Rules Agenda
March 12, 2009

I. Items subject to the Administrative Procedures Act (Emergency)

A. ADvantage Program Waiver Services rules are revised to add Assisted Living services as a compensable service under the ADvantage Waiver program. **(Reference APA WF # 09-06 A & B)**

II. Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency rulemaking.

A. Revising SoonerCare eligibility rules to allow individuals to apply for nursing home care (or Private ICF/MR) at the OKDHS human services center of their choice. **(Reference APA WF # 08-33)**

B. Revising Insure Oklahoma/O-EPIC rules to expand Individual Plan (IP) benefits to cover physical, occupational, and speech therapy services for adults in an outpatient hospital setting and outpatient behavioral health services provided by an individual Licensed Behavioral Health Professional. **(Reference APA WF # 08-35)**

C. Revising SoonerCare rules to: (1) incorporate the patient-centered medical home model of care in which providers are paid a monthly care coordination payment in addition to reimbursement for SoonerCare compensable services at the fee-for-service rate; (2) require provider or physician groups to designate a medical director to serve as primary contact with OHCA; (3) include a section on provider networks; and (4) include language regarding the development of a payment for excellence program. **(Reference APA WF # 08-19)**

D. Revising SoonerCare eligibility rules to: (1) allow the use of tribal membership cards, Certificate of Degree of Indian Blood cards, and Oklahoma Voter Registration cards to verify citizenship and/or identity; and (2) allow time-limited coverage for Iraqis and Afghans with special immigrant status pursuant to Public Law 110-161 and 110-181. **(Reference APA WF # 08-44)**

E. Revising Outpatient Hospital and Free-Standing Ambulatory Surgery Center rules to reflect upcoming changes to the reimbursement methodology for outpatient surgery services. **(Reference APA WF # 08-47)**

F. Revising Personal Care rules to transfer the responsibility for the authorization of service units and monitoring of service provisions from OKDHS nurses to agency provider nurses. **(Reference APA WF # 08-22)**

G. Revising rules to require the use of the new Interactive Voice Response Authentication (IVRA) time and attendance system for providers of Personal Care and certain in-home Advantage services. **(Reference APA WF # 08-29 A & B)**

H. Revising Non-Emergency Transportation rules to remove specific reimbursement language from policy and refer to the state plan. **(Reference APA WF # 08-49)**

I. Revising Dentist rules to add the American Dental Association's version of current dental terminology (CDT) in order to communicate information related to codes and procedures for administration. **(Reference APA WF # 08-04)**

J. Revising Dental rules to: (1) require a clinical examination preceding any radiographs, and consideration of patient history, prior radiographs, caries risk assessment and dental and general health needs of the patient; (2) allow, with prior authorization, panoramic x-rays more than once every 36 months for the detection and treatment of oral disease; (3)limit reimbursement for the application of ceramic based and cast mental based crowns to natural teeth only; and (4) add clarification that payment for crowns includes all related follow up service for a two year period. **(Reference APA WF # 08-41)**

K. Revising Grievance Procedures and Process rules to reflect current practice for provider appeals. **(Reference APA WF # 08-40)**

L. Revising Insure Oklahoma/O-EPIC rules to expand current Employer Sponsored Insurance and Individual Plan coverage from an employee size of 50 to 250 employees and include coverage for Oklahoma full-time college students age 19 through 22. **(Reference APA WF # 08-55)**

III. Adoption of Permanent Rules as required by the Administrative

Procedures Act.

The following rules HAVE previously been approved by the Board and are pending Gubernatorial approval under Emergency rulemaking.

A. Revising Outpatient Behavioral Health rules to: (1) remove references to billing and documentation details which will now be found in the Behavioral Health Provider Billing Manual; (2) add Multi-Systemic Therapy as a service option; and (3) update terminology. **(Reference APA WF # 08-50)**

IV. Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE NOT previously been reviewed by the Board.

A. Revising SoonerCare eligibility rules to: (1) remove an incorrect procedure for legal action that was added to ABD long term care policy effective August 2007; (2) clarify how loans and transfers of property can possible affect the member's eligibility for long term care; (3) clarify Workers' Compensation Medicare Set Aside Arrangements are not considered resources; (4) clarify transfer or disposal of capital resources for ABD individuals are not applicable unless the individual enters a nursing home or receives waiver services; and (5) remove incorrect language that references AFDC and spend down. **(Reference APA WF # 08-23)**

B. Revising rules to clarify that additional reimbursement is not allowed for joint injection codes that have a global coverage designation. **(Reference APA WF # 08-13)**

C. Revising eligibility rules to comply with Public Laws 104-204, 108-183, and 106-419 to disregard certain payments made to certain Vietnam and Korean veterans' children with spina bifida and children of women Vietnam veterans who suffer from certain birth defects. **(Reference APA WF # 08-25)**

D. Revising eligibility rules for individuals receiving pregnancy related benefits under Title XXI (Soon to be Sooners program) regarding the issuance of computer generated notices. **(Reference APA WF # 08-21)**

E. Revising rules to update sections referencing an incorrect citation regarding a health care provider's obligation to

report suspected child abuse and/or neglect discovered through screenings and regular examinations. **(Reference APA WF # 08-54)**

F. Revising rules to update the premium assistance program name from O-EPIC to Insure Oklahoma/O-EPIC. Several current business processes within the Insure Oklahoma/o-EPIC program are also updated. The premium assistance program's name changes to Insure Oklahoma/O-EPIC to coincide with an extensive statewide marketing campaign. **(Reference APA WF # 08-56)**

G. Revising rules to allow the Oklahoma Health Care Authority to accept cash medical support payments by non-custodial parents if there is no access to health insurance for their child at a reasonable cost (5% or less of the non-custodial parent's income). The administration and collection of the payments will be handled by the Oklahoma Department of Human Services, Child Support Enforcement Division. **(Reference APA WF # 08-51)**

H. Revising agency rules in order to remove provider eligibility requirements for psychologists from the coverage section of the psychologist rules. Revisions also update terminology and bring rules in to line with current OHCA practices. **(Reference APA WF # 08-53)**

I. Revising DDSD rules to: (1) provide clarification relating to service utilization, provisions, authorizations, limitations, and eligibility requirements; (2) specify provider requirements and related activities of targeted case management to meet federal requirements; (3) clarify provider responsibilities and limitations in the agency companion program; (4) specify devices and services allowable through assistive technology; (5) clarify physical plant expectations for services provided in center-based settings; and (6) amend policy to reflect appropriate terminology. **(Reference APA WF # A, B, & C)**

I. **Items subject to the Administrative Procedures Act (Emergency).**

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-761. [AMENDED]
OAC 317:30-5-763. through 317:30-5-764. [AMENDED]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-1. [AMENDED]
OAC 317:35-17-11. [AMENDED]
(Reference APA WF # 09-06 A & B)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow reimbursement for Assisted Living services for SoonerCare member who are eligible for the ADvantage Waiver program. By expanding the ADvantage program to include Assisted Living services, some SoonerCare members will be able to remain in a more homelike environment rather than having to be institutionalized in a nursing facility. ADvantage program services provided in an assisted living center will be less costly than institutional care and are anticipated to result in savings to the Oklahoma Health Care Authority in the form of reduced expenditures for nursing facility services.

SUMMARY: ADvantage Program Waiver Services rules are revised to add Assisted Living services as a compensable service under the ADvantage Waiver program. Assisted Living services are personal care and supportive services that are furnished to ADvantage members who reside in an ADvantage-certified assisted living center. Services include 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. ADvantage reimbursement for Assisted Living Services includes personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and

exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan. Provider standards regarding physical environment, sanitation, health and safety, staff to resident ratios, staff training and qualifications, staff supervision, residents' rights, incident reporting, and provision of or arrangement for necessary health services are included. Three per diem reimbursement rate levels based on different levels of the member's need for service are established. ADvantage members who reside in an ADvantage Assisted Living Services Center have a personal needs allowance set at 150% of the SSI Federal Benefit Rate; the member will be responsible for room and board costs which will not exceed 90% of the SSI Federal Benefit Rate. Rule revisions are needed to allow for reimbursement of Assisted Living services under the ADvantage Waiver program.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

RULE LENGTH IMPACT: These revisions will have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 17, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: May 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.180

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
ADvantage Program Waiver Services rules are revised to add Assisted Living services as a compensable service under the ADvantage Waiver program.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ~~Administrative Agent~~ ADvantage Administration (AA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process ~~shall verify~~ verifies that the provider meets licensure, certification and training standards as specified in the waiver document and agrees to ADvantage Program Conditions of Participation. Providers must obtain programmatic certification to be ADvantage Program certified.

(2) The provider financial certification process ~~shall verify~~ verifies that the provider uses sound business management practices and has a financially stable business. All providers, except for NF Respite, Medical Equipment and Supplies, and Environmental Modification providers, must obtain financial certification to be ADvantage Program certified.

(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, ~~the AA reevaluates~~ provider financial certification is reevaluated annually.

(5) The ~~AA relies upon the~~ Oklahoma Department of Human Services (OKDHS)/Aging Services Division (ASD) ~~for ongoing programmatic evaluation of~~ evaluates Adult Day Care and Home Delivered Meal providers for ~~continued programmatic certification~~ compliance with ADvantage programmatic certification requirements. For Assisted Living Services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of Health/Protective Health Services for review and verification of provider compliance with ADvantage standards for Assisted Living Services providers. Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite services do not have a programmatic evaluation after the initial certification.

(6) OKDHS/ASD may authorize a legally responsible spouse or legal guardian of an adult member to be ~~Medicaid~~ SoonerCare reimbursed under the 1915(c) ADvantage Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than 40 hours of services in a seven day period;

(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;

(iii) maintain and submit time sheets and other required

documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual ~~recipient~~ member; and

(ii) face-to-face visits with the ~~recipient~~ member by the Case Manager on at least a semi annual basis.

(7) The ~~AA or~~ OKDHS Aging Service Division (OKDHS/ASD) periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), ~~Comprehensive Home Care~~ Assisted Living Services, and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~AA and~~ OKDHS/ASD, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the

member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in Oklahoma Department of Human Services/Aging Services Division (OKDHS/ASD) identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties

population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in

adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent. All services must be prior authorized.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are

maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced

supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreementto provide the nurse assessment identified in the Medicaid in-home care services

for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services,

based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or

maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services**.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care

services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

(14) **ADvantage Personal Care.**

(A) ADvantage Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency.

The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

(16) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

(i) recruits, hires and, as necessary, discharges the PSA or APSA;
(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;
(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
(iv) supervises and documents employee work time; and,
(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:
(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
(ii) assistance with routine bodily functions that may include:
(I) bathing and personal hygiene;
(II) dressing and grooming;
(III) eating including meal preparation and cleanup;
(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services

Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

(ii) remove external catheters, inspect skin and reapplication of same;

(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;

(iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(v) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(17) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management

Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the OKDHS/ASD to bill for services provided.

(18) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for

arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living

center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

(I) Provide an emergency call system for each participating ADvantage member;

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

(vii) If the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs;

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

(IV) The member fails to pay room and board charges and/or the OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC;

and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.

(VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

(VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

(IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(X) The ALC must provide appropriately monitored outdoor space for resident use.

(ii) Sanitation

(I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety

(I) The ALC must provide building security that protects residents from intruders with security measures appropriate to building design, environment risk factors and the resident population.

(II) The ALC must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.

(III) The ALC must have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health.

(IV) The ALC must adopt policies for prevention of abuse, neglect and exploitation that include screening,

training, prevention, investigation, protection during investigation and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of resident to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure that staff are trained to respond appropriately to emergencies.

(VII) The ALC staff must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for residents.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals;

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social/recreational outings.

(iv) Staff to resident ratios

(I) The ALC must ensure that a sufficient number of trained staff be on duty, awake, and present at all times, 24 hours a day, seven days a week, to meet the needs of residents and to carry out all the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other natural disasters.

(II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

(III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must

receive four additional hours of dementia specific training. Annual first aid and CPR certification do not count towards the four hours of annual training.

(vi) Staff supervision

(I) The ALC must ensure delegation of tasks to non-licensed staff must be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the member's health and nutritional status.

(vii) Resident rights

(I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's

ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

(V) The preliminary incident report must at the minimum include who, what, when and where and the measures taken to protect the resident(s) during the investigation. The follow-up report must at the minimum include preliminary information, the extent of the injury or damage, if any, and preliminary findings of the investigation. The final report at the minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings; and corrective measures to prevent future occurrences. If necessary to omit items, the final report must include why items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service

for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

317:30-5-764. Reimbursement

(a) Rates for waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for routine level of care nursing facility services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) The individual Budget Allocation (IBA) expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the OKDHS/ASD during the CD-PASS service eligibility determination process. The OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and

not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The OKDHS/ASD, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ADL/IADL and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 of the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 of the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 of the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an Assisted Living Center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day care or environmental modifications to a member while receiving

Assisted Living Services since these services are integral to and inherent in the provision of Assisted Living Service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage Assisted Living. Separate payment is not made for ADvantage respite to a member while receiving Assisted Living Services since by definition Assisted Living Services assume the responsibility for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage Assisted Living Services provider is allowed to charge a maximum for room and board that is no more than 90% of the SSI Federal Benefit Rate. If in accordance with OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(b) The OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

(c) Service time for Personal Care, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to SURS for follow-up investigation.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid service eligibility

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

(1) care in a nursing facility (refer to OAC 317:35-19);
(2) care in a public or private intermediate care facility for the mentally retarded (refer to OAC 317:35-9);
(3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);
(4) Home and Community Based Services Waivers for the Mentally Retarded (refer to OAC 317:35-9);
(5) Personal Care services (refer to OAC 317:35-15); and
(6) the Home and Community Based Services Waiver for frail elderly, a targeted group of adults with physical disabilities age 21 and over who do not have mental retardation or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for ~~Medicaid~~ SoonerCare coverage of long-term care, the individual is also eligible for other ~~Medicaid~~ SoonerCare services. ~~Another application or spenddown computation is not required.~~ ADvantage Waiver ~~recipients~~ members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 150% of the federal benefit rate is available to defray the cost of the Assisted Living services received. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor pay obligation is met. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. ~~Another application for QMBP or SLMB benefits is not required.~~ An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted Living services.

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion

to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. D.

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of

ADvantage program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. D.

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is ~~no~~ not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program**. When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both

spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving ADvantage program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to

apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS ~~Appendix C-1~~ form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, ~~There~~ there is not a spenddown calculation ~~for individuals receiving ADvantage program services~~ as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, after allowable deeming to the community spouse, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of

each month in which services have been received until the vendor payment obligation is met.

(D) **Excess resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

II. Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency rulemaking.

A. CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

RULEMAKING ACTION:

PERMANENT rulemaking

RULES:

Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 3. Application Procedures
OAC 317:35-9-26. [AMENDED]
Subchapter 19. Nursing Facility Services
OAC 317:35-19-6. [AMENDED]
(Reference APA WF # 08-33)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 C.F.R. Section 435.902; 42 C.F.R. Section 435.930

DATES:

Adoption:
November 13, 2008

SUMMARY:

Agency rules are revised to allow individuals to apply for SoonerCare compensable nursing home and ICF/MR services at the OKDHS human services center of their choice. Current eligibility rules require individuals to apply at the local office in the county where the individual lives. Federal regulation 42 C.F.R. Section

435.902 requires eligibility to be determined in a manner that is consistent with simplicity of administration and the best interests of the applicant. Additionally, 42 C.F.R. Section 435.930 requires agencies to furnish Medicaid promptly to members without delay caused by the agency's administrative procedures. Allowing individuals to apply at the OKDHS human services center of their choice will help eliminate a barrier and serve the best interests of the individuals desiring to apply for and who qualify for SoonerCare services.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 3. APPLICATION PROCEDURES

317:35-9-26. Application procedures for private ICF/MR

~~A request for payment for private ICF/MR is made to the local office in the county where the applicant lives.~~ Individuals may apply for private ICF/MR at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. The ~~DHS~~ OKDHS Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice form ~~(ABCDM-83)~~ 08MA083E, when received in the ~~county office~~ HSC, also constitutes an application request and is handled the same as an oral request. The local ~~county office~~ HSC will send the ICF/MR ~~DHS~~ OKDHS form ~~ABDCM-37D~~ 08MA038E~~, Notice to Nursing Care Facility or LTCA,~~ within three working days of receipt of ~~DHS~~ OKDHS forms ~~ABCDM-83~~ 08MA083E and ~~ABCDM-96~~ 08MA084E, Management of Recipient's Funds, indicating actions that are needed or have been taken regarding the ~~client~~ member.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-6. Application procedures for NF

~~A request for payment for NF is made to the local office in the county where the applicant lives.~~ Individuals may apply for nursing home care at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. For NF, ~~DHS~~ OKDHS Form ~~ABCDM-83~~ 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or

Hospice form, when received in the ~~county office~~ HSC, also constitutes an application request and is handled the same as an oral request.

B. **CHAPTER 45. INSURE OKLAHOMA/ OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 3. Insure Oklahoma/O-EPIC IP Member Health Care Benefits
OAC 317:45-11-10. through 317:45-11-11. [AMENDED]
(Reference APA WF # 08-35)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1010.1 et seq. of Title 56 of Oklahoma Statutes

DATES:

Adoption:
November 13, 2008

SUMMARY:

Rules are revised to expand the Insure Oklahoma/O-EPIC IP benefits package to include physical therapy, occupational therapy and speech therapy in an outpatient hospital setting and outpatient behavioral health services provided by an individual LBHP. Currently, adult therapies is not offered as a covered service under the IP program. The added adult therapies benefit will only be compensable when provided in an outpatient hospital setting. This addition to the IP program is consistent with current benefit offerings within many private insurance plans. Without this added benefit, IP members will continue to be unable to have coverage for adult therapies that may be recommended as medically necessary. Following an injury or illness, the provision of adult therapies can help individuals more quickly and safely return to full working function and prevent further injury from occurring. Outpatient behavioral health services are currently offered under the IP program but only at mental health centers. The addition of outpatient behavioral health services by individual LBHPs is consistent will current benefit offerings within many private insurance plans. By allowing outpatient behavioral health services provided by individual LBHPs, IP members in rural parts of Oklahoma

will be better able to access behavioral health services as currently there are limited resources in rural areas.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

SUBCHAPTER 11. Insure Oklahoma/O-EPIC IP

PART 3. Insure Oklahoma/O-EPIC IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma/O-EPIC IP benefits

(a) All ~~O-EPIC~~ IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP benefits described in this Section are subject to specific non-covered services listed in OAC 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in OAC 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) ~~O-EPIC~~ IP covered benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-

pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.
(9) Outpatient Hospital/Facility Services.
(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.
(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.
(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.
(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.
(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; $0 co-pay.
(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; $0 co-pay.
(13) Immunizations ~~for Adults~~. Covered in accordance with OAC 317:30-5-2~~; $10 co-pay per immunization~~.
(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.
(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.
(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.
(17) ~~Mental~~ Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; $50 co-pay per admission.
(18) ~~Mental~~ Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). ~~Covered in accordance with OAC~~

~~317:30-5-241; $10 co-pay per visit.~~

(A) Agency services. Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Mental Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 '1353(4) and (5), 59 '1903(C) and (D), 59 '1925.3(B) and (C), and 59 '1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month and 8 testing units per year; $10 co-pay per visit.

~~(19) Substance Abuse Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.~~

~~(20)~~ (19) Durable Medical Equipment and Supplies. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual

maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.
~~(21)~~ (20) Diabetic Supplies. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.
~~(22)~~ (21) Oxygen. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.
~~(23)~~ (22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.
~~(24)~~ (23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with ~~OAC 317:30-5-77.2~~ OAC 317:30-5-72.1; $5/$10 co-pay per product.
~~(25)~~ (24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; $10 co-pay per visit.
~~(26)~~ (25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.13; $25 co-pay per prosthesis.
~~(27)~~ (26) Surgery. Covered in accordance with OAC 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
~~(28)~~ (27) Home Dialysis. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
~~(29)~~ (28) Parenteral Therapy. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
~~(30)~~ (29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; $0 co-pay.
~~(31)~~ (30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with ~~OAC 317:30-5-211(a)(3)(D)(i) and 317:30-5-41(2)(J)(iii)~~ OAC 317:30-5-211.15 and 317:30-5-42.16(b)(3).
~~(32)~~ (31) Ultraviolet Treatment-Actinotherapy.
~~(33)~~ (32) Fundus photography.
~~(34)~~ (33) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; $0 co-pay.

317:45-11-11. Insure Oklahoma/O-EPIC IP non-covered services

Certain health care services are not covered in the Insure Oklahoma/O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services that the member's PCP or Insure Oklahoma/O-EPIC does not consider medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) treatment of obesity;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including ~~speech, physical, occupational,~~ chiropractic, acupuncture and osteopathic manipulation therapy;
(13) hearing services;
(14) transportation [emergent or non-emergent (air or ground)];
(15) rehabilitation (inpatient);
(16) cardiac rehabilitation;
(17) allergy testing and treatment;
(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
(19) hospice regardless of location;
(20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(21) genetic counseling;
(22) fertility evaluation/treatment/and services;
(23) sterilization reversal;
(24) Christian Science Nurse;
(25) Christian Science Practitioner;
(26) skilled nursing facility;
(27) ~~longterm~~ long-term care;
(28) stand by services;
(29) thermograms;
(30) abortions (for exceptions, refer to OAC 317:30-5-6);
(31) services of a Lactation Consultant;
(32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
(33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

C. **CHAPTER 25. SOONERCARE CHOICE**
RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 7. SoonerCare
Part 1. General Provisions
OAC 317:25-7-1. through 317:25-7-2. [AMENDED]
OAC 317:25-7-3. [AMENDED]
OAC 317:25-7-5. through 317:25-7-6. [AMENDED]
Part 3. Enrollment Criteria
OAC 317:25-7-10. [AMENDED]
OAC 317:25-7-12. through 317:25-7-13. [AMENDED]
Part 5. Enrollment Process
OAC 317:25-7-25. through 317:25-7-28. [AMENDED]
Part 7. Coordination and Continuity of Care
OAC 317:25-7-29. through 317:25-7-30. [AMENDED]
Part 9. Reimbursement
OAC 317:25-7-40. [NEW]
(Reference APA WF # 08-19)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

DATES:

Adoption:
November 13, 2008

SUMMARY:

SoonerCare rules are revised to incorporate the patient-centered medical home model of care in which providers are paid a monthly care coordination payment in addition to reimbursement for SoonerCare compensable services at the fee-for-service rate. The medical home model provides a partnership between a patient and a personal physician built around preventive and primary care. Currently, primary care providers (PCPs) in the SoonerCare Choice program are paid a capitated rate per member per month. This monthly fee assures the delivery of medically necessary primary care services and any non-capitated services are reimbursed at the traditional fee-for-service rate. After reviewing claims data, OHCA determined that an improvement to the current payment methodology would include the removal of the base capitation rate, reimbursement of all services based on OHCA's fee-for-service rate, and a monthly care coordination payment to the member's PCP. The care coordination payment would vary based on the scope of services provided by the PCP. Currently, SoonerCare Choice members select or are aligned with a primary care provider (PCP). Beginning January 1, 2009, PCPs will be responsible for serving as the medical

home for enrolled members. Building on the success of the existing network, the OHCA believes this transition will help ensure that members get the right care at the right time from the right provider. OHCA intends to make this transition seamless to SoonerCare Choice members. SoonerCare rules are also amended to: (1) require provider or physician groups to designate a medical director to serve as primary contact with OHCA; (2) include a section on provider networks; and (3) include language regarding the development of a payment for excellence program. Without this transition, SoonerCare Choice members would be directly impacted by not allowing them the coordination of preventive and primary care services at the level promoted by the patient centered medical home model that is widely endorsed by primary care physicians' professional groups.

SUBCHAPTER 7. SOONERCARE
PART 1. GENERAL PROVISIONS

317:25-7-1. Purpose

The purpose of this Subchapter is to describe the rules governing the statewide SoonerCare program. The rules provide assurances that ~~Medicaid clients~~ SoonerCare members have adequate access to primary care, while reducing costs and preventing unnecessary and inappropriate utilization.

317:25-7-2. SoonerCare Choice: overview

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible members. ~~The program enrolls SoonerCare Choice members with Primary Care Provider/Case Managers PCP/CMs who provide and/or authorize all primary care services and all necessary specialty services, with the exception of services described in subsection (c) of this Section for which authorization is not required.~~ PCCM is a managed care model in which each enrollee has a medical home with a primary care provider (PCP). Enrollees may select their own primary care provider or clinic as their PCP if that provider is enrolled with OHCA as a PCP and as a SoonerCare provider. For those who do not choose a PCP, they will be assigned to one. Members may change PCPs at any time.

(b) ~~In exchange for a fixed, periodic rate, which~~ The PCP is paid a monthly care coordination payment in accordance with the conditions in the PCP's SoonerCare Choice contract ~~per member per month, the Primary Care Provider/Case Manager (PCP/CM)~~ to ~~provides,~~ provide or otherwise ~~assures~~ assure the delivery of medically-necessary preventive and primary care medical services, including securing

referrals for specialty services and prior authorizations for an enrolled group of eligible members, with the exception of services described in subsection (c) of this Section for which authorization is not required. The ~~PCP/CM~~ PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.
(c) Services which do not require a referral from the ~~PCP/CM~~ PCP include preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health agency services, vision ~~for refraction~~ services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, emergency physician and hospital services, disease management services, and services delivered to Native Americans at IHS, tribal, or urban Indian clinics. Female members may access a SoonerCare women's health specialist without a referral for covered routine and ~~preventative~~ preventive health care services. This is in addition to the enrollee's ~~PCP/CM~~ PCP if that source is not a woman's health specialist.
(d) ~~Non-capitated~~ SoonerCare Choice covered services delivered by the ~~PCP/CM~~ PCP are reimbursed at the SoonerCare ~~Traditional fee-for-service~~ fee schedule rate under the procedure code established for each individual service. To the extent services are provided or authorized by the Primary Care ~~Provider/Case Manager~~ Provider, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program, thus a referral by the ~~Primary Care Provider/Case Manager~~ PCP does not guarantee payment.
(e) The PCP may charge a co-payment for services provided to SoonerCare members in accordance with OAC 317:30-3-5(d).
(f) Members with chronic conditions may elect to enroll in a health management program to improve their health.
(g) PCPs may elect to participate in Health Access Networks to improve access to care.

317:25-7-3. Definitions

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

"Aged, Blind and Disabled" means the Medicaid covered populations under 42 U.S.C., Section 1396a (a)(10)(A)(i) and (F).

"Board" means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

"CEO" means the Chief Executive Officer of the Oklahoma Health Care Authority.

"Custody" means the custodial status, as reported by the

Oklahoma Department of Human Services.

"Medicaid" means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

"Medicare" means the program defined at 42 U.S.C. '1395 et seq.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCCM" means Primary Care Case Management.

"~~PCP/CM~~ PCP" means Primary Care ~~Provider/Case Manager~~ Provider, including a Provider or Physician Group.

"Primary Care Case Management" means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care ~~Provider/Case Managers~~ Providers.

"Primary Care ~~Provider/Case Manager~~ Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations.

"Provider or Physician Group" means a partnership, limited partnership, limited liability company, corporation or professional corporation composed of doctors of medicine and/or doctors of osteopathy and/or advanced ~~nurse practitioner~~ practice nurses, and/or physician assistants who provide health care of the nature provided by independent practitioners and ~~is~~ are permitted by state and federal law and regulations to receive ~~Medicaid~~ SoonerCare provider payments.

"SoonerCare" means the Medicaid program administered by the Oklahoma Health Care Authority.

"SoonerCare Choice" means a comprehensive medical benefit plan featuring a medical home including a Primary Care Provider for each member.

317:25-7-5. Primary care ~~provider/case managers~~ providers

For provision of health care services, the OHCA contracts with qualified Primary Care ~~Provider/Case Managers~~ Providers. All providers serving as ~~PCP/CMs~~ PCPs must have a valid ~~Medicaid Fee-for Service~~ SoonerCare Fee-for-Service contract as well as ~~a~~ an exercised SoonerCare Choice ~~contract~~ addendum. Additionally, all ~~PCP/CMs~~ PCPs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee ~~PCP/CMs~~ PCPs a minimum patient volume. Primary Care ~~Provider/Case Managers~~ Providers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a ~~PCP/CM~~ PCP. ~~In~~

~~addition, physicians who meet all requirements for employment by the Federal Government as a physician, are employed by the Federal Government in an IHS facility, and practice in one of the four designated primary care specialties may serve as a PCP/CM.~~ The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as ~~PCP/CMs~~ PCPs who are licensed to practice medicine in the state in which they ~~practices~~ practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to ~~Medicaid clients~~ SoonerCare members, and the physician's medical education and training.

(A) For physicians serving as SoonerCare Choice ~~PCP/CMs~~ PCPs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one FTE. Thus, the physician cannot exceed a maximum total capacity of 2500 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for ~~PCP/CM~~ PCP services. Out-of-State ~~PCP/CMs~~ PCPs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as ~~PCP/CMs~~ PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. ~~Additionally, Advanced Practice Nurses who meet all requirements for employment by the Federal Government as an advanced practice nurse, and is employed by the Federal Government in an Indian Health Service facility, may serve as a PCP/CM.~~ Advanced Practice Nurses who have prescriptive authority may serve as ~~primary care case managers~~ PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as ~~PCP/CMs~~ PCPs if licensed to practice in the state in which he or she practices. ~~Additionally, Physician Assistants who meet all requirements for employment by the Federal Government as a Physician Assistant, and are employed by the Federal Government~~

~~in an Indian Health Service facility, may serve as a PCP/CM.~~ Physician Assistants may serve as ~~primary care case managers~~ PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(4) **Medical Residents.**

(A) Medical residents may serve as ~~PCP/CMs~~ PCPs when the following conditions are met:

(i) The resident is licensed to practice in the state in which he or she practices.

