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

(3) **Qualified professionals.** Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP.

(4) **Limitations.** A maximum of 105 hours per member per year in the aggregate. All PACT compensable SoonerCare services are required to be face-to-face. SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for FBCS and CM.

(5) **Service requirements.** PACT services must include the following:

(A) PACT assessments (initial and comprehensive);

(i) **Initial assessment** – is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on

the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

(ii) **Comprehensive assessment** – is the organized process of gathering and analyzing current and past information with each member and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the member and his/her recovery planning team in pursuing goals. Providers must bill only the face-to-face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

(B) Behavioral health service plan (moderate and low complexity by a non-physician (treatment planning and review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

(C) Treatment team meetings (team conferences with the member present is a billable service. This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450:55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual member and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop should be recorded in the member's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill

one treatment team meeting per member as medically necessary.
(D) Individual and family psychotherapy;
(E) Individual rehabilitation;
(F) Recovery support services;
(G) Group rehabilitation;
(H) Group psychotherapy;
(I) Crisis Intervention;
(J) Medication training and support services;
(K) Blood draws and /or other lab sample collection services performed by the nurse.

(b) **Behavioral Health Aide Services.**

(1) **Definition.** Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral health aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(2) **Target population.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

(3) **Qualified professionals.** Behavioral Health Aides must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The Behavioral Health Aide cannot bill for more than one individual during the same time period.

(5) **Documentation requirements.** Providers must follow requirements listed in OAC 317:30-5-248.

(c) **Family Support and Training.**

(1) **Definition.** This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the treatment planning process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their

child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

(2) **Target population.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody, are residing within a RBMS level of care or are at risk for out of home placement, and who without these services would require psychiatric hospitalization.

(3) **Qualified professionals.** Family Support Providers (FSP) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The FSP cannot bill for more than one individual during the same time period.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(d) **Community Recovery Support (CRS).**

(1) **Definition.** CRS (or Peer Recovery Support) services are an EBP model of care which consists of a qualified recovery support specialist provider (RSS) who assists individuals with their recovery from behavioral health disorders. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the behavioral health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff members who usually work from the perspective of their training and/or their status as a licensed behavioral health provider; rather, this provider works from the perspective of their experimental expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery.

(2) **Target population.** Adults 18 and over with SMI and/or AOD disorder(s).

(3) **Qualified professionals.** Recovery Support Specialists (RSS) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The RSS cannot bill for more than one individual during the same time period. This service can be an individual or group service. Groups have no restriction on size.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(6) **Service requirements.**

(A) CRS/RSS staff utilizing their knowledge, skills and abilities will:

(i) teach and mentor the value of every individual's recovery experience;

(ii) model effective coping techniques and self-help strategies;

(iii) assist members in articulating personal goals for recovery; and

(iv) assist members in determining the objectives needed to reach his/her recovery goals.

(B) CRS/RSS staff utilizing ongoing training must:

(i) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;

(ii) facilitate peer support groups;

(iii)assist in setting up and sustaining self-help (mutual support) groups;

(iv) support members in using a Wellness Recovery Action Plan (WRAP);

(v) assist in creating a crisis plan/Psychiatric Advanced Directive;

(vi) utilize and teach problem solving techniques with members;

(vii) teach members how to identify and combat negative self-talk and fears;

(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;

(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;

(x) assist other staff in identifying program and service environments that are conducive to recovery; and

(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual~~, unless specified otherwise, and when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

~~(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.~~

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** There is no coverage for adults for services by a psychologist.

(c) **Children.** Coverage for children includes the following services ~~(all services, except Initial or Level of Care Assessment, health and behavior codes and/or Crisis Intervention services, require authorization by OHCA, or its designated agent)~~:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an

additional unit of PDIE can be prior authorized by OHCA, or their designated agent.
(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.
(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.
(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.
(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed ~~with authorization~~ every 12 months. ~~In circumstances where it is determined that further testing is medically necessary, and or needed for specialty testing, additional hours/units may be prior authorized by the OHCA or~~

~~designated agent based upon medical necessity and consultation review.~~ There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. ~~Any testing performed for a child under three must be prior authorized.~~ Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes B behavioral health services are available only to chronically and severely medically ill children.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. ~~All units/sessions, except the Initial or Level of Care Assessments or Crisis Intervention must be authorized by the OHCA or its designated agent.~~ A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing ~~without prior authorization~~ unless allowed by the OHCA or its designated agent.

(d) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled**. All providers participating in the Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled program must have a separate contract with this Authority to provide services under this

program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual~~, unless specified otherwise, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

~~(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.~~

~~(3) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.~~

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults**. There is no coverage for adults for services by a LBHP.

(c) **Children**. Coverage for children includes the following services ~~(all services, except for the Initial or Level of Care Assessments or Crisis Intervention, require authorization by OHCA or its designated agent, providers listed in 317:30-5-280(a)(1),(a)(3)and (a)(4) are exempt from authorization)~~:

(1) Bio-Psycho-Social and Level of Care Assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group,

just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed ~~with authorization~~ every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. ~~Any testing performed for a child under three must be prior authorized.~~ Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. ~~All units/sessions, except Assessment and Crisis Intervention must be authorized by the OHCA or their designated agent.~~ A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive

individual, group or family counseling or testing ~~without authorization~~ unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

(1) Payment is made for services rendered to SoonerCare ~~member's~~ members as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case

management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual’s ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will

be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the ~~member~~ member's (and ~~family's~~ family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d).

(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(IV) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an ~~individuals~~ individual's strengths and meet needs in order to achieve stability in the community. Standard managers have with caseloads of 30 – 35 members.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM).

Intensive Case Management is targeted to adults with serious and persistent mental illness (including ~~member's~~ members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders

(including ~~member's~~ members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited ~~to 25~~ between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

(C) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(i) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or

(ii) Managing finances; or

(iii) Providing specific services such as shopping or paying bills; or

(iv) Delivering bus tickets, food stamps, money, etc.; or

(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or

(vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or

(vii) Filling out SoonerCare forms, applications, etc.;

(viii) Mentoring or tutoring;

(ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies ; ~~or~~

(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork~~.~~;

(xi) monitoring financial goals;

(xii) services to nursing home residents;

(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or

(xix) services to members residing in ICF/MR facilities.

(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(ii) Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

(iii) Residents of ICF/MR and nursing facilities unless transitioning into the community;

(iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.3(a). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

(ii) person(s) to whom services are rendered;

(iii) start and stop times for each service;

(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);

(v) credentials of the service provider ;

(vi) specific service plan needs, goals and/or objectives addressed;

(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;

(viii) progress and barriers made towards goals, and/or objectives;

(ix) member (family when applicable) response to the service;

(x) any new service plan needs, goals, and/or objectives identified during the service; and

(xi) member satisfaction with staff intervention.

(G) **Case Management Travel Time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

317:30-5-596.1. Prior authorization

(a) ~~Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.~~ Prior to providing behavioral health case management services provider must submit to OHCA, or its designated agent member information which includes but is not limited to the following:

(A) Complete multi-axial DSM diagnosis with supportive documentation and mental status examination summary;

(B) Treatment history;

(C) Current psycho social information;

(D) Psychiatric history; and

(E) Fully developed case management service plan, with goals, objectives, and time frames for services.

