OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 13, 2014 at 1:00 P.M.
Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of January 9, 2014 OHCA Board Minutes

3. Discussion Item – Reports to the Board by Board Committees

   a) Audit/Finance Committee – George Miller
   b) Strategic Planning Committee – Vice-Chairman Armstrong
   c) Legislative Committee – Ann Bryant
   d) Rules Committee – Carol Robison

Item to be presented by Nico Gomez, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

   a) All Stars Introduction – Nico Gomez, Chief Executive Officer
      - Supervisor of the Quarter – Lisa Morgan, Provider Education Manager (Becky Pasternik-Ikard)
      - December – Demetria Bennett, Sr. Policy Specialist, Policy & Planning (Cindy Roberts)
      - January – Lori Alexander, Nurse Case Manager, Quality Compliance (Sylvia Lopez)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

   d) Legislative Update – Carter Kimble, Director of Governmental Relations

Item to be presented by James Smith, Chief of Staff

5. Discussion Item – Office Space Update

Item to be presented by Nicole Nantois, Interim Director of Legal Services

6. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Vickie Kersey, Fiscal Planning & Procurement Director

7. a) Action Item – Consideration and Vote of Authority for Expenditure of Funds for a Therapy Management Vendor. The Vendor Will Ensure Therapy Benefits Are Properly Utilized Including Prior Authorization of Physical Therapy, Speech Therapy and Occupational Therapy.

   b) Action Item – Consideration and Vote of Authority of Funds for the Amendment to Hewlett Packard (HP) Contract to Increase the Amount for Enrollment & Eligibility

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

8. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Permanent Rules:

   A) AMENDING Agency rules at OAC 317:25-9-2 to give providers greater flexibility in the populations with complex health care needs that can receive care management services through HANs. Policy is also amended to remove the HMP care management component as a responsibility of the HAN and to allow HMP to provide

health coaching services to “high risk” or “at risk” members within the HAN identified through MEDai. These changes streamline policy in the waiver, contract, and OHCA rules.
(Reference APA WF # 13-04)

B) AMENDING Agency rules at OAC 317:30-5-211.15 to clarify diabetic supplies (e.g., test strips and lancets) are covered items when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse using the appropriate diagnostic certification. In addition, the amended proposed rule change will allow OHCA flexibility to manage the dispensed quality and refill limit of glucose testing supplies related to gestational diabetes.
(Reference APA WF # 13-07)

C) AMENDING Agency rules at OAC 317:30-5-126 to remove reference to OKDHS form Adm 41, a form used to claim therapeutic and hospital leave. The form has not been utilized in over 7 years and the agency now tracks leave through its claims system; therefore, the process to claim leave in the rules is obsolete and must be amended to reflect current practice.
(Reference APA WF # 13-10)

D) AMENDING Agency rules at OAC 317:30-5-2 and 317:30-5-696 to revise tobacco cessation counseling policy to include Maternal/Child Health Licensed Clinical Social Workers (LCSWs) with certification as a tobacco treatment specialist as a qualified provider for cessation counseling services.
(Reference APA WF # 13-17)

E) AMENDING Agency rules at OAC 317:30-3-46 to update references to other areas of policy within the text. The policy that is referenced in the tuberculosis rules is outdated and it has been revoked. Correct policy references are inserted to replace the revoked policy.
(Reference APA WF # 13-18)

F) AMENDING Agency rules at OAC 317:30-5-763 to provide clarification that ADvantage program residential units are deemed to be rental units and that members in the program are to be provided with a lockable compartment within each member’s rental unit for valuables. Additionally, minor grammatical changes will be made through the policy. AMENDING Agency rules at OAC 317:35-17-14 to provide clarification regarding interdisciplinary team (IDT) meetings for case management services in the ADvantage Assisted Living waiver as well as other minor changes. Policy changes specify that IDT meetings, except for extraordinary circumstances, are to be held in the member’s home.
(Reference APA WF # 13-19A & B)

G) AMENDING Agency rules at OAC 317:35-18-5, 317:35-18-6, 317:35-18-7, and 317:35-18-9 and ADDING Agency rules at OAC 317:35-18-12 to clarify the PACE categorical, financial and medical eligibility criteria, along with other cleanup. The proposed rules changes for the PACE program, will align rules to reflect the PACE model and PACE regulations found at 42 CFR Part 460.
(Reference APA WF # 13-20)

H) AMENDING Agency rules at 317:30-5-70.3, 317:30-5-72, 317:30-5-77, and 317:30-5-77.3 to update and make general clean up changes and to comply with Federal Law on claims for covered over-the counter (OTC) products, which must be prescribed by a health care professional with prescriptive authority. Additional revisions include removing hard coded dates regarding the implementation of Medicare Part D in 2006 that no longer apply, removing the "Upper limit" reference from brand necessary certification product policy, and clarifying the product-based prior authorization for tier one and tier two products.
(Reference APA WF # 13-21)

I) ADDING Agency rule at OAC 317:30-5-133.3 to mirror federal law, 42 CFR 440.185, for ventilator-dependent individuals and clarify Nursing Home admission for ventilator-dependent and tracheostomy care services for residents in a nursing facility.
(Reference APA WF # 13-29)

J) AMENDING Agency rules at OAC 317:50-3-14, 317:50-5-5, and 317:50-5-14 to remove language regarding the Level of Care Evaluation Unit (LOCEU) and to state that only categorical relationship to age is necessary per SSA guidelines for Sooner Senior Waiver Services only. In addition, policy will be amended to change the scope of waiver services regarding Pharmacological Evaluations for Sooner Seniors and My Life, My Choice Waivers. This service will be redefined as Pharmacological Therapy Management, and its scope of work will be changed to include a case management approach to reviewing medication profiles of qualified members who meet medication utilization criterion or if they are referred for this service by a care manager.
(Reference APA WF # 13-32)

K) AMENDING Agency rules at OAC 317:30-5-565, 317:30-5-696, 317:30-5-697, 317:30-5-698, 317:30-5-699, 317:30-5-700, 317:30-5-700.1, 317:30-5-704, and 317:30-5-705 to clarify documentation and prior authorization

requirements for dental services and to clarify coverage for adult extractions, radiographs (x-rays) and endodontics procedures, among other services. Rules are further revised to remove the two tier orthodontic services and clarify treatment year is determined by the date of banding and clarify that reimbursement for orthodontic services is limited to authorized general dentist or orthodontist. Finally, rules are revised to align ambulatory surgical center (ASC) policy with Oklahoma Statute Title 63 § 2657. This law allows certified dental facilities to be recognized as ambulatory surgical centers.
(Reference APA WF # 13-39)

L) AMENDING Agency rules at OAC 317:30-5-41 and 317:30-5-42.1 to add definitions to inpatient and outpatient coverage limitations for hospitals. Specifically, how hospitals may bill in the event a member is admitted as an inpatient but later determined by OHCA not to meet criteria for inpatient status; current policy is silent to the appropriate claim filing for these instances. The proposed revisions would clarify that hospitals may submit an outpatient claim for the ancillary services provided to the member while they were on inpatient status, this change will align policy with current practice.
(Reference APA WF # 13-40)

Item to be presented by Chairman McFall

9. Discussion Item – Proposed Executive Session as Recommended by the Interim Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

   a) Discussion of Pending Litigation, Investigations and Claims

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
March 27, 2014
Oklahoma Health Care Authority
Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 9, 2014
Held at Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 8, 2014, 11:00 a.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 6, 2014, 12:00 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:03 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member Bryant, Member McVay, Member Robison

BOARD MEMBERS ABSENT: Member Nuttle

OTHERS PRESENT:

Terry Cothran, PMC
David Dude, American Cancer Society
Shellie Keast, OUCOP
Mike Herndon, OHCA
Lonny Wilson, PPOK
Will Widman, HP
Tim Tall Chief, CPN
Mike Fogarty
Ashley Neel, OMES
Christie Southern, eCapitol
Mark D.

OTHERS PRESENT:

Debbie Spaeth, Quest
Robert Evans, OHCA
Robert Dorrell, BCBS
Rick Snyder, OHA
Kara Kearns, OHCA
Charles Brodt, HP
Brenda Teel for Judy Parker, Chickasaw Nation
Lia Tepker, OMES
Dana Miller, OHCA
Melanie Fourkiller, Choctaw Nation

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD DECEMBER 11, 2013.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Vice-Chairman Armstrong moved for approval of the December 11, 2013 board meeting minutes as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Miller, Member Bryant, Member McVay

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Strategic Planning Committee
Vice-Chairman Armstrong stated that the committee did meet and had a discussion relative to what information exchanges are taking place in the legislative bodies and the Oklahoma Health Care Authority. He noted that everyone is aware that it will be a tough budget cycle upcoming but we are maintaining dialogue with the legislature and do as well as we can with the appropriated amount.

Legislative Committee
Member Bryant stated that the committee did meet and is looking forward to a full legislative report at the February board meeting.

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Nico Gomez, Chief Executive Officer

4a. ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

Mr. Gomez introduced the OHCA Employee All-Star for November 2013 through one of his direct reports.

Carrie Evans presented the November All Star – Michelle Powell, Assistant Payroll Specialist, General Accounting

4b. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of November and we did increase our positive variance of $3.4 million from the previous month for $26.2 million. We continue to be under budget in our program spending by 5.5 million state dollars and under budget in our administrative spending by 2.5 state dollars. Drug rebate went up slightly to $2.9 million. Ms. Evans stated that we will be considerably under budget for the month of December. For more detailed information, see Item 4b in the board packet.