(ii) The resident is at least at the Post-Graduate 2 (PG-2) level.

(iii) The resident serves as a ~~PCP/CM~~ PCP only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the ~~PCP/CM~~ PCP within the Family Practice Residency clinic setting).

(iv) The resident works under the supervision of a licensed attending physician.

(v) The resident specifies the residency program or clinic to which payment will be made.

(B) Medical residents practicing as a ~~PCP/CM~~ PCP may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.

(5) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups.**

(A) Indian Health Service facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) Federally Qualified Health Centers whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

~~(5)~~ (6) **Provider or physician group capacity and enrollment**.

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per ~~provider~~ physician participating in the provider group.

(B) If licensed physician assistants or advanced practice nurses are members of a group, the capacity may be increased by 1,250 members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

317:25-7-6. Primary Care ~~Provider/Case Manager~~ Provider ~~Payment to Subcontractors~~ responsibilities

(a) Under the provisions of the SoonerCare Choice Contract, the contractor is responsible for providing ~~all capitated services contained in the benefit package~~ care coordination services for all

enrolled members on his/her panel. ~~In the event that the PCP/CM orders a capitated service, the PCP/CM is responsible to make timely payment to the subcontractor or other provider.~~

(b) ~~For purposes of subsection (a) of this Section timely payment or adjudication means payment or denial of a claim within 30 days of presentation to the PCP/CM.~~ PCPs must provide access to medical care twenty-four hours per day, seven days a week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.

~~(c) No subcontractor of the PCP/CM may charge more than the Medicaid fee-for-service schedule for these services in the benefit package. The subcontractor may not bill the recipient for the services to the SoonerCare recipient until the PCP/CM has refused payment and the subcontractor/medical provider has appealed under OAC 317:2-1-2.1 and the OHCA permits the subcontractor to bill the recipient.~~

PART 3. ENROLLMENT CRITERIA

317:25-7-10. Enrollment with a Primary Care ~~Provider/Case Manager~~ Provider

(a) All SoonerCare Choice members described in OAC 317:25-7-12 ~~are enrolled~~ may enroll with a ~~PCP/CM~~ PCP. SoonerCare Choice applicants have the opportunity to select a ~~PCP/CM~~ PCP during the application process. Enrollment with a PCP may begin any day of the month. ~~Enrollment with a PCP/CM for members determined to be eligible on or before the fifteenth day of the month are effective on the first day of the following month. Enrollment with a PCP/CM for members determined to be eligible after the fifteenth day of the month are effective on the first day of the second month following determination.~~

(1) The OHCA offers all members the opportunity to choose a ~~PCP/CM~~ PCP from a directory which lists available ~~PCP/CMs~~ PCPs.

(2) ~~If a SoonerCare Choice member moves more than the authorized distance/driving time from their current PCP/CM, that member will be disenrolled and assigned to an appropriate PCP/CM.~~ When a notice of ~~PCP/CM assignment~~ PCP enrollment is sent to a member, the member is advised of the right to change the ~~PCP/CM,~~ PCP at any time~~, or after the effective date of enrollment with the PCP/CM pursuant to OAC 317:25-7-27~~.

(b) Members ~~are restricted to~~ may receive services from the ~~PCP/CM~~ PCP or from a provider to which the member has been referred by the ~~PCP/CM~~ PCP. Notwithstanding this provision, subject to limitations which may be placed on services by the OHCA, members may self refer for preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health agency services, vision ~~for refraction~~ services for children, dental services, child abuse/sexual abuse examinations, prenatal and

obstetrical services, family planning services, services delivered to Native Americans at IHS, tribal, or urban Indian clinics, and emergency physician and hospital services.

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible ~~***SoonerCare***~~ SoonerCare ~~***Choice***~~ members mandatorily enrolled in SoonerCare Choice include ~~Medicaid eligible~~ persons ~~or persons categorized~~ categorically related to AFDC, Pregnancy-related services and ~~as~~ Aged, Blind or Disabled who are not dually-eligible for ~~Medicaid~~ SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.

(2) Individuals privately enrolled in an HMO.

(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services~~, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a)~~.

(4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.

(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.

(6) Non-qualified or ineligible aliens.

(7) Children in subsidized adoptions.

(8) Individuals who are dually-eligible for ~~Medicaid~~ SoonerCare and Medicare.

(9) Individuals who are in an Institution for Mental Disease (IMD).

PART 5. ENROLLMENT PROCESS

317:25-7-25. ~~Recipient~~ Member enrollment process

(a) ~~Medicaid~~ SoonerCare eligible individuals ~~residing in any of the areas defined in OAC 317:25-7-11~~ whose eligibility is based on one of the aid categories included in the program as defined in OAC 317:25-7-12 must enroll with a ~~PCP/CM~~ PCP. Parents or guardians will choose on behalf of minor ~~clients~~ members in the household. Families with more than one ~~beneficiary~~ enrollee may choose a

different ~~PCP/CM~~ PCP for each family member. ~~If a beneficiary does not select a PCP/CM, the OHCA will assign the member to one, from the pool of providers within the established distance/driving time who have available capacity.~~

(b) Until the effective date of enrollment with a ~~PCP/CM~~ PCP, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a ~~PCP/CM~~ PCP ~~or are assigned to a PCP/CM~~ who is in general practice, family practice or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change the ~~PCP/CM~~ PCP after the effective date of enrollment.

(c) A description of the PCCM program and the ~~PCP/CM~~ PCP directory is provided by the OHCA to OKDHS for distribution to OKDHS county offices.

(d) For purposes of determining the ~~client's~~ member's choice of ~~PCP/CM~~ PCP, the most recent ~~PCP/CM~~ PCP selection received by the OHCA determines the ~~PCP/CM~~ PCP which the ~~client~~ member is enrolled with as long as capacity is available. If capacity is not available ~~then~~ or the member does not choose, the ~~client~~ member is assigned according to the assignment mechanism as defined by the OHCA. A member who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline.

(e) ~~PCP/CMs~~ PCPs may not refuse an assignment, seek to disenroll a ~~client~~ member, or otherwise discriminate against a ~~client~~ member on the basis of age, sex, race, physical or mental disability, national origin or type of illness or condition, unless that condition can be better treated by another provider type, except that IHS, tribal or urban Indian programs may provide services to Native American IHS ~~beneficiaries~~ members consistent with federal law.

~~(f) PCP/CMs must provide access to medical care twenty-four hours per day, seven days per week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.~~

~~(g) Until PCP/CM enrollment is effective, Medicaid eligible individuals receive all services on a fee-for-services basis.~~

317:25-7-26. Automatic re-enrollment

~~Medicaid recipients who are not in the six-month period of guaranteed eligibility~~ SoonerCare members who become disenrolled from a ~~PCP/CM~~ PCP solely by virtue of becoming temporarily (for ~~180~~ 365 days or less) ineligible for ~~Medicaid~~ SoonerCare services, are automatically re-enrolled with their previously-selected ~~PCP/CM~~ PCP, subject to capacity. The ~~client~~ member is notified of the automatic re-enrollment and any right to disenroll from that ~~PCP/CM~~ PCP.

317:25-7-27. Changing ~~PCP/CMs~~ PCPs

(a) The OHCA ~~shall be~~ is responsible for changing a member's enrollment from one ~~PCP/CM~~ PCP to another:

(1) without cause ~~up to 4 times per year,~~ upon the member's request; or

(2) upon demonstration of good cause. For purposes of this paragraph, ~~Good~~ good cause ~~shall mean~~ means:

(A) those members who are habitually non-compliant with the documented medical directions of the provider; or

(B) those members who pose a threat to employees, or other patients of the ~~PCP/CM~~ PCP; or

(C) as a result of a grievance determination by the OHCA; or

(D) in those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or

(E) the member's illness or condition would be better treated by another type of provider~~.~~; or

(3) when the state imposes an intermediate sanction.

(b) A written request by the ~~PCP/CM~~ PCP to change the enrollment of a member ~~shall be~~ is acted upon by the OHCA within ~~thirty (30)~~ days of its receipt. The decision to change ~~PCP/CMs~~ PCPs for cause ~~will be~~ is made at the discretion of the OHCA, subject to appeals policies delineated at OAC 317:2-1. The effective date of change ~~shall be~~ is set so as to avoid the issue of abandonment.

(c) In the event a SoonerCare ~~PCP/CM~~ PCP contract is terminated by OHCA for any reason, or the ~~PCP/CM~~ PCP terminates participation in the SoonerCare program the CEO may, at his or her discretion, assign members to a participating ~~PCP/CM~~ PCP when it is determined to be in the best interests of the ~~client~~ member whose ~~PCP/CM~~ PCP has terminated.

317:25-7-28. Disenrolling a ~~client~~ member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

(1) the member is no longer eligible for ~~Medicaid~~ SoonerCare services; ~~or~~

(2) the member has been incarcerated; ~~or~~

(3) the member dies; ~~or~~

(4) disenrollment is determined to be necessary by the OHCA; ~~or~~

(5) the status of the member changes, rendering him/her ineligible for SoonerCare; ~~or~~

(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services; ~~or~~

(7) the member is authorized to receive services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver; or

(8) the member becomes dually-eligible for ~~Medicaid~~ SoonerCare ~~or~~ and Medicare.

(b) The OHCA may disenroll the member at any time if the ~~client~~ member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the ~~PCP/CM~~ PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;

(B) is habitually non-compliant with the documented medical directions of the PCP; or

(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:

(A) documentation of the difficulty encountered with the member including the nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or

(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

PART 7. COORDINATION AND CONTINUITY OF CARE

317:25-7-29. ~~Plan benefit package~~ Screening, diagnosis and

preventive benefits

(a) The ~~PCP/CM~~ PCP is responsible for coordinating or delivering preventive and primary care ~~and case management~~ services ~~defined in a benefit package developed by the OHCA~~ which are medically necessary to all ~~Medicaid beneficiaries~~ SoonerCare members enrolled with him/her ~~and is reimbursed for these services on a per-member-per-month pre-determined capitated rate~~. ~~The PCP/CM benefit package will be determined by the Medical Director, with the approval of the CEO, and will be included with the PCP/CM contract~~.

~~(b) Services which are not included in the PCP/CM capitated rates will be reimbursed at a fee-for-service rate under the procedure code established for each individual service.~~

~~(c)~~ (b) School and health department clinics may conduct EPSDT screening examinations on children who have not been screened by their ~~PCP/CM~~ PCP pursuant to the EPSDT periodicity schedule. If it is ascertained that a child is not current, the school or health department clinic must first contact the ~~PCP/CM~~ PCP and attempt to set up an appointment for the child within three weeks. If the ~~PCP/CM~~ PCP cannot meet this condition, the clinic will be permitted to conduct the screen and bill fee-for-service. ~~The State considers the cost of these screens in the rate setting process.~~

(1) The school or health department clinic must submit a claim for reimbursement, as well as documentation that:

(A) the ~~PCP/CM~~ PCP was contacted and an examination could not be conducted by the ~~PCP/CM~~ PCP within the specified guidelines; and

(B) the ~~PCP/CM~~ PCP has forwarded information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation must be returned to the child's record for verification that ~~PCP/CMs~~ PCPs have first been contacted and that school and health department clinics are providing ~~PCP/CMs~~ PCPs with the information necessary to ensure continuity of care.

(2) The school-based clinic or health department must ~~obtain a referral number from the PCP/CM and~~ conduct the screening examination within ~~3~~ three weeks from the date the determination was made that the ~~PCP/CM~~ PCP could not conduct the exam within the specified guidelines.

~~(d) PCP/CM providers are protected from excessive losses incurred through the provision of services to Medicaid clients with conditions which result in costs to the provider which greatly exceed the average cost of a Medicaid client through a stop-loss mechanism.~~

~~(e) The PCP/CM is prohibited from charging a co-payment for services provided to SoonerCare recipients.~~

~~(f) For capitated services purchased by the PCP/CM from a Medicaid contracted provider, the provider is prohibited from charging the PCP/CM more than the current Medicaid fee-for-service schedule for~~

~~these services, but may charge less.~~
~~(g) The PCP/CM is not obligated to provide emergency services, and is not responsible for authorization or approval for payment for recipients seen in the emergency room. The PCP/CM may not require recipients to seek prior authorization for emergency services. However, the PCP/CM may provide emergency care in an emergency room setting, within his/her legal scope of practice. The PCP/CM may receive reimbursement for Medicaid covered emergency services at the fee-for-service rate.~~

317:25-7-30. Obtaining ~~Medicaid~~ SoonerCare services ~~not covered by the PCP/CM~~

(a) Medical services ~~which are not included as capitated primary care services or~~ which are not the responsibility of the ~~PCP/CM~~ PCP to authorize under the ~~case management~~ care coordination component of SoonerCare, as described in ~~OAC 317:25-7-2(d) and~~ OAC 317:25-7-10(b), are obtained in the same manner as under the regular ~~Medicaid~~ SoonerCare fee-for-service program.

(b) Authorization for out-of-state transportation for primary care and specialty care is determined by the OHCA Medical Director.

(c) An eligible SoonerCare member may choose a ~~PCP/CM~~ PCP from the provider directory, including the IHS, tribal and Urban Indian clinics that participate as SoonerCare ~~PCP/CMs~~ PCPs. The member needs to have the Certified Degree of Indian Blood information in order to enroll. An American Indian member in SoonerCare may enroll with a ~~PCP/CM~~ PCP who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal or urban Indian clinic for medical care. A referral from the ~~PCP/CM~~ PCP is needed for services that the clinic cannot provide, except for self-referred services. ~~Except services delivered through an Indian facility for which the State receives 100% Federal reimbursement, services are reimbursed at the Medicaid fee-for-service rate under the procedure code established for each individual service.~~

(d) If an IHS, tribal or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the ~~client~~ member for the service to a non-IHS, tribal or urban Indian clinic, ~~Medicaid~~ SoonerCare reimbursement is made only when the service is referred by the ~~PCP/CM~~ PCP, unless ~~PCP/CM~~ PCP authorization is not required under ~~OAC 317:25-7-2(d) and~~ OAC 317:25-7-10(b).

~~(e) Capitated services delivered at IHS, tribal, and urban Indian clinics during the preceding year to SoonerCare clients enrolled with non-Indian PCP/CMs are considered during the rate setting process.~~

~~(f) For non-capitated covered Medicaid compensable services provided for individuals enrolled in SoonerCare, reimbursement is made at the Medicaid fee-for-service rate under the procedure code established.~~

(e) The PCP is not obligated to provide emergency services and is

not responsible for authorization or approval for payment for members seen in the emergency room. The PCP may not require members to seek prior authorization for emergency services. However, the PCP may provide emergency care in an emergency setting, within his/her legal scope of practice.
(f) Some outpatient procedures require prior authorization. The PCP is responsible for obtaining a list before an outpatient procedure is done.

PART 9. REIMBURSEMENT

317:25-7-40. SoonerCare Choice reimbursement

(a) **Care coordination component.** Participating PCPs are paid a monthly care coordination payment to assure the delivery of medically-necessary preventive and primary care medical services, including referrals for specialty services for an enrolled group of eligible members. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.
(b) **Visit-based fee-for-service component.** SoonerCare Choice covered services provided by the PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. To the extent services are authorized by the PCP, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program, thus a referral by the PCP does not guarantee payment.
(c) **Incentive program component.** Subject to the availability of funds, OHCA will develop a bonus payment program to encourage coordination of services, to reward improvement in health outcome and promote efficiency.
(d) **SoonerCare networks.** For every PCP who participates in an OHCA approved health care access network, a per-member-per-month payment is established by OHCA and paid to the network.

D. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

RULEMAKING ACTION:
PERMANENT adoption
RULES:
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
OAC 317:35-5-25. [AMENDED]
(Reference APA WF # 08-44)
AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma

Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 6036 of the Deficit Reduction Act of 2005 (P.L. 109-171); Public Law 109-163; Public Law 110-181; Public Law 110-161

DATES:

Adoption:

December 11, 2008

SUMMARY:

SoonerCare eligibility rules regarding citizenship are revised to allow the use of tribal membership cards, Certificate of Degree of Indian Blood cards, and Oklahoma Voter Registration cards to verify citizenship and/or identity. Section 6036 of the Deficit Reduction Act of 2005 required states to obtain satisfactory documentary evidence of citizenship and identity in order to receive federal matching funds. Some SoonerCare members who are United States citizens by virtue of being born in the United States have lost eligibility for benefits and others have been denied benefits as they were unable to furnish a copy of their birth certificate or other documentation as outlined in existing rules. Eligibility rules are revised to include these other types of documents which may be more easily obtainable by the SoonerCare applicant than a birth certificate, particularly if the individual was born in a state other than Oklahoma. Additional revisions clarify that individuals who are classified as permanent non-immigrants includes persons from the Marshall Islands, the Republic of Palau and the Federated States of Micronesia. Citizenship rules are further revised to include Iraqis and Afghans with special immigrant status as qualified aliens. Iraqi and Afghan Special Immigrants are a relatively new category of special immigrants, created by Public Law 109-163. Each Federal fiscal year, a certain number of Iraqis and Afghans and their families who were employed by the U.S. military as translators and meet other requirements, may be granted Iraqi or Afghan Special Immigrant Status under section 101(a)(27) of the Immigration and Nationality Act (INA). Public Law 110-161 allows six months of eligibility for Afghan special immigrants and Public Law 110-181 allows eight months of eligibility for Iraqi special immigrants. All other eligibility requirements must be met in order to qualify for SoonerCare services during this time-limited period. After this time-limited period of eligibility, Iraqi and Afghan special immigrants will lose eligibility for SoonerCare services until they meet the 5-year bar or otherwise meet the citizenship or alien eligibility

criteria.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for Medicaid.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561); ~~or~~

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873)

(Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976; ~~or~~

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for Medicaid. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany

citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided.**

(b) **Centralized Verification Unit.**

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for Medicaid. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the CVU may extend the time frame to a period not to exceed an additional 60 days.

(2) Additional methods of verification are available to the CVU. These methods are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that

indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements**. Medicaid services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of Medicaid services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or

(B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph.

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for Medicaid for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services for a time-

limited period. The time-limited exemption period for Afghan special immigrants is six months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the six month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Iraqi special immigrants are considered lawful permanent residents.

~~(3)~~ (5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

~~(4)~~ (6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract

workers. This group is ineligible for Medicaid, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

~~(5)~~ (7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for Medicaid if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) ~~**Marshall Islanders**~~ **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
OAC 317:30-5-42.14. [AMENDED]
Part 63. Ambulatory Surgical Centers (ASC)
OAC 317:30-5-565. through 30-5-567. [AMENDED]
(Reference APA WF # 08-47)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.20

DATES:

Adoption:
December 11, 2008

SUMMARY:

Agency rules are revised to reflect upcoming changes to the reimbursement methodology for outpatient surgery services. Currently, OHCA does not use the same methodology to process Ambulatory Surgical Center/Ambulatory Payment Classification (ASC/APC) claims as Medicare. OHCA currently pays for outpatient surgery under a "hierarchical" methodology that does not align with any other payer. This current methodology creates an administrative burden for facilities submitting claims and makes it difficult for OHCA to coordinate benefits with other payers. Beginning January 1, 2009, OHCA will no longer process outpatient surgery claims under a "hierarchical" payment methodology. This change in payment methodology will more closely align OHCA's payment methodology with Medicare's, thereby relieving the administrative burden on contracted SoonerCare outpatient surgery providers and facilitating the coordination of benefits between OHCA and other third party payers.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.14. Surgery <u>and diagnostic services</u>

~~(a) **Reimbursement.** Reimbursement is made for selected surgeries performed in an outpatient hospital. When an ambulatory surgery is~~

~~performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.~~

~~(b) **Ambulatory Surgery Center Groups.** The Medicare definition of covered Ambulatory Surgery Center (ASC) facility services includes services furnished on a outpatient basis in connection with a covered surgical procedure. This is a bundled payment that includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients scheduled for surgical procedures. It includes all services and procedures in connection with covered procedures provided by facility personnel and others involved in patient care. These services do not include physician services, or other health services for which payment can be made under other OHCA medical program provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intra ocular lenses (IOLs), anesthetist services, DME). (See OAC 317:30-5-565 for items separately billable.)~~

~~(c)~~ (a) **Ambulatory Patient Classification (APC) Groups.** ~~Certain surgical services filed with revenue code series 36X and 49X and that do not fall within an Ambulatory Patient Classification (ASC) group will pay a SoonerCare rate based on Medicare's APC groups. This is not a bundled rate. Other lines on the claim may pay.~~ All outpatient hospital services paid under the Medicare Outpatient Prospective Payment System (OPPS) are classified into groups called Ambulatory Payment Classifications or APCs. Group services identified by Health Care Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under OPPS. Services in each APC are similar clinically and in terms of the resources they require. The payment rate calculated for an APC applies to all of the services assigned to the APC. Depending on the services provided, a hospital may receive a number of APC payments for the services furnished to a member on a single day.

(b) **Reimbursement.** Reimbursement is made for selected services performed in an outpatient hospital. Hospital outpatient services are paid on a rate-per-service basis that varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned.

~~(d)~~ (c) **Multiple Surgeries.** ~~Multiple surgeries refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries may be discounted.~~ Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment group. Fifty percent is paid for any other surgical procedure(s) performed at the same time if the procedure is subject to

discounting based on the status indicator established by Medicare.
(d) **Status indicators**. Status indicators identify whether the service described by a HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged and if payment is subject to discounting. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.
(e) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.
(f) **Ambulatory Surgery.** When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.
~~(f)~~(g) **Dental Procedures.** ~~Dental services are routinely rendered in the dental office, unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or member. Dental procedures are not covered as Medicare ASC procedures.~~ Routine dental procedures that are normally performed in a dentist's office are not covered in an outpatient hospital setting unless medically necessary as determined by OHCA. For OHCA payment purposes, the ~~ASC~~ APC list has been expanded to cover ~~these~~ dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an outpatient hospital setting is covered under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition which renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an outpatient hospital setting is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances ~~for children or adults who are residents in ICFs/MR~~:

~~(1)~~ (A) A concurrent hazardous medical condition exists;

~~(2)~~ (B) The nature of the procedure requires hospitalization or;

~~(3)~~ (C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

~~(g) **Special Procedures**. Certain procedures rendered in a designated area of a licensed hospital dedicated to specific procedures (i.e, Cardiac Catheterization Lab, etc.) are covered~~

~~and are not paid at a bundled rate. When multiple APC procedures are performed in the same visit, payment will be the rate of the procedure in the highest payment group.~~

PART 63. AMBULATORY SURGICAL CENTERS

317:30-5-565. Eligible providers

~~All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. (1) **Definition of ambulatory surgical center.**~~ An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients~~, and which enters into an agreement with HCFA to do so~~. All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. ~~An ASC may be either independent (i.e., not part of a provider of services or any other facility), or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:~~

~~(A) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;~~

~~(B) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and~~

~~(C) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.~~

~~(2) **Federal requirements.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.~~

317:30-5-566. ~~Outpatient surgery~~ Ambulatory Surgery Center services

(a) ~~The covered facility services are defined as those services furnished by an Ambulatory Surgical Center (ASC) or Outpatient Hospital Facility (OHF) in connection with a covered surgical procedure.~~ **Reimbursement**. Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate

payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

~~(1) **Services included in the facility reimbursement rates are:**~~

~~(A) Nursing, technicians, and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.~~

~~(B) Use by the member of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.~~

~~(C) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures including any drugs and biologicals administered while the member is in the facility. Surgical dressings, other supplies, splints, and casts include only those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the member and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.~~

~~(D) Diagnostic or therapeutic items and services directly related to the surgical procedures. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.~~

~~(E) Administrative, recordkeeping and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.~~

~~(F) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood fractions furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.~~

~~(G) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.~~

~~(2) **Services not included in facility reimbursement rates are:**~~

~~(A) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set global fee for a given surgical procedure.~~

~~(B) The sale, lease or rental of durable medical equipment (DME) to members for use in their homes. If the facility furnishes items of DME to members it should be treated as a DME supplier and this requires a separate contract and separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.~~

~~(C) Prosthetic devices. Non-implantable Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prostheses is intra ocular lenses (IOL's). These should be billed as a separate line item.~~

~~(D) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs. This requires a separate contract and a separate claim form.~~

~~(E) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(F) Artificial legs, arms and eyes. This equipment is not considered part of a facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(G) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.~~

~~(H) Reimbursement - facility services. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, the second and subsequent surgeries may be discounted. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups as adapted for SoonerCare.~~

(b) **Multiple surgeries**. Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators**. Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC.

(e) **Dental Procedures**. For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization or;

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on the Medicare's ~~List of Covered Surgical Procedures~~ list of covered ASC surgical procedures and dental procedures in certain circumstances.

(A) Services, deemed medically necessary and allowable under federal regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(B) Federal regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or

services that the State determines are not safe and effective or which are considered experimental.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's ~~the List of Covered Surgical Procedures~~ list of covered ASC surgical procedures.

(3) **Individuals eligible For Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services.

F. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 15. Personal Care Services
OAC 317:35-15-1. through 317:35-15-10. [AMENDED]
OAC 317:35-15-11. [AMENDED]
OAC 317:35-15-15. [AMENDED]
(Reference APA WF # 08-22)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

DATES:

Adoption:
December 11, 2008

SUMMARY:

Personal Care rules are revised to transfer the responsibilities for the authorization of service units and monitoring of service provisions from the OKDHS nurses to Personal Care agency nurses. Personal Care services are provided to SoonerCare members to help them carry out activities of daily living, such as bathing, grooming, meal preparation, and laundry. Medical need for Personal Care services is determined by the OKDHS nurse using the Uniform Comprehensive Assessment Tool (UCAT) criteria and professional judgment. Due in part to the current nurse shortage, the OKDHS Aging Division has requested these revisions to remove the current duplication of responsibilities by their nurses and Personal Care agency nurses. The OKDHS nurses will still determine the level of care and maintain oversight of the units of Personal Care services authorized for all SoonerCare members. Also, they will have more time to attend to their other responsibilities including mandatory visits to nursing facilities in order to determine medical need for long

term care for SoonerCare applicants. Other revisions update terminology, forms, and procedures.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to ~~QMB~~ QMBP, SLMB and other ~~Medicaid service~~ SoonerCare services and eligibility ~~and spenddown calculation~~

Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Mentally Retarded (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for ~~Medicaid~~ SoonerCare coverage of long-term care, the individual is also eligible for other ~~Medicaid~~ SoonerCare services. Another application ~~or spenddown computation~~ is not required. ~~Spenddown is applied to the first long-term care claim filed.~~ Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. ~~Any spenddown computed for long-term care is not applicable to QMB coverage.~~

317:35-15-2. Personal Care services

(a) Personal Care is assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical services such as, tracheal suctioning, bladder

catheterization, colostomy irrigation, and operation of equipment of a technical nature.
(b) Personal Care services support informal care being provided in the member's home. A rented apartment, room or shelter shared with others is considered "the member's home". A facility which meets the definition of a nursing facility, room and board, licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not considered the "the member's home" for delivery of SoonerCare Personal Care Program services.
(c) Personal Care services may be provided by an individual employed by the member referred to as a Personal Care Assistant (PCA) or by a qualified employee of a home care agency that is certified to provide ~~PC~~ Personal Care services and contracted with the OHCA to provide ~~PC~~ Personal Care services. OKDHS must determine a PCA to be qualified to provide ~~PC~~ Personal Care services before they can provide services.

317:35-15-3. Application for Personal Care~~; forms~~
(a) **Requests for Personal Care.** A request for Personal Care is made to the local ~~DHS~~ OKDHS office. A written financial application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. A financial application for Personal Care consists of the Medical Assistance Application form. The form is signed by the ~~client~~ applicant, parent, spouse, guardian or someone else acting on the ~~client's~~ applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, the 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) **Date of application**.
(1) The date of application is:
(A) the date the applicant or someone acting on his/her behalf signs the application in the county office;
(B) the date the application is stamped into the county office when the application is initiated outside the county office; or,
(C) the date when the request for ~~Medicaid~~ SoonerCare is made orally and the financial application form is signed later.
(2) An exception to paragraph (1) of this subsection would occur when ~~DHS~~ OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and

documentation to the ~~DHS~~ OKDHS county office of the ~~client's~~ applicant's county of residence for ~~Medicaid~~ SoonerCare eligibility determination. The application date is the date the ~~client~~ applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility**. The OKDHS area nurse, or designee, utilizes the UCAT criteria and professional judgment in determining medical eligibility and level of care. To be eligible for Personal Care services, the individual must:

(1) have adequate informal supports that contribute to care, or decision making ability as documented on the UCAT, to remain in his/her home without risk to his/her health, safety, and well-being:

(A) the individual must have the decision making ability to respond appropriately to situations that jeopardize his/her health and safety or available supports that compensate for his/her lack of ability as documented on the UCAT, or

(B) the individual who has his/her decision making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been informed by the ~~LTC~~ OKDHS nurse of potential risks and consequences may be eligible;

(2) require a ~~care~~ plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) have a physical impairment or combination of physical and mental impairments. An individual who poses a threat to self or others as supported by professional documentation may not be approved for Personal Care services;

(4) not have members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the ~~client~~ individual or other household visitors;

(5) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms when used in this subsection, ~~shall~~ have the following meaning, unless the context clearly indicates otherwise:

(1) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the ~~client's~~ member's ability to perform self-care tasks essential for sustaining

health and safety such as:
(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"ADLs score of three or greater"** means the ~~client~~ member cannot do one ADL at all or needs some help with two ADLs.