(b) SoonerCare members who are eligible for services will be considered for ~~prior authorization~~ behavioral health case management services after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be ~~approved to receive~~ eligible for case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. ~~A SoonerCare member may be approved for a time frame of one to twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation~~

~~to OHCA, or its designated agent.~~ A fully developed individual plan of service is not required ~~at the time of initial request~~ prior to providing the service. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family ~~and corresponding units of service will be approved prior to the completion of the service plan. Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240~~.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-741. Coverage by category

(a) **Adults.** Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** Outpatient behavioral health services are ~~authorized~~ allowed in therapeutic foster care settings for certain children and youth ~~by the designated agent of the Oklahoma Health Care Authority~~ as medically necessary. The children and youth ~~authorized for~~ receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting. ~~The medical necessity criteria are continually met for initial requests for services and all subsequent requests for services/ extensions.~~

(1) Medical necessity criteria is delineated ~~in the OHCA Behavioral Health Provider Manual.~~ as follows:

(A) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-5-240.3(a) within the 30 day period resulting in an Axis I primary diagnosis form the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.

(B) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.
(C) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.
(D) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.
(E) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.
(F) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category

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

(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening ~~examination~~.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include ~~a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.~~ any of the following:

(A) vision
(B) hearing
(C) dental
(D) a child health history
(E) physical examination
(F) developmental assessment
(G) physical examination
(H) developmental assessment
(I) nutrition assessment and counseling
(J) social assessment and counseling
(K) genetic evaluation and counseling
(L) indicated laboratory and screening tests
(M) screening for appropriate immunizations
(N) health counseling and treatment of childhood illness and conditions

(3) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening. Approved diagnostic encounters may include the following:

~~(3)~~ (A) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(4)~~ (B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(5)~~ (C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a member's ear and providing a finished earmold which is used with the member's hearing aid provided by a state licensed audiologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(6)~~ (D) **Vision Screening.** Vision screening ~~examination~~ in school children includes application of tests and examinations to identify visual defects or vision disorders and must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision

services include diagnosis and treatment for defects in vision.

~~(7)~~ (E) **Speech Language evaluation.** Speech Language evaluation is for the purpose of identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language services and must be provided by state licensed speech language pathologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(8)~~ (F) **Physical Therapy evaluation.** Physical Therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems and must be provided by a state licensed physical therapist.

~~(9)~~ (G) **Occupational Therapy evaluation.** Occupational Therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state licensed occupational therapist.

~~(10)~~ (H) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE).

~~(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.~~

~~(12)~~ (4) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in

development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services include provisions of speech and language services for the habilitation or prevention of communicative disorders and must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more ~~that~~ than two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the child's education and must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

~~(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.~~

~~(G)~~(F) **Psychotherapy ~~Counseling~~ Services.** Psychotherapy ~~counseling~~ services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy ~~counseling~~ services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas.

~~(H)~~(G) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

~~(13)~~(H) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants ~~who~~ that have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

~~(14)~~(I) **Therapeutic Behavioral Services.** Therapeutic behavioral services ~~is~~ are an intervention to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and evaluation. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive

skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelors level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education are required per year.

~~(15)~~(K) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for ~~those Medicaid eligible~~ children enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible ~~recipients~~ members are billed directly to the fiscal agent.

317:30-5-1027. Billing

(a) Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.

(2)There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the Psychological Evaluation, which is billed in hourly increments.

(b) The following units of service are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.

(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.

(3) Service: Child Health Encounter; ~~Unit: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units;~~ Unit: per encounter; limited to ~~30 units per~~

~~year, additional units must be prior authorized~~ 3 encounters per day.

(4) Service: Individual Treatment Encounter ~~for IEP School Based and School Based~~; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~ (B) Speech Language Therapy~~, IEP School Based~~; Unit: per session, limited to one per day.

~~(D) Speech Language Therapy, School Based~~

~~(E)~~ (C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~ (D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I)~~ (E) Nursing Services~~, IEP School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day~~Unit: up to 15 minutes; maximum 32 units per day.

~~(J) Nursing Services, School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day~~

~~(K) Psychological Services, IEP School Based~~.

~~(L) Psychological Services, School Based.~~

~~(M)~~ (F) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~; maximum 8 units per day.

~~(N) Psychotherapy Counseling Services, School Based.~~

~~(O)~~ (G) Assistive Technology~~, IEP School Based~~.

~~(P) Assistive Technology, School Based.~~

~~(Q) Dental Screening, IEP School Based.~~

~~(R) Dental Screening, School Based.~~

~~(S)~~ (H) Therapeutic Behavioral Services~~, IEP School Based; limited to 12 units per day~~.

(5) Service: Group Treatment Encounter ~~for IEP School Based and School Based~~; No more than 5 ~~recipients~~ members per group, Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~ (B) Speech Language Therapy~~, IEP School Based~~; Unit: per session, limited to one per day.

~~(D) Speech Language Therapy, School Based.~~

~~(E)~~ (C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~ (D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I) Psychological Services, IEP School Based.~~

~~(J) Psychological Services, School Based.~~

~~(K)~~ (E) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~; maximum 8 units per day.

~~(L) Psychotherapy Counseling Services, School Based.~~

(6) Service: Administration only, Immunization; Unit: one administration.
(7) Service: Hearing Evaluation; Unit: Completed Evaluation.
(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.
(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).
(10) Service: Tympanometry and acoustic reflexes.
(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).
(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.
(13) Service: Speech Language Evaluation; Unit: one evaluation.
(14) Service: Physical Therapy Evaluation; Unit: one evaluation.
(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.
(16) Service: Psychological Evaluation and Testing; Unit: one hour ~~(with written report)~~.
(17) Service: Personal Care Services; Unit: 10 minutes.
(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.
(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Oklahoma Department of Central Services (DCS) Purchasing rules ~~(OAC 580:15)~~ (OAC 580:16) whenever DCS has final authority on an acquisition.

(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by DCS, the DCS Purchasing rules at OAC ~~580:15~~ 580:16 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the DCS rules.

317:10-1-12. Protest of award

(a) Protests of awards made by the Authority under 74 Okla. Stat. ' 85.5T are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the Oklahoma Department of Central Services rules at OAC ~~580:15-4-13~~ 580:16-3-21.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending

from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in OAC 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.

"In-network" means providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma IP" means the Individual Plan program.

"Insure Oklahoma ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract with the

Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

"Qualified Health Plan (QHP)" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) Out-of-pocket medical expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket medical expenses in excess of the 5 percent annual gross household income. A medical expense must be for an allowed and covered service by a qualified health plan (QHP) to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies. For instance, if a QHP has multiple in-network reimbursement percentage methodologies (80% for level 1 provider and 70% for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible medical expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket medical expense. The required documentation must be submitted no later than 90 days after the close of the member's eligibility period. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket medical expenses.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.15. Supplies

(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.

(b) Special requirements:

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** A maximum of 100 glucose test strips and 100 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. ~~Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.~~ Coverage for intermittent catheters is limited to a maximum of 200 catheters per month when medically necessary and prescribed by a physician. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit.

(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

317:35-18-1. Programs of All-Inclusive Care for the Elderly (PACE)

This chapter establishes the requirements for ~~the Cherokee Nation Pilot Program~~ approved SoonerCare contracted Program of All-Inclusive Care for the Elderly (PACE) providers to provide services to eligible elderly ~~clients~~ individuals through the Oklahoma Health Care Authority's (OHCA) ~~Programs of All-Inclusive Care for the Elderly (PACE)~~ PACE program.