4c. MEDICAID DIRECOR'S UPDATE
Becky Pasternik-Ikard, Deputy State Medicaid Director

Ms. Pasternik-Ikard provided a report that included a report on the number of enrollees in the Medicaid Program, a historical analysis of enrollees in Medicaid or Soonercare and a report on the number of providers. Ms. Pasternik-Ikard gave a summary of SoonerCare traditional and choice patient-centered medical homes as well as SoonerCare enrollment low cost and high cost trends. She discussed the electronic health records incentive statistics. For more detailed information, see Item 4c in the board packet.

ITEM 5 / PRESENTATION OF THE OKLAHOMA HEALTH CARE AUTHORITY 7TH ANNUAL TRIBAL CONSULTATION MEETING
Dana Miller, Tribal Relations Director

Ms. Miller first introduced Tim Tall Chief, Director of Health for Citizen Potawatomi Nation and also the Vice Chairman for the Oklahoma City area Intertribal Health Board. Ms. Miller presented a summary of the annual tribal consultation meeting held on October 23, 2013 at the Hard Rock Conference Center in Catoosa that included 140 participants representing 13 tribes, Indian Health Service (IHS) and urban Indian health care facilities. Ms. Miller discussed the top three areas of concerns from tribal leaders as well as the next steps to address these concerns. She also noted and recognized Brenda Teel's attendance, representing the Chickasaw Nation. For more detailed information, see Item 5 in the board packet.

ITEM 6 / PRESENTATION OF THE FY 2012 OKLAHOMA PAYMENT ERROR RATE MEASUREMENT (PERM) REPORT
Kelly Shropshire, Program Integrity & Accountability Director

Mr. Shropshire stated that the payment error rate measurement (PERM) was started in 2001 as a way for CMS to measure improper payments in the Medicaid program. He noted that it was mandated in 2006 to be conducted as a three year cycle. Mr. Shropshire said that in 2001 we had an error rate of 2.51%, in 2009 a rate of 1.24% and 2012 a rate of .28%. He noted that the national average is 5.7%. Mr. Shropshire discussed the 2012 CHIP PERM findings. For more detailed information, see Item 6 in the board packet.

ITEM 7 / INDEPENDENT REVIEW OF THE SOONERCARE PHARMACY BENEFIT AND MANAGEMENT
Shawna Kittridge, RPh, MHS, Principal of Mercer and Barb Mart, RPh, Senior Consultant of Mercer

Ms. Kittridge and Ms. Mart gave a presentation of the independent review of the SoonerCare pharmacy benefit and management which included pharmacy program review, notice of proposed rulemaking review and cost benefit analysis. For more detailed information on this presentation, see Item 7 in the board packet.

ITEM 8 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Interim Director of Legal Services

There were no recommendations regarding conflicts.

ITEM 9 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTLIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.
Nancy Nesser, Pharmacy Director

Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.3.

a) Consideration and Vote to Add Ketoconazole Oral Tablets to the Utilization and Scope Prior Authorization Program Under OAC 317:30-5-77.2(e).

MOTION:	Vice-Chairman Armstrong moved for approval of Item 9 as published. Member Bryant seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member McVay, Member Robison
BOARD MEMBERS ABSENT:	Member Nuttle

ITEM 10 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), AND (7).
Nicole Nantois, Interim Director of Legal Services

Chairman McFall entertained a motion to go into Executive Session at this time.

MOTION:	Member Bryant moved for approval to go into Executive Session. The motion was seconded by Member Robison.
FOR THE MOTION:	Vice-Chairman Armstrong, Chairman McFall, Member Miller, Member McVay
BOARD MEMBERS ABSENT:	Member Nuttle

6. Discussion Item – Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9)

    a) Discussion of Pending Litigation, Investigations and Claims

ITEM 11 / NEW BUSINESS

There was no new business.

ITEM 12 / ADJOURNMENT

MOTION:	Member Bryant moved for adjournment. The motion was seconded by Member Robison.
FOR THE MOTION:	Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member McVay
BOARD MEMBERS ABSENT:	Member Nuttle

Meeting adjourned at 3:00 p.m., 1/9/2014

NEXT BOARD MEETING
February 13, 2014
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

FINANCIAL REPORT

For the Six Months Ended December 31, 2013
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$1,939,084,263** or **.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,874,757,951 or 2% under** budget.
- The state dollar budget variance through December is **$36,315,978 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		13.2
Administration		4.3
Revenues:		
Unanticipated Revenue		15.7
Drug Rebate		4.5
Taxes and Fees		(.7)
Overpayments/Settlements		(.7)
Total FY 14 Variance	**$**	**36.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2014, For the Six Months Ended December 31, 2013

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 477,228,268	$ 477,228,268	$ -	0.0%
Federal Funds	1,012,616,532	985,540,979	(27,075,553)	(2.7)%
Tobacco Tax Collections	28,382,401	27,620,024	(762,377)	(2.7)%
Quality of Care Collections	40,619,382	40,619,382	-	0.0%
Prior Year Carryover	41,811,007	41,811,007	-	0.0%
Unanticipated Revenue	-	15,683,810	15,683,810	100.0%
Federal Deferral - Interest	118,557	118,557	-	0.0%
Drug Rebates	110,838,974	123,394,378	12,555,404	11.3%
Medical Refunds	23,279,631	21,343,683	(1,935,948)	(8.3)%
SHOPP	197,246,967	197,246,967	-	0.0%
Other Revenues	8,362,604	8,477,208	114,604	1.4%
TOTAL REVENUES	**$ 1,940,504,324**	**$ 1,939,084,263**	**$ (1,420,061)**	**(0.1)%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 26,124,191**	**$ 22,424,092**	**$ 3,700,099**	**14.2%**
ADMINISTRATION - CONTRACTS	**$ 55,534,106**	**$ 48,638,097**	**$ 6,896,009**	**12.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	18,271,170	17,538,732	732,438	4.0%
Acute Fee for Service Payments:				
Hospital Services	472,143,239	462,784,732	9,358,507	2.0%
Behavioral Health	10,779,880	10,490,829	289,051	2.7%
Physicians	250,009,121	244,304,724	5,704,397	2.3%
Dentists	74,845,131	72,183,343	2,661,787	3.6%
Other Practitioners	23,042,160	20,973,758	2,068,402	9.0%
Home Health Care	11,105,200	10,392,018	713,182	6.4%
Lab & Radiology	33,137,747	30,990,233	2,147,514	6.5%
Medical Supplies	25,157,769	23,470,719	1,687,051	6.7%
Ambulatory/Clinics	56,848,847	55,978,098	870,749	1.5%
Prescription Drugs	209,255,306	209,695,037	(439,730)	(0.2)%
OHCA TFC	892,920	934,155	(41,235)	0.0%
Other Payments:				
Nursing Facilities	286,882,771	285,959,642	923,129	0.3%
ICF-MR Private	29,889,428	29,832,552	56,876	0.2%
Medicare Buy-In	67,295,615	67,948,846	(653,230)	(1.0)%
Transportation	31,513,764	30,815,456	698,308	2.2%
MFP-OHCA	811,575	527,679	283,895	0.0%
EHR-Incentive Payments	7,524,548	7,524,548	-	0.0%
Part D Phase-In Contribution	39,223,893	39,234,435	(10,542)	(0.0)%
SHOPP payments	182,116,227	182,116,227	-	0.0%
Total OHCA Medical Programs	**1,830,746,311**	**1,803,695,762**	**27,050,549**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,912,493,990**	**$ 1,874,757,951**	**$ 37,736,039**	**2.0%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 28,010,334**	**$ 64,326,312**	**$ 36,315,978**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2014, For the Six Months Ended December 31, 2013

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 17,755,266	$ 17,530,154	$ -	$ 216,534	$ -	$ 8,578	$ -
Inpatient Acute Care	409,037,665	299,517,559	243,343	5,326,810	25,370,849	1,072,292	77,506,811
Outpatient Acute Care	142,186,109	134,406,553	20,802	5,605,420	-	2,153,334	-
Behavioral Health - Inpatient	11,976,942	6,222,515	-	316,178	-		5,438,249
Behavioral Health - Psychiatrist	4,268,314	4,268,314	-	-	-	-	-
Behavioral Health - Outpatient	12,799,574	-	-	-	-	-	12,799,574
Behavioral Health Facility- Rehab	132,735,614	-	-	-	-	46,895	132,735,614
Behavioral Health - Case Management	4,813,142	-	-	-	-	-	4,813,142
Behavioral Health - PRTF	47,136,670	-	-	-	-	-	47,136,670
Residential Behavioral Management	10,095,297	-	-	-	-	-	10,095,297
Targeted Case Management	32,160,685	-	-	-	-	-	32,160,685
Therapeutic Foster Care	934,155	934,155	-	-	-	-	-
Physicians	273,720,439	207,266,028	29,050	7,245,487	33,950,849	3,058,796	22,170,228
Dentists	72,232,873	68,502,709	-	49,530	3,664,890	15,744	-
Mid Level Practitioners	1,774,650	1,735,041	-	38,208	-	1,402	-
Other Practitioners	19,389,140	18,491,015	223,182	151,824	517,903	5,215	-
Home Health Care	10,392,136	10,378,237	-	119	-	13,781	-
Lab & Radiology	32,922,886	30,638,179	-	1,932,653	-	352,054	-
Medical Supplies	23,826,530	22,089,345	1,355,768	355,811	-	25,606	-
Clinic Services	59,642,356	51,004,395	-	729,815	-	133,281	7,774,865
Ambulatory Surgery Centers	5,116,960	4,831,832	-	276,538	-	8,590	-
Personal Care Services	6,747,480	-	-	-	-	-	6,747,480
Nursing Facilities	285,959,642	160,513,178	105,169,966	-	20,268,176	8,323	-
Transportation	30,678,513	27,725,401	1,324,597	-	1,601,649	26,866	-
GME/IME/DME	62,498,835	-	-	-	-	-	62,498,835
ICF/MR Private	29,832,552	23,887,176	5,517,815	-	427,560	-	-
ICF/MR Public	22,441,676	-	-	-	-	-	22,441,676
CMS Payments	107,183,280	106,800,965	382,315	-	-	-	
Prescription Drugs	219,799,129	185,216,747	-	10,104,092	23,618,523	859,767	-
Miscellaneous Medical Payments	137,022	131,352	-	79	-	5,591	-
Home and Community Based Waiver	85,508,291	-	-	-	-	-	85,508,291
Homeward Bound Waiver	45,016,813	-	-	-	-	-	45,016,813
Money Follows the Person	3,976,400	527,679	-	-	-	-	3,448,721
In-Home Support Waiver	11,962,477	-	-	-	-	-	11,962,477
ADvantage Waiver	92,546,469	-	-	-	-	-	92,546,469
Family Planning/Family Planning Waiver	6,322,918	-	-	-	-	-	6,322,918
Premium Assistance*	23,615,288	-	-	23,615,288		-	-
EHR Incentive Payments	7,524,548	7,524,548	-	-	-	-	-
SHOPP Payments**	182,116,227	182,116,227	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,548,784,963**	**$1,390,143,077**	**$ 114,266,839**	**$ 55,964,386**	**$ 109,420,400**	**$ 7,796,114**	**$ 689,124,816**