(3) **"ADLs score is two"** means the ~~client~~ member needs some help with one ADL.

(4) **"Client support very low need"** means the ~~client's~~ member's UCAT Client Support score is zero which indicates in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of ~~client~~ member need in most functional areas.

(5) **"Client support low need"** means the member's UCAT Client Support score is 5 which indicates in the UCAT assessor's clinical judgment, support from formal and informal sources are nearly sufficient for present level of ~~client~~ member need in most functional areas.

(6) **"Client support moderate need"** means the UCAT Client Support score is 15, which indicates in the UCAT assessor's clinical judgment formal and informal support is available, but overall, it is inadequate, changing, fragile or otherwise problematic.

(7) **"Client support high need"** means the ~~client's~~ member's UCAT Client Support score is 25 ~~and~~ which indicates in the UCAT assessor's clinical judgment, formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of ~~client~~ member need.

(8) **"Community Services Worker"** means any person employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities, and who is not a licensed health professional.

(9) **"Community Services Worker Registry"** means a registry established by the Oklahoma Department of Human Services, as required by Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes, to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes, involving a frail elderly, disabled person(s) or person(s) with developmental disabilities has been made by ~~DHS~~

OKDHS or an administrative law judge, amended in 2002 to include the listing of ~~Medicaid~~ SoonerCare personal care assistants providing personal care services.

(10) **"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

~~(10)~~ (11) "**IADL**" means the instrumental activities of daily living.

~~(11)~~ (12) "**IADLs score is at least six**" means the ~~client~~ member needs some help with at least three IADLs or cannot do two IADLs at all.

~~(12)~~ (13) "**IADLs score of eight or greater**" means the ~~client~~ member needs some help with four IADLs or the ~~client~~ member cannot do two IADLs at all and needs some help with one other IADLs.

~~(13) "**Instrumental activities of daily living**" means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:~~

~~(A) shopping,~~
~~(B) cooking,~~
~~(C) cleaning,~~
~~(D) managing money,~~
~~(E) using a telephone,~~
~~(F) doing laundry,~~
~~(G) taking medication, and~~
~~(H) accessing transportation.~~

(14) **"~~Medicaid~~ SoonerCare personal care services provider"** means a program, corporation, or individual who provides services under the state's ~~Medicaid~~ SoonerCare personal care program or ADvantage Waiver to individuals who are elderly or who have a physical disability.

(15) **"MSQ"** means the mental status questionnaire.

(16) **"MSQ moderate risk range"** means a total weighted score of seven or more which indicates an orientation-memory-concentration impairment or a memory impairment.

(17) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is 8 or more which indicates poor appetite or

weight loss combined with special diet requirements, medications or difficulties in eating.

(18) **"Social resources score is eight or more"** means the ~~client~~ member lives alone or has no informal support when sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for Personal Care.** The medical eligibility minimum criteria for Personal Care is the minimum UCAT score criteria which a ~~client~~ member must meet for medical eligibility for personal care and are:

(1) functional ADLs score is a five or greater; or IADLs score of eight or greater; or Nutrition score is eight or greater; or the MSQ score is seven or greater; or the ADLs score is three and IADLs score is at least six, and

(2) Client Support is moderate risk; or Client Support score is five~~ or more~~ and the Social Resources score is eight or more.

(d) **Medical eligibility determination**. Medical eligibility for Personal Care is determined by the Oklahoma Department of Human Services. The medical decision for Personal Care~~, the care plan and service plan approval for Personal Care~~ is made by the ~~DHS~~ OKDHS area nurse, or designee, utilizing the Uniform Comprehensive Assessment Tool (UCAT).

(1) When Personal Care services are requested, the local office is responsible for completing the UCAT, Part III.

(2) Categorical relationship must be established for determination of eligibility for Personal Care. If categorical relationship to Aid to the Disabled has not already been established but there is an extremely emergent need for Personal Care and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues the Authorization for Examination, ~~DHS~~ OKDHS form ~~ABCDM-16~~ 08MA016E, and the Report of Physician's Examination, ~~DHS~~ OKDHS form ~~ABCDM-80~~ 08MA02E, to a licensed medical or osteopathic physician (refer to OAC 317:30-5-1). The physician cannot be in a medical facility intern, residency, or fellowship program or in the full time employment of the Veterans Administration, Public Health Service or other agency. The OKDHS county ~~social~~ worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship using the same definition used by SSA. A follow-up is required by the ~~DHS social~~ OKDHS county worker with the Social Security Administration (SSA) to be sure that SSA's disability decision agrees with the decision of LOCEU.

(3) Approved contract agencies may complete the UCAT Part I for intake and screening and forward the form to the county office.

(4) When ~~DHS~~ the OKDHS county office does not receive a UCAT from the AA, a UCAT I is initiated by the DHS county staff upon

receipt of the referral.
(5) The ~~DHS Long Term Care (LTC)~~ OKDHS nurse completes the ~~UCAT III~~ assessment visit within 10 working days of receipt of the referral for Personal Care from the ~~social~~ OKDHS county worker or receipt of the UCAT I ~~and II~~ (Intake and Screening) request for Personal Care for the ~~client~~ member who is ~~Medicaid~~ SoonerCare eligible at the time of the request. The ~~LTC~~ OKDHS nurse completes the assessment visit within 20 working days of the ~~Medicaid~~ SoonerCare application for the ~~client~~ applicant who has not been determined financially ~~Medicaid~~ SoonerCare eligible at the time of the request. The ~~DHS social~~ OKDHS county worker is responsible for contacting the ~~individual~~ applicant within three working days from the date of the receipt of the request for services to initiate the financial eligibility process. If the UCAT Part I ~~or II~~ indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the ~~client~~ person (emergency situation) or to avoid institutional placement, the UCAT Part III assessment visit has top priority for scheduling.
(6) During the assessment visit, the ~~LTC~~ OKDHS nurse completes the UCAT III and reviews with the member rights to privacy, fair hearing and provider choice. The OKDHS nurse informs the ~~client~~ member of medical eligibility criteria and provides information about the different ~~DHS~~ OKDHS long-term care service options. The OKDHS nurse documents on the UCAT III whether the ~~client~~ member wants to be considered for nursing facility level of care services or if the ~~client~~ member is applying for a specific service program. If based upon the information obtained during the assessment, the OKDHS nurse determines ~~that~~ the ~~client~~ member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS) ~~staff are notified immediately~~. The referral is documented on the UCAT.

~~(A) The LTC nurse uses the Personal Care service plan form to develop an individual plan of care. The plan of care and service plan, including the amount and frequency of DHS Personal Care services, is based on the client's needs as determined by the UCAT III assessment.~~

~~(B)~~ (A) If the ~~client's~~ member's needs cannot be met by ~~DHS~~ Personal Care ~~and Home Health~~ services alone, the ~~LTC~~ OKDHS nurse informs the ~~client~~ member of the other ~~DHS Long Term Care (LTC)~~ community long term care service options. The ~~LTC~~ OKDHS nurse assists the ~~client~~ member in accessing service options selected by the ~~client~~ member in addition to, or in place of, Personal Care services.

~~(C)~~ (B) If multiple household members are applying for ~~DHS~~ SoonerCare Personal Care services, the UCAT assessment is done for all the ~~client~~ household members at the same time.

~~Individual care plans and service plans are discussed and~~

~~developed with the group of clients who appear eligible so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of service allocated to each individual is distributed between family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.~~

~~(D) If the length of time from the date the initial assessment information was obtained to the date the assessment is submitted to the area nurse, or designee, exceeds 60 days, the assessment must be updated as necessary including a new signature and date. A new UCAT and assessment visit is required if the length of time exceeds 90 days.~~

(C) The OKDHS nurse informs the member of the qualified agencies in their local area available to provide services and obtains the member's primary and secondary choice of agencies. If the member or family declines to choose a primary personal care service agency, the OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected personal care service agency.

(7) The ~~LTC~~ OKDHS nurse ~~scores~~ completes the UCAT III~~. Within five~~ within three working days of the assessment visit~~, the nurse forwards the UCAT and the completed Personal Care plan and service plan forms~~ and sends it to the OKDHS area nurse, or designee, for medical eligibility determination. Personal care service eligibility is established as of the date that both medical eligibility is approved and financial eligibility is established. ~~The client's Personal Care service plan and care plan include:~~

(A) ~~goals and tasks;~~ If the length of time from the date the initial assessment to the date of service eligibility determination exceeds 60 days, the assessment must be updated as necessary including a new signature and date. A new UCAT and assessment visit is required if the length of time exceeds 90 days.

(B) ~~the number of authorized Personal Care units (hours) per month;~~ Upon establishment of Personal Care service eligibility, the OKDHS nurse contacts the member's preferred personal care service agency, or if necessary, the secondary agency or the agency selected by the rotation system.

(C) ~~frequency of service visits;~~ Within one working day of agency acceptance, the OKDHS nurse forwards the referral to the personal care service agency for Service Authorization Model (SAM) packet development. [Refer to OAC 317:35-15-8(a)]. The date the referral is forwarded is the certification effective date.

~~(D) the effective date for services; and~~
~~(E) the certification period for the care plan and service plan.~~

(8) Following the development of the Service Authorization Model (SAM) packet by the personal care service agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the packet to ensure agreement with the plan. Once agreement is established, the packet is forwarded to the OKDHS area nurse or designees for review.

~~(8)~~ (9) Within 10 working days of receiving the ~~UCAT, care plan, and service plan~~ Service Authorization Model (SAM) packet from the ~~LTC~~ OKDHS nurse, the OKDHS area nurse, or designee, ~~determines medical eligibility for Personal Care services,~~ certifies or denies the ~~care plan and service plan~~ Service Authorization Model (SAM) packet ~~and enters the medical decision on MEDATS~~. If there is certification, the OKDHS area nurse enters into the system the units authorized. ~~Denied service and care plans~~ Service Authorization Model (SAM) packets that fail to meet authorization are returned to the ~~LTC~~ OKDHS nurse for revision or further justification by the personal care service agency. ~~The LTC nurse revises and re-submits the denied service and care plans to the area nurse, or designee, within five working days of receipt of the returned documents.~~

~~(9)~~ (10) The OKDHS area nurse, or designee, ~~determines the medical certification period for the plan of care and service plan which is the same as the certification period for the medical eligibility decision [see OAC 317:35-15-7(b)]~~ assigns a medical certification period of not more than 36 months. The service plan certification period under the Service Authorization Model (SAM) is for a period of 12 month.

(11) Once the OKDHS nurse is notified of the service plan authorization, and within one working day, forwards copies of the certified Personal Care Service Plan [OKDHS form 02AG031E (AG-6)] to the agency.

(12) The OKDHS nurse notifies the OKDHS county worker in writing of the service and the number of authorized personal care service units including the start and end dates. The OKDHS county worker opens the service authorization. These steps are automated via ELDERS. Once the authorization is opened, five Service Authorization Model (SAM) visits by a skilled nurse are automatically authorized.

317:35-15-5. General financial eligibility requirements for Personal Care

Financial eligibility for Personal Care is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-10 for individuals categorically related to AFDC, and OAC 317:35-7-36 for those

categorically related to ABD.) ~~(1)~~ Income~~,~~ and resources ~~and expenses~~ are evaluated on a monthly basis for all individuals requesting payment for Personal Care who are categorically related to ABD; maximum countable monthly income and resource standards for individuals related to ABD are found on OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP program standards).

~~(2) The maintenance standards on the DHS Appendix C-1, Schedule II. A. are used to evaluate income and resources when an individual requests Personal Care with income and resources that exceed the categorically needy standards. Any vendor copayment for Personal Care is deducted from the claim prior to payment.~~

317:35-15-6. Determining financial eligibility of categorically needy individuals

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

(1) **Financial eligibility/categorically related to AFDC**. In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

(B) parent(s) and minor children of their own.

(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule X.

(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule I. A.

(2) **Financial eligibility/categorically related to ABD**. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule ~~VIII. A~~ VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for Personal Care**. For individuals determined categorically needy for Personal Care, ~~excess income is not applied to~~ the member will not pay a vendor payment for Personal Care services.

317:35-15-7. Certification for Personal Care

(a) ~~**Application date.**~~ The first month of the Personal Care certification period must be the first month the ~~client~~ member was determined eligible for Personal Care, both financially and medically.

(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.

(2) An applicant approved for Personal Care under ~~Medicaid~~ SoonerCare as categorically needy is mailed a Medical Identification Card.

(b) ~~**Certification period for Personal Care.**~~ A medical certification period of not more than 36 months is assigned for an individual categorically related to ABD who is approved for Personal Care. The certification period for Personal Care is based on the UCAT evaluation and clinical ~~judgement~~ judgment of the OKDHS area nurse or designee. When the individual determined eligible for Personal Care is categorically related to AFDC, a medical certification period of not more than 36 months is assigned.

317:35-15-8. Agency Personal Care ~~service management~~ Service Authorization and Monitoring

~~(a) At the time of assessment, the OKDHS nurse informs the member of the qualified agencies in their local area available to provide services and obtains the member's primary and secondary choice of agencies. If the member or family declines to choose a primary PC service agency, the OKDHS nurse selects an agency from a list of all local available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected PC service agency.~~

~~(b) After medical and financial eligibility are established, OKDHS contacts the member's preferred PC service agency or, if necessary, the secondary agency or the agency selected by the rotation system. The OKDHS nurse forwards the referral to the PC services agency and establishes an initial PC skilled nursing service authorization for assessment and care plan development. Within one working day, OKDHS notifies the PC service agency and member of eligibility approval and also the authorization for PC skilled nursing for assessment and care plan development. The agency, prior to placing a PCA in the member's home, initiates an OSBI background check, checks the OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and, as~~

~~appropriate, checks the Certified Nurse Aid Registry.~~

~~(c)~~ (a) Within ten working days of receipt of the ~~member's PC eligibility approval,~~ referral for Personal Care services, the ~~PC services agency skilled nurse~~ Personal Care Assessment/Service Planning Nurse completes ~~an in-home assessment of~~ a Service Authorization Model (SAM) visit in the home to assess the member's ~~PC~~ Personal Care service needs, ~~develops a care plan~~ completes a Service Authorization Model (SAM) packet based on the member's needs and submits the ~~plan~~ packet to the OKDHS nurse. The member's ~~PC services care plan includes PC services goals and tasks, the number of authorized PC service units per month, frequency of PC service visits, the begin date for PC services, and the care plan end date which is no more than one year from the plan begin date. If more than one person in the household has been authorized to receive PC services, all household members' care plans are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of PC service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.~~ Service Authorization Model (SAM) packet includes:

(1) State Plan Personal Care Progress Notes (OKDHS form 02AG044E);

(2) Personal Care Planning Schedule [OKDHS form 02AG030E (AG-5)];

(3) Personal Care Plan [OKDHS form 02AG029E (AG-4)]; and

(4) Personal Care Service Plan [02AG031E (AG-6)].

(b) If more than one person in the household has been referred to receive Personal Care services, all household members' Service Authorization Model (SAM) packets are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of Personal Care service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.

~~(d) Within three working days of receipt of the care plan from the PC services agency, the OKDHS nurse reviews and approves or denies the care plan and notifies the agency. The OKDHS nurse may also reduce the number of units requested by the PC services agency and then approve the care plan. When the OKDHS nurse denies a plan or approves a plan with fewer authorized units than the submitted plan, OKDHS consults with the PC services agency prior to denying the care plan or approving the care plan with reduced units.~~

(c) The Personal Care service agency receives a certified Service Plan [OKDHS form 02AG031E (AG-6)] from OKDHS as authorization to begin services. The agency delivers a copy of the care plan and

service plan to the member upon initiating services.

~~(e)~~ (d) Prior to placing a ~~PC~~ Personal Care attendant in the member's home or other service-delivery setting, an OSBI background check, OKDHS Community Service Worker Registry check in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and as appropriate, the Certified Nurse Aide Registry Check must be completed.

~~(f)~~ (e) The ~~PC service skilled nurse~~ Personal Care Assessment/Service Planning Nurse monitors their member's ~~care~~ plan of care.

(1) The ~~PC~~ Personal Care service provider agency contacts the member within ~~5~~ five calendar days of receipt of the approved ~~care plan~~ Service Plan [OKDHS form 02AG031E (AG-6)] in order to make sure that services have been implemented and the needs of the member are being met.

(2) The ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse makes a Service Authorization Model (SAM) home visit at least every 180 days to assess the member's satisfaction with their care and to evaluate the ~~care plan~~ Service Authorization Model (SAM) packet for adequacy of goals and units authorized. Whenever a home visit is made, the ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse documents their findings in the ~~personal care services progress notes~~ State Plan Personal Care Progress Notes (OKDHS form 02AG044E). The personal care agency forwards a copy of the Progress Notes to the OKDHS nurse for review. The monitoring visit may be conducted by an LPN. If an LPN or social worker conducts the monitoring visit, an RN must co-sign the progress notes.

(3) Requests by the ~~PC~~ Personal Care service agency to change the number of units authorized in the ~~care plan~~ Service Authorization Model (SAM) packet are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee prior to implementation of the changed number of units.

(4) Annually, or more frequently if the member's needs change, the ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse re-assesses member's need and develops a new ~~care plan~~ Service Authorization Model (SAM) eligibility packet to meet personal care needs. ~~If the member's need does not change, the agency nurse may re-authorize the member's existing plan.~~

~~(g) When the PC services agency returns the member's care plan containing a service start date to OKDHS, the OKDHS nurse notifies the OKDHS county social worker in writing of the service and number of authorized PC service units and the start and end date of PC service authorization.~~

(5) If the member is unstaffed, the Personal Care service agency communicates with the member and makes efforts to restaff. If the member is unstaffed for 30 calendar days, the agency

notifies the OKDHS nurse on an OKDHS form 02AG032E (AG-7), Provider Communication Form. The OKDHS nurse contacts the member and if the member chooses, initiates a transfer of the member to another Personal Care service agency that can provide staff.

317:35-15-8.1. Agency Personal Care services; billing, and ~~issue~~ problem resolution

The ~~Administrative Agent~~ ADvantage Administration (AA) certifies qualified ~~PC~~ Personal Care service agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of OHCA. OHCA will check the list of providers that have been barred from ~~Medicare/Medicaid~~ Medicare/SoonerCare participation to ensure that the ~~PC~~ Personal Care services agency is not listed.

(1) **Payment for Personal Care.** Payment for ~~PC~~ Personal Care services is generally made for care in the member's "own home". In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of ~~PC~~ Personal Care services through SoonerCare. With prior approval of the OKDHS area nurse, ~~PC~~ Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.

(A) **Use of Personal Care service agency**. To provide ~~PC~~ Personal Care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS ~~or the AA~~, and possess a current SoonerCare contract.

(B) **Reimbursement**. Personal Care services payment on behalf of a member is made according to the type of service and number of units of ~~PC~~ Personal Care services authorized in the ~~care plan~~ Service Authorization Model (SAM) packet.

(i) The amount paid to ~~PC~~ Personal Care services providers for each unit of service is according to the established SoonerCare rates for the ~~PC~~ Personal Care services. Only authorized units contained ~~on~~ in each eligible member's individual ~~care plan~~ Service Authorization Model (SAM) packet are eligible for reimbursement. Providers serving

more than one ~~PC~~ Personal Care service member residing in the same residence will assure that the members' ~~care plans~~ Service Authorization Model (SAM) packets combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.

(ii) Payment for ~~PC~~ Personal Care services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized ~~care~~ plan of care. Payment for ~~PC~~ Personal Care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by the ~~provider agency personal care skilled nurse~~ Personal Care Assessment/Service Planning Nurse.

(2) **Issue resolution.**

(A) If the member is dissatisfied with the ~~PC~~ Personal Care services provider agency or the assigned PCA, and has exhausted attempts to work with the ~~PC~~ Personal Care services agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the issues. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.

(B) When a problem with performance of the Personal Care attendant is identified, agency staff will conduct a counseling conference with the member and/or the attendant as appropriate. Agency staff will counsel the attendant regarding problems with his/her performance.

317:35-15-9. Redetermination of financial eligibility for Personal Care

~~(a)~~ The ~~social~~ OKDHS county worker must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the client's financial ~~responsibility~~ eligibility.

~~(b) The area nurse, or designee, must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.~~

317:35-15-10. Redetermination of medical eligibility for Personal Care services

(a) **Medical eligibility redetermination.** The OKDHS area nurse, or designee, must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

~~(a)~~ (b) **Recertification**. The OKDHS nurse re-assesses the ~~PC~~ Personal Care services member for medical re-certification based on the member's needs and level ~~or~~ of caregiver support required, using the UCAT at least every 36 months. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The OKDHS nurse submits the re-assessment~~,~~ to the OKDHS area nurse, or designee, for re-certification. ~~Recertification documents are~~ Documentation is sent to the OKDHS area nurse, or designee, no later than the tenth day of the month in which the certification expires. When the OKDHS area nurse, or designee determines medical eligibility for ~~PC~~ Personal Care services, a re-certification review date is entered on the system.

~~(b)~~ (c) **Change in ~~service plan and care plan~~ amount of units or tasks within Personal Care service for ~~State Plan PC~~ Personal Care service members.** ~~Upon notification by the PC service agency of the member's need for a change in the amount of PC service required, the OKDHS nurse initiates the process to increase or decrease the approved units of service on the member's care plan. Based on the documentation provided by the PC service agency to OKDHS, the area nurse or designee approves or denies the care plan changes within three working days of receipt of the request. A copy of the signed care plan is included in the case record. The social worker updates the service authorization system after they are notified of the increase or decrease.~~ When the Personal Care services agency determines a need for a change in the amount of units or tasks within the Personal Care service, a new Personal Care Service Authorization Model (SAM) packet is completed and submitted to OKDHS. The change is approved or denied by the OKDHS area nurse, or designee prior to implementation.

~~(c)~~ (d) **Voluntary closure of ~~State Plan PC~~ Personal Care services**. If a member decides Personal Care services are no longer needed to meet his/her needs, a medical decision is not needed. The member and the OKDHS nurse or ~~social~~ OKDHS county worker completes and signs OKDHS form 02AG038E, AG-17, Voluntary Action of Personal Care Case Closure form.

~~(d)~~ (e) **Resuming ~~State Plan PC~~ Personal Care services.** If a member approved for Personal Care services has been without ~~PC~~ Personal Care services for less than 90 days but still has a current ~~PC~~ Personal Care services medical and SoonerCare financial eligibility approval, ~~PC~~ Personal Care services may be resumed using the member's previously approved ~~care plan~~ Service Authorization Model (SAM) packet. The ~~PC~~ Personal Care service agency submits a ~~PC~~ Personal Care services skilled nursing re-assessment of need within

ten working days of the resumed plan start date using the State Plan Personal Care Progress Notes, OKDHS form 02AG044E. If the member's needs dictate, the ~~PC~~ Personal Care services agency may submit a request for a change in authorized ~~PC~~ Personal Care services units with ~~the re-assessment for authorization review by~~ a Service Authorization Model (SAM) packet to OKDHS.

~~(e)~~ (f) **Financial ineligibility**. Anytime OKDHS determines a ~~PC~~ Personal Care services member does not meet the SoonerCare financial eligibility criteria, the local OKDHS office notifies the member, ~~PC~~ Personal Care service provider, and the OKDHS nurse of financial ineligibility.

~~(f)~~ (g) **Closure due to medical ineligibility**. If the local OKDHS office is notified through the system that a member is no longer medically eligible for Personal Care, the ~~social~~ OKDHS county worker notifies the member of the decision. The OKDHS nurse notifies the ~~PC~~ Personal Care service agency.

~~(g)~~ (h) **Termination of State Plan Personal Care Services**.

(1) Personal Care services may be discontinued if:

(A) the member poses a threat to self or others as supported by professional documentation; or

(B) other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the member or other household visitors; or

(C) the member or family member fails to cooperate with Personal Care service delivery or to comply with OHCA or OKDHS rules as supported by professional documentation; or

(D) the member's health or safety is at risk as ~~documented on the UCAT~~ supported by professional documentation; or

(E) additional services, either "formal" (i.e., paid by ~~Medicaid~~ SoonerCare or some other funding source) or "informal" (i.e., unpaid) are provided in the home eliminating the need for SoonerCare Personal Care services.

(2) The member refuses to select and/or accept the services of a ~~PC~~ Personal Care service agency or PCA for 90 consecutive days as supported by professional documentation.

(3) For persons receiving ~~State Plan PC~~ Personal Care services, the ~~PC~~ Personal Care services agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS nurse reviews the documentation and submits it to the OKDHS Area Nurse for determination. The OKDHS nurse notifies the member and the Personal Care service agency or PCA, and the local OKDHS county ~~social~~ worker of the decision to terminate services. ~~The social worker closes the authorization on the OKDHS system which sends~~ The member is sent an official closure notice ~~to the member~~ informing them of their appropriate member rights to appeal the decision to discontinue services.

317:35-15-11. Case transfer between categories [REVOKED]

~~If it becomes necessary to transfer a Medicaid Personal Care case from one category to another because of change of age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the member's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Members and appropriate medical contractors are notified of the new case number and category by computer generated notice.~~

317:35-15-15. Referral for social services

In many situations, adults who are receiving medical services through ~~Medicaid~~ SoonerCare need social services. The ~~LTC~~ OKDHS nurse may make referrals for social services to the OKDHS worker in the local office. In addition to these referrals, a request for social services may be initiated by a ~~client~~ member or by another individual acting upon behalf of a ~~client~~ member.

(1) The OKDHS county worker is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the OKDHS worker are:

(A) Services that will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services, which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

G. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-764. [AMENDED]
Part 95. Agency Personal Care Services
OAC 317:30-5-953. [AMENDED]
Chapter 35. Medical Assistance for Adults and Children-Eligibility
Subchapter 15. Personal Care Services
OAC 317:35-15-14.[AMENDED]
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-22.[AMENDED]
(Reference APA WF # 08-29A and B)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

DATES:

Adoption:

December 11, 2008

SUMMARY:

Rules are revised to require the use of the new Interactive Voice Response Authentication (IVRA) system to document time and attendance for all Personal Care and certain in-home ADvantage services provided to SoonerCare members. Currently, claims for Personal Care and associated in-home ADvantage services represent the highest volume of claim records processed through the Medicaid Management Information System. In-home services are necessarily provided in the individual homes of persons with physical and cognitive disabilities. The verification of service delivery is typically a paper time sheet signed by the member receiving services with a high potential for errors. Additionally, a paper based time and attendance system which requires transcription of time units from paper to computer is both inefficient and affords many opportunities for inadvertent errors.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-764. Reimbursement

(a) Rates for waiver services are set in accordance with the rate setting process by the ~~Committee for Rates and Standards~~ State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for routine level of care nursing facility services that require

providers having equivalent qualifications;
(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;
(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;
(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;
(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;
(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) The individual Budget Allocation (IBA) expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.
(B) The PSA and APSA service unit rates are calculated by the ~~AA~~ OKDHS/ASD during the CD-PASS service eligibility determination process. The ~~AA~~ OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.
(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The ~~AA~~ OKDHS/ASD, upon favorable review, authorizes the amended plan and updates the member's

IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(b) The ~~AA~~ OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

(c) ~~As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to SURS for follow-up investigation.~~ Service time for Personal Care, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to SURS for follow-up investigation.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-953. Billing

A billing unit of service for ~~personal care~~ Personal Care skilled nursing service equals a visit. A billing unit of service for ~~personal care~~ Personal Care services provided by a PC service agency is 15 minutes of PC services delivery. Billing procedures for Personal Care services are contained in the OKMMIS Billing and Procedure Manual. Service time for Personal Care and Nursing is documented solely through the Interactive Voice Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event

of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-14. Billing procedures for Personal Care

Billing procedures for Personal Care Services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the OHCA. Contractors for Personal Care bill on ~~HCFA-1500~~ CMS-1500. The OKDHS county office ~~provide~~ provides instructions to an individual PCA for completion of the claim at the time of the contractor orientation. Each Personal Care contractor submits a claim for each ~~client~~ member. The contractor prepares claims for services provided and submits the claims to the fiscal agent who is responsible for assuring that the claims have been properly completed. All Personal Care contractors must have a unique provider number. New contractors will be mailed the provider number after they have been placed on the claims processing contractor's provider file. Service time of Personal Care and Nursing is documented solely through the Interactive Voice Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The ~~AA~~ OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be

turned over to SURS for follow-up investigation.
(d) Service time of Personal Care, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance and Advanced Personal Services Assistance is reimbursed solely through the Interactive Voice Response Authentication (IVRA) system. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

H. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 32. Soonerride Non-Emergency Transportation
OAC 317:30-5-326. [AMENDED]
(Reference APA WF #08-49)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Sections 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.170

DATES:

Adoption:
December 11, 2008

SUMMARY:

The 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 NET under the SOonerRide program. Language in the current SoonerRide rule only addresses reimbursement under a capitated methodology and is silent as to reimbursement at a fee for service mileage rate for those members eligible for NET but not included in the NET capitation roster, as is outlined in the State Plan Amendment. This revision will bring OHCA rules in line with current OHCA practices and Oklahoma Title XIX State Plan requirements thereby avoiding a potential PERM error.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-326. Provider eligibility

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 capitated methodology based on per member per month~~ is made pursuant to the methodology described in the Oklahoma Title XIX State Plan. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide.

I. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICES**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
OAC 317:30-5-695. [AMENDED]
(Reference APA WF# 08-04)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.100

DATES:

Adoption:
March 13, 2008

SUMMARY:

SoonerCare Dentist rules are revised to add the American Dental Association's version of current dental terminology (CDT) in order to communicate information related to codes and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply with the exception of more specific definitions or limitations as listed in rules.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-695. Eligible dental providers and definitions

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

(1) individuals licensed as dentists under 59 Oklahoma Statutes '' 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);
(2) individuals issued permits as dental interns under 59 Oklahoma Statute ' 328.26;
(3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
(4) any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

(d) The American Dental Association's version of Current Dental Terminology (CDT) is used by the OHCA to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) "Decay" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.

(2) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an all inclusive service. No other codes are billable on the same date of service.

(3) "Radiographic Caries" means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(4) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.

(5) "Unbinding" means billing separately for several individual procedures that are included within one Current Dental Terminology or Current Procedural Terminology (CPT) code.

J. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICES**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
OAC 317:30-5-696. [AMENDED]
OAC 317:30-5-698. through 317:30-5-699. [AMENDED]
(Reference APA WF# 08-41)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.100

DATES:

Adoption:

December 11, 2008

SUMMARY:

Dental rules are revised to: (1) require a clinical examination preceding any radiographs, and consideration of patient history, prior radiographs, caries risk assessment and dental and general health needs of the patient; (2) allow, with prior authorization, panoramic x-rays more than once every 36 months for the detection and treatment of oral disease; (3)limit reimbursement for the application of ceramic based and cast mental based crowns to natural teeth only; and (4) add clarification that payment for crowns includes all related follow up service for a two year period. Rules are also revised to allow the OHCA Dental Director to prior authorize the correction of poorly rendered or insufficient treatment of restorative procedures by a different provider than the original provider of sub-standard treatment.

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 <u>(HCBWS)</u> for the**

mentally retarded ~~(HCBWS)~~. 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.

(A) **Comprehensive oral evaluation.** ~~Comprehensive oral evaluation~~ Evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18 months. This procedure is allowed once each 18 month period.

(B) **Periodic oral evaluation.** This procedure may be provided for a ~~client~~ 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) **Emergency extractions.** This procedure is only for the relief of pain or treatment of acute infection.~~

~~(E)~~ (D) **Oral hygiene instructions.** This service is limited to once every 12 months. The ~~dentist or~~ designated ~~qualified~~ dental staff ~~shall instruct~~ instructs the member or the responsible adult~~,~~ (if the child is under five years of age)~~,~~ in proper tooth brushing and flossing by actual demonstration~~. Verbal~~ and provides proper verbal and/or written ~~proper~~ diet information ~~should be discussed~~. This service also includes dispensing a new tooth brush, and may include disclosing tablets ~~if available,~~ and ~~a small container of six or more yards of~~ dental floss ~~dispensed to the patient when appropriate~~. ~~This service is limited to once per 12 months.~~

~~(F)~~ (E) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be ~~determined as~~ of diagnostic quality and medically necessary ~~by the dentist, of diagnostic quality and taken within the allowable limits of the program~~. A clinical examination must precede any radiographs, and chart documentation must include patient history, prior radiographs, caries risk assessment and both dental and general health needs of the patient. 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.

~~(G)~~ (F) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on all surfaces to be eligible for this service. This service is available through ~~18~~ 18.0 years of age and is compensable only once per lifetime. Replacement of ~~lost~~ sealants ~~will be at no cost to the OHCA~~ is not a covered service under the SoonerCare program.

~~(H)~~ (G) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

~~(I)~~ (H) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4.0 years;
(II) tooth numbers E and F to age 6.0 years;
(III) tooth numbers N and Q to 5.0 years; and
(IV) tooth numbers D and G to 6.0 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).

~~(J)~~ (I) **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.

~~(K)~~ (J) **Stainless steel crowns.** The use of 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~~,~~ ; ~~and for~~

(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 16.0 years.

(iv) Preoperative periapical x-rays 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.

~~(L)~~ (K) **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 5.0 years;

(III) Tooth numbers E and F before 6.0 years;

(IV) Tooth numbers N and Q before 5.0 years; and

(V) Tooth numbers D and G before 6.0 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.

~~(M)~~ (L) **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 ~~not~~ 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.

~~(N)~~ (M) **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) ~~Procedure.~~ 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.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used where 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 6.0 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** ~~These dentures are used~~ This service is for ~~an~~ anterior permanent tooth

replacement or if the member is missing three or more posterior teeth to age 16.0 years of age.

~~(O)~~ (N) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year.

~~(P)~~ (O) **Pulp caps (direct).** ADA accepted CAOH containing material must be used.

~~(Q)~~ (P) **Sedative treatment.** ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days.

~~(R)~~ (Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

~~(S)~~ (R) **Local anesthesia.** This procedure is included in the fee for all services.

~~(T)~~ (S) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient to describe his/her smoking, advising the patient to quit, assessing the willingness of the patient 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 patient 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 client, or established client not

seen for more than 24 months;
(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(a)(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 patient, or if the patient is under active treatment;
(iv) Oral hygiene instructions as defined in OAC 317:30-5-696(a)(3)(E);
(v) Radiographs as defined in OAC 317:30-5-696(a)(3)(F);
(vi) Dental prophylaxis as defined in OAC 317:30-5-696(a)(3)(H);
(vii) 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;
(viii) 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
(ix) Analgesia. Use of nitrous oxide is compensable for four occurrences.

(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 4 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 ~~utilizing the Medicaid allowable for comparable services. This is an all inclusive payment on assigned claims~~ based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as noncompensable should be filed directly with ~~this Authority~~ the OHCA with a copy of the Medicare EOB ~~attached~~ 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. Emergency dental care is immediate service that must be provided to relieve the ~~recipient~~ member from pain due to an acute infection, swelling, trismus or trauma.

Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Study models (where indicated), x-rays, six point periodontal charting, comprehensive treatment plan and narrative may be requested. 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.

(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 mounted so that they are viewed from the front of the member. If required x-rays sent are copies, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with member name, date, ~~recipient~~ member ID number, provider name, and provider number. X-rays must be placed together in an envelope and stapled to the submission form. 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 whom, by the provider's documentation, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. 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 ~~not~~ no other missing teeth in the same arch requiring replacement, unless numbers 6~~.~~ , 11~~.~~ , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling 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 in order to present adequate structure to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(B) Posterior endodontics. The guidelines for this procedure are as follows:

(i) The provider ~~should document~~ documents that the ~~client~~ member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to minimally retain a crown 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.

(vi) Only ADA accepted filling 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; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a single failing root canal is determined not medically necessary for re-treatment.

(2) Cast metal crowns or ceramic-based crowns. ~~This procedure is~~ These procedures 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 ~~(IF/MR)~~ (ICF/MR) and who have been approved for ~~IF/MR~~ (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 ~~incisa~~ incisal function.

(ii) The clinical crown is 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)~~ (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 ~~cleansable~~ cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

(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) Full cast metal crowns are treatment of choice for all posterior teeth.

(H) Provider is responsible for replacement or repair of cast crowns 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.

~~(5)~~ (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 an acrylic or cast frame partial denture are considered. Study models with narrative are required to substantiate need for fixed bridge(s). Members must have excellent oral hygiene documented in the requesting provider's records.

~~(6)~~ (7) Periodontal scaling and root planing. This procedure requires that 50% or more of the six point measurements be four 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 ~~occurs~~. ~~Tooth planing is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism.~~ 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.

~~(7)~~ (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;
(D) juvenile periodontitis.

317:30-5-699. Restorations

(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:

(1) replacement of any occlusal cusp;
(2) sub-gingival margins; and
(3) a restoration replacing more than 50 percent of the dentin.

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 12 months. Providers must document

use of rubber dam isolation in daily treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

(c) **Coverage for dental restorations.** Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

(d) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These two codes are the only codes that may be used 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.
(e) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Utilization of these codes are verified on a post payment review.

K. **CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

OAC 317:2-1-7. [AMENDED]

(Reference APA WF # 08-40)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 C.F.R. Section 435.902; 42 C.F.R. Section 435.930

DATES:

Adoption:

December 11, 2008

SUMMARY:

Agency rules are revised to ensure policy is consistent with the agency's practices. Currently, agency's practices are an appeal is forwarded to the Legal Services Division after it has been docketed. The revision is needed to reflect accurate agency practices and to ensure provider appeals are forwarded to the correct division without unnecessary delays.

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-7. Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews appeals

SURS and Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of the ~~Surveillance, Utilization and Review System Unit (SURS)~~ SURS or Program Integrity Audit/Review which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the SURS or Program Integrity Audit/Review decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the

allegedly erroneous decision. The letter ~~will~~ should also include all relevant exhibits the provider believes necessary to decide the appeal.
(3) Upon ~~the~~ receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the ~~MAC~~ Medical Advisory Committee (MAC). Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.
(4) The appeal will be forwarded to the ~~SURS unit or Program Integrity Audit/Review unit~~ OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.
(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.
(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.
(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.
(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.

L. **CHAPTER 45. INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 1. General Provisions

OAC 317:45-1-1. through 317:45-1-3. [AMENDED]
Subchapter 7. Insure Oklahoma/O-EPIC ~~PA~~ ESI Employer Eligibility
OAC 317:45-7-1. [AMENDED]
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 5. Insure Oklahoma/O-EPIC ~~Individual Plan~~ IP Member Eligibility
OAC 317:45-11-25. [AMENDED]
(Reference APA WF # 08-55)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1009.2, Section 1010.1, and Section 1011.10 of Title 56 of Oklahoma Statutes

DATES:

Adoption:

January 8, 2009

SUMMARY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Insure Oklahoma/O-EPIC program to comply with Sections 1009.2, 1010.1, and 1011.10 of Title 56 of Oklahoma Statutes. Rules are revised to expand current Employer Sponsored Insurance (ESI) and Individual Plan (IP) coverage from an employee size of 50 to 250 employees and include coverage for Oklahoma full-time college students age 19 through 22. This expansion to the Insure Oklahoma/O-EPIC program will help increase access to health care for Oklahomans, thereby reducing the amount of uncompensated care provided by health care providers.

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) program that establishes access to affordable health coverage for low-income working adults, ~~and~~ their spouses, and qualified college students. The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the ~~Program~~ program.

317:45-1-2. Program limitations

(a) The Insure Oklahoma/O-EPIC program is contingent upon sufficient funding that is collected and dispersed through a

revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

~~(b)~~ (1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the ~~Program~~ program.

~~(c)~~ (2) The ~~Program~~ program is funded through a portion of monthly proceeds from the Tobacco Tax, O.S.S. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

~~(d)~~ (3) The ~~Program~~ program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma/O-EPIC program continues to operate within its fiscal capacity.

~~(1)~~ (A) Insure Oklahoma/O-EPIC may limit eligibility based on:

~~(A)~~ (i) the federally-approved capacity of the Insure Oklahoma/O-EPIC services for the Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; and

~~(B)~~ (ii) Tobacco Tax collections.

~~(2)~~ (B) The Insure Oklahoma/O-EPIC program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

~~(A)~~ (i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma/O-EPIC program are placed on a waiting list. These applications are date and time stamped when received by the TPA. Applications, with the exception of college students, are identified by region and Insure Oklahoma/O-EPIC program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma/O-EPIC program size is determined by OHCA and may be periodically adjusted.

~~(B)~~ (ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and ~~O-EPIC~~ program.

~~(C)~~ (iii) When an applicant is determined eligible and

moves from the waiting list to active participation, the applicant must submit a new application.

~~(D)~~ (iv) Enrolled applicants who are currently participating in the ~~O-EPIC~~ program are not subject to the waiting list.

~~(E)~~ (v) For approved employers ~~of O-EPIC~~, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate ~~in O-EPIC~~ during the employer's current eligibility period.

~~(F)~~ (vi) For approved employers ~~of O-EPIC~~, if the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.

(b) College students= eligibility and participation in the Insure Oklahoma/O-EPIC program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

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, ~~group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512~~ 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~~ a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; ~~or~~

(C) ~~A~~ 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.

"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~~ carrier that indicates services rendered and financial responsibilities for the ~~Carrier~~ carrier and Insure Oklahoma/O-EPIC ~~PA~~ 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.

"Individual Plan" means the ~~O-EPIC program that provides services to those individuals who do not meet the criteria for O-EPIC PA~~ safety net program for those qualified individuals who do not have access to Insure Oklahoma/O-EPIC ESI.

~~**"O-EPIC"** means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

"Insure Oklahoma/O-EPIC" 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/O-EPIC IP" means the Individual Plan program.

"Insure Oklahoma/O-EPIC ~~PA~~ ESI" means the ~~Premium Assistance~~ Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma/O-EPIC 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.

~~**"Oklahoma Employer and Employee Partnership for Insurance Coverage"** means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.~~

"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.

~~**"Premium Assistance"** means the O-EPIC program that provides premium assistance to small business for certain employees.~~

"Primary Care Provider" means a provider under contract to the Oklahoma Health Care Authority to provide primary care services, including all medically-necessary referrals.

~~**"Primary Employer"** means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.~~

"Premium" means a monthly payment to a ~~Carrier~~ carrier for health plan coverage.

"QHP" means Qualified Health Plan.

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma/O-EPIC 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~~ 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 or its designee.

"TPA" means the Third Party Administrator.

"Third Party Administrator" means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.

SUBCHAPTER 7. INSURE OKLAHOMA/O-EPIC ~~PA~~ ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma/O-EPIC ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma/O-EPIC program the employer must:

(1) have no more than a total of ~~50~~ 250 employees on its payroll. The increase in the number of employees from 50 to 250

will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC. Employers may provide additional documentation confirming terminated ~~or part time~~ employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form ~~as required under OAC 365:10-5-156~~ to verify employee count;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering, or ~~intending~~ at the contracting stage to offer, ~~within 90 calendar days an O-EPIC Qualified Health Plan~~ a QHP. The ~~Qualified Health Plan~~ QHP coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer ~~Qualified Health Plan~~ QHP coverage to employees ~~in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies~~; and

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any Insure Oklahoma/O-EPIC employee's termination or resignation.

SUBCHAPTER 11. INSURE OKLAHOMA/O-EPIC IP
PART 5. INSURE OKLAHOMA/O-EPIC ~~INDIVIDUAL PLAN~~ IP MEMBER ELIGIBILITY

317:45-11-25. Premium payment

~~(a) O-EPIC IP premiums are based upon a percentage of the Federal Poverty Level (FPL) income guidelines. The FPL income guidelines are determined annually by the Federal Government.~~

~~(b) Monthly premiums in the IP program vary based on:~~

~~(1) income reported on the member's application; and~~

~~(2) a family size of one for single coverage or a family size of two for dual coverage.~~

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their

IP health plan premium. The employees are also responsible for up to 20 percent of their spouse=s IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college student=s cost sharing for IP health plan premiums cannot exceed four percent of his/her gross annual household income computed monthly.

III. Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE previously been approved by the Board and are pending Gubernatorial approval under Emergency rulemaking.

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

RULEMAKING ACTION:

PERMANENT adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-240. [AMENDED]
OAC 317:30-5-240.1. through 317:30-5-240.3. [NEW]
OAC 317:30-5-241. [AMENDED]
OAC 317:30-5-241.1. through 317:30-5-241.5. [NEW]
OAC 317:30-5-244. [AMENDED]
OAC 317:30-5-248. [AMENDED]
OAC 317:30-5-249. [NEW]
(Reference APA WF # 08-50)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Sections 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.130

DATES:

Adoption:
February 12, 2009

SUMMARY:

Outpatient behavioral health rules are revised to: (1) add Multi-Systemic Therapy as a service option which will be provided by the Office of Juvenile Affairs staff who will also certify the state share; (2) revise rules to remove details related to billing procedures and terminology and instead refer providers to the Behavioral Health Provider Billing Manual; (3) amend policy to reflect appropriate terminology; and (4) expand the scope of provider qualifications for Psychiatric Social Rehabilitation Specialists.

PUBLIC HEARING:

A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

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

~~(a) **Definitions.** The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) **"AOA"** means American Osteopathic Association.~~

~~(2) **"AOD"** means Alcohol and Other Drug.~~

~~(3) **"AODTP"** means Alcohol and Other Drug Treatment Professionals.~~

~~(4) **"ASAM"** means the American Society of Addiction Medicine.~~

~~(5) **"ASI"** means the Addiction Severity Index.~~

~~(6) **"CAR"** means Clinical Assessment Record.~~

~~(7) **"CARF"** means Commission on Accreditation of Rehabilitation Facilities.~~

~~(8) **"CHCs"** means Community Health Centers.~~

~~(9) **"CMHCs"** means Community Mental Health Centers.~~

~~(10) **"COA"** means Council on Accreditation of Services for Families and Children, Inc.~~

~~(11) **"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.~~

~~(12) **"DSM"** means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.~~

~~(13) **"EBP"** means an Evidenced Based Practice per SAMHSA.~~

~~(14) **"FQHC"** means Federally Qualified Health Centers that are entities known as Community Health Centers.~~

~~(15) **"ICF/MR"** means Intermediate Care Facility for the Mentally Retarded.~~

~~(16) **"I/T/U"** means Indian Health Services/Tribal Clinics/Urban Tribal Clinic facilities.~~

~~(17) **"JCAHO"** means Joint Commission on Accreditation of Healthcare Organizations.~~

~~(18) **"LBHP"** means a Licensed Behavioral Health Professional.~~

~~(19) **"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.

(20) **"Objectives"** means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

(21) **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

(22) **"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.

(23) **"OHCA"** means the Oklahoma Health Care Authority.

(24) **"Private Facilities"** means those providers that contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

(25) **"PSRS"** means Psychiatric-Social Rehabilitation Specialist.

(26) **"Public Facilities"** means those providers who are regionally based Community Mental Health Centers who are also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

(27) **"RBMS"** means Residential Behavioral Management Services within a group home or therapeutic foster home.

(28) **"RHC"** means Rural Health Clinic.

(29) **"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.

(30) **"SAMHSA"** means the Substance Abuse and Mental Health Services Administration.

(31) **"T-ASI"** means the Teen Alcohol Severity Index.

(32) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

(b) **Provider Agency Requirements.** Rehabilitative services are provided by:

(1) Community based outpatient behavioral health organizations, that have a current accreditation status as a provider of behavioral health services, from the CARF, JCAHO, or COA. Providers accredited by CARF/JCAHO/COA must be able to demonstrate that the Scope of the current accreditation includes all programs, services and sites where SoonerCare compensated services are rendered. CARF/JCAHO/COA accredited providers will only receive SoonerCare reimbursement for services provided under the programs, which are accredited.

(A) Psychiatric Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards including JCAHO accreditation.

~~Psychiatric Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where SoonerCare Outpatient Behavioral services will be performed.~~

~~(B) Acute Care Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA certification. Acute Care Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where Medicaid Outpatient Behavioral Health Services will be performed.~~

~~(C) Providers of Alcohol and other Drug Treatment Disorders must be certified by the designated state certifying agency, the ODMHSAS. Providers in this category must have achieved accreditation from JCAHO, CARF, or COA for the provision of outpatient alcohol and other drug treatment services.~~

~~(2) Eligible organizations must meet one of the following standards and criteria:~~

~~(A) Be an incorporated organization governed by a board of directors; or~~

~~(B) A state-operated program under the direction of the ODMHSAS.~~

~~(3) Eligible organizations must meet each of the following:~~

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

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

~~(i) One of the following licensed behavioral health professionals:~~

~~(I) A Psychologist, Clinical Social Worker, Professional Counselor, Behavioral Practitioner, Marriage and Family Therapist, or Alcohol and Drug Counselor licensed in the state in which the services are delivered, or~~

~~(II) An Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided, or~~

~~(III) An allopathic or osteopathic physician with a current license and board certification in psychiatry in the state in which the service is delivered, or board eligible.~~

~~(ii) A Behavioral Health Rehabilitation Specialist as described in subsection (e) of this section, if individual or group rehabilitative services for mental illnesses are provided.~~

~~(iii) An Alcohol and Other Drug Treatment Professional if~~

~~treatment of alcohol and other drug disorders is provided.~~
~~(iv) 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.~~
~~(v) The member for which the services will be provided, and parent/guardian for those under 18 years of age.~~
~~(vi) A member treatment advocate if desired and signed off on by the member.~~

~~(C) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241, 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.~~

~~(i) Mental Health Assessments and/or Alcohol and Drug assessments;~~
~~(ii) Individual, Group, and Family Psychotherapy;~~
~~(iii) Individual and Group Rehabilitative services and Alcohol and other Drug Related Services Skill development services;~~
~~(iv) Mental Health and/or Substance Abuse Services Plan done by a non-physician (moderate and low complexity; and~~
~~(v) Crisis Intervention services.~~

~~(D) Be available 24 hours a day, seven days a week, for Crisis Intervention services.~~

~~(E) 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.~~

~~(F) Comply with all applicable Federal and State Regulations.~~

~~(G) 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.~~

~~(H) Demonstrate the ability to keep appropriate records and documentation of services performed.~~

~~(I) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.~~

~~(J) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.~~

~~(4) Provider Specialties.~~

~~(A) Public and ODMHSAS Contracted Programs Facilities - Public facilities are the regionally based Community Mental Health Centers and ODMHSAS contracted programs are providers that have a contract with the ODMHSAS to provide Mental~~

Health and/or Substance Abuse Treatment Services.

(B) Private Programs - Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

(C) Federally Qualified Health Centers/Community Health Centers - FQHCs are those facilities that qualify under OAC 317:30-5-660.

(D) Indian Health Services/Tribal Clinics/Urban Tribal Clinics - I/T/Us are those facilities that qualify under Federal regulation.

(E) Rural Health Clinics - RHCs are those facilities that qualify under OAC 317:30-5-355.

(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. If the application is approved, a separate provider identification number for each outpatient Behavioral Health Service site will be assigned. The contract must include copies of all required state licenses, accreditation and SoonerCare certifications.

(2) Each site operated by an outpatient mental health facility must have a separate provider number. 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.

(d) **Licensed Behavioral Health Professional.** Licensed Behavioral Health Professionals (LBHP) are defined as follows for the purpose of Outpatient Behavioral Health Services:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) below. The exemptions from licensure under 59 _1353(4)

~~(Supp. 2000) and (5), 59 ' 1903(C) and (D) (Supp. 2000), 59 _1925.3(B) (Supp. 2000) and (C), and 59 _1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.~~

~~(A) Psychology,~~

~~(B) Social Work (clinical specialty only),~~

~~(C) Professional Counselor,~~

~~(D) Marriage and Family Therapist,~~

~~(E) Behavioral Practitioner, or~~

~~(F) Alcohol and Drug Counselor.~~

~~(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~

~~(e) **Psychiatric-Social Rehabilitation Specialist.** The definition of a Psychiatric-Social Rehabilitation Specialist (PSRS) is as follows:~~

~~(1) Bachelor or master degree in a behavioral health related field including, but not limited to, psychology, social work, occupational therapy, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency, rehabilitative services, sociology, school guidance and counseling, criminal justice family studies, earned from a regionally accredited college or university recognized by the United States Department of Education; or~~

~~(2) Bachelor or master degree that demonstrates the individual completed and passed equivalent college level course work to meet the degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or~~

~~(3) A current license as a registered nurse in the state where services are provided with behavioral health experience; or~~

~~(4) Certification as an Alcohol and Drug Counselor. Allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; or~~

~~(5) Current certification as a Behavioral Health Case Manager from ODMHSAS and meets OHCA requirements to perform case management services, as described in OAC 317:30-5-585(1).~~

~~(f) **Alcohol and other Drug (AOD) Treatment Professionals (AODTP).** Alcohol and other Drug Treatment Professionals are defined as practitioners who are:~~

~~(1) Licensed to practice as an Alcohol and Drug Counselor in the state in which services are provided, or those actively and regularly receiving board approved supervision to become licensed;~~

~~(2) Certified as an Advanced Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying~~

~~and/or licensing body;~~
~~(3) Certified as an Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body; or~~
~~(4) A Licensed Behavioral Health Professional with a current license, or those actively and regularly receiving board approved supervision to become licensed, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to practice who can demonstrate competency in the area of alcohol and drug counseling and treatment.~~

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited organization/agency and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and psychologists), who provide outpatient behavioral health services and bill under their own taxpayer identification 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.

"Child" means an individual younger than 21, unless otherwise

specified.
"CHMCs" 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.
"CM" means case management.
"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 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 certifications 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 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.

(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.

317:30-5-240.3 Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly

receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) of this paragraph. The exemptions from licensure under 59 '1353(4) (Supp. 2000) and (5), 59 '1903(C) and (D) (Supp. 2000), 59 '1925.3(B) (Supp. 2000) and (C), and 59 '1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A Physician Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Alcohol and other Drug Treatment Professionals (AODTPs).** AODTPs are defined as follows:

(1) Licensed to practice as an Alcohol and Drug Counselor in the state in which services are provided, or those actively and regularly receiving board approved supervision to become licensed;

(2) Certified as an Advanced Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body;

(3) Certified as an Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body; or

(4) A Licensed Behavioral Health Professional with a current license, or those actively and regularly receiving board approved supervision to become licensed, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to practice who can demonstrate competency in the area of alcohol and drug counseling and treatment.

(c) **Behavioral Health Rehabilitation Specialists (BHRS).** BHRSs are defined as follows:

(1) Bachelor or master degree in a behavioral health related field including, psychology, social work, occupational therapy, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency, rehabilitative services, sociology, school guidance

and counseling, education, criminal justice family studies, earned from a regionally accredited college or university recognized by the United States Department of Education; or

(2) Bachelor or master degree that demonstrates the individual completed and passed equivalent college level course work to meet the degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or

(3) A current license as a registered nurse in the state where services are provided; or

(4) Certification as an Alcohol and Drug Counselor. They are allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; or

(5) Current certification as a Behavioral Health Case Manager from ODMHSAS as described in OAC 317:30-5-585(1).

(d) **Multi-Systemic Therapy (MST) Provider**. Masters level who work on a team established by OJA which may include Bachelor level staff.

(e) **Community Recovery Support Specialist (RSS).** RSSs are defined as follows:

(1) The community/recovery support worker must meet the following criteria:

(A) High School diploma or GED;

(B) Minimum one year participation in local or national member advocacy or knowledge in the area of behavioral health recovery;

(C) current or former member of behavioral health services; and

(D) successful completion of the ODMHSAS Recovery Support Provider Training and Test.

(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;

(4) pass background checks; and

(5) treatment plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

(g) **Behavioral Health Aide (BHA)**. BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or

(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and

(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(4) must be supervised by a bachelor's level individual with a minimum of two years case management experience; and

(5) treatment plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP and/or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

317:30-5-241. ~~Coverage for adults and children~~ Covered Services

(a) ~~**Service descriptions and conditions.**~~ 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 Billing Manual, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified ~~mental~~ behavioral health and/or substance abuse disorder(s). ~~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. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria and will require prior authorization. For all outpatient behavioral health facilities, the OHCA, or its designated agent, will comply with established medical necessity criteria. Non prior authorized services will not be SoonerCare compensable with the exception of Mental Health Assessment by a Non-Physician, Alcohol and Drug Assessment, Mental Health Service Plan Development (moderate complexity), Alcohol and/or Substance Abuse Services Treatment Plan Development (moderate complexity), Crisis Intervention, and Adult Facility Based Crisis Stabilization. Payment is not made for outpatient behavioral health services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care unless authorized by the OHCA or its designated agent as medically necessary. Adults and children in Facility Based Crisis Intervention Services cannot receive additional outpatient behavioral health services outside of the admission and discharge~~

dates. Residents of nursing facilities are not eligible for outpatient behavioral health services.

(1) **Mental Health Assessment by a Non-Physician**. All agencies must assess the medical necessity of each individual to determine the appropriate level of care. The assessment must contain but is not limited to the following:

(A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;

(B) Source of information;

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

(D) Gender;

(E) Birth date;

(F) Home address;

(G) Telephone number;

(H) Referral source;

(I) Reason for referral;

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

(K) Presenting reason for seeking services;

(L) Psychiatric social information, which includes: personal history, including; family B social; educational; cultural and religious orientation; occupational B military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; financial; clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations; legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate; substance abuse and dependence, both current and historical; gambling abuse and dependence, both current and historical; and present life situation.

(M) Mental status 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., and

(iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and

(iv) Full Five Axes DSM diagnosis.

(N) A section on health history and pharmaceutical information, with 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;

(iv) benefit(s) and side effects of medication; and

(v) level of functionality.

(O) Identification of the member's strengths, needs, abilities, and preferences:

(i) LBHP's interpretation of findings;

(ii) signature and credentials of LBHP.

