TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-61. Self-Directed Services

(a) **Agency Model.** The OHCA Self-Direction Model is an overarching set of guidelines to standardize policy for all self-directed service programs operated through the SoonerCare program. The following rules set forth minimum requirements to which all self-directed service programs must adhere. As the infrastructures for new or renewing self-direction programs are developed, the following elements will serve as a template for the programs to follow.

(b) **Definitions.**

(1) **"Self-Direction"** is defined as a method of service delivery that allows members to determine what supports and services they need to live successfully in a home and community based setting.

(2) **"Program"** is defined as a set of benefits offered to a specific population of SoonerCare members (the program can be operated by the OHCA or another agency partner).

(3) **"Financial Management Service"** (FMS) is defined as a fiscal intermediary that provides at a minimum, accounting, billing and payroll services on behalf of the member, for reimbursement through the OHCA.

(4) **"Rendering provider"** is defined as the actual deliverer of allowable goods or services.

(c) **Member processes.** The program will establish, at a minimum, the following processes for members who choose to self direct:

(1) The program will establish requirements for member eligibility including a process for evaluating member needs. These requirements will also include a process for denial of eligibility.

(2) The program will determine detailed benefit packages and will specify allowable goods and services available to members.

(3) The program will define the member's options for self-direction. These will vary according to the approved benefit package. At a minimum, the options for self-direction will include:

(A) training for members that is appropriate to the care provided;

(B) utilization of a Financial Management Service (FMS) for purposes of payroll and payment to vendors.

by the individual program;

(C) detailed description demonstrating that members have freedom of choice under all levels of self-direction options offered;

(D) for security and auditing purposes, the program will design and implement a system for verification of services in accordance with CMS standards; and

(E) designate methods of outreach to inform members and potential members of available services, emergency procedures, concerns and general information.

(d) **Provider processes.** The program will establish minimum criteria for providers. These criteria will be specific to provider type and at a minimum include:

(1) training appropriate to each level of service to be provided;

(2) credentialing or licensure by a recognized state agency, if applicable to the provider type and duties;

(3) establish and specify an appropriate provider type and specialty code to apply to approved providers for the program. This provider type and specialty code must meet requirements for data integrity and auditing purposes.

(4) specify the minimum and maximum allowed rates for providers by provider type. Rates will be governed by guidelines determined by the program within approved limits and budget allowances. The program will also establish an appropriate methodology for fees paid to the FMS for administration of payroll, accounting and any other contracted duties;

(5) provider contracts with the OHCA or with a contracted agency operating as an Organized Health Care Delivery System (OHCDS);

(6) establish a provider enrollment process. At a minimum, the process shall include the following:

(A) all rendering providers will be entered into the OHCA provider tracking system and given a unique rendering provider ID number. In instances of an Organized Health Care Delivery System, the OHCDS will be considered the rendering provider for purposes of enrollment;

(B) the FMS will be entered into the OHCA provider tracking system and given a unique provider ID number as the billing or group provider;

(C) all rendering providers must pass a background investigation prior to employment.

(e) **Provider selection & outreach.**

(1) The program will identify methods for assisting members in provider selection.

(2) The program will determine processes for informing and recruiting providers.

(3) The program will develop processes for provider communication to inform providers of procedures, concerns and general information.

(f) **Claims filing process.**

(1) The program will ensure claims are billed to the OHCA from the FMS and processed through the OHCA claims system.

(2) The program will have appropriate procedure codes with necessary modifiers for each benefit in the program.

(3) Procedure codes must provide sufficient detail to allow for claims identification in the OHCA claims system (all claims must have at a minimum a billing, rendering and pay to).

(g) **Claims payment processes for providers, agents, agencies.** Payments for rendering providers must be paid through an FMS. The program will establish the payment options for the FMS to utilize for paying the rendering providers.

(h) **Payment Processes For Alternative Goods & Services.** Some programs may allow for non-traditional services and alternative sources for goods with approval. The program shall determine the process for the payment of these alternative benefits with the following restrictions:

(1) identify appropriate procedure codes with necessary modifiers to allow claims to be processed and identified in the OHCA claims system;

(2) prior authorization for alternative goods and services and payment made directly to the vendor. No payment for good or services will be made to the member.