* Includes $23,438,371.38 paid out of Fund 245 and **$182,116,227.02 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2014, For the Six Months Ended December 31, 2013

		FY14
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	282,805,784
Federal Funds		443,471,603
TOTAL REVENUES	**$**	**726,277,387**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	85,508,291
Money Follows the Person		3,448,721
Homeward Bound Waiver		45,016,813
In-Home Support Waivers		11,962,477
ADvantage Waiver		92,546,469
ICF/MR Public		22,441,676
Personal Care		6,747,480
Residential Behavioral Management		7,338,789
Targeted Case Management		24,419,472
Total Department of Human Services		**299,430,187**
State Employees Physician Payment		
Physician Payments		22,170,228
Total State Employees Physician Payment		**22,170,228**
Education Payments		
Graduate Medical Education		21,422,222
Graduate Medical Education - PMTC		1,866,941
Indirect Medical Education		31,088,706
Direct Medical Education		8,120,966
Total Education Payments		**62,498,835**
Office of Juvenile Affairs		
Targeted Case Management		1,469,105
Residential Behavioral Management		2,756,508
Total Office of Juvenile Affairs		**4,225,613**
Department of Mental Health		
Case Management		4,813,142
Inpatient Psych FS		5,438,249
Outpatient		12,799,574
PRTF		47,136,670
Rehab		132,735,614
Total Department of Mental Health		**202,923,250**
State Department of Health		
Children's First		1,154,627
Sooner Start		1,376,244
Early Intervention		2,787,876
EPSDT Clinic		958,787
Family Planning		(121,119)
Family Planning Waiver		6,428,353
Maternity Clinic		31,079
Total Department of Health		**12,615,848**
County Health Departments		
EPSDT Clinic		450,697
Family Planning Waiver		15,684
Total County Health Departments		**466,382**
State Department of Education		**56,340**
Public Schools		**2,273,265**
Medicare DRG Limit		**70,952,312**
Native American Tribal Agreements		**4,958,057**
Department of Corrections		**1,208,991**
JD McCarty		**5,345,508**
Total OSA Medicaid Programs	**$**	**689,124,816**
OSA Non-Medicaid Programs	**$**	**39,351,912**
Accounts Receivable from OSA	**$**	**2,199,341**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2014, For the Six Months Ended December 31, 2013

REVENUES		FY 14 Revenue
SHOPP Assessment Fee	$	80,562,925
Federal Draws		116,572,474
Interest		110,026
Penalties		1,542
State Appropriations		(15,200,000)
TOTAL REVENUES	$	182,046,967

EXPENDITURES	Quarter	Quarter		FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13		
Hospital - Inpatient Care	76,710,371	86,962,208	$	163,672,579
Hospital -Outpatient Care	2,748,407	2,899,948	$	5,648,355
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	$	12,268,486
Rehabilitation Facilities-Inpatient	248,410	278,398	$	526,808
Total OHCA Program Costs	85,492,242	96,623,985	$	182,116,227
Total Expenditures			$	182,116,227

CASH BALANCE		
	$	(69,260)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2014, For the Six Months Ended December 31, 2013

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 39,024,146**	**$ 39,024,146**
Interest Earned	**110,026**	**110,026**
TOTAL REVENUES	**$ 39,134,173**	**$ 39,134,173**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 103,319,601	$ 37,195,056	
Eyeglasses and Dentures	140,426	50,553	
Personal Allowance Increase	1,709,940	615,578	
Coverage for DME and supplies	1,355,768	488,076	
Coverage of QMB's	516,378	185,896	
Part D Phase-In	382,315	382,315	
ICF/MR Rate Adjustment	2,805,021	1,009,808	
Acute/MR Adjustments	2,712,794	976,606	
NET - Soonerride	1,324,597	476,855	
Total Program Costs	**$ 114,266,839**	**$ 41,380,744**	**$ 41,380,744**
Administration			
OHCA Administration Costs	$ 234,350	$ 117,175	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 234,350**	**$ 117,175**	**$ 117,175**
Total Quality of Care Fee Costs	**$ 114,501,189**	**$ 41,497,919**	
TOTAL STATE SHARE OF COSTS			**$ 41,497,919**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2014, For the Six Months Ended December 31, 2013

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,405,260
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	22,716,626	22,716,626
Interest Income	-	115,313	115,313
Federal Draws	176,996	14,403,296	14,403,296
All Kids Act	(6,839,300)	144,204	144,204
TOTAL REVENUES	$ 3,765,546	$ 37,379,439	$ 37,640,495

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 23,109,885	$ 23,109,885
	College Students		176,917	176,917
	All Kids Act		328,486	328,486
Individual Plan				
	SoonerCare Choice		$ 207,816	$ 74,814
	Inpatient Hospital		5,314,682	1,913,286
	Outpatient Hospital		5,524,961	1,988,986
	BH - Inpatient Services-DRG		304,437	109,597
	BH -Psychiatrist		-	-
	Physicians		7,176,290	2,583,464
	Dentists		34,034	12,252
	Mid Level Practitioner		37,822	13,616
	Other Practitioners		146,518	52,747
	Home Health		119	43
	Lab and Radiology		1,911,042	687,975
	Medical Supplies		352,484	126,894
	Clinic Services		715,048	257,417
	Ambulatory Surgery Center		275,680	99,245
	Prescription Drugs		9,996,017	3,598,566
	Miscellaneous Medical		78	78
	Premiums Collected		-	(903,800)
Total Individual Plan			$ 31,997,028	$ 10,615,180
	College Students-Service Costs		$ 280,263	$ 100,895
	All Kids Act- Service Costs		$ 71,806	$ 25,850
Total OHCA Program Costs			$ 55,964,385	$ 34,357,213
Administrative Costs				
	Salaries	$ 7,360	$ 528,322	$ 535,682
	Operating Costs	85,634	294,306	379,941
	Health Dept-Postponing	-	-	-
	Contract - HP	267,291	327,550	594,841
Total Administrative Costs		$ 360,286	$ 1,150,178	$ 1,510,463
Total Expenditures				$ 35,867,676
NET CASH BALANCE		$ 3,405,260		$ 1,772,819

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2014, For the Six Months Ended December 31, 2013

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 456,350	$ 456,350
TOTAL REVENUES	**$ 456,350**	**$ 456,350**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 8,578	$ 2,162	
Inpatient Hospital	1,072,292	270,218	
Outpatient Hospital	2,153,334	542,640	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	3,058,796	770,817	
Dentists	15,744	3,967	
Mid-level Practitioner	1,402	353	
Other Practitioners	5,215	1,314	
Home Health	13,781	3,473	
Lab & Radiology	352,054	88,718	
Medical Supplies	25,606	6,453	
Clinic Services	133,281	33,587	
Ambulatory Surgery Center	8,590	2,165	
Prescription Drugs	859,767	216,661	
Transportation	26,866	6,770	
Miscellaneous Medical	5,591	1,409	
Total OHCA Program Costs	$ 7,749,219	$ 1,952,803	
OSA DMHSAS Rehab	$ 46,895	$ 11,818	
Total Medicaid Program Costs	$ 7,796,114	$ 1,964,621	
TOTAL STATE SHARE OF COSTS			**$ 1,964,621**

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

SoonerCare Programs

December 2013 Data for February 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2013	Enrollment December 2013	Total Expenditures December 2013	Average Dollars Per Member Per Month December 2013
SoonerCare Choice Patient-Centered Medical Home			513,315	**555,436**	**$136,078,507**	
	Lower Cost	*(Children/Parents; Other)*		509,206	$98,929,629	$194
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,230	$37,148,878	$804
SoonerCare Traditional			217,231	**195,193**	**$165,090,436**	
	Lower Cost	*(Children/Parents; Other)*		87,495	$34,664,390	$396
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,698	$130,426,046	$1,211
SoonerPlan			48,346	**52,617**	**$787,879**	$15
Insure Oklahoma			30,202	**25,734**	**$7,890,585**	
	Employer-Sponsored Insurance		16,644	14,379	$3,279,165	$228
	Individual Plan		13,559	11,355	$4,611,420	$406
TOTAL			**809,094**	**828,980**	**$309,847,407**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $113,259,726 are excluded.