(P) The assessment includes all elements and tools required by the OHCA. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the member. For children under the age of 16, it includes an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an LBHP. The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. 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 services of more than six months and it has been more than one year since the previous assessment.

(2) **Alcohol and Drug Assessment**. All providers must assess the medical necessity of each individual to determine the appropriate level of care. The assessment contains but is not limited to the following:

(A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;

(B) Source of information;

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

(D) Gender;

(E) Birth date;

(F) Home address;

(G) Telephone number;

(H) Referral source;

(I) Reason for referral;

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

(K) Presenting reason for seeking services; and

(L) Psychiatric social information, which must include:

(i) personal history, including: family B social; educational; cultural and religious orientation; occupational B military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; and financial;

(ii) clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations;

(iii) legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate;

(iv) substance abuse and dependence, both current and historical;

(v) gambling abuse and dependence, both current and historical;

(M) Present life situation;

(N) Mental status 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.; and

(iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.;

(O) Full Five Axes DSM diagnosis;

(P) A section on health history and pharmaceutical information, with 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;

(iv) benefit(s) and side effects of medication; and

(v) level of functionality;

(Q) Identification of the member's strengths, needs, abilities, and preferences:

(i) AODTP OR LBHP's interpretation of findings; and

(ii) signature and credentials of AODTP OR LBHP;

(R) The assessment includes all elements and tools required by the OHCA; and

(S) For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the member. For children under the age of 16, it must include an interview with a parent or other adult caretaker. For children, the assessment also includes information on school performance and school based services. This service is performed by an AODTP or LBHP. The minimum face to face time spent in assessment with the member (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. The 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 services of more than six months and it has been more than one year since the previous assessment.

(3) **Mental Health Services Plan Development by a Non-Physician (moderate complexity).**

(A) Mental Health Services Plan Development by a Non-Physician (moderate complexity) is performed by the practitioners and others who will comprise the treatment team. It 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 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate.

(B) The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment and determined diagnosis by the practitioners and the member of all pertinent information. 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.

(C) For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan addresses school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(D) Comprehensive and integrated service plan content addresses the following:

(i) member strengths, needs, abilities, and preferences;

(ii) identified presenting challenges, problems, needs, and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, measurable, attainable, realistic, and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed);

(v) each type of service and estimated frequency to be received;

(vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;

(vii) the practitioner(s) name and credentials that will be providing and responsible for each service;
(viii) any needed referrals for services;
(ix) specific discharge criteria;
(x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(xi) service plans are not valid until all signatures are present (signatures are required from the member, the parent/guardian when applicable, and the primary LBHP); and
(xii) changes in service plans can be documented in a service plan update (low complexity) or in the progress notes until time for the update (low complexity).

(E) One unit per SoonerCare member per provider is allowed without prior authorization. If determined by the OHCA or its designated agent, one additional unit per year may be authorized.

(4) **Mental Health Services Plan Development by a Non-Physician (low complexity).**

(A) Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the member and treatment progress assessed.
(B) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the six month review/update is due.
(C) Service plan updates must address the following:
(i) progress, or lack of, on previous service plan goals and/or objectives;
(ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(iv) change in frequency and/or type of services provided;
(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;
(vi) change in practitioner(s) who will be responsible for providing services on the plan;
(vii) additional referrals for needed services;
(viii) change in discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and

(x) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age 16 or otherwise applicable), and the primary LBHP.

(D) Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(5) **Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity).**

(A) Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria or other required tool is to be utilized and followed.

(B) The service 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 16, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. The service includes a discharge plan. The service 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.

(C) For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assist the family in caring for the child in the least restrictive level of care.

(D) Comprehensive and integrated service plan contents must address the following:

(i) member strengths, needs, abilities, and preferences;

(ii) identified presenting challenges and problems, needs, and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, measurable, attainable, realistic and time-limited (unless the individual is on a recovery maintenance/relapse prevention services plan, then objectives may be broad while the progress notes are detailed);

(v) each type of service and estimated frequency to be received;

(vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;
(vii) the practitioner(s) name and credentials who will be providing and responsible for each service;
(viii) any needed referrals for services;
(ix) specific discharge criteria;
(x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(xi) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age 16 or otherwise applicable), and the primary LBHP; and
(xii) changes in service plans can be documented in a Service Plan Update (low complexity) or in the progress notes until time for the Update (low complexity).

(6) **Alcohol and/or Substance Abuse Treatment Plan Development (low complexity).**

(A) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria or other required tool is utilized in the development of the Plan. All elements of the plan are reviewed with the member and treatment progress assessed.
(B) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) are provided by the treatment team members.
(C) Service plan updates are to address the following:
(i) progress, or lack of, on previous service plan goals and/or objectives;
(ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(iv) change in frequency and/or type of services provided;
(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;
(vi) change in practitioner(s) who will be responsible for providing services on the plan;
(vii) additional referrals for needed services;
(viii) change in 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. The required signatures are the:

(I) member (if over age 14),

(II) parent/guardian (if under age 16 or otherwise applicable), and

(III) primary LBHP.

(D) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the six month review/update is due.

(E) Service Plan updates are required every six months during which services are provided. Updates can be conducted whenever needed as determined by the provider and member.

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

(A) 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.

(B) 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.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the member and the LBPH or AODTP 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.(D) Individual/Interactive counseling must be provided by a LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) **Group Psychotherapy.**

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, 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 Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

(B) Group Psychotherapy must take place in a confidential setting limited to the LBHP or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult 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. A maximum of three units per day per member are allowed. Individual or group breaks will be discounted from the overall time and are not required to be noted separately. The individual member's behavior, the size of the group, and the focus of the group must be included in each member's medical record. As other members' personal health information cannot be included, the agency may keep a separate group log which contains detailed data on the group's attendees. A group may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(9) **Family Psychotherapy.**

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or an AODTP 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.

(B) A maximum of three units of Family Psychotherapy are allowed per day per member/family. Family Psychotherapy must be provided by a LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) **Psychiatric Social Rehabilitation Services (group).**

(A) Psychiatric Social Rehabilitation Services (PSR) are behavioral health remedial 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. This service is generally performed with only the members, 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. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. PSR services must be reflected by documentation (daily or weekly summary notes) in the member's records, and must include the following:

(i) date;

(ii) start and stop time(s) for each day of service;

(iii) signature of the primary rehabilitation clinician;

(iv) credentials of the primary rehabilitation clinician;

(v) specific goal(s) and/or objectives addressed (these must be identified on service plan);

(vi) type of skills training provided;

(vii) progress made toward goals and objectives;

(viii) member's report of satisfaction with staff intervention; and

(ix) any new needed supports identified during service.

(B) Compensable Psychiatric Rehabilitation Services are provided to members who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the member's current service plan. 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.

~~(C) Travel time to and from PSR treatment is not compensable. 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. The minimum staffing ratio is fourteen members for each PSRS, AODTP, or LBHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology. 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 PSRS, AODTP, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.~~

~~(D) A PSRS, AODTP, or LBHP may perform group psychiatric social rehabilitation services, using a treatment curriculum approved by a LBHP.~~

~~(11)~~ **~~Psychiatric Social Rehabilitation Services (individual).~~**

~~(A) Psychiatric Social Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the member present, but may include the member's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives. This service may include the Evidence Based Practice of Illness, Management, and Recovery.~~

~~(B) A PSRS, AODTP, or LBHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS~~

Systems of Care program may be prior authorized additional units as part of an intensive transition period.

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

(A) Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Mental Health, Substance Abuse, or Integrated Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessment conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

(13) **Alcohol and/or Substance Abuse Services, Skills Development (group).**

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of members regarding their alcohol and other drugs (AOD) addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the member's current service plan. 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. This service is generally performed with only the members, but may include a member and member family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum.

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. 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. The minimum staffing ratio is fourteen members for each PSRS, LBHP, or AODTP for adults and eight to one for children under the age of eighteen. This service may be performed by an AODTP, LBHP, or a PSRS. In order to develop and improve the member's community and interpersonal functioning and self care abilities, services may take place in settings away from the agency site. When this occurs, the AODTP, LBHP, or PSRS must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum

~~of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.~~

~~(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP or LBHP.~~

~~(14) **Alcohol and/or Substance Abuse Services, Skills Development (individual).**~~

~~(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services, Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the member present, but may include the member's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.~~

~~(B) An AODTP, LBHP, or PSRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable.~~

~~(15) **Medication Training and Support.**~~

~~(A) 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 progress notes. 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. Medication Training and Support may not be billed for SoonerCare member who reside in ICF/MR facilities. One unit is allowed per month per patient without prior authorization.~~

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(16) **Crisis Intervention Services**.

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. 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, or members who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of 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.

(B) Crisis Intervention Services must be provided by a LBHP.

(17) **Crisis Intervention Services (facility based stabilization).** Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) 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. Crisis Intervention Services (facility based stabilization) are compensable for child and adult SoonerCare member. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code. Children's facility based stabilization (0-18 years of age) requires prior authorization.

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

(A) The reimbursement for PACT services will end effective June 30, 2008.

(B) Program of Assertive Community Treatment (PACT) Services are provided through the Oklahoma Department of Mental Health and Substance Abuse Services and 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 uses 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. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:~~

~~(i) Assessment and evaluation;~~

~~(ii) Treatment planning;~~

~~(iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;~~

~~(iv) Symptom assessment, management, and individual supportive psychotherapy;~~

~~(v) Medication evaluation and management, administration, monitoring and documentation;~~

~~(vi) Rehabilitation services;~~

~~(vii) Substance abuse treatment services;~~

~~(viii) Activities of daily living training and supports;~~

~~(ix) Social, interpersonal relationship, and related skills training; and,~~

~~(x) Case management services.~~

~~(C) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for Crisis Intervention Services (facility based stabilization).~~

~~(19) **Behavioral Health Aide.** 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. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral 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.~~

~~(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit or may substitute one year of~~

relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience, and:

(i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(ii) must be supervised by a bachelor's level individual with a minimum of two years case management experience. Treatment plans must be overseen and approved by a LBHP; and

(iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent). The Behavioral Health Aide cannot bill for more than one individual during the same time period.

(20) **Family Support and Training.** 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 residing within a RBMS level of care and who without these services would require psychiatric hospitalization. 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. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements, such as the crisis plan and plan of care process; training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. 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. Services are goal directed as identified in the child's individualized plan of care and provided under the direction of a child and family treatment team and are intended to support the family with maintaining the child in the home and community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the member.

(A) The family support and training worker must meet the following criteria:

(i) have a high school diploma or equivalent;

(ii) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(iii) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS prior to providing the service;

(iv) pass OSBI and OKDHS child abuse check as well as adult abuse registry and motor vehicle screens; and

(v) receive ongoing and regular supervision by a person meeting the qualifications of a LBHP. A LBHP must be available at all times to provide back up, support, and/or consultation.

(B) These services may be retrospectively reviewed by OHCA or its designated agent.

(21) **Community Recovery Support**. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the mental 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 that usually work from the perspective of their training and/or their status as a licensed mental health provider; rather, this provider works from the perspective of their experiential expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery. Each provider must successfully complete over 40 hours of specialized training, demonstrate integration of newly acquired skills and pass a written exam in order to become

~~credentialed. A code of ethics and continuing education opportunities are components which inform the continued professional development of this provider.~~

~~(A) The community/recovery support worker must meet the following criteria:~~

~~(i) High School diploma or GED;~~

~~(ii) minimum one year participation in local or national member advocacy or knowledge in the area of mental health recovery;~~

~~(iii) current or former member of mental health services; and~~

~~(iv) successful completion of the ODMHSAS Recovery Support Provider Training and Test to be credentialed.~~

~~(B) These services may be retrospectively reviewed by OHCA or its designated agent.~~

~~(C) Example of work performed:~~

~~(i) 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.~~

~~(ii) Utilizing ongoing training may:~~

~~(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.

(iii) Possess knowledge about various mental health settings and ancillary services (i.e., Social Security, housing services, and advocacy organizations).

(iv) Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.

(I) attend continuing education assemblies when offered by or approved by the ODMHSAS's Office of Consumer Affairs; and

(II) develop and share recovery oriented material at member specific continuing education trainings.

(v) Serve by:

(I) providing and advocating for effective recovery oriented services;

(II) assisting members in obtaining services that suit that individual's recovery needs;

(III) informing members about community and natural supports and how to utilize these in the recovery process; and

(IV) assisting members in developing empowerment skills through self-advocacy.

(vi) Develop specific competencies which will enhance their work skills and abilities. Identified tasks include, but are not limited to:

(I) becoming a trained facilitator of Double Trouble in Recovery (DTR);

(II) becoming a trained facilitator of Wellness Recovery Action Plan (WRAP);

(III) pursuing the USPRA credential of Certified Psychiatric Rehabilitation Practitioner (CPRP).

(b) **Prior authorization and review of services requirements.**

(1) **General requirement.** All SoonerCare providers who provide outpatient behavioral health services are required to have the services they provide prior authorized by the OHCA or its designated agent. Services that do not require prior authorization are as follows:

(A) Mental Health Assessment by a Non-Physician;

(B) the initial four individual or family sessions before finalization of the service plan;

(C) Mental Health Service Plan Development by a Non-Physician (moderate complexity);

(D) Crisis Intervention Services; and

(E) Adult Facility Based Crisis Intervention.

(2) **Prior authorization and review of services**. The OHCA or its designated agent who performs the services identified in

paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) **Prior authorization process.**

(A) **Definitions.** The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

(i) "**Outpatient Request for Prior Authorization**" means the form used to request the OHCA or its designated agent to approve services.

(ii) **"Authorization Number"** means the number that is assigned per member and per provider that authorizes payment after services are rendered.

(iii) **"Initial Request for Treatment"** means a request to authorize treatment for a member that has not received outpatient treatment in the last six months.

(iv) **"Extension Request"** means a request to authorize treatment for a member who has received outpatient treatment in the last six months.

(v) **"Modification of Current Authorization Request"** means a request to modify the current array or amount of services a member is receiving.

(vi) **"Correction Request"** means a request to change a prior authorization error made by the OHCA or its designated agent.

(vii) **"Provider change in demographic information notification"** means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(viii) **"Status request"** means a request to ask the OHCA or its designated agent the status of a request.

(ix) **"Important notice"** means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(x) **"Letter of collaboration"** means an agreement between the member and two providers when a member chooses more than one provider during a course of treatment.

(B) **Process**. A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA or its designated agent, prior to rendering the initial services or any additional array of

~~services, with the exception of Mental Health Assessment by a Non-Physician; the first four sessions prior to completion of the service plan; Mental Health Service Plan Development by a Non-Physician (moderate complexity); and Crisis Intervention Services; and Adult Facility Based Crisis Intervention.~~

~~(i) These request forms must be fully completed including the following:~~

~~(I) pertinent demographic and identifying information;~~

~~(II) complete and current CAR or ASI unless another appropriate assessment tool is authorized by the OHCA or its designated agent;~~

~~(III) complete multi axial, DSM diagnosis using the most current edition;~~

~~(IV) psychiatric and treatment history;~~

~~(V) service plan with goals, objectives, treatment duration; and~~

~~(VI) services requested.~~

~~(ii) The OHCA or its designated agent may also require supporting documentation for any data submitted by the provider. The request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.~~

~~(iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.~~

~~(C)~~ **~~Authorization for services.~~**

~~(i) Services are authorized by the OHCA or its designated agent using independent medical judgment to perform the review of prior authorization requests to determine whether the request meets medical necessity criteria. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon seven levels of care for children and six levels of care for adults. The numerically based levels of care are designed to reflect the member's acuity as each level of care, in ascending order. Additional levels of care are known as Exceptional Case, 0-36 months, ICF/MR, Recovery Maintenance/Relapse Prevention, and RBMS.~~

~~(ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.~~

(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 prior 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 Billing Manual. The OHCA or its designated agent who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(d) Non prior authorized services will not be SoonerCare compensable with the exception of the initial 1-4 sessions (to be used prior to completion of the Service Plan), Assessment Service Plan (moderate complexity), Crisis Intervention, and Adult Facility Based Crisis Stabilization.

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 Billing Manual.

(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 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 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 or AODTP for AOD.

(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.

(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 16, 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 or AODTP for AOD.

(C) **Time requirements.** Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(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.

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 LBPH or AODTP 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 when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(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 when treating mental illness or the AODTP when treating alcohol and other drug disorders, 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 Psychiatric-social 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 when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder. Group Psychotherapy must take place in a confidential setting limited to the LBHP or the AODTP 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 an AODTP 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 when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(3) **Limitations**. A maximum of 12 units per day per member/family unit is compensable.

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

(1) **Definition**. MST intensive outpatient program services are limited to children within an 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.

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

(a) **Definition**. BHRS are behavioral health remedial 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**.

(A) Individual. Only the BHRS and member are present for the session.

(B) Group. This service is generally performed with only the members, 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, AODTP, or LBHP may perform BHR, following a treatment curriculum approved by a LBHP or AODTP for AOD. 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, AODTP, 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.

(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, AODTP, 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 prior approved 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.

(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 progress notes. 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.

(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.

317:30-5-241.4 Crisis Intervention

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

(1) **Definition**. Crisis Intervention Services are 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.

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.

(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.

(4) **Limitations**. A maximum of 105 hours per member per year in the aggregate. SoonerCare members who are enrolled in this

service may not receive other outpatient behavioral health services except for FBCS and CM.

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

(1) **Definition**. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral 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 certified through ODMHSAS.

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

(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 residing within a RBMS level of care and who without these services would require psychiatric hospitalization.

(3) **Qualified professionals**. Family Support Providers (FSP) must be certified through ODMHSAS.
(4) **Limitations**. The FSP cannot bill for more than one individual during the same time period.

(d) **Community Recovery Support**.
(1) **Definition**. CRS (or Peer Recovery Support) services are an EBP model of care which consists of a qualified peer support provider (RSS) who assists individuals with their recovery from behavioral health disorders.
(2) **Target population**. Adults 18 and over with SMI and/or AOD disorder(s).
(3) **Qualified professionals**. Recovery Support Specialist (RSS) who is certified through ODMHSAS.
(4) **Limitations**. The RSS cannot bill for more than one individual during the same time period.

317:30-5-244. Individuals eligible for Part B of Medicare

Outpatient Behavioral Health services provided to Medicare eligible ~~recipients~~ members ~~should be~~ are filed directly with the fiscal agent.

317:30-5-248. Documentation of records

All outpatient behavioral health services must be reflected by documentation in the ~~member~~ member=s records.
(1) For ~~Mental~~ Behavioral Health and Alcohol and Drug Assessments (see OAC 317:30-5-241), no progress ~~note~~ notes are required.
(2) For ~~Mental~~ Behavioral Health Services Plan and Alcohol and/or Substance Abuse Services, Treatment Plan (see OAC 317:30-5-241), no progress ~~note~~ notes are required.
(3) Treatment Services must be documented by progress notes.
(A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack ~~or~~ of, in treatment and must include the following:
(i) Date;
(ii) Person(s) to whom services were rendered, must be HIPAA compliant if other individuals in session are mentioned;
~~(iii) SoonerCare number for member;~~
~~(iv)~~ (iii) Start and stop time for each timed treatment session or service;
~~(v)~~ (iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the

clinical file within 30 days and no stamped or Xeroxed signatures are allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;
~~(vi)~~(v) Credentials of therapist/service provider;
~~(vii)~~(vi) Specific treatment plan problems(s), goals and/or objectives addressed;
~~(viii)~~(vii) Services provided to address need(s), goals and/or objectives;
~~(ix)~~(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
~~(x)~~(ix) Member (and family, when applicable) response to the session or intervention; (what did the member do in session? What did the provider do in session?);
~~(xi)~~(x) Any new need(s), goals and/or objectives identified during the session or service.

(4) In addition to the items listed in (1) of this subsection:
(A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;
(B) a list of participants for each Group rehabilitative or counseling session and facilitating ~~PSRS~~ BHRS, LBHP, or AODTP must be maintained; and
(C) for medication training and support, vital signs must be recorded in the progress note, but are not required on the ~~mental~~ behavioral health services plan;

(5) Progress notes for intensive outpatient ~~mental~~ behavioral health, substance abuse, or integrated BHR programs may be in the form of daily ~~summary~~ or weekly summary notes and must include the following:
(A) Curriculum sessions attended each day and/or dates attended during the week;
(B) Start and stop times for each day attended;
(C) Specific goal(s) and objectives addressed during the week;
(D) Type of Skills Training provided each day and/or during the week;
(E) Member satisfaction with staff intervention(s);
(F) Progress, or barriers to, made toward goals, objectives;
(G) New goal(s) or objective(s) identified;
(H) Signature of the lead ~~PSRS~~ BHRS; and
(I) Credentials of the lead ~~PSRS~~ BHRS.

(6) Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes and signed by the member.

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

(1) Talking about the past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.

(2) Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.

(3) Work/school-specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following 317:30-5-285 through 317:30-5-285.

(4) Job specific supports such as teaching/coaching a job task.

IV. Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE NOT previously been reviewed by the Board.

A. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-41.8. through 317:35-5-41.10. [AMENDED]
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 7. Determination of Financial Eligibility
OAC 317:35-9-65. [AMENDED]
(Reference APA WF # 08-23)

SUMMARY: Medical Assistance for Adults and Children rules are being revised to: (1)remove an incorrect procedure for legal action that was added to long term care resource policy for individuals categorically related to age, blind, and disability (ABD) effective August 2007; (2) clarify how loans and transfers of property can possibly affect the member's eligibility for long term care; (3) clarify Workers' Compensation Medicare Set Aside Arrangements are not considered resources; (4) clarify transfer or disposal of capital resources for ABD individuals are not applicable unless the individual enters a nursing home or receives waiver services; and (5) remove incorrect language that references AFDC and spend down. Without the rule changes members may possibly be denied service options based on an obsolete or ambiguous language.

BUDGET IMPACT: Agency staff has determined that the rule revisions are budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000.

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include services detailed in (A) through (B) of this paragraph.

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life. ~~If the undue hardship exists because the applicant was exploited, legal action must be pursued before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.~~

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the

facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson,

stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages**. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities**. Treatment of annuities purchased on or after February 8, 2006.

(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal

Revenue Code of 1986;
(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;
(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(C) The annuity:
(i) is irrevocable and nonassignable;
(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and
(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:
(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or
(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) **Life Estates**. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:
(A) The life estate was purchased before February 8, 2006; or
(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

317:35-5-41.9. Resource disregards

In determining need, the following are not considered as resources:

(1) The coupon allotment under the Food Stamp Act of 1977;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:
(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Loan Verification form, is completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Loan Verification form are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;
(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide;
(C) Proceeds of a loan secured by an exempt asset are ~~not an asset;~~ considered in relation to the maximum reserve.
(5) Indian payments or items purchased from Indian payments (including ~~judgement~~ judgment funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with ~~judgement~~ judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;
(6) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;
(7) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(9) Payment to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(10) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;
(11) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;
(12) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(13) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(14) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(15) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;
(16) Interests of individual Indians in trust or restricted lands. However, any disbursements from the trust or the restricted lands are considered as income;
(17) Resources set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of resources excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
(18) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(19) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;
(20) Payments received under the Civil Liberties Act of 1988.

These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
(21) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released;
(22) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC 317:35-5-41.6 regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment;
(23) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
(24) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(25) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419); ~~and~~
(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer are disregarded at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies~~.~~; and
(27) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs), which allocate a portion of the workers' compensation settlement for future medical expenses.

317:35-5-41.10. Changes in capital resources
(a) **Capital resources of an applicant or member currently receiving assistance.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. If a member who is currently receiving medical assistance acquires resources which increase his/her available resources at an amount above the maximum resource standard, he/she is given a reasonable amount of time to make the resources available. A reasonable

amount of time would normally not exceed 90 days. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90 day period is justified only after interviewing the member, determining that a good faith effort is still being made and that failure to make the resource available is due to circumstances beyond the control of the member.

(b) **Money borrowed on member's resources.** Money borrowed on any of the member's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the maximum ~~resource~~ reserve standard.

(c) **Transfer of resources**. Rules on transfer or disposal of capital resources are not applicable ~~if~~ unless the individual enters a nursing home or receives Home and Community Based Waiver Services, HCBWS/MR or ADvantage waiver services. [See OAC 317:35-9, OAC 317:35-17, and OAC 317:35-19]

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-65. General financial eligibility requirements for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals

Financial eligibility for these types of long-term medical care is determined using the rules on income and resources according to ~~the category to which the individual is related. (See OAC 317:35-10 for individuals categorically related to AFDC, and~~ OAC 317:35-7-36. ~~for those categorically related to ABD.)~~

(1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for long-term medical care.

(2) To be eligible for long-term care in an ICF/MR (private and public), HCBW/MR services and for persons 65 years or older in mental health hospitals, the individual must be determined categorically needy. ~~according to the standards appropriate to the categorical relationship.~~

(3) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS ~~Appendix C-1~~ Form 08AX001E, Schedule VIII. B. 1., refer to OAC 317:35-5-41.6(a)(6)(B) for rules on establishing a Medicaid Income Pension Trust.

(4) When eligibility for long-term care has been determined, the vendor payment amount, if applicable, is determined based on type of care, ~~categorical relationship,~~ community spouse, etc. Individuals determined eligible for HCBW/MR services will not have a vendor payment.

(5) The ~~spenddown~~ vendor payment is applied to the ~~vendor payment on the~~ first claim(s) received on behalf of the

individual.
(6) For an individual eligible for long-term care in an ICF/MR (private and public) or for an individual 65 years or older in a mental health hospital, the ~~individual's share of the~~ vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the ~~member's share of the~~ vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins.

B. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-9. [AMENDED]
(Reference APA WF # 08-13)

SUMMARY: Rules are revised to clarify that additional reimbursement is not allowed for joint injection codes that have a global coverage designation. Current rules are too broad and state that payment is made for both an office visit and an injection of joints performed during the visit. Although in some cases it is appropriate to reimburse for both the visit and the injection, in most cases the CPT joint injection code has a global coverage designation and should be excluded from additional reimbursement because it has been established to include an evaluation prior to the injection.

BUDGET IMPACT: Agency staff have determined that there will be a savings of $768.57 based on calendar year 2007 data. The state share of the savings will be $252.86.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 17, 2008, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 19, 2009. It was unattended by the public and no comments were received.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers**. The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month

per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.
(2) Visits for the purpose of family planning are excluded from the four per month limitation.
(3) Payment is allowed for insertion of IUD in addition to the office visit.
(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.
(A) Casting materials
(B) Dressing for burns
(C) Intrauterine device
(D) IV Fluids
(E) Medications administered by IV
(F) Glucose administered IV in connection with chemotherapy in office
(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.
(6) Medically necessary office lab and X-rays are covered.
(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
(8) Hearing aid evaluations are covered for members under 21 years of age.
(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.
(11) Payment is made for an office visit in addition to allergy testing.
(12) Separate payment is made for antigen.
(13) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.
(14) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
(15) Separate payment is made for the following specimen collections:
(A) Catheterization for collection of specimen; and
(B) Routine Venipuncture.
(16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
(17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
(4) Additional payment will not be made for night calls, unusual hours or mileage.
(5) Payment is not made for an office visit where the member did not keep appointment.
(6) Refractive services are not covered for persons between the ages of 21 and 65.
(7) Removal of stitches is considered part of post-operative care.
(8) Payment is not made for a consultation in the office when the physician also bills for surgery.
(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**
(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.
(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care are used.
(3) Certain medical procedures are allowed in addition to office visits.
(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day and 4 units per month. Payment for critical care, each additional 30 minutes is limited to two units per day/month.

(e) **Non-covered inpatient medical services.**
(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.
(2) A hospital admittance or visit and surgery on the same day

would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing home visits per month. The appropriate CPT code is used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

C. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility anc Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-42. [AMENDED]
(Reference APA WF # 08-25)

SUMMARY: Eligibility rules are revised to comply with Public Laws 104-204, 108-183, and 106-419. Public Law 104-204 requires payments made to certain Vietnam veterans' children with spina bifida to be disregarded for purposes of SoonerCare eligibility. Public Law 108-183 requires payments made to certain Korea service veterans' children with spina bifida to be disregarded for purposes of SoonerCare eligibility. Public Law 106-419 requires payments made to children of women Vietnam veterans who suffer from certain birth defects to be disregarded for purposes of SoonerCare eligibility. Other revisions correct procedures for lump sum payments and the child care expense earned income exemption. Proposed revisions are required to comply with state and federal regulations.

BUDGET IMPACT: Agency staff have determined that these revisions will be budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 20, 2007, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 104-2-4; Public Law 108-183; Public Law 106-419

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 10. MEDICAL AID TO FAMILIES WITH DEPENDENT CHILDREN
PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income is questionable the worker must verify the income. The worker views all data exchange screens on all individuals included in the household size. If the data exchange screen reveals conflicting information, the worker must resolve the conflicting information and if necessary, request verification.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Department of Human Services (OKDHS). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 30 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC related unit.