317:35-18-2. Introduction

(a) Programs of All-Inclusive Care for the Elderly (PACE) provide home and community-based acute and long-term care services to eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community. PACE is optional in a State Medicaid program. PACE is jointly funded and administered by the Centers for Medicare and Medicaid Services and the state of Oklahoma. The PACE provider receives a monthly capitation payment and is at full risk for the delivery of all medically necessary services for the ~~recipient~~ individual. For eligible individuals who elect to participate in the PACE program, the OHCA will make capitation payments for individuals who are only eligible for Medicaid or who are dually eligible for Medicaid and Medicare. OHCA will contract with ~~the Cherokee Nation~~ providers for ~~a~~ the PACE ~~pilot~~ program in the geographic areas as specified and approved in the ~~Cherokee Nation~~ provider PACE application. ~~The Cherokee Nation PACE pilot~~ The PACE program will provide medically necessary services to both American Indian/Alaska Native (AI/AN) and non-Indian Medicaid eligible ~~recipients~~ individuals.

(b) Rules applicable to the operation of the PACE program are contained in 42 Code of Federal Regulations (CFR), Part 460. These regulations, as currently written or amended in the future, are incorporated by reference as the rule base for operating the PACE program in Oklahoma.

317:35-18-3. Definitions

The words and terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;

(2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays ~~to the~~ PACE ~~provider~~ providers for PACE compensable services.

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE ~~clients~~ participants and plan for their care as set forth in 42 CFR ~~460:102~~ 460.102. The IDT may also include the PACE ~~client's~~ participant's personal representative or advocate.

(4) **"Participant"** means an individual enrolled in a PACE program.

(5) **"Program agreement"** means the three-party agreement between the PACE provider, ~~CMS~~ Centers for Medicare & Medicaid Services (CMS), and OHCA.

(6) **"Provider"** means the non-profit entity ~~established by the Cherokee Nation~~ that delivers required PACE services under an agreement with OHCA and CMS.

(7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.

(8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, and the regulations in 42 CFR, Part 460.

(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.

(c) The provider must meet all applicable local, state, and federal regulations.

(d) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;

(2) date of contact;

(3) name and phone number of the individual requesting services;

(4) name and address of the potential ~~client~~ participant; and
(5) date of enrollment, or reason for denial if the individual is not enrolled.

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:
(1) meet categorical relationship to disability (reference OAC 317:35-5-4);
(2) meet medical and financial criteria for the ADvantage program (reference OAC 317:35-17-2, 317:35-17-10, and 317:35-17-11);
(3) be age 55 years or older
(4) live in a PACE service area;
(5) be determined by the PACE Interdisciplinary team as able to be safely served in the community. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:
(A) notify the applicant in writing of the reason for the denial;
(B) refer the ~~individual~~ applicant to alternative services as appropriate;
(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and
(D) advise the ~~client~~ applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for ~~Medicaid~~ SoonerCare capitated payments, the ~~participant~~ individual must:
(1) be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;
(2) be eligible for ~~Medicaid~~ SoonerCare State Plan services;
(3) be eligible for the ~~Medicaid~~ SoonerCare ADvantage program per OAC 317:35-17-3 and 317:35-17-5.

(c) To obtain and maintain eligibility, the ~~participant~~ individual must agree to accept the PACE providers and its contractors as the ~~participant's~~ individual's only service provider. The ~~participant~~ individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-6. Program benefits

(a) A provider agency must provide a participant all the services listed in 42 CFR 460.92 that are approved by the IDT. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

(1) All ~~Medicaid-covered~~ SoonerCare-covered services, as specified in the State's approved ~~Medicaid~~ SoonerCare plan.

(2) Interdisciplinary assessment and treatment planning.

(3) Primary care, including physician and nursing services.

(4) Social work services.

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

(6) Personal care and supportive services.

(7) Nutritional counseling.

(8) Recreational therapy.

(9) Transportation.

(10) Meals.

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology.

(B) Audiology.

(C) Cardiology.

(D) Dentistry.

(E) Dermatology.

(F) Gastroenterology.

(G) Gynecology.

(H) Internal medicine.

(I) Nephrology.

(J) Neurosurgery.

(K) Oncology.

(L) Ophthalmology.

(M) Oral surgery.

(N) Orthopedic surgery.

(O) Otorhinolaryngology.

(P) Plastic surgery.

(Q) Pharmacy consulting services.

(R) Podiatry.

(S) Psychiatry.

(T) Pulmonary disease.

(U) Radiology.

(V) Rheumatology.

(W) General surgery.

(X) Thoracic and vascular surgery.

(Y) Urology.

(12) Laboratory tests, x-rays and other diagnostic procedures.
(13) Drugs and biologicals.
(14) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.
(15) Acute inpatient care, including the following:
(A) Ambulance.
(B) Emergency room care and treatment room services.
(C) Semi-private room and board.
(D) General medical and nursing services.
(E) Medical surgical/intensive care/coronary care unit.
(F) Laboratory tests, x-rays and other diagnostic procedures.
(G) Drugs and biologicals.
(H) Blood and blood derivatives.
(I) Surgical care, including the use of anesthesia.
(J) Use of oxygen.
(K) Physical, occupational, respiratory therapies, and speech-language pathology services.
(L) Social services.
(16) Nursing facility care including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;
(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies and appliances.
(17) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:
(1) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.
(2) In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting ~~fran~~ from an accidental injury or for reconstruction following mastectomy.
(4) Experimental medical, surgical, or other health procedures.
(5) Services furnished outside of the United States, except as follows:
(A) in accordance with 42 CFR 424.122 through 42 CFR 424.124, and
(B) as permitted under the State's approved Medicaid plan.

317:35-18-7. Appeals process

(a) Internal appeals
(1) Any ~~client~~ individual who is denied program services is entitled to an appeal through the provider.
(2) If the ~~client~~ individual also chooses to file an external appeal, the provider must assist the ~~client~~ individual in filing an external appeal.

(b) External appeals may be filed by any ~~client~~ individual covered by:
(1) ~~Medicaid~~ SoonerCare through the OHCA legal division.
(2) Medicare but not ~~Medicaid~~ SoonerCare through the Centers for Medicare and Medicaid Services hearing process.

317:35-18-9. Continuation of enrollment

(a) At least annually, OHCA must reevaluate whether a participant needs the level of care for nursing facility services.
(b) At least annually, OKDHS will reevaluate the participant's financial eligibility for ~~Medicaid~~ SoonerCare.
(c) If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could ~~reasonable~~ reasonably be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and the ~~client~~ participant ~~may~~ will be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.

(d) If OHCA determines that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant ~~may~~ will be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the ~~client~~ participant would meet the nursing facility level of care criteria within the next six months.
(e) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care. The participant's medical record and plan of care must support deemed continued eligibility.