Net Enrollee Count Change from Previous Month Total	1,556

New Enrollees	16,049

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2013	Enrolled December 2013
Dual Enrollees		**108,514**	**109,589**
	Child	*201*	183
	Adult	*108,313*	109,406

		Monthly Average SFY2013	Enrolled December 2013	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,674**	**15,416**	**$3,571**
	Child	64	66	
	Adult	15,610	15,350	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled December 2013
Total Providers		**36,948**	**37,746**
	In-State	28,587	28,848
	Out-of-State	8,362	8,898

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	45%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2013	*Enrolled December 2013**	Monthly Average SFY2013	Enrolled December 2013
Physician	*7,859*	*8,300*	*12,432*	13,454
Pharmacy	*901*	*935*	*1,208*	1,263
Mental Health Provider**	*5,811*	*4,819*	*5,880*	4,859
Dentist**	*1,205*	*975*	*1,380*	1,083
Hospital**	*194*	*183*	*923*	676
Optometrist	*578*	*569*	*612*	598
Extended Care Facility	*362*	*355*	362	355

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers***	*4,997*	*5,165*	6,541	6,663
Patient-Centered Medical Home	*1,935*	*1,974*	1,985	2,067

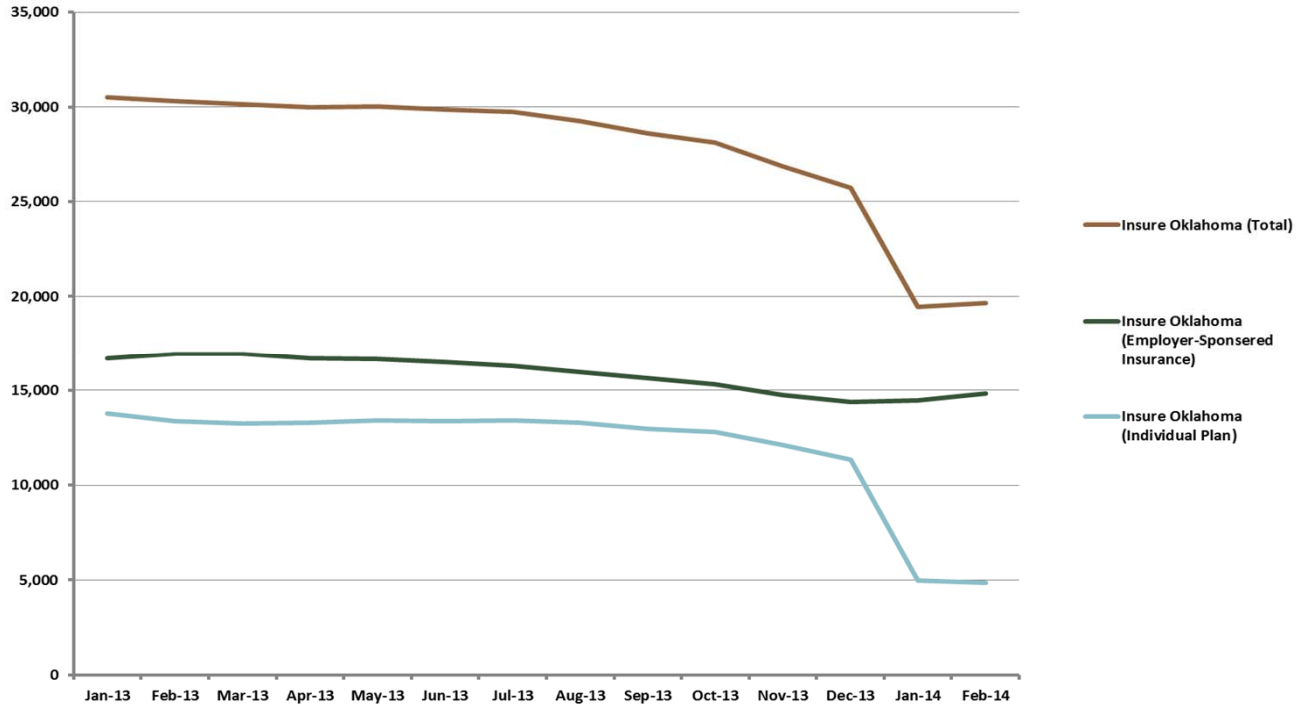
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals renewal started in March 2013, renewals for Mental Health Providers started in June 2013 and Dentist renewals started in October 2013.

SoonerCare Programs

INSURE OKLAHOMA ENROLLMENT



In January 2014, Insure Oklahoma IP decreased its qualifying income guidelines from 200 to 100 percent of the federal poverty level.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

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

As Of 2/4/2014	January 2014		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	59	$807,500	1,908	$44,830,418
Eligible Hospitals	3*	$313,013	91	$81,561,298
Totals	62	$1,120,513	1,999	$126,391,716

*Current Eligible Hospitals Paid
HOLDENVILLE GEN HSP
KINGFISHER REGIONAL HOSPITAL
NORMAN REGIONAL HOSPITAL

OHCA BOARD MEETING

FEBRUARY 13TH, 2014 OHCA BOARD MEETING

The Governor's State of the State address and the 2013 legislative session began Monday, February 3rd at noon.

As of February 5, 2014, the Oklahoma Legislature is tracking a total of 4,307 legislative bills, which includes carryover bills from last session that can be brought up this session for consideration. OHCA is currently tracking 58 bills, one of which is an OHCA request bill. At this time we have not added Employee Interest bills to our tracking and are still reviewing bills for Agency Interest. We have an additional 110 Carryover bills from last session.

OHCA REQUEST BILL:

- HB2402 – Rep. Arthur Hulbert – Allows OHCA to recover funds put in a trust for, but not spent on, burial/funeral expenses. Recovery amount not to exceed cost of services provided.

The following are the Senate and House deadlines for 2014:

SENATE AND HOUSE DEADLINES

February 17, 2014	Deadline for Reporting Double Assigned Senate Bills from lst Committee
February 24, 2014	Deadline for Reporting Single-Assigned Senate Bills from Senate Committees
February 27, 2014	Deadline for Reporting Double-Assigned Senate Bills from 2nd Committee
March 13, 2014	Deadline for Third Reading/Final Passage of Bills in the House of Origin
March 27, 2014	Deadline for Double-Assigned House Bills from lst Senate Committee
April 3, 2014	Deadline for Reporting Single Assigned House Bills from Senate Committees
April 10, 2014	Deadline for Reporting Double-Assigned House Bills from 2nd Senate Committee
April 24, 2014	Deadline for Third Reading & Final Passage of Bills from Opposite Chamber
May 30, 2014	Sine Die Adjournment, No later than 5:00 p.m.

A Legislative Bill Tracking Report will be included in your handout at the Board Meeting.


EXIT


Knoll


EXIT


WERNER
SWTB
SWTB
EXIT


EXIT


EXIT


SSL II
SSL II
Armstrong
Elastomeric Pipe Insulation


Elastomeric Pipe Insulation
Elastomérique pour Tuyaux
SSL II
HUSKY
PLASTIC SHEETING


Armstrong


KOHLER


GP
DensGlass
Sheathing


DensGlass
DensGlass
DensGlass
DensGlass
DensGlass
DensGlass


Future Home of
Oklahoma Health Care Authority
Construction By:
Financed By:
SNB
Architectural Design By:
Development By:
TANENBAUM

Submitted to the C.E.O. and Board on February 13, 2014

AUTHORITY FOR EXPENDITURE OF FUNDS
Therapy Management Program Services

BACKGROUND

The Therapy Management Program will be responsible for developing and implementing a program that ensures therapy benefits are utilized appropriately. This includes Prior Authorization (PA) of Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT).

SCOPE OF WORK

- Review and approve/deny requests for services based on OHCA policy and the Contractor's standard criteria and protocols
- Provide written notification to providers of the approval or denial of their request
- Provide recommendations to OHCA about utilization management, provider education, new technologies, and claims edit or review
- Improve providers' knowledge of incentives to use appropriate therapy services

CONTRACT PERIOD

Date of Award through June 30, 2015 with annual options to renew through June 30, 2017

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through competitive bidding conducted by OHCA
- Federal matching is estimated at 50-75% dependent on winning bidder
- Estimated at $1 million per year
- $450,000 Implementation cost projected for SFY 14

RECOMMENDATION

- Board approval to procure the services discussed above

Submitted to the C.E.O. and Board on February 13, 2014
AUTHORITY FOR EXPENDITURE OF FUNDS
MMIS Fiscal Agent
HP Enterprise Services

BACKGROUND

The Board previously approved this contract in 2010 for MMIS Fiscal Agent Services. This contract is being amended to increase expenditure of authority to comply with federal initiatives funded under the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act of 2010 (PPACA).

AMENDMENT SCOPE OF WORK

Additional tasks added to the scope include are as follows:

- Affordable Care Act (ACA) mandated application updates with associated database updates. A redesign of the current database and web applications is in progress to change the system from an application (household) centered system architecture to a person-centered system architecture.
- Implementation of the Enterprise Service Bus (ESB) is in development to expand the use of web services and to link the applications using service-oriented architecture (SOA). This includes links with other agencies, the Health Information Exchange (HIE), and the Health Insurance Exchange (HIX).
- Implementation of Workflow and an associated Business Process Modeling tool to document and further automate eligibility business processes. A key feature of Release 2 is to provide real-time application, eligibility determination, data exchange, identification, authorization, and enrollment services for all populations covered under the ACA.

AMENDMENT AMOUNT AND PROCUREMENT METHOD

Additional expenditures are estimated as follows:

State Fiscal Year / Total Increase	Item	Additional Budget	Federal Matching Fund %
2014 - $6,078,161.00	Hardware / Computer off the shelf software	$145,248.00	75%
	System design, development, and implementation	$5,932,913.00	90%
2015 - $15,000,000.00	Hardware / Computer off the shelf software	$1,000,000.00	75%
	System design, development, and implementation	$14,000,000.00	90%

The original acquisition was made by competitive bid.