(E) Income which can reasonably be anticipated to be received

is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. Pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

~~(B) The worker must ask applicants if they have received a lump sum payment during the month of application, any month during the application process or anticipate to receive a lump sum in the future. Members are asked at the time of periodic redetermination if the benefit group has received or is expecting to receive a lump sum. The worker provides an oral explanation, including examples of lump sum payments,~~

~~how the rule affects other benefits and the importance of reporting anticipated receipt of a lump sum payment. The worker also offers counseling when there is indication of anticipated receipt, including voluntary withdrawal of the application or case closure and availability of free legal advice.~~

~~(C)~~ (B) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

~~(D)~~ (C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

~~(E)~~ (D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

~~(F)~~ (E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

~~(G)~~ (F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) A caretaker relative can only be included in the benefit

group when the biological or adoptive parent is not in the home. A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children regardless of whether the caretaker relative's needs are or are not included. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the ~~relative~~ caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

(8) When there is a stepparent or person living in the home with the ~~natural~~ biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent ~~but who is acting in the role of a spouse~~, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been

established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the ~~"true~~ wage~~"~~ prior to payroll deductions and/or withholdings.

(1) **Earned income from self-employment.** If the income results from the individuals's activities primarily as a result of the individuals's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income~~, if necessary,~~ only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered**. The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money

set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

(4) **Individual earned income exemptions.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) Child care expenses must be verified and the actual

amount per month, as paid, up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted. ~~In considering the care expense, only actual work hours and travel time between work and the child care facility or child care home will be allowed.~~

~~(iii) In explaining child care expenses, the worker informs the individual that payment for care is the responsibility of the member and any changes in the plan for care must be reported immediately.~~

~~(iv)~~ (iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider. ~~However, in cases where licensed dependent care facilities and/or approved in-home providers are not available (e.g, night employment), and the member arranges for care outside the home, an immediate referral is made by OKDHS Form K-13 to the licensing worker for a licensing decision. The cost of child care can be considered until the worker receives notification from the licensing worker that the home does not meet licensing standards or registration. If licensing or registration is denied, the member will be allowed 30 days after notification to make other child care arrangements, during which time the child care exemption will continue to be allowed.~~

~~(v)~~ (iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the ~~case~~ home meets applicable standards of State, local or Tribal law.

~~(vi)~~ (v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other

than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits ~~are~~ is considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. ~~If the individual states that he/she does not receive OASDI, has a pending application or has been denied OASDI, this can be verified, if necessary, by use of TPQYC computer transaction.~~ Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator.

(C) When disbursements have been made, the worker verifies whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers obtain documentation to verify services rendered and payment made by BIA.

(D) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona

fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form ~~Adm-103~~ 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form Adm-103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;
(5) Indian payments (including judgement funds or funds held in trust) which are distributed per capita by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;
(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;
(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;
(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;
(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for

children under the National School Lunch Act;
(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;
(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(15) Earnings of a child who is a full-time student are disregarded;
(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
(24) Interests of individual Indians in trust or restricted lands;
(25) Income up to $2,000 per year received by individual

Indians, which is derived from leases or other uses of individually-owned trust or restricted lands;

(26) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);

(27) Any payments made directly to a third party for the benefit of a member of the benefit group;

(28) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;

(29) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and an other such complimentary payments; ~~and~~

(30) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(31) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);

(32) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183); and

(33) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419).

(e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplies by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by 2.

(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

D. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 22. Pregnancy Related Benefits Covered Under Title ~~Xxi~~ XXI
OAC 317:35-22-9. through 317:35-22-11. [AMENDED]
(Reference APA WF # 08-21)

SUMMARY: Eligibility rules for Pregnancy Related Benefits Covered Under Title XXI (Soon to be Sooners program) are revised to make a correction regarding computer generated notices. Currently, rules state that a notice is sent to both the applicant/member and the provider whenever the application is certified or denied, or an active case is closed. Rules are revised to state that the notice generated when an eligibility decision on an application is made or when an active case is closed, is sent to the applicant/member only; a notice is not sent to the provider.

BUDGET IMPACT: Agency staff have determined that these revisions will be budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 17, 2008, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 431.200 through 431.214

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE ~~Xxi~~ XXI

317:35-22-9 Notification of eligibility
When eligibility for the pregnancy benefits covered under Title XXI is established, the OKDHS county office updates the computer form and the appropriate notice is computer generated to the member ~~and provider~~.

317:35-22-10 Denials

If denied the computer input form is updated and the appropriate notice is computer generated to the ~~client and provider~~ applicant.

317:35-22-11 Closures

Health benefit cases are closed by the OKDHS county office at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the member ~~and the provider~~.

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 3. General Provider Policies
Part 4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program/Child Health Services
OAC 317:30-3-65.4. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-2. [AMENDED]
Part 3. Hospitals
OAC 317:30-5-49. [AMENDED]
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-97. [AMENDED]
Part 103. Qualified Schools as Providers of Health Related Services
OAC 317:30-5-1026. [AMENDED]
(Reference APA WF # 08-54)

SUMMARY: Rules are revised to update sections referencing an incorrect citation regarding a health care provider's obligation to report suspected child abuse and/or neglect discovered through screenings and regular examinations. Section 7103 of Title 10 of Oklahoma Statutes requires health care providers to report suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of Oklahoma Statutes requires health care providers to report criminally injurious conduct to the nearest law enforcement agency.

BUDGET IMPACT: Agency staff have determined that these revisions will be budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 15, 2009, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 7103 of Title 10 of Oklahoma Statutes; Section 7104 of Title 10 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.4. Screening components

Comprehensive EPSDT screenings are performed by, or under the supervision of, a SoonerCare physician or other SoonerCare practitioner. SoonerCare physicians are defined as all licensed ~~medical~~ allopathic and osteopathic physicians in accordance with the rules and regulations covering OHCA=s SoonerCare program.~~,~~ Other SoonerCare practitioners are defined as all contracted physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's ~~medical care~~ SoonerCare program. At a minimum, screening examinations must include, but not be limited to, the following components:

(1) **Comprehensive health and developmental history**. Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(A) **Developmental assessment**. Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information on the child's usual functioning as reported by the child, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the child's age and culture. As appropriate, assess the following elements:

(i) Gross and fine motor development;
(ii) Communication skills, language and speech development;
(iii) Self-help, self-care skills;
(iv) Social-emotional development;
(v) Cognitive skills;
(vi) Visual-motor skills;
(vii) Learning disabilities;
(viii) Psychological/psychiatric problems;
(ix) Peer relations; and
(x) Vocational skills.

(B) **Assessment of nutritional status**. Nutritional assessment may include preventive treatment and follow-up services

including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

(i) Questions about dietary practices;

(ii) Complete physical examination, including an oral dental examination;

(iii) Height and weight measurements;

(iv) Laboratory test for iron deficiency; and

(v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination**. Comprehensive unclothed physical examination includes the following:

(A) **Physical growth**. Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection**. Check the general appearance of the child to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program ~~to be~~ effective October 1, 1994. Vaccines ~~will be~~ are provided free of charge to all enrolled providers for ~~Medicaid~~ SoonerCare eligible children. Participating providers may bill for an administration fee ~~to be~~ set by the Centers for Medicare and Medicaid Services (CMS)~~, formerly known as HCFA~~ on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests**. A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5).

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from

laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered. General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule found at OAC 317:30-3-65.2.

(5) **Health education**. Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or children is required. It is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens**. Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined in the periodicity schedule found at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services**. An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every child in accordance with the periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Child abuse.** Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency. ~~Title 21, Oklahoma Statutes, Section 846, as amended, states in part: "Every physician or surgeon, including doctors of medicine and dentistry, licensed~~

~~osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflected upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above". Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) ~~medical programs~~ SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgicenter or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in

office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs ~~under the jurisdiction of the Authority~~ administered by OHCA. A copy of the authorization, OKDHS form ~~ABCDM-16~~ 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and~~, executes~~ execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for I.U.D. insertion during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling (requires special medical review prior to approval).
(Q) Weekly blood counts for members receiving the drug Clozaril.
(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penacillamine on a regular basis for treatment other than for malignancy.
(S) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:
(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;
(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
(iii) Hold unrestricted license to practice medicine in Oklahoma;
(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
(v) Seeing members without supervision;
(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
(viii) Additionally, if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.
(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.
(i) Attending physician performs chart review and sign off on the billed encounter;
(ii) Attending physician present in the clinic/or hospital setting and available for consultation;
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.
(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:
(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
(ii) The contact must be documented in the medical record.
(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.
(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically

indicated.
(Z) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and ~~adult~~ adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:
(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(iv) Procedures considered experimental or investigational are not covered.
(AA) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.
(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.
(BB) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.
(CC) Ventilator equipment.
(DD) Home dialysis equipment and supplies.
(EE) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB ~~not listed in OAC 317:30-3-46~~ beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.
(FF) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.
(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:
(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP ~~capitation~~ care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with 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.

(GG) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) Refractions and visual aids.

(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered ~~to be~~ experimental or

investigational.
(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.
(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
(M) Physician supervision of hemodialysis or peritoneal dialysis.
(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury, or illness related to a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(R) Night calls ~~or unusual hours~~.
(S) Speech and Hearing services.
(T) Mileage.
(U) A routine hospital visit on the date of discharge unless the member expired.
(V) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(W) Inpatient chemical dependency treatment.
(X) Fertility treatment.
(Y) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's ~~medical programs~~ SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for

children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements ~~will~~ are not ~~be~~ authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements ~~will be~~ is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency. ~~Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*~~

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care must be used.

(D) A separate payment for pre-operative care, if provided on

the day before or the day of surgery, or for typical post-operative follow-up care.
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of persons who are under 21 years of age.
(G) Non-therapeutic hysterectomy.
(H) Medical Services considered ~~to be~~ experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician supervision of hemodialysis or peritoneal dialysis.
(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(M) Payment for the services of physicians' assistants except as specifically set out in OHCA rules.
(N) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(P) Night calls ~~or unusual hours~~.
(Q) Mileage.
(R) A routine hospital visit on date of discharge unless the member expired.
(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

PART 3. HOSPITALS

317:30-5-49. Child abuse

(a) Instances of child abuse and/or neglect are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency. ~~Title 21, Oklahoma Statutes, Section 846, as amended, states in part; every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Provided it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.~~

(b) Each hospital must designate a person, or persons, within the facility who is responsible for reporting suspected instances of medical neglect, including instances of withholding of medically indicated treatment (including appropriate nutrition, hydration and medication) from disabled infants with life-threatening conditions. The hospital must report the name of the individual so designated to this agency, which is responsible for administering this provision within the State of Oklahoma. The hospital administrator ~~will be~~ is assumed to be the contact person unless someone else is specifically designated.

(c) The Child Abuse Unit of the Oklahoma Child Welfare Unit ~~will be~~ is responsible for coordination and consultation with the individual designated. In turn, the hospital is responsible for prompt notification to the Child Abuse Unit of any case of suspected medical neglect or withholding of medically-indicated

treatment from disabled infants with life-threatening conditions. This information must be communicated to Child Abuse Unit, Child Welfare Services, P.O. Box 25352, Oklahoma City, OK 73125, Telephone: (405) 521-2283. Should a report need to be made when the office is closed, telephone the statewide toll-free Child Abuse Hot Line: 1-800-522-3511.
(d) Each Hospital should provide the name, title and telephone number of the designated individual and return it to the OHCA. This information ~~will be~~ is updated annually as part of the contract renewal. Should the designation change before that time, OHCA should be furnished revised information.

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-97. Child abuse

(a) Instances of child abuse and/or neglect are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency. ~~Title 21, Oklahoma Statutes, Section 846, as amended, states in part; every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Provided it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.~~
(b) Each hospital must designate a person, or persons, within the facility who is responsible for reporting suspected instances of medical neglect, including instances of withholding of medically indicated treatment (including appropriate nutrition, hydration and medication) from disabled infants with life-threatening conditions. The hospital must report the name of the individual so designated to this agency, which is responsible for administering this provision within the State of Oklahoma. The hospital administrator

~~will be~~ is assumed to be the contact person unless someone else is specifically designated.
(c) The Child Abuse Unit of the Oklahoma Child Welfare Unit ~~will be~~ is responsible for coordination and consultation with the individual designated. In turn, the hospital is responsible for prompt notification to the Child Abuse Unit of any case of suspected medical neglect or withholding of medically-indicated treatment.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1026. Reporting of suspected child abuse/neglect

Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.
~~Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *"Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above."* Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.~~

F. **CHAPTER 45. INSURE OKLAHOMA/ OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**
Subchapter 1. General Provisions
OAC 317:45-1-4. [AMENDED]
Subchapter 3. Insure Oklahoma/O-EPIC ~~PA~~ Carriers
OAC 317:45-3-1. through 317:45-3-2. [AMENDED]
Subchapter 5. Insure Oklahoma/O-EPIC ~~PA~~ Qualified Health Plans
OAC 317:45-5-1. through 317:45-5-2. [AMENDED]
Subchapter 7. Insure Oklahoma/O-EPIC ~~PA~~ ESI Employer Eligibility
OAC 317:45-7-2. through 317:45-7-3. [AMENDED]
OAC 317:45-7-5. [AMENDED]
OAC 317:45-7-8. [AMENDED]
Subchapter 9. Insure Oklahoma/O-EPIC ~~PA~~ ESI Employee Eligibility
OAC 317:45-9-1. through 317:45-9-4. [AMENDED]
OAC 317:45-9-6. through 317:45-9-7. [AMENDED]
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 1. Individual Plan Providers
OAC 317:45-11-1. through 317:45-11-2. [AMENDED]
Part 5. Insure Oklahoma/O-EPIC ~~Individual Plan~~ IP Member Eligibility
OAC 317:45-11-20. through 317:45-11-24. [AMENDED]
OAC 317:45-11-26. through 317:45-11-27. [AMENDED]
(Reference APA WF # 08-56)

SUMMARY: Rules are revised to update the premium assistance program name from O-EPIC to Insure Oklahoma/O-EPIC. Several current business processes within the Insure Oklahoma/O-EPIC program are also updated. The premium assistance program's name changed to Insure Oklahoma/O-EPIC to coincide with an extensive statewide marketing campaign.

BUDGET IMPACT: Agency staff have determined that these revisions will be budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 27, 2008, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1010.1 et seq. of

Title 56 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 45. INSURE OKLAHOMA/ OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) ~~O-EPIC members~~ Members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed ~~5%~~ five percent of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The ~~O-EPIC~~ member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period to be considered for reimbursement. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.

(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the ~~5%~~ five percent threshold would be absorbed.

SUBCHAPTER 3. INSURE OKLAHOMA/O-EPIC ~~PA~~ CARRIERS

317:45-3-1. Carrier eligibility

Carriers must ~~file a quarterly financial statement with the Oklahoma Insurance Department and~~ submit requested information to OHCA for each health plan to be considered for qualification. Carriers must also provide the name, address, telephone number,

and, if available, email address of a contact individual who is able to verify ~~O-EPIC~~ employer enrollment status in a ~~Qualified Health Plan~~ QHP.

317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if ~~Qualified Health Plans~~ QHPs continue to meet all requirements as defined in OAC 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA/O-EPIC ~~PA~~ QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Participating ~~Qualified Health Plans~~ ~~participating in O-EPIC~~ QHPs must offer, at a minimum, benefits that include:

(1) hospital services;
(2) physician services;
(3) clinical laboratory and radiology;
(4) pharmacy; and
(5) office visits.

(b) The health plan, if required, must be approved by the ~~Oklahoma Department of Insurance~~ Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual out-of-pocket maximum cannot exceed ~~$3,000 per individual~~ an amount that is established by OHCA. This amount includes any ~~individual~~ non-pharmacy, annual deductible amount for in-network services~~, except for pharmacy~~.
(2) Office visits cannot require a co-payment exceeding $50 per visit.
(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) ~~Qualified Health Plans~~ QHPs may provide an ~~Explanation of Benefits~~ ~~(~~EOB~~)~~ for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it must contain, at a minimum, the:

(1) provider's name;
(2) patient's name;
(3) date(s) of service;
(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) reason code(s) and description(s) for any denied service(s);

and
(6) amount due and/or paid from the patient or responsible party.

317:45-5-2. Closure criteria for health plans

Eligibility for the ~~Carrier=s~~ carrier's health plans ends when:
(1) changes are made to the design or benefits of the ~~Qualified Health Plan~~ QHP such that it no longer meets ~~O-EPIC~~ requirements for ~~Qualified Health Plans~~ QHPs. Carriers are required to report to OHCA any changes in health plans potentially affecting its qualification for participation in the ~~O-EPIC~~ program not less than 90 days prior to the effective date of such change(s).
(2) the ~~Carrier~~ carrier no longer meets the definition set forth in OAC 317:45-1-3.
(3) the health plan is no longer an available product in the Oklahoma market.
(4) the health plan fails to meet or comply with all requirements for a ~~Qualified Health Plan~~ QHP as defined OAC 317:45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA/O-EPIC ~~PA~~ ESI EMPLOYER ELIGIBILITY

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for Insure Oklahoma/O-EPIC is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). The TPA notifies the employer of the eligibility decision for employer and employees.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. Employers are not required to contribute to an eligible ~~spouse's~~ dependent's coverage.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit the current health plan invoice or other approved documentation to the TPA ~~via fax or mail~~.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma/O-EPIC ESI program ~~ends~~ may end during the eligibility period when:

(1) ~~the employer terminates its contract with all Qualified Health Plans~~ the employer no longer meets the eligibility requirements in OAC 317:45-7-1;
(2) the employer fails to pay premiums to the ~~Carrier~~ carrier;
(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid; or
(4) an audit indicates a discrepancy that makes the employer ineligible~~;~~.
~~(5) the employer no longer has a business location in Oklahoma; or~~
~~(6) the Qualified Health Plan or Carrier no longer qualifies for Insure Oklahoma/O-EPIC.~~

SUBCHAPTER 9. INSURE OKLAHOMA/O-EPIC ~~PA~~ ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employee ~~premium assistance~~ applications are ~~made with~~ submitted to the TPA.
(b) ~~The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility.~~ The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.
(c) All ~~O-EPIC~~ eligible employees described in this Section are enrolled in their Employer's QHP. ~~Employees eligible for O-EPIC~~ Eligible employees must:
(1) have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member;
(2) be a US citizen or alien as described in OAC 317:35-5-25;
(3) be Oklahoma residents;
(4) provide ~~his/her~~ social security number for all household members;
(5) not be ~~currently enrolled in, or have an open application for,~~ receiving benefits from SoonerCare/Medicare;
(6) be employed with a qualified employer at a business location in Oklahoma;
(7) be age 19 through age 64 or an emancipated minor;
(8) be eligible for enrollment in the employer's ~~Qualified Health Plan~~ QHP;
(9) ~~be working for primary employer(s)~~ not have full-time employment with any employer who ~~all meet~~ does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(10) select one of the ~~Qualified Health Plans~~ QHPs the employer

is offering.
(d) An employee's ~~spouse is~~ dependents are eligible ~~for O-EPIC if~~ when:
(1) the employer's health plan includes coverage for ~~spouses~~ dependents;
(2) the employee is eligible ~~for O-EPIC~~;
(3) if employed, the ~~spouse's primary~~ spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); ~~employer(s) meets employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);~~ and
(4) the ~~spouse is~~ dependents are enrolled in the same health plan as the employee.
(e) If an employee or ~~spouse is~~ their dependents are eligible for multiple ~~O-EPIC Qualified Health Plans~~ QHPs, each may receive a subsidy under only one health plan.

317:45-9-2. Employee eligibility period
(a) Employee eligibility is contingent upon the employer's program eligibility.
(b) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1.
(c) If the employee is determined eligible ~~for O-EPIC~~, he/she is approved for a period not greater than 12 months. The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.
(d) The employee's eligibility period begins on the first day of the month following the date of approval.

317:45-9-3. Qualifying Event
(a) Employees are allowed to apply ~~for O-EPIC~~ following a Qualifying Event.
(b) An employee's ~~spouse~~ dependents may become eligible for coverage and ~~is~~ are allowed to apply ~~for O-EPIC~~ following a Qualifying Event ~~of the employee or spouse~~.

317:45-9-4. Employee cost sharing
Employees are responsible for up to 15% percent of their health plan premium. The employees are also responsible for up to 15% of their ~~spouse's~~ dependent's health plan premium if the ~~spouse~~ dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her gross annual household income computed monthly.

317:45-9-6. Audits
Individuals participating in the Insure Oklahoma/O-EPIC program

are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer ~~no longer meets the requirements for O-EPIC~~ is no longer eligible, then ~~eligibility for~~ the associated employees enrolled under that employer are also ineligible. Employees are mailed a ~~written~~ notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the ~~Qualified Health Plan~~ QHP;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from ~~O-EPIC~~ the program;

(8) the employer fails to pay the premium;

(9) the ~~Qualified Health Plan~~ QHP or ~~Carrier~~ carrier is no longer qualified;

(10) the employee becomes eligible for Medicaid/Medicare;

(11) the employee or employer reports to the OHCA or the TPA any change affecting eligibility;

(12) the employee is no longer listed as a covered person on the employer's health plan invoice; or

(13) the employee requests closure.

SUBCHAPTER 11. INSURE OKLAHOMA/O-EPIC IP
PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. Insure Oklahoma/O-EPIC Individual Plan providers

Insure Oklahoma/O-EPIC Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive ~~SoonerCare~~ reimbursement, the IP provider:

(1) must enter into a SoonerCare contract; and

~~(2) may collect the member's co-pay in addition to the SoonerCare reimbursement;~~

~~(3) may refuse to see members based on their inability to pay their co-pay; and~~

~~(4)~~ (2) must complete Insure Oklahoma/O-EPIC IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. Insure Oklahoma/O-EPIC IP provider payments

Payment for covered benefits rendered to Insure Oklahoma/O-EPIC IP members, as shown in OAC 317:45-11-10 and not listed as a non-covered service in OAC 317:45-11-11, ~~rendered to O-EPIC IP members~~ is made to contracted Insure Oklahoma/O-EPIC IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f).

(1) Coverage of certain services requires prior authorization as shown in OAC 317:45-11-10 and may be based on a determination made by a medical consultant in individual circumstances~~.~~;

(2) The decision to charge a copayment for a missed visit is at the provider's discretion;

(3) The provider may collect the member's co-pay in addition to the SoonerCare reimbursement for services provided; and

(4) The provider may refuse to see members based on their inability to pay their co-pay.

PART 5. INSURE OKLAHOMA/O-EPIC ~~INDIVIDUAL PLAN~~ IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma/O-EPIC ~~Individual Plan~~ IP eligibility requirements

(a) Employees not eligible ~~for participating~~ to participate in an employer's ~~Qualified Health Plan (QHP)~~ QHP, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the ~~O-EPIC~~ Individual Plan. Applicants cannot obtain ~~O-EPIC~~ IP coverage if they are eligible for ~~O-EPIC PA~~ ESI.

~~(b) Applications may be found on the World Wide Web or may be requested by calling the O-EPIC helpline. Completed applications are submitted to the TPA.~~

~~(c)~~ (b) ~~The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility.~~ The eligibility determination is processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

~~(d)~~ (c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide ~~his/her~~ social security ~~number~~ numbers for all household members;

(5) be not currently enrolled in, or have an open application

for, Medicaid/Medicare;
(6) be age 19 through 64 or an emancipated minor; ~~and~~
(7) make premium payments by the due date on the invoice~~.~~; and
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

~~(e)~~ (d) If employed and working for an approved Insure Oklahoma/O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection ~~(d)~~ (c) of this Section and:
(1) have household income at or below 200% of the Federal Poverty Level.
(2) be ineligible for participation in their employer's QHP due to number of hours worked.
(3) have received notification from Insure Oklahoma/O-EPIC indicating their employer has applied for Insure Oklahoma/O-EPIC and has been approved.

~~(f)~~ (e) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection ~~(d)~~ (c) of this Section and~~: (1)~~ have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member~~; and (2) have received notification from O-EPIC indicating their employer has applied and has been approved with the attestation that they are not offering a QHP~~.

~~(g)~~ (f) If self-employed, the applicant must meet the requirements in subsection ~~(d)~~ (c) of this Section and:
(1) must have household income at or below 200% of the Federal Poverty Level;
(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; ~~and~~
(3) verify current income by providing appropriate supporting documentation~~.~~; and
(4) must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2).

~~(h)~~ (g) If unemployed seeking work, the applicant must meet the requirements in subsection ~~(d)~~ (c) of this Section and:
(1) must have household income at or below 200% of the Federal Poverty Level; and
(2) verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:
(A) OESC eligibility letter,
(B) OESC weekly unemployment payment statement, or
(C) bank statement showing state treasurer deposit.

~~(i)~~ (h) If working with a disability, the applicant must meet the

requirements in subsection ~~(d)~~ (c) of this Section and:
(1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and
(2) verify eligibility by providing a copy of their:
(A) ticket to work, or
(B) ticket to work offer letter.

317:45-11-21. ~~Spouse~~ Dependent eligibility
(a) If the spouse of an Insure Oklahoma/O-EPIC IP approved individual is eligible for Insure Oklahoma/O-EPIC ~~PA~~ ESI, they must apply for Insure Oklahoma/O-EPIC ~~PA~~ ESI. Spouses cannot obtain Insure Oklahoma/O-EPIC IP coverage if they are eligible for Insure Oklahoma/O-EPIC ~~PA~~ ESI.
(b) The employed or self-employed spouse of an approved applicant ~~approved according to the~~ must meet the guidelines listed in ~~OAC 317:45-11-20(a) through (h)~~ OAC 317:45-11-20(a) through (g) ~~is~~ to be eligible for Insure Oklahoma/O-EPIC IP.
(c) The ~~spouse~~ dependent of an applicant approved according to the guidelines listed in ~~OAC 317:45-11-20(i)~~ OAC 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma/O-EPIC IP. ~~The spouse may choose to apply separately.~~
(d) The applicant and the ~~spouses'~~ dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma/O-EPIC IP, then the associated ~~spouse~~ dependent enrolled under that applicant is also ineligible.

317:45-11-21.1. Certification of newborn child deemed eligible
(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma/~~Oklahoma Employer and Employee Partnership for Insurance Coverage Individual Plan (~~O-EPIC IP~~)~~ and the household countable income does not exceed SoonerCare requirements. (For purposes of this subparagraph, a newborn child is defined as any child under the age of one year). The newborn child is deemed eligible through the last day of the month the child attains the age of one year.
(b) The newborn child's eligibility is not dependent on the mother's continued eligibility for Insure Oklahoma/O-EPIC IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma/O-EPIC IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
(c) The newborn child's certification period is shortened only in the event the child:
(1) leaves the mother's home;
(2) loses Oklahoma residence;
(3) has medical needs included in another assistance case; or
(4) expires.

(d) No other conditions of eligibility are applicable, including social security number enumeration; however, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.

317:45-11-22. PCP choices

(a) The ~~applicants~~ applicant (and ~~spouse~~ dependents if also applying for Insure Oklahoma/O-EPIC IP) ~~are~~ is required to select valid PCP choices as required on the application.

(b) If a valid PCP is selected by the applicant or ~~spouse~~ dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected.

(c) After initial enrollment in Insure Oklahoma/O-EPIC IP, the applicant or ~~spouse~~ dependents can change their PCP selection by calling the Insure Oklahoma/O-EPIC helpline. Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and ~~spouse~~ dependents are only allowed to change their PCP a maximum of four times per calendar year.

317:45-11-23. Employee eligibility period

(a) The rules in this subsection apply to applicants eligible according to ~~OAC 317:45-11-20(a)-(f)~~ OAC 317:45-11-20(a) through (e).

(1) The employee's coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on ~~1-14-06~~ January 14th and the premium is received before ~~2-15-06~~ February 15th, eligibility begins ~~3-1-06~~ March 1st; or an application is received and approved ~~1-15-06~~ January 15th and the premium is received on ~~3-15-06~~ March 15th, eligibility begins ~~4-1-06~~ April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the ~~employer's program eligibility~~ employer meeting the program guidelines.

(3) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1 or ~~OAC 317:45-11-20(a)- (f)~~ OAC 317:45-11-20(a) through (e).

(4) If the employee is determined eligible for Insure

Oklahoma/O-EPIC IP, he/she is approved for a period not greater than 12 months. The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.

(b) The rules in this subsection apply to applicants eligible according to ~~OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i)~~ OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined by the TPA using the eligibility requirements listed in ~~OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i)~~ OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma/O-EPIC IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on ~~1-14-06~~ January 14th and the premium is received before ~~2-15-06~~ February 15th, eligibility begins ~~3-1-06~~ March 1st; or an application is approved ~~1-15-06~~ January 15th and the premium is received on ~~3-15-06~~ March 15th, eligibility begins ~~4-1-06~~ April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their gross monthly household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed 4% of their gross monthly household income, based on a family size of one and capped at ~~151%~~ 200% of the Federal Poverty Level.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

317:45-11-26. Audits

Members participating in the Insure Oklahoma/O-EPIC program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a ~~written~~ notice 10 days prior to closure of eligibility.

(b) ~~Employer~~ The employer and ~~employees~~ employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma/O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible.