317:35-18-10. Disenrollment (voluntary and involuntary)
(a) ~~The member~~ A participant may voluntarily disenroll from PACE at any time without cause ~~but~~ however, the effective date of disenrollment must be the last day of the month that the participant elects to disenroll.
(b) A participant may be involuntarily disenrolled for any of the following reasons:
(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.
(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
(4) The participant is determined to no longer meet the ~~State Medicaid~~ SoonerCare nursing facility level of care requirements and is not deemed eligible.
(5) The PACE program agreement with CMS and ~~the State administering agency~~ OHCA is not renewed or is terminated.
(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.
(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:
(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(e) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, ~~the State administering agency must~~ OHCA will review ~~it~~ the participant's medical record and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

317:35-18-11. Data collection and reporting

The PACE provider must:

(1) collect ~~and enter~~ data to comply with reporting requirements in provider application ~~into the DATA PACE system.~~;

(2) generate and maintain monthly reports from ~~the DATA PACE system.~~ collected data;

(3) make the reports available to the OHCA~~.~~; and

(4) comply with all data requests as specified by the OHCA within 30 days of such requests.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the ~~mentally retarded~~ intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16 years.

(iv) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years; and

(V) Tooth numbers D and G before 5 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure

is remaining.

(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and multiple missing teeth exist in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of

chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(Q) **Local anesthesia.** This procedure is included in the fee for all services.

(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;

(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);
(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);
(vi) Composite restorations:
(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;
(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and
(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M).

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as

they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with x-ray film mounts and each film or print must be of good readable quality. X-rays must be identified by left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. ~~A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.~~

(A) **Anterior root canals.** This procedure is for members who have a treatment plan requiring more than four anterior and/or posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA materials must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved unless prior authorized; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a failing root canal is determined not medically necessary for re-treatment.

(2) **~~Cast metal crowns or ceramic-based crowns.~~ Crowns for permanent teeth.** ~~These procedures~~ Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be ~~fractured or~~ decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is fractured or destroyed ~~by the above elements~~ by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

~~(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.~~

~~(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.~~

~~(H) Full cast metal crowns are treatment for all posterior teeth,~~

~~(I)~~ (F) Provider is responsible for replacement or repair of all ~~cast~~ crowns if ~~due to~~ failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care

Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of removable partial dentures are considered. Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;

(B) cerebral palsy;

(C) ~~mental retardation~~ intellectual disabilities;

(D) juvenile periodontitis.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

(1) hospital beds;
(2) support surfaces;
~~(3) continuous positive airway pressure devices (BiPAP and CPAP);~~
~~(4)~~ (3) patient lift devices;
~~(5)~~ (4) external infusions pumps;
~~(6)~~ (5) enteral and parenteral nutrition;
~~(7)~~ (6) osteogenesis stimulators; and
~~(8)~~ (7) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) **Determination of categorical relationship to the disabled by SSA.** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSI on disability.** If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical

relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical

relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical

information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ~~ABCDM-80-B~~ ABCDM-80-D 08MA022E with pertinent medical

information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form ~~MS-MA-5~~ 08MA005E are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form ~~ABCDM-16~~ 08MA016E, Authorization for Examination and Billing. The OKDHS worker sends the ~~ABCDM-16~~ 08MA016E and OKDHS form ~~ABCDM-80~~ 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.

(V) Setting a date for re-examination, if needed.

(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason

must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays expected to last not less than 60 days. In addition to disability LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TB infection.** Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60

days), nursing facility or intermediate care facility for the mentally retarded, is determined eligible using only his/her income and resources as though he/she were institutionalized.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be considered as a possibly liable third party, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care

because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, the member must assist OHCA with the subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit the appropriate information.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is ~~not~~ required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of

child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(ii) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CFSD or retained by the member.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-1. Pregnancy related benefits covered under Title XXI

(a) The revision of the definition of child at 42 CFR 457.10, allows states to cover pregnancy related services under Title XXI, individuals who would not otherwise qualify for services under SoonerCare. This coverage is intended to benefit newborn children who are Oklahoma residents at birth.

(b) To receive pregnancy related services under Title XXI, the pregnant woman must:

(1) be otherwise ineligible for any other categorically SoonerCare eligibility group;

(2) reside in Oklahoma with the intent to remain, at the time services are rendered;

(3) have household income at or below 185% FPL; and

(4) not be covered by creditable insurance, the term creditable insurance means coverage under a group health plan or other health insurance as defined in the Health Insurance Portability and Accountability Act (HIPAA).

(c) All services are subject to post payment review by the OHCA or its designated agent.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited or Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certified organization/agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own national provider identification (NPI) number are covered under OAC 317:30-5-1 and OAC 317:30-5-275. Other outpatient ambulatory clinics (e.g. Federally Qualified Health Centers, Indian Health Clinics, school-based clinics) that offer outpatient behavioral health services are covered elsewhere in the agency rules.

317:30-5-240.1. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Accrediting body" means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"BH" means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.
"BHAs" means Behavioral Health Aides.
"BHRS" means Behavioral Health Rehabilitation Specialist.
"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
"Child" means an individual younger than 21, unless otherwise specified.
"CM" means case management.
"CMHC's" means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with severe mental illnesses, and youth with serious emotional disturbances.
"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual_s racial, ethnic, age group, religious, sexual orientation, and/or social group.
"DSM" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).
"FBCS" means Facility Based Crisis Stabilization.
"FSPs" means Family Support Providers.
"ICF/MR" means Intermediate Care Facility for the Mentally Retarded.
"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).
"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].

"LBHP" means a Licensed Behavioral Health Professional.
"MST" means the EBP Multi-Systemic Therapy.
"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.
"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.
"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.
"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.
"OHCA" means the Oklahoma Health Care Authority.
"OJA" means the Office of Juvenile Affairs.
"Provider Manual" means the OHCA BH Provider Billing Manual.
"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.
"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.
"RSS" means Recovery Support Specialist.
"SAMHSA" means the Substance Abuse and Mental Health Services Administration.
"SED" means Severe Emotional Disturbance.
"SMI" means Severely Mentally Ill.
"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-240.2 Provider participation standards
(a) **Accreditation and certification status.** Any agency may participate as an OPBH provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.
(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an

incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes;
(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes;
(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;
(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;
(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;
(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
(8) Public Health Clinics and County Health Departments;
(9) Public School Systems.
(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification(s) in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:
(1) Substance Abuse agencies (OAC 450:18-1-1);
(2) Evidenced Based Best Practices but not limited to:
(A) Assertive Community Treatment (OAC 450:55-1-1);
(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and
(C) Peer Support/Community Recovery Support;
(3) Systems of Care (OAC 340:75-16-46);
(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
(5) Case Management (OAC 450:50-1-1);
(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);
(7) Day Treatment - CARF, JCAHO, and COA will be required as of December 31, 2009; and
(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, and COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) Effective 07/01/10, all behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in the OHCA BH Provider Manual.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A BHRS, if individual or group rehabilitative services for behavioral health disorders are provided;

(C) An AODTP, if treatment of alcohol and other drug disorders is provided;

(D) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Treatment Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and

(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable Federal and State Regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 13. MEMBER RIGHTS AND RESPONSIBILITIES

317:35-13-7. Program Abuse and Administrative Sanctions

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

(1) ~~"Abuse"~~ **"Abuse"** means ~~recipient~~ member actions that defraud the Oklahoma Health Care Authority (OHCA), cause unnecessary medical expenses to the program or over-utilize services provided by the OHCA. It shall also mean causing unnecessary or excessive claims to be submitted to the OHCA.

(2) ~~"Conviction"~~ **"Conviction"** or ~~"Convicted"~~ **"Convicted"** means a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

(3) ~~"Exclusion"~~ **"Exclusion"** means not being able to be certified for Medicaid benefits under the State Plan or Waivered services in Oklahoma.