RECOMMENDATION

Board approval to expend funds as explained above

A.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 9. HEALTH ACCESS NETWORKS
317: 25-9-2. [AMENDED]
(REFERENCE APA WF # 13-04)

317:25-9-2. Requirements
(a) HAN's are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:
(1) be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;
(2) offer patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the State;
(3) submit an application to the OHCA as specified in (c) of this Section;
(4) offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies;
(5) have an organized and systematic quality improvement process, including the identification of measurable performance targets; and
~~(6) offer care management/care coordination to persons with complex health care needs including:~~
~~(A) the co-management of individuals enrolled in OHCA's Health Management Program;~~
~~(B) individuals with frequent emergency room utilization;~~
~~(C) women enrolled in the Oklahoma Cares Program diagnosed with breast or cervical cancer;~~
~~(D) pregnant women enrolled in the High Risk OB Program; and~~
~~(E) individuals enrolled in the Pharmacy Lock-In Program; and~~
(6) offer care management/care coordination to persons in the HANs. This includes care management for specified members with complex health care needs as approved by OHCA. The HAN will not provide care management services to HMP members in the HAN, as these members will receive care management from HMP health coaches or from the OHCA internal Chronic Care Unit.
(b) Networks must meet at least two of the following:
(1) have a formal affiliation agreement/partnership at the community-level with traditional and non-traditional providers;
(2) have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and
(3) have 501(c)3 or not-for-profit status.
(c) In order to qualify to participate as a SoonerCare contracted HAN's, the network must submit an application to the OHCA that details how the network plans to:
(1) reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;

(2) improve access to, and the availability of, health care services provided to individuals served by the health access network;
(3) enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;
(4) improve the health status of communities served by the health access network;
(5) reduce health disparities in such communities;
(6) identify all PCPs, specialty providers, and other provider types affiliated with the health access network.

(d) The application to participate as a SoonerCare contracted HAN's will be accepted and approved at the sole discretion of OHCA with implementation initiated after completion of a readiness review by OHCA staff and approval by OHCA's Medical Advisory Taskforce (MAT).

B.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS
317:30-5-211.15. [AMENDED]
(REFERENCE APA WF # 13-07)

317:30-5-211.15. Supplies
(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.
(b) Special requirements:

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. A maximum of 100 glucose test strips and 100 lancets per month ~~when medically necessary and prescribed by a physician~~ are covered items for insulin dependent members and a maximum of 100 glucose test strips and 100 lancets per 90 days are covered for non-insulin dependent members. Members diagnosed with gestational diabetes may receive a maximum of 150 glucose test strips and 150 lancets per month when the appropriate diagnostic classification for gestational diabetes is used. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.

(4) **Colostomy and urostomy supplies**. Colostomy and urostomy bags and accessories are covered items.

C.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES
317:30-5-126. [AMENDED]
(REFERENCE APA WF # 13-10)

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed. ~~Claims for therapeutic leave are to be submitted on Form Adm-41 (Long Term Care Claim Form)~~.

(2) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.

(3) The Intermediate Care Facility for ~~the Mentally Retarded (ICF/MR)~~Individuals with Intellectual Disabilities (ICF/IID) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/~~MR~~IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. ~~Claims for therapeutic leave are to be submitted on Form Adm-41~~.

(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.

(5) Therapeutic and hospital leave balances are recorded on the Medicaid Management Information System (MMIS) ~~recipient record based on the Form Adm-41 submitted by the facility~~. When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility. ~~Forms are available in the local county OKDHS office.~~

D.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS
317:30-5-2. [AMENDED]
PART 79. DENTISTS
317:30-5-696. [AMENDED]
(REFERENCE APA WF # 13-17)

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)~~(OHCA) 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 surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(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 member, 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 administered by OHCA. A copy of the authorization, OKDHS form 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 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 the insertion and/or implantation of contraceptive devices 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.
(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) 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.
(T) 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.

(U) 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 signs off on the billed encounter;

(ii) Attending physician is 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.

(V) 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.

(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and 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.

(Z) 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.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) 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 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.

(EE) 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, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP 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.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing is considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) The result of the test will directly impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is considered scientifically valid for the identification of a specific genetically-linked inheritable disease; and

(iv) Documentation is provided from a licensed genetic counselor or physician with genetic expertise that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for 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 on the same day, except when supplemental skills are required and different specialties are involved.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(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 hysterectomies.

(I) Medical services considered 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 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.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) 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.)
(Q) Speech and Hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) 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 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. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. 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) 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 are not 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 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.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for 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 on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered 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 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.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(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 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)~~Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ~~ICF/MR~~ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative

services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material.

(See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative 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.

(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 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years; and

(V) Tooth numbers D and G before 5 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(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 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.

(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) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and multiple missing teeth exist in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as

analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(O) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(P) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(R) **Local anesthesia.** This procedure is included in the fee for all services.

(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 member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, ~~and~~ Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the

diagnosis of pregnancy and ending upon 60 days post partum.
(C) In addition to dental services for adults, other services available include:
(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;
(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);
(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;
(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);
(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);
(vi) Composite restorations:
(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;
(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and
(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(3)(N).
(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).
(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**
(A) Payment is made based on the member's coinsurance and deductibles.
(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

E.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION
317:30-3-46. [AMENDED]
(REFERENCE APA WF # 13-18)

317:30-3-46. Services for persons infected with tuberculosis
(a) Oklahoma Medicaid provides optional coverage of tuberculosis (TB) related services for certain TB infected individuals. Services covered under this program are not restricted to the Medicaid scope of coverage or limitations. Services for TB infected individuals that exceed the scope of Medicaid services must be prior authorized. Individuals eligible only under the optional TB-related services program can receive TB related services such as:

(1) Prescribed medications:
(A) Prescription drugs indicated for the treatment of TB up to the Medicaid established prescription limit; and
(B) Other drugs related to the treatment of TB beyond the prescriptions covered under Medicaid, require prior authorization obtained from the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(2) Physician services:
(A) Physician services include:
(i) ambulatory physician services;
(ii) office visits; and
(iii) ambulatory surgery and such, but not including inpatient services.
(B) Office visits are not limited for TB infected persons. However, prior authorization is required when the limit under Medicaid is exceeded;

(3) Outpatient hospital services;

(4) Rural Health Clinic services;

(5) Federally Qualified Health Clinic services;

(6) Laboratory and x-ray services. Necessary laboratory and x-ray services (including services to confirm presence of TB infection) are covered for infected persons. Screening tests to detect and confirm presence of TB do not require prior authorization;

(7) Tuberculosis Clinic services (See ~~317:30-5-911~~317:30-5-1159 for description of these services); and

(8) Targeted Case Management services~~ (See 317:30-5-921 for a description of these services)~~.

(b) Persons eligible for services only under optional TB coverage do not receive the full range of Medicaid benefits. Coverage is limited as set out in this Section.

(c) Persons eligible under Medicaid who are infected with TB may also be eligible for TB services and receive these extended benefits.

F-1.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES
317:30-5-763. [AMENDED]
(REFERENCE APA WF # 13-19A)

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, 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. 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, hair care or laundry is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care or laundry will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing, hair care or laundry to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 8 hours (32 units) 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, hair care or laundry 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 the SoonerCare rate if established, to the Medicare rate or to 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 may be provided on an intermittent or part time basis or may be comprised of continuous care. 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 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 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 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 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 nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to 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) **Skilled Nursing Services**.

(A) Skilled Nursing Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse 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. Skilled Nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are for treatment of a disease or a medical condition and are beyond the scope of ADvantage Nursing Services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. It is the responsibility of the RN to contact the member's physician to obtain any necessary information or orders pertaining to the care of the member. If the member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.

(B) Skilled Nursing services are provided on an intermittent or part-time basis, and billed in units of 15 minute increments. ADvantage Skilled Nursing services are provided when nursing services are not available through Medicare or other sources or when nursing services furnished under SoonerCare plan limits are exhausted. Amount, frequency and duration of services are prior authorized in accordance with member's service plan.

(9) **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.

(10) **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.

(11) **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.

(12) **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.

(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. ADvantage Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) 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. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(C) 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. The maximum total annual reimbursement for a member=s Hospice care within a twelve month period is limited to an amount

equivalent to 85% of the Medicare Hospice Cap payment.

(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 provided are not reimbursable.

(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) rental 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 rental units the provider is making available to service ADvantage participants. The number of rental units available to service ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

(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 rental 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 the 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~~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, and the AA. 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, the ADvantage Case Manager, and the AA;

(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 rental 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 rental unit and to a lockable compartment within each member's rental unit for valuables except in the case of documented contraindication. ~~Units~~Rental units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each rental 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~~rental 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 rental 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~~rental unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A) at no additional cost to the member.

(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 rental 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 rental 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~~is 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~~are 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 or Memory Care 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~~Assisted Living Member 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~~,~~ and to the ~~ADvantage Program AA and to other entities as required by law or regulation~~AA utilizing the AA Critical Incident Reporting form. Incident reports are also to be made to Adult Protective Services (APS) and to the Oklahoma State Department of Health (OSDH), as appropriate, in accordance with the ALC's licensure rules, utilizing the specific reporting forms required.

(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 and listed on the Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage Case Manager and to the AA via facsimile ~~or by telephone~~ within one business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. ~~A~~If required, a follow-up report of the incident ~~must~~will be submitted via facsimile or mail to the member's ADvantage Case Manager. The follow-up report must be submitted 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. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(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. The determination of the appropriate per diem rate is made by the AA clinical review staff.