(c) The employee's certification period may be terminated when:

(1) the member requests closure;

(2) the member moves out-of-state;

(3) the covered member dies;

(4) the employer's eligibility ends;

(5) an audit indicates a discrepancy that makes the member or employer ineligible;

(6) the employer is terminated from Insure Oklahoma/O-EPIC;

(7) the member fails to pay the ~~premium as well as any other amounts on or before the due date~~ amount due within 60 days of the date on the bill;

(8) the ~~Qualified Health Plan~~ QHP or ~~Carrier~~ carrier is no longer qualified;

(9) the member ~~becomes eligible~~ begins receiving SoonerCare benefits ~~for Medicaid/Medicare~~; or

(10) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

(d) This subsection applies to applicants eligible according to ~~OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i)~~ OAC 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:

(1) the member requests closure;

(2) the member moves out-of-state;

(3) the covered member dies;

(4) the employer's eligibility ends;

(5) an audit indicates a discrepancy that makes the member or employer ineligible;

(6) the member fails to pay the ~~premium~~ amount due within 60 days of the date on the bill;

(7) the member becomes eligible for ~~Medicaid~~ SoonerCare/Medicare; or

(8) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

G. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-43. [AMENDED]
(Reference APA WF #08-51)

SUMMARY: Agency rules are revised to allow the Oklahoma Health Care Authority to accept cash medical support payments by non-custodial parents if there is no access to health insurance for their child at a reasonable cost (5% or less of the non-custodial parent=s income). The administration and collection of the payments will be handled by the Oklahoma Department of Human Services, Child Support Enforcement Division.
BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 15, 2009, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Sections 5003 through 5016 of Title 63 of Oklahoma Statutes and 43 Okla. Stat. 118F.

PUBLIC HEARING: A public hearing was held on February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
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 Title XIX has been made available, reimbursement to the extent of such legal liability must be sought. If the applicant or recipient has already received payments from a third

party, OKDHS Form ~~Adm-50~~ 08AD050E, Third Party Liability Resources, is completed by ~~DHS~~ OKDHS staff and submitted 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 for payment of medical care must be determined as possible third party liability, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting ~~Title XIX services~~ 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. The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(B) **Government benefits.** When an individual requesting ~~Title XIX~~ SoonerCare is eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), payment is not made from ~~Title XIX~~ SoonerCare funds until the worker receives confirmation that other benefits are not available from this source. Payments from ~~Champus~~ CHAMPUS for medical care are not considered as income in determining eligibility. They are, however, considered as third party liability sources.

(2) **Workers' Compensation.** When an applicant for SoonerCare or ~~recipient of Title XIX~~ a SoonerCare member requires medical care because of work injury or occupational disease, the worker immediately ascertains the facts related to the injury or disease (such as date, details of the accident, etc.) and sends OKDHS Form ~~Adm-50~~ 08AD050E to OHCA/TPL to be referred to the ~~DHS~~ OKDHS Audit Unit of OIG. The ~~DHS~~ OKDHS Legal Division clears periodically with the Industrial Court all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or ~~recipient of Title XIX~~ a SoonerCare member is obtained, the ~~DHS~~ OKDHS Legal Division sends a memo to OHCA asking for an itemization of claims paid.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a ~~recipient of Title XIX~~ SoonerCare member as the result of an accident or injury known to the worker, the worker is responsible for determining 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 ~~clear~~ report liability insurance on all cars involved.

(A) The worker completes OKDHS Form ~~Adm-50~~ 08AD050E and submits it with any additional information available to the appropriate ~~DHS~~ OKDHS State Office Division where it is referred to ~~DHS~~ the OKDHS Audit and Review Division for determination of liability for medical care. A copy of this referral is sent to OHCA, Third Party Liability.

(B) If such report has not been received from the county but the OHCA receives a claim for payment from ~~Title XIX~~ SoonerCare funds and the diagnosis indicates the possibility the need for services resulted from an accident or injury involving third party liability, OHCA sends this information to ~~DHS~~ the OKDHS Office of Inspector General. The local office may be requested by the ~~DHS~~ OKDHS Audit and Review Division to submit OKDHS Form ~~Adm-50~~ 08AD050E. The worker completes this form and submits it to the ~~DHS~~ OKDHS State Office, where the ~~DHS~~ OKDHS Office of Inspector General will make any necessary follow-up and take the appropriate action.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the worker clears with the Social Security Office and enters the findings and the date of the verification in the case 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 ~~Title XIX~~ SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services 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 DCFS. The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing Child Support Enforcement case, the only action required is a memo to the appropriate Child Support Enforcement district

office notifying them of the certification.

(2) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CSED or retained by the member.

(3) Children who are in custody of OKDHS may be exempt from referral to CSED. Should the pursuit of the CSED services be determined to be detrimental to the OKDHS DCFS 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 OKDHS 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 CSED 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-CSED guidelines.

H. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 25. Psychologists
OAC 317:30-5-276. [AMENDED]
OAC 317:30-5-278.1 [AMENDED]
(Reference APA WF #08-53)

SUMMARY: Agency rules are revised in order to remove provider eligibility requirements for psychologists from the coverage section of the psychologist rules. Revisions also update terminology and bring rules in line with current OHCA practices.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 15, 2009, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Sections 5003 through 5016 of Title 63 of Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during or after the hearing.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

~~Payment is made to psychologists with a license to practice in the state where the service is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed, as set forth in this section.~~

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

(2) **Children.** Coverage for children includes the following:

(A) Psychiatric Diagnostic Interview Examination (PDIE). The interview and assessment is defined as a face-to-face interaction with the ~~client~~ 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 ~~unless there has been a break in service over a six month period~~. If there has been a break in service over a six month period, then an additional unit can be prior authorized by OHCA, or their designated agent.

(B) Individual and/or Interactive psychotherapy in an outpatient setting including an office or clinic. The services may be performed at the residence of the ~~recipient~~ member if it is demonstrated that it is clinically beneficial, or if the ~~client~~ 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. ~~It is a service personally rendered to an individual by a licensed psychologist.~~

(C) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or ~~client~~ member's residence. 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 ~~Medicaid~~ SoonerCare eligible child as a specifically identified component of an individual treatment plan.

(D) 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 eight patients. Group therapy must be provided for the benefit of a ~~Medicaid~~ SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. ~~Group therapy is billed per session. No more than one per patient session is allowed per day.~~

(E) Psychological, Developmental, Neuropsychological, Neurobehavioral Testing is clinically appropriate and allowable ~~utilized~~ when an accurate diagnosis and determination of treatment needs is needed ~~cannot be made~~

~~otherwise~~. Four hours/units of testing per patient (over the age of two), per provider is allowed without prior authorization every 12 months ~~each calendar year~~. In circumstances where it is determined that further testing is medically necessary, ~~an~~ additional ~~four~~ hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can be authorized. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the ~~actual~~ testing, interpretation, scoring, and/or reporting ~~is~~ was performed and supported by documentation.

(F) Payment for therapy services provided by a psychologist to any one member is limited to ~~four~~ five sessions/units ~~encounters~~ per month without prior authorization. ~~An encounter is defined as one hour of individual therapy, one hour of family therapy, or one group therapy session. The four encounters can be any combination of the treatment options.~~ In circumstances where it is determined that further sessions/units are medically necessary, then more sessions/units can be prior authorized by the Oklahoma Health Care Authority or their designated agent. A maximum of ~~8 hours~~ 12 sessions/units of therapy and testing services per day per provider are allowed. ~~A child who is being treated in an acute or residential inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only. 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 unless prior authorized by the OHCA or its designated agent.~~

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

(H) 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 by the OHCA or its designated agent.

(3) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the mentally retarded 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.

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

317:30-5-278.1. Documentation of records

All psychological services ~~must~~ will be reflected by documentation in the patient records.

(1) All assessment, testing, and treatment services/units billed must include the following:

(A) date;

(B) start and stop time for each ~~timed treatment~~ session/unit billed;

(C) signature of the provider;

(D) credentials of provider;

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

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

(G) progress made toward goals and objectives;

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

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

(2) For each Group psychotherapy session, a separate list of participants must be maintained.

(3) Psychological testing will be documented ~~by report~~ for each date of service performed which should include at a minimum, the objectives for testing, the tests administered, the results/conclusions and interpretation of the tests, and recommendations for treatment and/or care based on testing results and analysis.

I. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5.Individual Providers and Specialties
Part 41. Family Support Services
OAC 317:30-5-410. [AMENDED]
Part 43. Agency companion, Specialized Foster Care, Daily Living Supports, Group Homes, and community Transition Services
OAC 317:30-5-422. [AMENDED]
Part 101. Targeted Case Management Services for Persons with Mental Retardation and/or Related Conditions
OAC 317:30-5-1010. through 317:30-5-1010.1. [AMENDED]
Chapter 35. Medical Assistance for Adults and Children-Eligibility
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 1. Services
OAC 317:35-9-5. [AMENDED]
Chapter 40. Developmental Disabilities Services
Subchapter 1. General Provisions
OAC 317:40-1-1. [AMENDED]
Subchapter 5. Member Services
Part 1. Agency Companion Services
OAC 317:40-5-1. [REVOKED]
OAC 317:40-5-3. [AMENDED]
OAC 317:40-5-5. [AMENDED]
Part 9. Service Provisions
OAC 317:40-5-100. [AMENDED]
Subchapter 7. Employment Services through Home and Community-Based Services Waivers
OAC 317:40-7-6. [AMENDED]
OAC 317:40-7-8. [AMENDED]
OAC 317:40-7-11. [AMENDED]
OAC 317:40-7-13. [AMENDED]
(Reference APA WF # 08-46 A, B, & C)

SUMMARY: Developmental Disabilities Services rules are revised to: (1) provide clarification relating to service utilization, provisions, authorizations, limitations, and eligibility requirements; (2) specify provider requirements and related activities of targeted case management to meet federal requirements; (3) clarify provider responsibilities and limitations in the agency companion program; (4) specify devices and services allowable through assistive technology; (5) clarify physical plant expectations for services provided in center-based settings; and (6) amend policy to reflect appropriate terminology.

BUDGET IMPACT: Agency staff have determined that these revisions will be budget neutral.

RULE LENGTH IMPACT: These revisions have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 15, 2009, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.180

PUBLIC HEARING: A public hearing was held February 19, 2009. No comments were received before, during, or after the hearing.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with mental retardation and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member'=s capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount,

frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services (ACS) ~~provided in accordance with Part 1 of~~ per OAC 317:40-5;

(2) specialized foster care (SFC) ~~provided in accordance with Part 5 of~~ per OAC 317:40-5;

(3) daily living supports (DLS) ~~provided in~~:

(A) Community Waiver ~~in accordance with~~ per OAC 317:40-5-150; and

(B) Homeward Bound Waiver ~~in accordance with~~ per OAC 317:40-5-153;

(4) group home services provided ~~in accordance with~~ per OAC 317:40-5-152; and

(5) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for the mentally retarded (ICF/MR) or provider-operated residential setting to the member's own home or apartment. The cost per member of Community Transition Services cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) ~~is~~ are furnished only when the member is unable to meet such expense and must be ~~authorized~~ documented in the member's Individual Plan (IP);

(ii) ~~includes~~ include security deposits, essential furnishings such as major appliances, dining table/chairs, bedroom set, sofa, chair, window coverings, kitchen pots/pans, dishes, eating utensils, bed/bath linens, kitchen dish towel/potholders, one month supply of laundry/cleaning products, setup fees or deposits for initiating utility ~~or~~ service ~~access~~, including phone, electricity, gas, and water~~,~~ . CTS also includes moving expenses, ~~and services~~ services/items necessary for the member's health and safety such as pest eradication, allergen control, one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, tempering valve or other anti-scald device when determined by the Team necessary to ensure the member's safety~~. Utilities must be in the members's name~~; and

(iii) does not include:

(I) recreational items, such as television, cable ~~television access~~, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as diversion or recreation; ~~and~~

(II) monthly rental or mortgage expense~~, food, or regular utility charges.~~ ;

(III) food;

(IV) personal hygiene items;

(V) disposable items such as paper plates/napkins, plastic utensils, disposable food storage bags, aluminum foil, plastic wrap;

(VI) items that could be considered decorative such as rugs, pictures, bread box, canisters, or more than one basic clock;

(VII) any item not considered an essential basic one time expense; or

(VIII) regular ongoing utility charges.

(iv) prior approval for exceptions and/or questions regarding eligible items and/or expenditures are directed to the program manager for community transition services at OKDHS/DDSD state office.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH MENTAL RETARDATION AND/OR RELATED CONDITIONS

317:30-5-1010. Eligible providers

(a) **Eligible providers.** Services are provided by Oklahoma Department of Human Services (~~DHS~~ OKDHS) Developmental Disabilities Services Division (DDSD) case managers.

(1) **Certification requirements.** ~~Medicaid~~ SoonerCare Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services must be made available to all eligible ~~recipients~~ members and must be delivered on a statewide basis with procedures that assure 24 hour availability, the protection and safety of ~~recipients~~ members, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. A DDSDTCM case manager must:

(A) be employed by the ~~DHS~~ OKDHS, DDSD.

(B) possess knowledge of:

(i) case management methods, principles and techniques;

(ii) types of developmental disabilities represented within the caseload;

(iii) types of providers and services available for ~~consumers~~ members;

(iv) the behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;

(v) interviewing principles and techniques;

(vi) counseling principles and techniques; and

(vii) adaptive communication techniques and non-verbal communication.

(C) possess skill in:

(i) managing a caseload;

(ii) effectively intervening in crisis situations;

(iii) working cooperatively and effectively with other professionals in a team situation;

(iv) collecting and analyzing information;

(v) making decisions relating to services provided to ~~consumers~~ members;

(vi) developing a logical and practical plan of treatment for ~~consumers~~ members with developmental disabilities;

(vii) evaluating the progress of ~~consumers~~ members and the quality of their habilitation programs;

(viii) communicating effectively; and

(ix) mediating with providers and agencies to resolve problems.

(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider for DDSDTCM services must be in effect before reimbursement can be made for compensable services.

(c) **Provider selection.** ~~Provision of case management services must not restrict an individual's free choice of providers. Eligible recipients retain the right to free choice of qualified providers of targeted case management services identified by the State.~~

Target group consists of eligible members with developmental disabilities. Providers are limited to providers of case management services capable of ensuring that members with developmental disabilities receive needed services.

317:30-5-1010.1. Scope of service

(a) **Description of targeted case management services.**

(1) ~~Targeted case~~ Case management services are ~~activities that~~ services furnished to assist ~~the target population~~ members, eligible under the Medicaid State Plan, in gaining access to needed medical, social, educational and other services ~~and supports~~. ~~These supports and services include those not provided under the Oklahoma Home and Community Based Services waiver as well as those covered under the waiver. Services include~~ Case management includes the following assistance:

(A) assessment~~;~~ of a member to determine the need for medical, educational, social, or other services. Assessment activities include:

(i) taking member history;

(ii) identifying the member's needs and completing related documentation; and

(iii) gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the member.

(B) ~~support/service planning;~~ development of an individual plan and a specific plan of care that:

(i) are based on the information collected through the assessment;

(ii) specify the goals and actions to address medical, social, educational, and other services needed by the member;

(iii) include activities such as ensuring the active participation of the eligible member; and work with the member or member's authorized health care decision maker, and others to develop the goals; and

(iv) identify a course of action to respond to the assessed needs of the eligible member.

(C) ~~monitoring and coordination; and~~ referral and related activities to help an eligible member obtain needed services including activities that help link a member with:

(i) medical, social, educational providers; or

(ii) other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the member.

(D) ~~reassessment.~~ monitoring and follow-up activities include activities and contact necessary to ensure the individual

plan and the plan of care are implemented and adequately address the member's needs. Activities and contact may be with the member, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary including at least one annual monitoring to assure the following conditions are met:

(i) services are being furnished in accordance with the member's plan of care;

(ii) services in the plan of care are adequate; and

(iii) if there are changes in the needs or status of the member, necessary adjustments are made to the plan of care, and to service arrangements with providers.

(2) ~~Targeted case management is designed to assist individuals in accessing services. The client has the right to refuse targeted case management and cannot be restricted from services because of a refusal for targeted case management services.~~ Case management may include contact with individuals who are directly related to identifying the needs and supports for helping the eligible member to access services.

~~(3) Targeted case management does not include:~~

~~(A) physically escorting or transporting a client to scheduled appointment or staying with the client during an appointment;~~

~~(B) monitoring financial goals;~~

~~(C) providing specific services such as shopping or paying bills; or~~

~~(D) delivering bus tickets, food stamps, money, etc.~~

(b) **Targeted Case Management Service Requirements.** DDSD assures that:

(1) case management services are provided in a manner consistent with the best interest of members and are not used to restrict a member's access to other services under the plan;

(2) members are not compelled to receive case management services, condition receipt of case management services on the receipt of other SoonerCare services, or condition receipt of other SoonerCare services on receipt of case management services;

(3) case management conducts activities to ensure the health and welfare of HCBS waiver members. For members who refuse case management services, these activities are completed as follows:

(A) the member develops an Individual Plan (IP) per OAC 340:100-5-50 through 340:100-5-58.

(B) the member develops a plan of care requesting authorization for services and submits it with the IP to the Developmental Disabilities Services Division (DDSD) plan of care reviewer for review and approval per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(C) monthly progress reports, incident reports, OKDHS form

06HM005E, OKDHS form 06HM006E, and other documentation required to be submitted to case management are submitted to the DDSD state office program manager for case management for monitoring and follow-up per OAC 340:100-3-27.

(D) monitoring visits required by OAC 340:100-3-27 are conducted by DDSD Quality Assurance staff.

(E) the DDSD state office program manager assigns staff responsibility for maintaining the record in Client Contact Manager (CCM), obtaining necessary documents from the member and others for continuing service eligibility, providing information regarding available HCBS Waiver providers, making referrals to other programs and identifying training available to assist the member in completing the required tasks.

(4) providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~~(b)~~ (c) **Non-Duplication of services.** To the extent any eligible ~~recipients~~ members in the identified target population are receiving case management services from another provider agency as a result of being members of other covered target groups, the provider assures that case management activities are coordinated to avoid unnecessary duplication of service.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 1. SERVICES

317:35-9-5. Home and Community - Based Waiver Services for ~~the Mentally Retarded~~ persons with mental retardation or certain persons with related conditions

(a) Services provided through Home and Community - Based ~~Waiver~~ Services (HCBS) Waivers ~~for the Mentally Retarded (HCBW/MR) are services which~~ are outside the normal scope of ~~the Medicaid~~ SoonerCare services. HCBS Waivers are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Oklahoma=s Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of waiver administration. ~~The Medicaid waiver~~ HCBS Waivers ~~allows~~ allow the OHCA to offer certain home and community based services to categorically needy ~~individuals~~ members who, without such services, would be eligible for care in a facility for ~~the mentally retarded~~ persons with mental retardation.

(b) Individuals with mental retardation are eligible for ~~Medicaid~~ SoonerCare as categorically needy under the ~~HCBW/MR Program~~ HCBS

Waiver program when ~~the following medical and financial~~ eligibility conditions in (1) through (5) are met:

(1) The individual is ~~categorically needy as his/her income and resources are within the standards as listed on the appropriate schedule of DHS Appendix C-1, Schedule VIII. B. and D~~. determined financially eligible per OAC 317:35-9-68;

(2) The individual meets the Social Security Administration (SSA) ~~test for~~ definition of ~~disability~~ disabled~~.~~ ;

(3) The individual requires a level of care provided in a public or private intermediate care facility for ~~the mentally retarded~~ persons with mental retardation (ICF/MR) and has ~~an IQ score of 75 or below~~ a diagnosis of mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability~~.~~ ;

(4) It is appropriate to provide care outside the ICF/MR~~.~~ ; and

(5) The average cost of providing care outside the ICF/MR does not exceed the cost of providing institutional care.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers ~~providing services~~ for persons with ~~certain developmental disabilities~~ mental retardation or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid ~~Home and Community-Based Services (HCBS)~~ Waivers as defined in Section 1915(c) of the Social Security Act and administered by the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD). The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

(b) **Program Administration.** Services funded through a ~~Home and Community-Based Services~~ HCBS Waiver for persons with mental retardation or for certain persons with related conditions are administered by DDSD, under the oversight of the Oklahoma Health Care Authority (OHCA), the State Medicaid agency. The rules in this subsection ~~shall~~ do not ~~be construed as a limitation of~~ limit the rights of class members set forth in the ~~Consent Decree~~ Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved ~~recipient~~ member capacity for the individual HCBS Waivers;

(B) the cost-effectiveness of the individual HCBS Waivers as determined according to federal requirements; and

(C) State appropriations.

(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.

(c) **Program provisions.** Each individual requesting HCBS Waiver services and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between HCBS Waiver services and institutional care.

(d) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) HCBS Waiver services are available to Oklahoma residents meeting ~~Medicaid~~ SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must first be determined financially eligible for ~~Medicaid~~ SoonerCare through the OKDHS Family Support Services Division per OAC 317:35-9-68. The ~~Medicaid~~ SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or ~~ICF/MR~~ Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may ~~also~~ not be receiving DDSD state-funded services such as the Family Support Assistance Payment, sheltered workshop services, community integrated employment services, or assisted living without waiver supports ~~as described in~~ per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports ~~Waivers~~ Waiver (IHSW), a person must:

(i) meet all criteria for HCBS Waiver services given in subsection (d) of this Section;
(ii) be determined to have a disability, with a diagnosis of mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability, by:
(I) the Social Security Administration; or
(II) the ~~Oklahoma Health Care Authority~~ OHCA, Level of Care Evaluation Unit (LOCEU);
(iii) be three years of age or older;
(iv) be determined by the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit,~~ OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements ~~in accordance with~~ per OAC 317:30-5-122;
(v) reside in:
(I) the home of a family member or friend;
(II) his or her own home;
(III) an OKDHS Children and Family Services Division (CFSD) foster home; or
(IV) a CFSD group home; and
(vi) have critical support needs that can be met through a combination of non-paid, non-Waiver, and State Plan resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:
(i) meet all criteria given in subsection (d) of this Section;
(ii) be age three or older;
(iii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee;
(iv) be determined, in accordance with either subunit I or both subunits II and III of this unit:
(I) to have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorder in Persons with Intellectual Disability or a related condition by the ~~Mental Retardation Authority~~ DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or
(II) to have a disability, with a diagnosis of mental retardation, by the Social Security Administration or the ~~Oklahoma Health Care Authority, Level of Care~~

~~Evaluation Unit~~ OHCA/LOCEU; and

(III) to meet the ICF/MR Institutional Level of Care requirements by the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit~~ OHCA/LOCEU.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection (d) of this Section; and

(iii) be determined to:

(I) have mental retardation as defined in the Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability or a related condition by ~~the Mental Retardation Authority~~ DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(II) meet the ICF/MR Institutional Level of Care requirements by the ~~Oklahoma Health Care Authority, Level of Care Evaluation Unit~~ OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, current within one year, that includes:

(i) a functional assessment; and

(ii) a statement of age of onset of the disability;

(B) a social service summary, current within one year, that includes a developmental history; and

(C) a medical evaluation current within 90 days.

(3) The ~~Oklahoma Health Care Authority~~ OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDSD services and ICF/MR level of care for the services funded through an IHSW or the Community Waiver.

(4) For individuals who are determined to have mental retardation or a related condition by ~~the Mental Retardation Authority~~ DDSD in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDSD reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDSD services and

ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(e) **Waiting list.** When State DDSD resources are unavailable for new persons to be added to services funded through a ~~Home and Community-Based Services~~ HCBS Waiver, persons are placed on a statewide waiting list for services.

(1) The waiting list is maintained in chronological order based on the date of receipt of a written request for services.

(2) The waiting list for persons requesting HCBS Waiver services is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the waiting list if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

(D) is not a resident of the state of Oklahoma; or

(E) is offered Waiver services through either an ~~In-Home Supports Waiver~~ IHSW or the Community Waiver and declines services.

(f) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDSD to determine eligibility for services.

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the waiting list.

(g) **Admission protocol.** Initiation of services funded through a ~~Home and Community-Based Services~~ HCBS Waiver occurs in chronological order from the waiting list in accordance with subsection (e) of this Section based on the date of DDSD receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (d) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:
(I) is hospitalized;
(II) has moved into a nursing facility;
(III) is permanently incapacitated; or
(IV) has died; and
(ii) there is no caretaker to provide needed care to the individual; or
(iii) an eligible person is living at a homeless shelter or on the street;
(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;
(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or
(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.
(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;
(3) Waiver services are required for people who transition to the community from a public ~~intermediate care facility for persons with mental retardation (~~ICF/MR~~)~~ or who are children in the State's custody receiving services from OKDHS~~;~~ . ~~or~~ Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;
(4) individuals residing in nursing facilities prior to January 1, 1989, who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have mental retardation or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community Waiver.

(h) **Movement between DDSD HCBS Waiver programs.** A person's movement from services funded through one ~~Home and Community-Based Services~~ HCBS Waiver to services funded through another DDSD-

administered HCBS Waiver is explained in this subsection.

(1) When a ~~child~~ member receiving services funded through the IHSW for children becomes 18 years of age, services ~~under~~ through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a ~~person~~ member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDSD Director or designee; and

(B) funding is available in accordance with subsection (b) of this Section.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when ~~an individual's~~ a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When ~~an individual~~ a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(i) **Continued eligibility for HCBS Waiver services.** Eligibility for children receiving HCBS Waiver services is re-determined if a determination of disability due to mental retardation has not been made by the Social Security Administration when~~:~~ the OHCA/LOCEU determines categorical relationship to the SoonerCare program according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:35-9-5. DDSD may require a new diagnostic evaluation in accordance with paragraph (d)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (d)(2) of this Section has been noted.

~~(1) a child who is receiving HCBS Waiver services prior to age six reaches age six. The child must be determined to continue to have a disability with a diagnosis of mental retardation. The determination must be made no later than the first Plan of Care review after the seventh birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection;~~

~~(2) a child who is receiving HCBS Waiver services reaches age 18. The service recipient must be determined to continue to have a disability with a diagnosis of mental retardation. The determination must be made at the first Plan of Care review after the nineteenth birthday. A new diagnostic evaluation is required in accordance with paragraph (d)(2) of this subsection; and~~

~~(3) required by DDSD. DDSD may require a new diagnostic evaluation in accordance with paragraph (d)(2) of this~~

~~subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (d)(2) of this Section has been noted.~~

(j) **HCBS Waiver services case closure.** HCBS Waiver services are terminated ~~when an individual receiving services~~:

(1) when a member or the ~~service recipient's~~ member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

(3) when a member is financially ineligible to receive Waiver services;

(4) when a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) when a member is determined by the ~~Oklahoma Health Care Authority Level of Care Evaluation Unit~~ OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;

(8) ~~or~~ when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;

(9) ~~or~~ when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the ~~service recipient~~ member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective; ~~or~~

(10) when the member is determined to no longer be ~~Medicaid~~ SoonerCare eligible~~.~~ ;

(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;

(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) when it is determined that HCBS Waiver services are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;
(15) when the member or his/her legal representative fails to cooperate with service delivery;
(16) when a family member, authorized representative, other individual in the member's household or persons who routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or
(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

(k) **Reinstatement of services.** Waiver services are reinstated when:
(1) the situation resulting in case closure of a Hissom class member is resolved;
(2) a ~~service recipient~~ member is incarcerated for 90 days or less;
(3) a ~~service recipient~~ member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or
(4) a ~~service recipient's Medicaid~~ member's SoonerCare eligibility is re-established within 90 days of the date of ~~the DDSD Notice of Action~~ SoonerCare ineligibility.

SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-1. Purpose of Agency Companion Services
~~(a) The Agency Companion Services (ACS) program serves persons with developmental disabilities who are 18 years of age or older.~~
~~(b) Persons under the age of 18 years may be served with approval from the Developmental Disabilities Services Division (DDSD) director or designee.~~
~~(c) Agency Companion services provides an individualized living arrangement with a companion eligible according to OAC 317:40-5-4, that offers up to 24 hour supervision, supportive assistance, and training in daily living skills.~~

317:40-5-3. ~~Scope of agency~~ Agency companion services
(a) Agency companion services (ACS):
(1) are provided by ~~private~~ agencies contracted with the

Oklahoma Health Care Authority (OHCA);
(2) ~~are available to members who are eligible for services through the Community Waiver or Homeward Bound Waiver~~ 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 based on the member's need for support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58~~ 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 provided in a nurturing environment in the member's home, the companion's home, or in a mutually rented or owned home; and~~ 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), per OAC 340:100-5-50 through 340:100-5-58.
~~(5) support visitation desired by the member with his or her natural family and friends, and in accordance with the member's IP.~~

(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) ~~is limited to serving as~~ may provide companion services for one member. Exceptions to serve as companion for two members may be ~~granted only upon review and approval~~ 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;
~~(3)~~ (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 have other employment when:~~
~~(i) serving members approved for intermittent or regular levels of support;~~
~~(ii) the Personal Support Team addresses all documented related concerns in the member's IP; and~~
~~(iii) the other employment is approved in advance by the DDSD area manager or designee; and~~
(B) The companion may not have other employment when:
(i) the member(s) require enhanced or pervasive level of support;
(ii) 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 member requires intermittent or close levels of support;
(ii) the personal support Team documents and addresses all related concerns in the member's IP; and
(iii) the other employment is approved in advance by the DDSD area manager or designee;
~~(4)~~ (7) approved for other employment may not be employed in another position that requires on-call duties.
(A) 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.
(B) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform 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 ~~Medicaid~~ 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 year; and
(D) cannot be accrued from one Plan of Care 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) 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 assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) communicates needs and wants;

(iii) is able to spend short periods of time unsupervised inside and outside the home;

(iv) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~, and arranging transportation~~; and

(v) has stable or no ongoing medical or behavioral difficulties.