(4) ~~"Fraud"~~ **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

(5) ~~"Knowingly"~~ **"Knowingly"** means that a person, with respect to information:

(A) has actual knowledge of the information;

(B) acts in deliberate ignorance of the truth or falsity of the information; or

(C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(6) ~~"Medical Services Providers"~~ **"Medical Services Providers"** means:

(A) ~~"Practitioner"~~ **"Practitioner"** means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirements for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.

(B) ~~"Supplier"~~ **"Supplier"** means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the OHCA.

(C) ~~"Provider"~~ **"Provider"** means:

(i) a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the OHCA, or

(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.

(D) ~~"Laboratories"~~ **"Laboratories"** means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the OHCA to receive Medicaid monies.

(E) ~~"Pharmacy"~~ **"Pharmacy"** means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.

(F) ~~"Any other provider"~~ **"Another other provider"** means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.

(7) ~~"OIG"~~ **"OIG"** means the Office of Inspector General of the Department of Health and Human Services.

(8) ~~"Recipient"~~ **"Member"** means a beneficiary, patient or person served by the OHCA.

(9) ~~"Sanctions"~~ **"Sanctions"** means any administrative decision by OHCA to suspend or exclude a ~~recipient~~ member from the ability to be certified for medical assistance. A sanction may include a decision to use the remedy provided in OAC 317:30-3-14(b) or to require payment by the ~~recipient~~ member of the service.

(10) ~~"Suspension"~~ **"Suspension"** means an administrative action to suspend temporarily the certification of a case for medical assistance.

(11) ~~"Willfully"~~ **"Willfully"** means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) **Basis for sanctions.**

(1) The OHCA may sanction a ~~recipient~~ member who has or has had a certified medical assistance case with OHCA for the following reasons:

(A) Knowingly or willfully made, or causing to be made, any false statement or misrepresentation of material fact to get a case certified or causing services to be rendered to the ~~recipient~~ member;

(B) Caused or ordered services under ~~Medicaid~~ SoonerCare that are substantially in excess of the ~~**recipient's**~~ **member's** needs or that fail to meet professionally recognized standards for health care;

(C) Submitted or caused to be submitted to the ~~Medicaid~~

SoonerCare program, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(D) Threatened harm to medical providers or state officials.

(2) The agency may base its determination that services are excessive or unnecessary based upon reports, including sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local law enforcement agencies and licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) ~~Surveillance and Utilization Review Section~~ Program Integrity Reports done by OHCA;

(F) Medicaid Fraud Control Unit;

(G) Other sources, including internal investigations, deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the ~~Medicaid program~~ SoonerCare any ~~recipient~~ member who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum, the same period as the Medicare suspension.

(c) **Procedures for imposing sanctions.**

(1) Notice of proposed administrative sanction.

(A) If the OHCA proposes to sanction, it will send the ~~recipient~~ member a written notice stating:

(i) the reasons for the proposed sanction;

(ii) the date upon which the sanction will be effective;

(iii) the result of the sanction should it be imposed; and

(iv) a statement that the ~~recipient~~ member has a right to an evidentiary hearing prior to the imposition of the sanction.

(B) A copy of this section of the rules will be attached to the letter of proposed action.

(2) Notice of sanction.

(A) After an evidentiary hearing is conducted under OAC 317:2-1-2, the Agency will make a final administrative decision regarding the decision to sanction.

(B) Based upon its final decision, the Agency shall send a notice to the ~~recipient~~ member that provides:

(i) the reasons for the decision;

(ii) the effective date of the sanction;

(iii) the effect of the sanction on the party's participation in ~~the Medicaid program~~ SoonerCare;

(iv) the ~~recipient's~~ member's right to request a reconsideration of the Agency's final decision;

(v) the earliest date in which the Agency will accept a

request for reinstatement;
(vi) the requirements and procedures for reinstatement; and
(vii) instructions on how to ask for reconsideration.

(d) **Effect of sanction.** OHCA will advise its eligibility agent of the closure or suspension of the case and when the ~~recipient~~ member can be recertified. The sanctions are as follows:

(1) For the first violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 6 months.

(2) For the second violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 12 months.

(3) For the third violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended indefinitely.

(4) All members sanctions, including the length of the penalty period, are subject to administrative due process as described in this Section.

(e) **Criteria for reinstatement.**

(1) Upon the request for reinstatement made by the ~~recipient~~ member, OHCA may consider the following factors to reinstate the ~~recipient~~ member;

(A) The number and nature of the program violations and other related offenses.

(B) The nature and extent of any adverse impact the violations have had on providers or other ~~recipients~~ members;

(C) The amount of any damages;

(D) Any mitigating circumstances;

(E) Other facts bearing on the nature and seriousness of the program violations and related offenses;

(F) Convictions in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion; and

(G) Whether the state or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.

(2) Regardless of the applicability of one or many of the factors in paragraph (1) of this subsection, reinstatement shall not be granted unless it is reasonably certain that the violation(s) that led to the exclusion will not be repeated.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-7. Anesthesia

(a) **Procedure codes.** Anesthesia codes from the Physicians' Current Procedural Terminology should be used. Payment is made only for the major procedure during an operative session.

(b) **Modifiers.** All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied.

(c) **Qualifying circumstances.** Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. The appropriate modifiers should be added to these codes. Additional payment can be made for extremes of age, total body hypothermia, and controlled hypertension.

(d) **Hypothermia.** Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(e) **Anesthesia with Blood Gas Analysis.** Blood gas analysis is part of anesthesia service. Payment for anesthesia includes payment for blood gas analysis.

(f) **Steroid injections.** Steroid injections administered by an anesthesiologist are covered as nerve block. The appropriate CPT procedure code is used to bill services.

(g) **Local anesthesia.** If local anesthesia is administered by attending surgeon, payment is included in the global surgery fee, except for spinal or epidural anesthesia in conjunction with childbirth.

(h) **Stand by anesthesia.** This is not covered unless the physician is actually in the operating room administering medication, etc. If this is indicated, claim will be processed as if anesthesia was given. Use appropriate anesthesia code.

(i) **Other qualifying circumstances.** All other qualifying circumstances, i.e., physical status, emergency, etc. have been structured into the total allowable for the procedure.

(j) **Central venous catheter and anesthesia.** Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(k) **Pain management.** Pain management procedures performed during the anesthesia session will be covered when medically necessary to adequately control anticipated post-operative pain.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
PART 9. LONG TERM CARE FACILIIES

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and ~~mental retardation~~ intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The nursing facility (NF) must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).

(2) **PASRR Level I screen.**

(A) Form ~~LTC-300R~~ LTC-300, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(i) The nursing facility administrator or co-administrator;

(ii) A licensed nurse, social service director, or social worker from the nursing facility; or

(iii) A licensed nurse, social service director, or social worker from the hospital.