F-2.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES
317:35-17-14. [AMENDED]
(REFERENCE APA WF # 13-19B)

317:35-17-14. Case management services
(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and OKDHS in the program), review, update and complete the UCAT assessment, discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. Except for extraordinary circumstances, the IDT meetings are to be held in the member's home. Variances from this policy must be presented

to, and approved by, the AA in advance of the meeting. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the care plan the presence of two or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the IVRA system in the member record any instance in which a member's health or safety would be "at risk" if even one personal care visit is missed. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the OKDHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager develops an individualized plan to overcome challenges to receiving services focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allow the member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the member's signature when, for these members, the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may authorize the service plan if the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Consumer-Directed Personal Assistance Services and Supports (CD-PASS) services to a member may not be designated the "authorized representative" for the member.

(iii) The case manager reviews the designation of Authorized Representative, Power of Attorney and Legal Guardian status on an annual basis and this is included in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. Principles of Person-Centered Planning are as follows:

(i) The person is the center of all planning activities.

(ii) The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

(v) Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the member, or as

applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan. The start date must be after authorization of services, after completion and approval of the background checks and after completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the member's APSA has been providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's well being and the

quality of supports and services and assists the member in revising the PSA services plan as needed. 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 CDA/CM, based upon an updated assessment, amends the service plan to modify CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) if the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management will submit the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit will work with the member and provider to reach a mutually agreed upon resolution;

(iii) if the dispute cannot be resolved by the ADvantage Escalated Issues Unit it will be heard by the Ethics of Care Committee. The Ethics of Care Committee will make a final determination with regard to settlement of the dispute;

(iv) at any step of this dispute resolution process the member may request a fair hearing, to appeal the dispute resolution decision.

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request

the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within five working days of notification of an initial service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The ADvantage Administration (AA) authorizes the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1)Except as provided by the process described in OAC 317:30-5-

761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).

(2) The OKDHS/ASD may under criteria described in OAC 317:35-15-13 authorize personal care service provision by an Individual PCA (an individual contracted directly with OHCA). Legally responsible family members are not eligible to serve as Individual PCA's.

(3) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

(4) The AA authorizes the service plan by entering the authorization date and assigning a control number that internally identifies the OKDHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the authorization date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within 5 working days.

(5) For audit purposes (including Program Integrity reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan**. The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within

five calendar days of assessed need. The AA authorizes or denies the care plan and service plan changes per 317:35-17-14.
(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA or by calling the toll-free number established to process requests for CD-PASS services.
(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires an updated UCAT reassessment by the case manager. The case manager develops an amended or new service plan and care plan, as appropriate, and submits the new amended plans for authorization.
(4) One or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two or more ADvantage members residing in the same household, or

(B) the member and personal care provider residing together, or

(C) a request for a family member to be a paid ADvantage service provider, or

(D) a request for an Individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care.

G.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY
317:35-18-5. [AMENDED]
317:35-18-6. [AMENDED]
317:35-18-7. [AMENDED]
317:35-18-9. [AMENDED]
317:35-18-12. [NEW]
(REFERENCE APA WF # 13-20)

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:

~~(1) meet categorical relationship to disability (reference OAC 317:35-5-4);~~

~~(2) meet medical and financial criteria for the ADvantage program (reference OAC 317:35-17-2, 317:35-17-10, and 317:35-17-11);~~

~~(3)~~(1) be age 55 years or older

~~(4)~~(2) live in a PACE service area;

(3) be determined by the state to meet nursing facility level of care.

~~(5)~~(4) be determined by the PACE Interdisciplinary team as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) notify the applicant in writing of the reason for the denial;

(B) refer the applicant to alternative services as appropriate;

(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and

(D) advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:

(1) meet categorical relationship to disability (reference OAC 317:35-5-4).

~~(1)~~(2)be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;

~~(2)~~(3) be eligible for SoonerCare State Plan services;

~~(3)~~(4) ~~be~~ meet the same financial ~~eligible~~eligibility criteria as set forth for the SoonerCare Advantage program per ~~OAC 317:35-17-3~~OAC 317:35-17-10 and ~~317:30-35-17-5~~ 317:30-17-11~~.~~;and

(5) meet appropriate medical eligibility criteria.

(c) Medical determination of Eligibility. The nurse designee makes

the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) I, Part III, and other available medical information.

(1) When PACE services are requested:

(A) The PACE nurse or OKDHS nurse is responsible for completing the UCAT assessment.

(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting OKDHS to initiate the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with the PACE enrollee within 10 days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) From PACE to Advantage.

(B) From Pace to State Plan Personal Care Services.

(C) From Nursing Facility to PACE.

(D) From Advantage to PACE if previous UCAT was completed more than 6 months prior to member requesting PACE enrollment.

~~(c)~~(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-6. PACE Program benefits

(a) The PACE program offers a comprehensive benefit plan. A provider agency must provide a participant all the services listed in 42 CFR 460.92 that are approved by the IDT. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

(1) All SoonerCare-covered services, as specified in the State's approved SoonerCare plan.

(2) Interdisciplinary assessment and treatment planning.

(3) Primary care, including physician and nursing services.

(4) Social work services.

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

(6) Personal care and supportive services.

(7) Nutritional counseling.

(8) Recreational therapy.

(9) Transportation.

(10) Meals.

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology.

(B) Audiology.
(C) Cardiology.
(D) Dentistry.
(E) Dermatology.
(F) Gastroenterology.
(G) Gynecology.
(H) Internal medicine.
(I) Nephrology.
(J) Neurosurgery.
(K) Oncology.
(L) Ophthalmology.
(M) Oral surgery.
(N) Orthopedic surgery.
(O) Otorhinolaryngology.
(P) Plastic surgery.
(Q) Pharmacy consulting services.
(R) Podiatry.
(S) Psychiatry.
(T) Pulmonary disease.
(U) Radiology.
(V) Rheumatology.
(W) General surgery.
(X) Thoracic and vascular surgery.
(Y) Urology.

(12) Laboratory tests, x-rays and other diagnostic procedures.

(13) Drugs and biologicals.

(14) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

(15) Acute inpatient care, including the following:
(A) Ambulance.
(B) Emergency room care and treatment room services.
(C) Semi-private room and board.
(D) General medical and nursing services.
(E) Medical surgical/intensive care/coronary care unit.
(F) Laboratory tests, x-rays and other diagnostic procedures.
(G) Drugs and biologicals.
(H) Blood and blood derivatives.
(I) Surgical care, including the use of anesthesia.
(J) Use of oxygen.
(K) Physical, occupational, respiratory therapies, and speech-language pathology services.
(L) Social services.

(16) Nursing facility care including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;

(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies and appliances.

(17) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.

(5) Services furnished outside of the United States, except as follows:

(A) in accordance with 42 CFR 424.122 through 42 CFR 424.124, and

(B) as permitted under the State's approved Medicaid plan.

(c) In the event that a PACE participant is in need of permanent placement in a nursing facility, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing nursing facility care. However, for a PACE participant, the participants responsibility will be to make payment directly to the PACE provider; the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.

(d) All PACE Program Benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that they be institutionalized.

317:35-18-7. Appeals process

(a) Internal appeals

(1) Any individual who is denied program services is entitled to an appeal through the provider.

(2) If the individual also chooses to file an external appeal, the provider must assist the individual in filing an external appeal.

(b) External appeals may be filed ~~by any individual covered by:~~

~~(1) SoonerCare through the OHCA legal division.~~
~~(2) Medicare but not SoonerCare through the Centers for Medicare and Medicaid Services hearing process~~through the OHCA legal division and follow the process outlined in 317:2-1-2.

317:35-18-9. Continuation of enrollment

(a) At least annually, OHCA must reevaluate whether a participant ~~needs~~ continues to meet the level of care ~~for nursing facility services~~required for PACE eligibility.

(b) At least annually, OKDHS will reevaluate the participant's financial eligibility for SoonerCare.

~~(c)~~(1) Waiver of Annual level of Care Reassessment. If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could reasonably be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and the participant will be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.

~~(d)~~(2) Deemed Continued Eligibility. If ~~OHCA~~it is ~~determines~~determined that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant will be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the participant would meet the nursing facility level of care criteria within the next six months.

~~(e)~~(c) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care. The participant's medical record and plan of care must support deemed continued eligibility.

317:35-18-12. Medicaid Payments

(a) The OHCA makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

(b) The payment amount represents:

(1) is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.

(2) Takes into account the comparative frailty of PACE participant.

(3) is a fixed amount regardless of changes in the participant's health status.

(c) The PACE organization must accept the capitation payment amount

as payment in full for Medicaid participants.

H.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES
317:30-5-70.3. [AMENDED]
317:30-5-72. [AMENDED]
317:30-5-77. [AMENDED]
317:30-5-77.3. [AMENDED]
(REFERENCE APA WF # 13-21)

317:30-5-70.3. Prescriber identification numbers
(a) Pharmacies must use the prescriber's National Provider Identification (NPI) number to identify the prescribing provider.
(b) To comply with Federal law, ~~Claims~~claims for covered over-the-counter products ~~may~~must be prescribed by a health care professional with prescriptive authority. The claim should be submitted using the prescriber name ~~"OTC"~~and NPI number ~~referenced on the OHCA's public website~~.

317:30-5-72. Categories of service eligibility
(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.
(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of two brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six covered prescriptions for the month.
(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:
(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and
(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the two brand name or thirteen total prescriptions will be covered with prior authorization.
(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory

monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under 21 years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. ~~The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later.~~ This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

317:30-5-77. Brand necessary certification

(a) When a product is available in both a brand and generic form, a prior authorization is required before the branded product may be dispensed. The prescribing provider must certify the brand name drug product is medically necessary for the well being of the patient, otherwise a generic must be substituted for the name brand product.