(B) **~~Regular~~ Close level of support**. ~~Regular~~ Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant assistance and support or is totally dependent on others to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) has difficulty or is unable to communicate basic needs and wants;

(iii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~, and arranging transportation~~; and

(iv) requires regular monitoring and assistance with health, medication, or behavior interventions, and 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~~, and arranging transportation~~;

(ii) demonstrates ongoing complex medical or behavioral issues requiring specialized training courses per OAC 340:100-3-38.3; and

(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDSD director or designee; or

(iv) requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must ~~be~~:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14; ~~and~~

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, and

(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.

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 ~~service recipient~~ member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, as described in subsection (b) of 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 ~~served~~ cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, and friends without prior written authorization from the ~~Oklahoma Department of Human Services'~~ 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 ~~service recipient~~ member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;
(4) delivers services in a manner that contributes to the ~~service recipient's~~ member's enhanced independence, self sufficiency, community inclusion, and well-being;
(5) participates as a member of the ~~service recipient's~~ member's Team and assists in the development of the ~~service recipient's~~ member's Individual 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 ~~develops and gives~~ documents and provides monthly data ~~collection~~ 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 ~~service recipient~~ member in participating in the ~~service recipient's~~ member's chosen religious faith. No ~~service recipient~~ member is expected to attend any religious service against his or her wishes;
(10) participates in and supports visitation and contact with

the ~~service recipient's~~ member's natural family, guardian, and friends, provided this visitation is desired by the ~~service recipient~~ member;
(11) obtains permission from the ~~service recipient's~~ 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 ~~service recipient~~ member in any publicity;
(12) serves as the ~~service recipient's~~ member's health care coordinator in accordance with OAC 340:100-5-26;
(13) ensures the monthly room and board contribution received from the ~~service recipient~~ member as reflected on OKDHS Form ~~DDS-SAB-1~~ 06AC074E, Service Authorization Budget (SAB), is used toward the cost of operating the household;
(14) assists the ~~service recipient~~ member ~~to access~~ in accessing entitlement programs for which the ~~service recipient~~ member may be eligible and maintains records required for the ~~service recipient's~~ 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 ~~service recipient's~~ member's program are implemented to the satisfaction of the ~~service recipient~~ member, the ~~service recipient's~~ member's family or legal guardian, when appropriate, and the ~~service recipient's~~ member's Team;
(16) assists the ~~service recipient~~ member in achieving the ~~service recipient's~~ member's maximum level of independence;
(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the ~~service recipient~~ member;
(18) ensures that the ~~service recipient's~~ member's confidentiality is maintained in accordance with OAC 340:100-3-2;
(19) supports the ~~service recipient~~ 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 ~~service recipient~~ member to actively join in community life;
(21) does not serve as representative payee for the ~~service recipient~~ member without a written exception approval from the DDSD area manager or designee;
(A) The written approval is retained in the ~~service recipient's~~ member's home record.
(B) When serving as payee, the companion complies with the requirements of OAC ~~340:100-3-4.1~~ 340:100-3-4.
(22) ensures the ~~service recipient's~~ member's funds are properly

safeguarded.
(23) must obtain prior approval from the provider agency when making a purchase of over $50.00 with the ~~service recipient's~~ 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, OKDHS Form ~~DDS-20~~ 06AC020E, for the home and conducts training with the ~~service recipient~~ member;
(26) conducts fire and weather drills at least quarterly and maintains the Fire and Weather Drill Record, OKDHS Form ~~DDS-21~~ 06AC021E, available for review:
(27) develops and maintains a Personal Possession Inventory, OKDHS Form ~~DDS-22~~ 06AC022E, documenting the ~~service recipient's~~ member's possessions and adaptive equipment;
(28) supports the ~~service recipient's~~ member's employment program by:
(A) assisting the ~~service recipient~~ member to wear appropriate work attire; and
(B) contacting the ~~service recipient's~~ member's employer only as outlined by the Team and in the Individual Plan; and
(29) follows all applicable rules promulgated by the Oklahoma Health Care Authority or DDSD, including:
(A) OAC 340:100-3-40~~, Community records system~~;
(B) OAC 340:100-5-50 through 100-5-58~~, Individual planning~~;
(C) OAC 340:100-5-26~~, Health services~~;
(D) OAC 340:100-5-34~~, Incident reporting~~;
(E) OAC 340:100-5-32~~, Medication administration~~;
(F) OAC 340:100-5-22.1~~, Community residential supports~~;
(G) OAC 340:100-3-24~~, Quality assurance~~; and
(H) OAC 340:100-3-38~~, Staff training~~.

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology devices and services

(a) **Applicability.** The rules in this Section apply to assistive technology (AT) services and devices authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.
~~(a)~~ (b) **General information.** ~~Assistive technology (AT) services, also called Adaptive Equipment Services:~~
(1) ~~provide for evaluation,~~ AT devices include the purchase, rental, customization, maintenance, and repair of ~~specialized equipment for eligible persons, contingent on availability of resources;~~ devices, controls, and appliances. AT devices include:

(A) visual alarms;
(B) telecommunication devices (TDDS);
(C) telephone amplifying devices;
(D) other devices for protection of health and safety of members who are deaf or hard of hearing;
(E) tape recorders;
(F) talking calculators;
(G) specialized lamps;
(H) magnifiers;
(I) braille writers;
(J) braille paper;
(K) talking computerized devices;
(L) other devices for protection of health and safety of members who are blind or visually impaired;
(M) augmentative and alternative communication devices including language board and electronic communication devices;
(N) competence based cause and effect systems such as switches;
(O) mobility and positioning devices including:
(i) wheelchairs;
(ii) travel chairs;
(iii) walkers;
(iv) positioning systems;
(v) ramps;
(vi) seating systems;
(vii) standers;
(viii) lifts;
(ix) bathing equipment;
(x) specialized beds;
(xi) specialized chairs; and
(P) orthotic and prosthetic devices, including:
(i) braces;
(ii) prescribed modified shoes;
(iii) splints; and
(Q) environmental controls or devices;
(R) items necessary for life support and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare.

~~(2) enable persons receiving services to:~~
~~(A) perform daily living skills;~~
~~(B) socialize;~~
~~(C) engage in work activities with reduced reliance upon others; or~~
~~(D) promote or maintain health or safety;~~

(2) AT services include:
(A) sign language interpreter services for members who are

deaf;
(B) reader services;
(C) auxiliary aids;
(D) training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) repair of AT devices; and
(F) evaluation of the AT needs of a member.

~~(3) are supplied in any community setting as specified in the Individual Plan of the person receiving services;~~

~~(4)~~ (3) ~~are justified by professional assessment in accordance with subsection (c) of this Section;~~ AT devices and services must be included in the member's Individual Plan (IP) and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).

(5) ~~require prior authorization; and~~ AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, OAC 580:15 and OKDHS approved purchasing procedures.

(6) ~~provide only equipment that~~ AT devices or services may be authorized when the device or service:

(A) has no utility apart from the needs of the person receiving services~~.~~ ; ~~DDSD state funds or funds through a Home and Community-Based Waiver are not used to purchase equipment such as:~~

~~(i) trampolines;~~
~~(ii) hot tubs;~~
~~(iii) bean bag chairs;~~
~~(iv) recliners; and~~
~~(v) computers, except as adapted for individual needs and approved in accordance with this Section;~~

(B) is not otherwise available through ~~Oklahoma's Title XIX State Plan~~ SoonerCare, Department of Rehabilitative Services, or any other third party or known community resource; ~~and~~

(C) has no less expensive equivalent that meets the ~~person's~~ member's needs~~.~~ ;

(D) is not solely for family or staff convenience or preference;

(E) is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;

(F) is of direct medical or remedial benefit to the member;

(G) enables the member to maintain, increase, or improve functional capabilities;

(H) is supported by objective documentation included in a professional assessment except as specified per OAC 317:40-5-100;

(I) is within the scope of assistive technology per OAC 317:40-5-100; and

(J) is the most appropriate and cost effective bid if applicable.

~~(b) **Applicability.** The rules in this Section address only equipment that is authorized by the Department of Human Services for purchase, rental, lease, or lease/purchase through a DDSD Home and Community-Based Waiver, or DDSD state funds. If the person receiving services, the family, or guardian desires to purchase assistive technology through other resources, these rules do not apply. The rules in this Section shall not be construed as a limitation of the rights of class members set forth in the Consent Decree in Homeward Bound vs. The Hissom Memorial Center.~~

(c) **Assessments.** Assessments for ~~assistive technology~~ AT devices or services are ~~conducted~~ performed by ~~the prescribing~~ a licensed professional service ~~provider~~ provider(s) and reviewed by other ~~professional~~ providers whose services may be affected by the type of device selected. A licensed professional must:

~~(1) Prior to recommending assistive technology devices or services, the prescribing professional completes a decision-making review that provides justification for purchase, repair, rental, or fabrication of an assistive technology device.~~

~~(2)~~ (1) ~~The prescribing professional determines~~ determine whether the person's identified outcome can be accomplished through the creative use of other resources such as:

(A) household items or toys;

(B) equipment loan programs;

(C) low-technology devices or other less intrusive options; or

(D) a similar, more cost-effective device.

(2) recommend the most appropriate AT based on the member's:

(A) present and future needs, especially for members with degenerative conditions;

(B) history of use of similar AT, and ability to use the device currently and for at least the foreseeable future (no less than 5 years); and

(C) outcomes.

(3) complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) review of device considered;

(B) availability of device rental with discussion of advantages and disadvantages;

(C) how frequently and in what situations device will be used in daily activities and routines;

(D) how the member and caregiver(s) will be trained to use

the AT device; and

(E) features and specifications of the device that are necessary for the member, including rationale for why other alternatives are not available to meet the member's needs.

~~(3)~~ (4) ~~Upon request by DDSD staff, the prescribing professional provides~~ provide a current, unedited videotape or pictures of the person member using the device, including the time frames of the trials recorded, upon request by DDSD staff.

(d) **Authorization of repairs, or replacement of parts.** Repairs to AT devices, or replacement of device parts, do not require a professional assessment or recommendation. DDSD area office resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended assistive technology.

(e) **Retrieval of assistive technology devices.** When devices are no longer needed by a member, OKDHS/DDSD staff may retrieve the device.

~~(d)~~ (f) **Team decision-making process.** The ~~individual's~~ member's Personal Support Team ~~considers the functional outcome to be achieved by the person's use of the proposed assistive technology service or equipment~~ reviews the licensed professional's assessment and decision making review. The Team ensures the recommended AT:

~~(1) The Team considers AT services that:~~

~~(A)~~ (1) ~~are~~ is needed by the ~~person~~ member to achieve a specific, identified functional outcome;

~~(i)~~ (A) A functional outcome, in this Section, means ~~an~~ the activity ~~that~~ is meaningful to the ~~person~~ member, occurs on a frequent basis, and would require assistance from others, if the ~~person~~ member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

~~(ii)~~ (B) Functional outcomes must be reasonable and necessary given a member's age ~~appropriate, considering~~ the ~~person's developmental functioning~~ diagnosis and abilities.

~~(B)~~ (2) ~~improve~~ allows ~~the ability of~~ the ~~person~~ member receiving services to:

~~(i)~~ (A) improve or maintain health and safety;

~~(ii)~~ (B) participate in community life;

~~(iii) establish meaningful relationships;~~

~~(iv)~~ (C) express choices; or

~~(v)~~ (D) participate in vocational training or employment; ~~or~~

~~(vi) live with dignity;~~

~~(C)~~ (3) can will be used frequently or in a variety of situations; ~~and~~

~~(D)~~ (4) ~~can~~ will fit easily into the ~~person's life style~~ member's lifestyle and work place~~.~~ ;

(5) is specific to the member's unique needs; and

(6) is not authorized solely for family or staff convenience.

~~(2) The Team recommends the most appropriate assistive technology based on the individual's:~~

~~(A) current situation;~~

~~(B) present needs;~~

~~(C) ability to use the device; and~~

~~(D) outcomes desired.~~

~~(3) When the Team determines that existing equipment no longer meets the needs of the person receiving services, the Team considers a new AT device. In recommending a new AT device, the Team:~~

~~(A) examines the history of other, similar equipment used by the person;~~

~~(B) considers the advantages or disadvantages of renting the device; and~~

~~(C) clearly defines functional outcomes anticipated with the use of the requested device(s).~~

~~(4) The Team documents:~~

~~(A) how the person and caregiver(s) are to be trained in the use of the assistive technology; and~~

~~(B) time frames for Team evaluation after the receipt of assistive technology to determine if the identified outcomes are achieved.~~

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluate the need for AT and individually customize AT devices as needed.

(h) **Services not covered through AT devices and services.** Assistive technology devices and services do not include;

(1) trampolines;

(2) hot tubs;

(3) bean bag chairs;

(4) recliners with lift capabilities;

(5) computers except as adapted for individual needs as a primary means of oral communication and approved per OAC 317:40-5-100;

(6) massage tables; and

(7) educational games and toys.

~~(e)~~ (i) **Approval or denial of ~~assistive technology~~ AT.** DDSD approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease/purchase of the ~~device or equipment~~ AT is determined ~~in accordance with this subsection~~ per OAC 317:40-5-100.

~~(1) **Standard Assistive Technology List.** Requests for assistive technology that are authorized by the case manager are explained in this paragraph.~~

~~(A) The case manager may authorize requests for:~~

~~(i) devices which are included on the Standard Assistive Technology List, DHS Appendix D-30; or~~

~~(ii) emergency repairs included on DHS Appendix D-30, up to $350.00.~~

~~(B) The case manager contacts the vendor for a price quote for the service or device.~~

~~(C) The case manager provides a letter of authorization to the vendor or to the person receiving services for delivery to the vendor. The case manager keeps a copy of the letter of authorization and sends a copy to DDSD AT staff.~~

~~(D) The letter of authorization includes:~~

~~(i) the list of services or devices;~~

~~(ii) a complete description of each service or device;~~

~~(iii) the catalog number, if applicable;~~

~~(iv) the name and provider number of the vendor;~~

~~(v) the cost of the service(s) or device(s);~~

~~(vi) the authorization (PB) number; and~~

~~(vii) the case manager's signature.~~

~~(E) The AT staff is available for consultation if problems are encountered.~~

~~(2) **Other requests under $2,500.** Assistive technology devices not listed in DHS Appendix D-30 are requested in accordance with this paragraph.~~

~~(A) The case manager sends requests for assistive technology devices or services to the DDSD AT staff for approval or denial if the request is not included in DHS Appendix D-30, but costs less than $2,500.~~

~~(B)~~ (1) ~~The assistive technology request sent by the~~ The DDSD case manager sends the AT request to designated DDSD ~~Area Office~~ area office resource development staff ~~includes~~ with AT experience. The request must include:

~~(i)~~ (A) the licensed professional's assessment and ~~professional prescription from the designated Team professional~~ decision making review;

~~(ii)~~ (B) a copy of the Plan of Care;

~~(iii)~~ (C) documentation of current Team consensus, including consideration of issues ~~stated in subsection (d) of this Section~~ per OAC 317:40-5-100; and

~~(iv)~~ (D) all additional ~~justification~~ documentation to support the need for ~~securing~~ the assistive technology device or service.

~~(C)~~ (2) The designated ~~Area Office~~ area office resource development staff, with AT ~~expertise~~ experience, approves or

denies the AT ~~services~~ request when there is no fixed rate for the device and the device has a cost less than $2500 based on:

~~(i)~~ (A) the criteria given in subsection (d) of this Section;

~~(ii)~~ (B) the scope of the program, as explained in subsection (a) of this Section; and

~~(iii)~~ (C) the cost effectiveness of the ~~device(s) or service(s)~~ AT, as explained in subsection (a) of this Section.

~~(D)~~ (3) Authorization for purchase or a written denial is provided within ~~10~~ ten working days of receipt of a complete request.

~~(i)~~ (A) If the ~~device(s) or service(s)~~ AT is approved, a letter of authorization~~, as explained in subparagraph (e)(1)(D) of this Section,~~ is issued.

~~(ii) The prescribing professional supplies further information upon request of the designated Area Office staff.~~

~~(iii)~~ (B) If additional ~~information~~ documentation is required ~~in order for~~ by the ~~AT~~ area office resource development staff with AT experience, to authorize the ~~device(s) or service(s)cannot be readily obtained~~ recommended AT, the request packet is returned to the case manager for completion.

(C) If necessary, the case manager will contact the licensed professional to request the additional documentation and the licensed professional will supply further documentation upon request of the area office resource development staff with AT experience.

~~(3) **Requests costing $2,500 or more.**~~ (D) The authorization of ~~device(s) or service(s) costing~~ AT that has no fixed rate and is $2,500 or more is performed as in paragraph (2) of this subsection, except that the area office resource development staff with AT experience:

~~(A)~~ (i) ~~the AT staff obtains~~ solicits three bids for the ~~service(s) or device(s)~~ AT;

~~(B)~~ (ii) ~~the AT staff~~ submits the AT request, ~~the three~~ bids, and other relevant information to the DDSD State Office AT programs manager within ~~15~~ five working days of receipt of the ~~complete request from the case manager~~ required bids; and

~~(C)~~ (iii) the State Office AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five working days of receipt of all required documentation for AT.

~~(4)~~ (j) **Approval of vehicle adaptations.** Vehicle adaptations are assessed and approved ~~in accordance with the requirements of this Section~~ per OAC 317:40-5-100. In addition, the requirements in

this paragraph must be met.

~~(A)~~ (1) The vehicle to be adapted must be owned or ~~leased~~ in the process of being purchased by the ~~person~~ member receiving services or his or her family.

~~(B)~~ (2) The AT request must include a certified mechanic's statement that the vehicle and adaptations ~~is~~ are mechanically sound.

~~(C)~~ (3) ~~AT services~~ Vehicle adaptations are ~~used to adapt~~ limited to one vehicle in a ten year period per ~~eligible individual~~ member. ~~Any additional adaptation request within~~ Authorization for more than one vehicle adaptation in a ~~5-year~~ 10-year period must be approved by the DDSD ~~Division Administrator~~ division administrator or designee.

~~(5)~~ (k) **Denial.** Procedures for denial of ~~acquisition of equipment or service(s)~~ an AT device or service are described in this paragraph.

~~(A)~~ (1) The person denying the AT request provides a written denial to the case manager ~~explaining the rationale~~ citing the reason for denial ~~and suggesting alternatives~~ per policy.

~~(B)~~ (2) The case manager ~~provides a verbal explanation and~~ sends the Notice of Action, ~~DHS form DDS-4~~ OKDHS form 06MP004E, to the ~~individual~~ member and his or her family or guardian.

~~(C)~~ (3) Denial of assistive technology services may be appealed through the ~~DHS~~ OKDHS hearing process ~~described in~~ per OAC 340:2-5.

~~(6)~~ (l) **Return of an AT device ~~or equipment~~.** If, during a trial use period or rental of a device, the therapist or Team including the licensed professional if available, who recommended the AT, ~~decides~~ determines the device is not appropriate, the ~~prescribing~~ licensed professional sends a brief report describing the reason(s) for the change of ~~equipment~~ device recommendation to the DDSD case manager. The case manager forwards the report to the designated ~~Area Office~~ area office resource development staff, who arranges for the return of the equipment to the vendor or manufacturer.

~~(f)~~ (m) **Rental of AT devices.** ~~Assistive technology~~ AT devices are rented when the ~~DDSD area manager or designee~~ licensed professional or area office resource development staff with AT experience determines ~~that the cost of rental is less than the purchase price~~ rental of the device is more cost effective than purchase of the device or the licensed professional recommends a trail period to determine if the device meets the needs of the member.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the ~~person receiving service~~ member, unless otherwise stated in advance by the manufacturer or vendor.

(2) ~~Designated DDSD~~ Area ~~Office~~ office resource development staff with AT experience monitor use of equipment during the

rental agreement for:

(A) cost effectiveness of the rental time frames;

(B) conditions of renewal; and

(C) the Team's re-evaluation of the ~~person's~~ member's need for the device ~~as described in subparagraph (d)(4)(B) of this Section~~ per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device whenever such option is available from the manufacturer or vendor.

(4) If ~~equipment~~ a device is rented for a trial use period, the Team decides within 90 days whether:

(A) the equipment meets the ~~individual's~~ member's needs; and

(B) to purchase the equipment or return it.

~~(g)~~ (n) **Assistive Technology Committee.** The ~~state-wide assistive technology (~~AT~~)~~ committee reviews equipment requests~~,~~ when ~~asked to do so by DDSD staff~~ deemed necessary by the OKDHS/DDSD state office assistive technology programs manager.

(1) The AT committee is comprised of:

(A) DDSD professional staff members of the appropriate therapy;

(B) DDSD AT state office programs manager;

(C) the DDSD area manager or designee; and

(D) an AT expert not employed by ~~DHS~~ OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria given in this Section. Any endorsement or denial includes a written rationale for the decision and, if necessary, an alternative solution(s), directed to the ~~DDSD Division Administrator or designee~~ case manager within 20 working days of receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified in OAC 317:40-5-100.

~~(4) A referral to the AT committee:~~

~~(A) is decided within 10 working days; and~~

~~(B) suspends the time frames given in paragraphs (e)(2) and (e)(3) of this Section.~~

~~(h) **Voluntarily donated equipment.** Equipment acquired in accordance with this Section is the sole property of the person receiving services.~~

~~(1) If the person for whom the equipment was purchased no longer needs the equipment and decides to donate it to another individual, DDSD assists only:~~

~~(A) to identify a recipient; and~~

~~(B) to transfer the equipment from the donor to the recipient.~~

~~(2) The voluntarily donated equipment program is designed to~~

~~match a donated piece of assistive technology with a person who can utilize and benefit from the equipment, according to the criteria given in subsection (d) of this Section.~~
~~(3) DDSD maintains a written record of equipment that is available for donation.~~

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-6. Center-Based Services

(a) Center-Based Services are provided in segregated settings, where the majority of people served have a disability. Any employment service provided where a majority of the people at the site are persons with a disability is billed as Center-Based Services.
(b) Center-Based Services are pre-planned, documented activities that relate to the ~~service recipient's~~ member's identified employment outcomes.
(c) Examples of Center-Based Services are active participation in:
(1) paid contract work which occurs in a workshop or other center-based setting.
(2) Team-prescribed therapy programs such as speech, physical therapy, or switch activation which are implemented by employment provider staff in the workshop or other center-based setting.
(3) unpaid training or paid work experience which occurs in a setting without opportunities for regular daily interactions with co-workers without disabilities or the general public.
(4) computer classes, GED preparation, job club, interviewing skills, or other classes whose participants all have disabilities, even if the location is in the community.
(d) Paid contract work is usually subcontracted, and the persons receiving services earn commensurate wage according to Department of Labor regulations.
(e) For ~~Medicaid~~ SoonerCare reimbursement in Center-Based Services, a ~~service recipient's~~ member's pay cannot exceed 50% of minimum wage.
(f) Participation in Center-Based Services is limited to 15 hours per week for persons receiving services through the Homeward Bound Waiver, unless approved through the exception process explained in OAC 317:40-7-21.
(g) Agency must meet physical plant expectations of OAC 340:100-17-13.
(h) During periods in which no paid work is available for members, despite the documented good faith efforts of the provider to secure such work, the employment provider agency ensures that each member participates in training activities that are age appropriate, work

related, and consistent with the IP. Such activities may include, but are not limited to:

(1) resume development and application writing;
(2) work attire selection;
(3) job interview training and practice;
(4) job safety and evacuation training;
(5) personal or social skills training; and
(6) stamina and wellness classes.

317:40-7-8. Employment training specialist services

Employment training specialist (ETS) services include evaluation, training, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:

(1) provided by a certified job coach;
(2) not available when subcontracting;
(3) used to help a member with a new job in a generic employment setting.
   (A) ETS services are:
      (i) not available if the member held the same job for the same employer in the past;
      (ii) available when the member requires 100% on-site intervention for up to the number of hours the member works per week for six weeks per Plan of Care year; and
      (iii) used in training members employed in individual placements on new jobs when the:
         (I) member receives at least minimum wage; and
         (II) employer is not the employment services provider.
   (B) If the member does not use all of the training units on the first job placement in the Plan of Care year, the balance of training units may be used on a subsequent job placement with the current provider, or with a new provider;
(4) used in assessment and outcome development for members residing in the community who are new to the provider agency, when determined necessary by the Personal Support Team (Team). The provider:
   (A) may claim a documented maximum of 20 hours per member for initial assessment. The projected units for the assessment and outcome development must:
      (i) be approved in advance by the Team; and
      (ii) relate to the member's desired outcomes; and
   (B) cannot claim the same period of time for more than one type of service;
(5) used in Team meetings, when the case manager has requested participation of direct service employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;
(6) used in job development for a member on an individual job site upon the member's completion of three consecutive months on

the job.

(A) Up to 40 hours may be used during a Plan of Care year after documentation of job development activities is submitted to the case manager.

(B) The job must:

(i) pay at least minimum wage;

(ii) employ each member at least 15 hours per week; and

(iii) be provided by an employer who is not the member's contract provider;

(7) used in development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by ~~an Oklahoma Benefit Specialist~~ a Community Work Incentives Coordinator or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;

(8) used in development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by ~~an Oklahoma Benefit Specialist~~ a Community Work Incentives Coordinator or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation is submitted to the case manager; and

(9) used in interviewing for a job that is eligible for ETS services.

(10) If the member needs job coach services after expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. The plan should include the process for fading as the member=s independence increases and progress documented on OKDHS form 06WP066E.

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain ~~one or two service recipients~~ a member in an integrated competitive employment site. Stabilization Services are provided for up to two years per job. Stabilization Services continue until the next Plan of Care following the end of two years of Stabilization Services. ~~If the service recipient needs job coach services after the expiration of Stabilization Services, Job Coach Services may be authorized for the hours necessary to provide direct support to the service recipient or consultation to the employer as described in outcomes and methods in the Individual Plan.~~

(1) Stabilization Services are provided when the job coach intervention time required at the job site is 20% or less of the ~~service recipient's~~ member's total work hours for four

consecutive weeks or when the ~~service recipient~~ member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the ~~service recipient~~ member moves to Stabilization, the Team determines that support is needed above 20% for longer than two weeks, the Team may revise the ~~service recipient's~~ member's Plan of Care to reflect the need for Job Coaching Services.

(B) A ~~person~~ member receiving services from DRS moves to services funded by DDSD upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) identify the supports needed, including development of natural supports;

(B) specify, in a measurable manner, the services to be provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the ~~service recipient~~ member is employed at a rate of minimum wage or above.

(4) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

317:40-7-13. Supplemental Supports for Center-Based Services

(a) In those instances when a ~~service recipient~~ member receiving Center-Based Services needs additional supports, the provider assigns staff in patterns that most effectively meet the needs of each ~~service recipient~~ member as indicated by a personal care and/or a risk assessment and defined in the Individual Plan (IP) or Protective Intervention Plan.

(b) If re-arranging staff patterns is not sufficient to meet the ~~service recipient's~~ member's needs, the provider may file a request and plan for Supplemental Supports utilizing Vocational Habilitation Training Specialist Services. Supplemental Supports can be claimed only if provided by a staff member who has completed all specialized training and individual-specific training prescribed by the Team in accordance with OAC 340:100-3-38.

(c) Supplemental Supports for Center-Based Services include two types of services, behavioral continuous support, and personal care intermittent support.

(1) **Continuous Supplemental Supports.** Continuous Supplemental Supports cannot exceed 15 hours per week for persons receiving services through the Homeward Bound waiver unless specifically

approved through the exception process described in OAC 317:40-7-21.

(A) To be eligible for continuous supplemental supports, the ~~service recipient~~ member must have:

(i) 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 submitted to the Human Rights Committee (HRC) ~~in accordance with~~ per OAC 340:100-3-6; and

(III) has been approved by the State Behavior Review Committee (SBRC) ~~in accordance with~~ per OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff ~~in accordance with subsection (d) of~~ per OAC 340:100-5-57; or

(ii) procedures included in the protective intervention plan which address dangerous behavior that places the ~~service recipient~~ member or others at risk of serious physical harm. The Team submits documentation of this risk and the procedures to the DDSD positive support field specialist to assure that positive approaches are being used to manage dangerous behavior.

(B) The Team documents discussion of the need for continuous Supplemental Supports.

(2) **Intermittent Supplemental Supports.** To receive personal care intermittent support, a ~~service recipient~~ member must have a personal care need ~~which~~ that requires staffing of at least one-to-one during that time frame when the support is needed.

(A) If a ~~service recipient~~ member needs intermittent personal care support during Center-Based Services, the Team documents discussion of:

(i) the specific support need(s) of the ~~service recipient~~ member, such as staff-assisted repositioning, lifting, transferring, individualized bathroom assistance, or nutritional support; and

~~(ii) the number of staff necessary to provide the support; and~~

~~(iii)~~ (ii) the calculations ~~which~~ that combine the time increments of support to determine the total number of units needed on the Plan of Care.

(B) The case manager sends the documentation to the case management supervisor for approval.

(C) The case management supervisor signs and forwards a copy of the approval, denial, or recommended modifications to the case manager within two working days of receipt.

(D) A ~~service recipient~~ member may receive Center-Based Services and Intermittent Supplemental Supports at the same time.

(d) Supplemental Support for Center-Based Services described in this Section cannot be accessed in Community-Based Services.
(e) Sufficient staff must be available in the center-based facility to provide the supplemental support in order for a provider to claim the units.