(B) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form ~~LTC-300R~~ LTC-300 and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), ~~mental retardation (MR)~~, intellectual disability or other related condition, or if such condition existed in the applicant's past history. Form ~~LTC-300R~~ LTC-

300 constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted. The NF is also responsible for consulting with the Level of Care Evaluation Unit (LOCEU) regarding any ~~MI/MR~~ mental illness/intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form ~~LTC-300R~~ LTC-300, Section E, will require the nursing facility to contact the LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of ~~MI, MR,~~ mental illness, intellectual disability or related condition, LOCEU should be contacted prior to admission. The original Form ~~LTC-300R~~ LTC-300 must be submitted by mail to the LOCEU within 10 days of the resident admission. SoonerCare payment may not be made for a resident whose ~~LTC-300R~~ LTC-300 requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form ~~LTC-300R~~ LTC-300, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or ~~mental retardation~~ intellectual disability or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of ~~mental retardation~~ intellectual disability or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or ~~mental retardation~~ intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge

is allowed only if all three of the following conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the patient has current indications of mental illness or ~~mental retardation~~ intellectual disability or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level II PASRR Assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The OHCA, LOCEU, authorizes Advance Group Determinations for the ~~MI and MR~~ mental illness and intellectual disability Authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, ~~mental retardation~~ intellectual disability or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, ~~mental retardation~~

intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, ~~mental retardation~~ intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR or MI~~ intellectally disaled or mentally ill. A new condition of ~~MR or MI~~ intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment may result in recoupment of funds.

(B) A Level II Resident Review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services

provided by a nursing facility and whether the resident requires specialized services.

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the ~~MI/MR~~ mental illness/intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or ~~mental retardation~~ intellectual disability or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent ~~LTC-300R~~ LTC-300 and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated ~~LTC-300R~~ LTC-300 that reflects the resident's current status to LOCEU within 10 days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or ~~mental retardation~~ intellectual disability or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county

OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience ~~MI, MR,~~ mental illness, intellectual disability or related condition through the Level II Assessment, the PASRR determination made by the ~~MR/MI~~ intellectual disability/mental illness authorities cannot be countermanded by the Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the ~~MR/MI~~ intellectual disability /mental illness authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of ~~MR~~ intellectual disability or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within ~~10~~ 30 calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment ~~(Form LTC-300R)~~ (Form LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not

already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

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

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of 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 examination;
(ii) bite-wing x-rays;
(iii) prophylaxis;
(iv) topical fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or improved 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 are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(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 must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their 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 must include a ~~physician's~~ practitioner's prescription.

(ii) ~~For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program~~ For purposes of this Section, a practitioner is defined as all medical and osteopathic physicians, physician assistants and other licensed professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational ~~therapy~~ therapist assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical ~~therapy~~ therapist assistants must have a current non-restrictive licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical ~~therapy~~ therapist assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-

being. Physical therapy services may include the use of physical ~~therapy~~ therapist assistants, within the limits of their 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 must include a ~~physician's~~ practitioner's prescription.

(ii) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical ~~therapy~~ therapist assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified 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, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

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

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

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

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

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

(i) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants and other licensed professionals with prescriptive authority to order speech/language services in accordance with rules and regulations covering the OHCA's SoonerCare program.

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

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

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

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, 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 a contracted agency staff with a minimum of four years of any combination of college level education or full-time

equivalent experience in serving persons with disabilities.

(B) **Description of services.** 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 will not be made for:

(I) routine care and supervision that is normally provided by family; 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 must 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 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

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

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

(v) DDSD case management supervisor review and approval 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 oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

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

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

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

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

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

(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) **Self Directed HTS (SD HTS).**

SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).**

SD GS are provided per 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a ~~physician's~~ practitioner's prescription.

(i) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA's SoonerCare program.

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

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

(12) **Prevocational services.**

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, 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 by a person with a minimum of four years of any combination of college level

education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** 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 Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in 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 hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, 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 and as allowed per 317:40-7-6.

(13) **Supported employment.**

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, 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 by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members 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 as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver 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 must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) 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 that are passed through to users of supported employment programs; or

(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, 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.

(14) **Intensive personal supports (IPS).**

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, 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 by a person with a minimum of four 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) **Description of services.**

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

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

(iii) DDSD case management supervisor review and approval is required.

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

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers in order to promote maximum level of independence and function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

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

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1012. Reimbursement

(a) Reimbursement for DDSDTCM services is a unit rate based on the ~~monthly~~ weekly cost per case for documented DDSDTCM services. The cost base consists of the annualized cost of case management staff including all applicable overhead and indirect service cost in accordance with the approved DHS cost allocation plan. A first year interim rate is computed by dividing the annual cost base by

the projected number of units. Subsequent annual rates will include an adjustment based on previous years cost versus total billable amount. A unit of service is defined as one calendar ~~month~~ week of targeted case management, provided that a minimum of one contact which meets the description of a targeted case management activity with or on behalf of the ~~recipient~~ member has been documented during the ~~month~~ week claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the ~~monthly~~ weekly unit rate for a documented unit of ~~Medicaid~~ SoonerCare DDSDTCM services provided to each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member during the calendar ~~month~~ week.

(b) Only one unit of DDSDTCM services may be billed for each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member per ~~month~~ week while the ~~recipient~~ member is receiving services under a DHS/DDSD HCBS Waiver or is in the transition process to receive those services. No more than twenty-six units of DDSDTCM may be provided and billed for each eligible ~~Medicaid~~ SoonerCare ~~recipient~~ member during their transition period from the institution. DHS/DDSD must provide documentation of all such transitional DDSDTCM services provided, indicating the date performed for each unit billed. In no case may DHS/DDSD bill for transitional and regular DDSDTCM services provided during the same ~~month~~ week (i.e., if DDSD bills transitional DDSDTCM for the third week in June and the ~~recipient~~ member is deinstitutionalized into the particular Waiver during the third week in June, DDSD cannot also bill for regular DDSDTCM for the third week in June). If DDSDTCM has been provided to an individual during such a transitional period but that individual dies before the placement into the community is made, decides to refuse the placement or the placement falls through, reimbursement is available.

(c) the billing week for DDSDTCM is Monday through Sunday.

317:30-5-1014. Documentation of records

All case management services rendered must be reflected by documentation in the records. All units of ~~Medicaid~~ SoonerCare DDSDTCM services provided are documented by the case manager ~~on the monthly Record of Contact form~~ weekly in Client Contact Manager. The following conditions must be met in order for case management services to reimbursed under ~~Medicaid~~ SoonerCare.

(1) The case manager must conduct a face-to-face interview with the ~~client~~ member in order to determine ~~client~~ member needs and develop approaches to meet these needs.

(2) The case manager with a team including the ~~client~~ member or ~~client's~~ member's representative, must develop a plan of care which is documented in the case record.

(3) The case manager must reassess the plan of care when necessary but at a minimum annually.

(4) The case manager must provide documentation to supplement the plan of care which includes:

(A) information supporting the selection of outcomes;
(B) information supporting the approaches selected;
(C) information supporting case management decisions and actions;
(D) documentation of communication with the ~~client~~ member and, as appropriate, his/her representative;
(E) documentation of linkages with resources;
(F) documentation of follow-up and monitoring of the plan; and
(G) other factual information relevant to the case.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):
(1) are provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);
(2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;
(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;
(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan ~~(IP)~~ (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:
(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);
(2) may provide companion services for one member. Exceptions to serve as companion for two members may be ~~granted only upon~~ approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;
(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;
(4) may not provide companion services to more than two members at any time;
(5) household may not serve more than three members through any combination of companion or respite services;

(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may not have other employment when approved to serve two members regardless of the levels of support required by the members.