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.

(3) A standard phrase indicating the need for a specific brand is required. The OHCA recommends use of the phrase "Brand Necessary".

(4) It is unacceptable to use a printed box on the prescription

blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to ~~CMS Federal Upper Limit and~~ State Maximum Allowable Cost (SMAC) products.

(c) For certain narrow therapeutic index drugs, a prior authorization will not be required. The DUR Board will select and maintain the list of narrow therapeutic index drugs.

(d) Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) facilities are exempt from prior authorization requirements for brand name drugs.

317:30-5-77.3. Product-Based Prior Authorization

~~(a)~~ The Oklahoma Health Care Authority utilizes a prior authorization system subject to their authority under 42 U.S.C. 1396r-8 and 63 O.S. 5030.3(B). The prior authorization program is not a drug formulary which is separately authorized in 42 U.S.C 1396r-8. Drugs are placed into two or more tiers based on similarities in clinical efficacy, side-effect profile and cost-effectiveness after recommendation by the Drug Utilization Review Board and approved by the OHCA Board of Directors ~~approval~~. Drugs placed in tier number one generally require no prior authorization. Drugs placed in any tier other than tier number one may require prior authorization.

(1) Three general exceptions exist to the requirement of prior authorization:

(A) inadequate response to one or more tier one products,

(B) a clinical exception for a certain product in the particular therapeutic category, or

(C) the manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product.

(i) After a drug or drug category has been added to the Prior Authorization program, OHCA or its contractor may establish a cost-effective benchmark value for each therapeutic category or individual drug. The benchmark value may be calculated based on an average cost, an average cost per day, a weighted average cost per day or any other generally accepted economic formula. A single formula for all drugs or drug categories is not required.

Supplemental rebate offers from manufacturers which are greater than the minimum required supplemental rebate will be accepted and may establish a new benchmark rebate value for the category.

(ii) Manufacturers of products assigned to tiers number two and higher may choose to pay a supplemental rebate to the state in order to ~~avoid~~remove or reduce a prior authorization requirement on their product or products assigned to the higher tier.

(iii) Supplemental rebate agreements shall be in effect for one year and may be terminated at the option of either party with a 60 day notice. Supplemental rebate agreements are subject to the approval of CMS. Termination of a Supplemental Rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(iv) The supplemental unit rebate amount for a tier two or higher product will be calculated by subtracting the federal rebate amount per unit from the benchmark rebate amount per unit.

(v) Supplemental rebates will be invoiced concurrent with the federal rebates and are subject to the same terms with respect to payment due dates, interest, and penalties for non-payment as specified at 42 U.S.C. Section 1396r-8. All terms and conditions not specifically listed in federal or state law shall be included in the supplemental rebate agreement as approved by CMS.

(vi) Drugs or drug categories which are not part of the Product Based Prior Authorization program as outlined in 63 O.S. Section 5030.5 may be eligible for supplemental rebate participation. The OHCA Drug Utilization Review Board shall ~~determine~~recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness and other applicable criteria.

(2) All clinical exceptions are recommended by the Drug Utilization Review Board and demonstrated by documentation sent by the prescribing physician and/or pharmacist.

~~(b) Additional therapeutic categories of drugs will be subject to subsection (a) of this Section if recommended by the Drug Utilization Review Board, considered by the Medical Advisory Committee and approved by the OHCA Board.~~

I.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES
317:30-5-133.3. [NEW]
(REFERENCE APA WF # 13-29)

317:30-5-133.3. Nursing Home Ventilator-Dependent and Tracheostomy Care Services

(a) Admission is limited to ventilator-dependent and/or qualified tracheostomy residents.

(b) The ventilator-dependent resident and/or qualified tracheostomy resident must meet the current nursing facility level of care criteria. (Refer to OAC 317:30-5-123.)

(c) All criteria must be present in order for a resident to be considered ventilator-dependent:

(1) The resident is not able to breathe without a volume with a backup.

(2) The resident must be medically dependent on a ventilator for life support 6 hours per day, seven days per week.

(3) The resident has a tracheostomy.

(4) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, physiotherapy or deep suctioning). These services must be available 24 hours a day.

(5) The resident must be medically stable and not require acute care services. A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit at all times.

(d) The resident will also be considered ventilator-dependent if all of the above requirements were met at admission but the resident is in the process of being weaned from the ventilator. This excludes residents who are on C-PAP or Bi-PAP devices only.

(e) All criteria must be present in order for a resident to be considered as tracheostomy care qualified:

(1) The resident is not able to breathe without the use of a tracheostomy.

(2) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, chest physiotherapy, or deep suctioning). These services must be available 24 hours a day.

(3) A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit.

(f) Not withstanding the foregoing, a ventilator-dependent or qualified tracheostomy resident who is in the process of being weaned from ventilator dependence or requiring qualified tracheostomy treatment shall continue to be considered a qualified resident until the weaning process is completed.

J.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 3. MY LIFE, MY CHOICE
317:50-3-14 [AMENDED]
SUBCHAPTER 5. SOONER SENIORS
317:50-5-5 [AMENDED]
317:50-5-14. [AMENDED]
(REFERENCE APA WF # 13-32)

317:50-3-14. Description of services

Services included in the My Life, My Choice Waiver 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 My Life, My Choice Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(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 317:50-3-14(1)(A) that only a My Life, My Choice 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 OHCA 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) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **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.

(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 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.

(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 include 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 My Life, My Choice Waiver 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 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 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 agreement, to 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 involves 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. My Life, My Choice Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that

includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) 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 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. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice 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 My Life, My Choice Hospice services.

(C) 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) **My Life, My Choice Waiver Personal Care.**

(A) My Life, My Choice 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) My Life, My Choice Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care

plan.

(C) My Life, My Choice 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 approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member 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.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, 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 coordination of transportation to and from medical appointments.

(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member’s service plan.

(D) Payment is not made for 24 hour skilled care.

(16) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.

(17) **Assistive Technology**. Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.

(18) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.

(19) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include 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;

(20) **Dental services**. Dental services include maintenance or improvement of dental health as well as relief of pain and

infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(21) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(22) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identity other alternatives to meet identified needs above the limit.

(23) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or

preventing, or minimizing the effects of illness.

(24) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(25) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self-care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual_s independence, self-sufficiency, community inclusion and well-being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.

(26) **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 a My Life, My Choice 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 My Life, My Choice approved plan of care.

(27) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(28) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(29) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(30) **Pharmacological ~~Evaluations~~ Therapy Management.** Pharmacological ~~evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:~~Therapy Management. Pharmacological Therapy Management willl utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for therapy management based on medication utilization, or if they are referred to the program by a care manager.

~~(A) An initial medication assessment performed in conjunction with the case manager and member.~~

~~(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.~~

~~(C) Follow-up visit, assessments and reports will be arranged~~

~~with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member~~.

(31) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRice NET services is located at 317:30-5-326.

(32) **Self-Direction**.

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for

emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities.

If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain 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 APSA'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.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. 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 Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite 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.

(I) 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.

(J) Self-Directed Services 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:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.
(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA 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 Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.
(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed 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, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, 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.

(33) **Self-Directed Goods and Services (SD-GS)**.

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-5. Sooner Seniors Waiver program medical eligibility determination

A medical eligibility determination is made for Sooner Seniors Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Sooner Seniors Waiver Program, or NF level services to assure member health and safety. Sooner Seniors Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Sooner Seniors Waiver service provision will supplement the system within the limitations of Sooner Seniors Waiver Program policy.

(1) Categorical relationship to the Aged must be established for determination of eligibility for Sooner Seniors Waiver services. ~~If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.~~

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.
(3) If the UCAT indicates member qualification for SoonerCare services and the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.
(4) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.
(5) Within ten (10) working days of receipt of a complete Sooner Seniors Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.
(6) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Sooner Seniors Waiver Program.
(7) If the member has a current certification and requests a change to Sooner Seniors Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from Sooner Seniors Waiver services to State Plan Personal Care services. If a member is receiving Sooner Seniors Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.
(8) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

317:50-5-14. Description of services

Services included in the Sooner Seniors Waiver 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 Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(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 317:50-5-14(1)(A) that only a Sooner Seniors 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 OHCA 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) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **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.

(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 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.

(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 include 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 Sooner Seniors Waiver 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 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 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 agreement, to 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 s 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. Sooner Seniors Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) 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 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. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors 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 Sooner Seniors Hospice services.

(C) 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) **Sooner Seniors Waiver Personal Care.**

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

(C) Sooner Seniors 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 approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member 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.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, 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 coordination of transportation to and from medical appointments.

(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member's service plan.

(D) Payment is not made for 24 hour skilled care.

(16) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.

(17) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include 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;

(18) **Dental services**. Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(19) **Family training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training

includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(20) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(21) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(22) **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 a Sooner Seniors 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 Sooner Seniors approved plan of care.

(23) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(24) **Pharmacological ~~Evaluations~~ Therapy Management.** Pharmacological ~~evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:~~Therapy Management. Pharmacological Therapy Management willl utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for therapy management based on medication utilization, or if they are referred to the program by a care manager.

~~(A) An initial medication assessment performed in conjunction with the case manager and member.~~

~~(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.~~

~~(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.~~

(25) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a

member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(26) **Self-Direction**.

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the

role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services

Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain 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 APSA_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.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. 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 Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite or 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.

(I) 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.

(J) Self-Directed Services 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:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA 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 Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed 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, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, 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.

(27) **Self-Directed Goods and Services (SD-GS)**.