(C) The companion may have other employment when:

(i) the ~~personal support~~ Team documents and addresses all related concerns in the member's ~~IP~~ Plan;

(ii) the other employment is approved in advance by the DDSD area manager or designee; and

(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

(D) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

(E) Homemaker, habilitation training specialist, and respite services are not provided ~~in order~~ for the companion to ~~perform~~ maintain other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care (POC) year; and

(D) cannot be accrued from one Plan of Care (POC) year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to 660 hours for respite for the companion.

(e) Habilitation Training Specialist (HTS) services:

(1) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) sleeping at night; or

(B) working or attending employment, educational, or day services with documented and continuing efforts by the Team;

(2) may be approved when a time-limited situation exists in which the ACS provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers.

(f) The agency receives a provider rate based on the agency's service model. The AC rate for the:

(1) employer model includes funding for the provider agency for the provision of benefits to the companion; or

(2) contractor model does not include funding for the provider agency for the provision of benefits to the companion.

~~(d)~~ (g) The agency receives a provider rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and

(iii) requires assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or

(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

(h) The Plan reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the additional amount must be:

(1) agreed upon by the member and, if applicable, legal guardian;

(2) recommended by the Team; and

(3) approved by the DDSD area manager or designee.

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, ~~as described in subsection (b) of~~ per OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, ~~and~~ or friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan (Plan) for service provision;

(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the ~~Individual~~ Plan;

(A) The companion documents and provides monthly data and

health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the ~~Individual~~ Plan;

(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;

(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator ~~in accordance with~~ per OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member ~~as reflected on OKDHS Form 06AC074E, Service Authorization Budget (SAB),~~ is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

(16) assists the member in achieving the member's maximum level of independence;

(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;

(18) ensures that the member's confidentiality is maintained ~~in accordance with~~ per OAC 340:100-3-2;

(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;

(20) implements training and provides supports that enable the member to actively join in community life;

(21) does not serve as representative payee for the member

without a written exception ~~approval~~ from the DDSD area manager or designee;

(A) The written ~~approval~~ exception is retained in the member's home record.

(B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.

(22) ensures the member's funds are properly safeguarded.

(23) ~~must obtain~~ obtains prior approval from the provider agency when making a purchase of over $50.00 with the member's funds;

(24) allows the provider agency staff and DDSD staff to make announced and unannounced visits to the home;

(25) develops an Evacuation Plan, using OKDHS Form 06AC020E, for the home and conducts training with the member;

(26) conducts fire and weather drills at least quarterly and ~~maintains~~ documents the ~~Fire and Weather Drill Record, OKDHS~~ fire and weather drills using Form 06AC021E~~, available for review:~~ ;

(27) develops and maintains a ~~Personal Possession Inventory~~ personal possession inventory for personal possessions and adaptive equipment, ~~OKDHS~~ using Form 06AC022E~~, documenting the member's possessions and adaptive equipment~~;

(28) supports the member's employment program by:

(A) assisting the member to wear appropriate work attire; and

(B) contacting the member's employer ~~only~~ as outlined by the Team and in the ~~Individual~~ Plan; and

(29) is responsible for the cost of their meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution.

~~(29)~~ (30) follows all applicable rules promulgated by the Oklahoma Health Care Authority ~~or~~ and DDSD, including:

(A) OAC 340:100-3-40;

(B) OAC 340:100-5-50 through 100-5-58;

(C) OAC 340:100-5-26;

(D) OAC 340:100-5-34;

(E) OAC 340:100-5-32;

(F) OAC 340:100-5-22.1;

(G) OAC 340:100-3-27; and

(H) OAC 340:100-3-38.

317:40-5-8. Agency companion services service authorization budget [REVOKED]

~~Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. The service authorization budget form is used to develop the individual service budget for the member's program and is~~

~~updated annually by the member's Personal Support Team (Team).~~

~~(1) The companion receives:~~

~~(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:~~

~~(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and~~

~~(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion.~~

~~(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on the service authorization budget form.~~

~~(C) Habilitation training specialist (HTS) services:~~

~~(i) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:~~

~~(I) sleeping at night; or~~

~~(II) working or attending employment services, with documented and continuing efforts by the Team.~~

~~(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.~~

~~(iii) must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.~~

~~(2) The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:~~

~~(A) agreed to by the member and, if applicable, legal guardian;~~

~~(B) recommended by the Team; and~~

~~(C) submitted with written justification attached to the service authorization budget form to the DDSD area manager or designee for approval.~~

~~(3) A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.~~

~~(A) The back-up plan:~~

~~(i) is submitted to the DDSD case manager for review and approval;~~

~~(ii) describes expected and emergency back-up support and program monitoring for the home; and~~

~~(iii) is reviewed initially and annually by the SFC specialist.~~

~~(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:~~

~~(i) knowledgeable about the member;~~

~~(ii) trained to implement the member's Individual Plan (Plan);~~

~~(iii) trained per OAC 340:100-3-38; and~~

~~(iv) when possible, involved in the member's daily life.~~

~~(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.~~

~~(D) The spouse or other adult residing in the home cannot serve as paid respite staff.~~

~~(4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.~~

~~(5) The member is allowed therapeutic leave per OAC 317:40-5-3.~~

317:40-5-9. Payment authorization for Agency Companion Services

Authorization for payment of Agency Companion Services (ACS) is ~~made~~ contingent upon ~~the completion~~ receipt of:

(1) ~~the letter that approves~~ the ~~applicant~~ applicant's approval letter authorizing ~~to provide~~ ACS for the identified ~~service recipient~~ member;

~~(2) an approved service authorization budget (SAB) in accordance with OAC 317:40-5-8;~~

~~(3)~~ (2) ~~an~~ approved relief and emergency back-up plan;

~~(4)~~ (3) ~~revision of the~~ revised Individual Plan;

~~(5)~~ (4) ~~revision of the service recipient's~~ revised Plan of Care; and

~~(6)~~ (5) ~~the~~ placement of the ~~service recipient~~ member in the ACS home.

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services policies and procedures governing all aspects of service provision.

(b) The provider agency is responsible for all employee or contract provider related activities detailed in this Subchapter.

(c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the Developmental Disabilities Services Division (DDSD) to secure alternative services in the least restrictive environment.

(d) The provider agency ensures that services provided meet requirements of OAC 340:100-5-22.1, unless different requirements

are stated in this Section.
(e) If the agency serves as the ~~service recipient's~~ member's representative payee, the agency must adhere to the requirements of OAC 340:100-3-4.1.
(f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the ~~service recipient~~ member.
(1) In the event of such a risk, the provider agency immediately notifies DDSD of the nature of the situation and notifies DDSD upon the resolution of the threatening situation.
(2) The provider agency's program coordination staff contacts and informs the DDSD case manager within 24 hours of an incident or injury. The provider agency completes and submits incident and injury reports to DDSD in accordance with OAC 340:100-3-34.
(3) A companion is immediately terminated when a provider agency becomes aware that a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.
(g) The provider agency ensures that only one ~~service recipient~~ member is served in a provider home. Exceptions may be approved by the DDSD area manager or designee.
(h) When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the ~~service recipient~~ member, the ~~service recipient's~~ member's legal guardian or advocate, the DDSD case manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.
(i) When a change in the provider agency is requested by the ~~service recipient~~ member or the companion, all participants attempt to resolve the issues. No change in the provider agency occurs unless the DDSD area manager or designee agrees that all issues have been discussed.
(j) The decision to remain or terminate services with the provider agency is the choice of the ~~service recipient~~ member or his or her legal guardian.
(k) When a ~~service recipient~~ member transfers from a provider agency, the provider agency ensures that the ~~service recipient~~ member has a 30-day supply of medication and a seven-day supply of food, household supplies, and personal supplies.
(l) The responsibilities of the provider agency's program coordination staff are:
(1) to visit the provider home daily during the first week of placement;
(2) to visit the home a minimum of three times per month ~~in accordance with~~ per OAC 340:100-5-22.1;
(3) to allow the needs of the ~~service recipient~~ member to determine the frequency of all other visits;
(4) to coordinate and submit ~~monthly~~ quarterly reports to the

provider agency for submission to the DDSD area office; and

(5) to communicate regularly with the DDSD case manager regarding any changes in the household or any other program issues or concerns.