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

K.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 63. AMBULATORY SURGICAL CENTERS (ASC)
317:30-5-565. ELIGIBLE PROVIDERS [AMENDED]
PART 79. DENTISTS
317:30-5-696. [AMENDED]
317:30-5-697. [AMENDED]
317:30-5-698. [AMENDED]
317:30-5-699. [AMENDED]
317:30-5-700. [AMENDED]
317:30-5-700.1. [AMENDED]
317:30-5-704. [AMENDED]
317:30-5-705. [AMENDED]
(REFERENCE APA WF # 13-39)

317:30-5-565. Eligible providers

An ambulatory surgical center (ASC) or dental ambulatory surgical center (DASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. All eligible ambulatory surgical center providers must be certified by Medicare or certified through a Center for Medicare and Medicaid Services (CMS) approved accreditor for ASC and have a current contract with the Oklahoma Health Care Authority.

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~~medically necessary extractions and approved boney adjustments. Surgical tooth extraction must have medical need documented if not apparent on images of tooth. In the SoonerCare program, it is usually performed for those teeth which are damaged to such extent that no tooth is visible above the gum line, the tooth fractures, the tooth is impacted, or tooth can’t be grasped with forceps;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist or physician ~~,~~ to the extent such services may be performed under State law ~~either by a doctor of dental~~

~~surgery or dental medicine,~~ when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if ~~she or he has~~ not ~~been~~ seen by any dentist 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. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two

posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/ dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology discovered by prior examination. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;
(II) tooth numbers E and F to age 6 years;
(III) tooth numbers N and Q to 5 years; and
(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;
(II) the teeth have no mobility; or(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;
(II) 70 percent or more of the root structure remains; or
(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:
(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;
(II) primary teeth where three surfaces of extensive decay exist; or
(III) primary teeth where cuspal occlusion is lost due to decay or accident.
(iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.
(iv) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:
(i) Stainless steel crowns are the treatment of choice for:
(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;
(II) posterior permanent teeth that have three or more surfaces of extensive decay; or
(III) where cuspal occlusion is lost due to decay prior to age 16 years.
(ii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.
(iii) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative 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.

(K) **Pulpotomies and pulpectomies.**
(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and ~~post-operative~~post-operative periapical x-rays must be available for review, if requested.
(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;
(II) Tooth numbers O and P before age 5 years;
(III) Tooth numbers E and F before 6 years;
(IV) Tooth numbers N and Q before 5 years; and
(V) Tooth numbers D and G before 5 years.
(ii) Pulpectomies are allowed for primary teeth if

exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(L)~~**Anterior root canals**~~**Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is ~~done for permanent teeth~~allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) ~~Acceptable ADA filling materials must be used.~~The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) ~~Preauthorization is required if the member's treatment plan involves more than four anterior root canals.~~Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Teeth with less than ~~50~~60 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~~Endodontically 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.~~

(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) 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 posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second (2^{nd}) primary molar (K or T) is missing ~~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~~4 years to prevent abnormal swallowing habits.

(IV) Pre and post-operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The medical need for this service must be documented in the member's record. ~~This procedure is not covered when it is the dentist's usual practice to offer it to all patients.~~

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(O) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner, chemical used for dentinal hypersensitivity or adhesive. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect or direct pulp cap. Utilization of these codes is verified by post payment review.

(P) **~~Sedative~~Protective restorations.** ~~Sedative~~This ~~restorations~~ restoration include removal of decay, if present, and are reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. ~~These services are reimbursable for the same tooth on the same date of service.~~ Permanent restoration of the tooth is allowed after ~~30~~60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(R) **Local anesthesia.** This procedure is included in the fee for all services.

(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 member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not

seen for more than 24 months;
(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);
(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;
(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);
(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);
(vi) Composite restorations:
(I) Any permanent tooth that has an opened lesion seen on radiograph or that is a documented food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
(II) ~~Class I~~One and two surface posterior composite resin restorations are allowed in ~~posterior~~ teeth that qualify;
(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and
(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(3)(N).
(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).
(E) Periodontal scaling and root planing. ~~Required that 50% or more of six point measurements be 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.~~Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 30 or more of the six point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

(5) **Individuals eligible for Part B of Medicare.**
(A) Payment is made based on the member's coinsurance and deductibles.
(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-697. Oral surgery procedures
Surgical tooth extraction is also known as open or transalveolar

tooth extraction. It is performed in those teeth which are damaged to such an extent that nothing is visible above the gum line or if the tooth is impacted in the bone or in the soft tissue. Tooth can't be grasped with the forceps so dental surgeon will give an incision that is cut in the gums to move the tooth out of the bone. Some elective oral surgery procedures require a written report or treatment plan be reviewed by the OHCA Dental Consultant prior to surgery to determine if the service is within the scope of the Dental Program. All oral surgeons may bill on the HCFA-1500 using CPT codes or the ADA dental claim form using the HCPCS, Level II, Dental codes.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with ~~x-ray~~ film mounts and each film or print must be of ~~good readable~~diagnostic quality. X-rays must be identified by ~~left and right sides with~~ the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be ~~placed~~ submitted together ~~in the same envelope~~ with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The

film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics

(A) ~~**Anterior root canals.** This procedure~~Prior authorization is required for members who have a treatment plan requiring more than ~~four~~two anterior and/or two posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only ~~numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis~~.

(ii) Accepted ADA materials must be used.

(iii) Pre and post-operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

~~(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.~~

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and ~~post operative~~post-operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is

not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure ~~is limited to a maximum of five teeth. A request~~ may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

~~(I) there are missing teeth in the same arch requiring replacement;~~

~~(II)~~(I) an opposing tooth has super erupted;

~~(III)~~(II) loss of tooth space is one third or greater;

~~(IV)~~(III) opposing second molars are involved unless prior authorized; or

~~(V)~~(IV) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

~~(x) a failing root canal is determined not medically necessary for re-treatment.~~

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is fractured or destroyed by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of ~~three or more~~ missing anterior permanent teeth; two or more missing posterior teeth in the same arch for members 16 through 20 years of age. Provider must indicate which teeth ~~tooth number to~~will be replaced ~~and teeth to be clasped~~. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(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~~medical necessity must be sent with prior authorization ~~request~~. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age ~~where the bite~~will be considered for this treatment ~~relationship precludes the use of removable partial dentures are considered~~. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility ~~for a period of five years post insertion~~.

(7) **Periodontal scaling and root planing.** ~~This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in~~

~~conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.~~Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the six point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss abd subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under the age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

~~(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) intellectual disabilities;~~

~~(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 or

(2) sub-gingival margins

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 18 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. 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, if the member is currently SoonerCare eligible. 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.** Restoration of incipent lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. 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. Indirect pulp cap code requires specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes are verified on a post payment review.~~

317:30-5-700. Orthodontic services

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member

can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) the member has had a caries free initial visit; or

(2) has all decayed areas restored and has ~~received a six month hygiene evaluation indicating the member remains~~remained caries free for six months; and

(3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The Oklahoma SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30;

(2) any classification secondary to cleft palate or other maxillofacial deformity;

(3) if a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) fixed appliances only; and

(5) permanent dentition with the exception of cleft defects.

(d) Reimbursement for Orthodontic services is limited to authorized general dentists and orthodontists:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping Malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one of each of the following types:

(i) deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) impacted canine or molar requiring surgical exposure;

(iii) bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The Oklahoma Health Care Authority requires all General dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least 20 continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental unit every three years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of 24 months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare Program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year~~;~~. Treatment year is determined by date of banding;

(4) The member must be SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired~~:~~.

~~(A) Members receive a permanent Medical Identification Card;~~ ~~(B)~~ It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age 18.

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of

the OHCA when the member has a total score of not less than 30 points or meets other eligibility criteria in paragraph (d).

(1) Completed currently approved ADA dental claim form;

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

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

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

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

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

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

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

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

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

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child.(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child.

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

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

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

(6) The OHCA Orthodontic Consultant may consult with and utilize

the opinion of the orthodontist who completes the form.

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

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

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

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

(B) Subsequent adjustments will be authorized in one year intervals and the treating orthodontist must provide a comprehensive progress report at the 24 month interval.

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

(2) Claim and payment are made as follows:

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

(B) Payment is not made for comprehensive treatment beyond 36 months.

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

(h) If the provider who received yearly payment does not agree to be financially responsible, then the Oklahoma Health Care Authority will recoup funds paid for the member's orthodontic treatment.

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

(j) Study models must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are preferred.
(4) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider may send new images that meet these requirements. If the provider does not respond, the request for treatment is denied.
(5) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

317:30-5-704. Billing instructions

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

(b) **Prior authorization.** Where applicable, the appropriate surface and tooth number must be included on the claim.

(c) **X-rays.** ~~X-rays~~Any type of film or prints submitted ~~with the claim form cannot~~will not be returned. ~~Those submitted with a request for prior authorization will be returned.~~ All x-rays must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

317:30-5-705. Billing

Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form ~~is done on the claim form developed by the American Dental Association. Paper claims must be submitted on the currently approved version of the ADA Claims forms.~~ Electronic submission must be made on the HIPPA compliant Form 837D.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS
317:30-5-41. [AMENDED]
317:30-5-42.1. [AMENDED]
(REFERENCE APA WF # 13-40)

317:30-5-41. Inpatient hospital coverage/limitations
(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.
(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge C obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

~~(3)~~(4) **Discharges and Transfers**.

(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

(i) The patient is formally released from the hospital; or

(ii) The patient dies in the hospital; or

(iii) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred

to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to OHCA contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient (see OAC 317:30-5-41).

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

~~(d)~~(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

~~(e)~~(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. 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. Claims for these services must include the appropriate revenue code(s).