(m) The provider agency works with the companion, member, and guardian to develop a back-up plan identifying respite staff.

(1) The back-up plan:

(i) is submitted to the DDSD case manager for approval;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is incorporated into the member's Individual Plan (Plan).

(n) The respite provider is:

(1) knowledgeable about the member;

(2) trained to implement the member's Plan;

(3) trained per OAC 340:100-3-38;

(4) responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

(o) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.

(p) The spouse or other adult residing in the home cannot serve as paid respite staff.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-59. Back-up Plan for persons receiving Specialized Foster Care

Prior to a member moving into Specialized Foster Care (SFC), the SFC provider and the SFC specialist develop a Back-up Plan. The SFC specialist communicates the Back-Up Plan in writing to the DDSD case manager for incorporation into the Individual Plan.

(1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.

(2) The member's natural family is considered as the first resource for the Back-up Plan at no cost to OKDHS, unless the member is in the custody of the Oklahoma Department of Human Services.

(3) The Back-up Plan contains the name(s) and current telephone number(s) of the person(s) providing back-up service.

(4) When paid providers are necessary, the Back-up Plan explains specifically where the service is to be provided.

(A) If back-up service is to be provided outside the SFC home, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all

necessary requirements to become a paid provider, including:
(i)an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search , including the Department of Public Safety (DPS), Sex Offender, and Mary Rippy Violent Offender Registries;
(ii) a Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant;
(iii) a search of any involvement as a party in a court action~~,~~ that may impact the safety or stability of the member that includes:
(I) victims protective order; or
(II) bankruptcy;
(iv) a search of all Oklahoma Department of Human Services (OKDHS) records, including child welfare (CW) records;
(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;
(vi) Community Services Worker registry check;
(vii) Oklahoma statutorily mandated liability insurance coverage, and a valid driver license; and
(viii) completion of required DDSD training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the member and provider will stay if the provider's home is not habitable. If there is a fee to stay in the alternate location, the fee is paid by the provider and not reimbursed by DDSD.

(5) The Back-up Plan is jointly reviewed at least monthly by the SFC specialist and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible to report any needed changes in the Back-up Plan to the SFC specialist.

(7) The SFC specialist will report any changes in the Back-up Plan to the case manager.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;
(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;
(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;
(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;
(5) are provided based on the:
(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);
(B) scope of architectural modifications per OAC 317:40-5-101;
(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;
(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and
(E) safety and suitability of the home.
(6) are limited to modifications of two different residences within any seven year period beginning with the member's first request for an approved architectural modification service;
(7) are provided with assurance of plans for the member to remain in the residence for at least five years;
(8) may be denied when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.
(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.
(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening in order to select a home with the fewest or most cost effective modifications;
(9) are provided to eligible members with the homeowner's signed permission;
(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;

(11) are provided on finished rooms complete with wiring and plumbing;
(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and
(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., ' 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification

projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; ~~and~~

(C) worker's compensation insurance or affidavit of exemption~~.~~ ; and

(D) lead paint safety certificate.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDSD area office resource development staff with architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDSD area office resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;

(M) foundation work;

(N) room additions;

(O) carports;

(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as

described in applicable national standards for persons with physical disabilities as applicable to private homes;

(Q) non-adapted home appliances;

(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or

(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDSD approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) The DDSD area office:

(A) authorizes architectural modification services less than $2500 when the plan of care is less than the state office reviewer limit; and

(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office limit or is $2500 or more.

(3) Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals.** The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult

Day Services. This service is available through the Community Waiver, Homeward Bound Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the member's maximum level of independence;

(2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;

(3) assisting the member in achieving the highest level of functioning possible;

(4) providing support, respite, and education for families and other caregivers; and

(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

(1) require ongoing support and supervision in a safe environment when away from their own residence;

(2) be 18 years of age or older; and

(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;

(2) comply with OAC 310:605, Adult Day Care Centers;

(3) allow DDSD staff to make announced and unannounced visits to the facility during the hours of operation;

(4) provide the DDSD case manager a copy of the individualized plan of care;

(5) submit incident reports per OAC 340:100-3-34;

(6) maintain a copy of the member's Individual Plan (Plan);

(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager ~~by the tenth of each month for the previous month's services~~ per OAC 340:100-5-52, for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) Team assessment per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26 of the member's needs.

(2) the member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

~~(D) have two or more of the circumstances given in this subparagraph.~~

~~(i) The member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.~~

~~(ii)~~ (D) ~~The member has~~ have nutritional needs requiring tube feeding or other dependency for food intake which must occur in the employment setting.

~~(iii)~~ (E) ~~The member has~~ have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined not feasible by the DDSD division director or designee; or

~~(E)~~ (F) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.
(4) There are no exceptions for the enhanced rate other than as allowed in this Section.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers

(a) The Developmental Disabilities Services Division (DDSD) case manager, member, a member's family or, if applicable, legal guardian, and provider develop a preliminary plan of services including:
(1) site and amount of the services to be offered;
(2) types of services to be delivered; and
(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.
(1) Employment services through Home and Community-Based Services (HCBS) Waivers cannot be reimbursed if those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.
(2) No exceptions to OAC 317:40-7-15(b) are authorized.

~~(c) Providers of HCBS employment services comply with OAC 340:100-17.~~

~~(d)~~ (c) The service provider is required to notify the DDSD case manager in writing when the member:
(1) is placed in a new job;
(2) loses his or her job. A Personal Support Team (Team) meeting must be held if the member loses the job;
(3) experiences significant changes in the community-based schedule or employment schedule; or
(4) experiences other circumstances, per OAC 340:100-3-34.

~~(e)~~ (d) The provider submits Oklahoma Department of Human Services (OKDHS) Provider Progress Report per OAC 340:100-5-52, for each member receiving services.

~~(f)~~ (e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $25,000 per Plan of Care year.

~~(g)~~ (f) Each member receiving residential supports per OAC 340:100-5-22.1 or group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ each week, excluding transportation to and from the member's residence.
(1) Thirty hours of employment service each week can be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, and job coaching services.

Center-based services cannot exceed 15 hours per week for members receiving services through the Homeward Bound Waiver.
(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:
(1) approved per OAC 317:40-7-21 prior to service implementation;
(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;
(3) identified in the Individual Plan (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and
(4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ per OAC 317:40-7-15, includes documentation of the Team's:
(1) discussion of:
(A) current specific situation that requires an exception;
(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and
(C) progress toward previous exception strategies or plans;
(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and
(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:
(1) discussion of:
(A) current specific situation that requires an exception;
(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and
(C) progress toward previous exception strategies or plans; and
(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of

Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted to the DDSD area manager or designee within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(f) The DDSD director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.