OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
March 27, 2014 at 1:00 P.M.
Oklahoma Health Care Authority
Boardroom
4345 N. Lincoln Blvd.
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 February 13, 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 James Smith, Chief of Staff

4. Discussion Item – Office Space Update

Item to be presented by Nico Gomez, Chief Executive Officer

5. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer

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

        1.) Provider Capacity Analysis – Connie Steffee, Reporting & Statistics Director

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

Item to be presented by Nicole Nantois, Chief of Legal Services

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

Item to be presented by Nancy Nesser, Pharmacy Director

7. 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 Procysbi™ (Cysteamine Bitartrate), Ravicti® (Glycerol Phenylbutyrate), Sirturo™ (Bedaquiline), Inhaled Tobramycin Products and Pulmozyme® (Dornase Alfa), Adempas® (Riociguat), Opsumit® (Macitentan), Suprax® (Cefixime), Cedax® (Ceftibuten), and Spectracef® (Cefditoren) to the Utilization and Scope Prior Authorization Program Under OAC 317:30-5-77.2(e).

Item to be presented by Tywanda Cox, Health Policy Director

8. Action Items – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.

    a) Consideration and Vote upon Recommendations to Alter the rate methodology paid for Anesthesiologist Services CPT code 01996 to the previous flat fee methodology from a base multiplied by time multiplied by conversion factor. The flat fee will increase from the budget reduction max fee of $91.44 ($94.50 default) to $117.00.

        b) Consideration and Vote upon Recommendations to approve a methodology change regarding the payment of Long-Acting Reversible Contraception (LARC). The LARC payment will be made outside of the DRG bundle if done in an inpatient setting.

Item to be presented by Tywanda Cox, Health Policy Director

9. 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:

The following permanent rule HAS previously been approved by the Board and the Governor under Emergency rulemaking.

A. AMENDING Agency rules at OAC 317:35-5-7, 317:35-5-43 through 317:35-5-46, 317:35-6-1, 317:35-6-15, 317:35-6-35 through 317:35-6-37, 317:35-6-60.1, 317:35-6-61, 317:35-7-48, 317:35-9-67, 317:35-10-10, 317:35-10-25, 317:35-10-26, 317:35-15-6, and 317:35-19-20 to implement Systems Simplification Implementation rules effective October 1, 2013, instead of January 1, 2014. Rules are also revised to delay periodic renewals that would fall during the period January – March, 2014 until April, 2014, and to delay the effective date of terminations of SoonerCare eligibility for reasons related to changes in household composition or income until April, 2014 when the agency is redetermining eligibility based on changes in circumstances from January to March, 2014. These emergency rule revisions allow the State to correct regulatory complications created by federal rules; they implement a waiver of the federal requirement that the State use two sets of financial eligibility rules for pregnant women and families with children from October 1, 2013 to March 31, 2014, thereby avoiding serious prejudice to the public interest.

(Reference APA WF # 13-08)

The following permanent rule HAS previously been approved by the Board and the Governor under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

B. AMENDING Agency rules at OAC 317:45-1-3, 317:45-11-10, 317:45-11-11, 317:45-11-20, 317:45-11-21, 317:45-11-24, REVOKING 317:45-11-12, 317:45-11-13, 317:45-11-21.1, and 317:45-13-1 to align Insure Oklahoma (IO) rules with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the IO program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of FPL. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00. Also, to remove outdated references related to eligibility income determinations from Insure Oklahoma rules.

(Reference APA WF # 13-16)

The following permanent rules HAVE NOT previously been approved by the Board.

C. ADDING Agency rules at OAC 317:30-5-42.19, 317:30-5-87, and 317:30-5-363 and AMENDING Agency rules at OAC 317:30-5-664.6 to implement the proposed 340B Drug Discount program rules to comply with a Federal Mandate. The 340B mandate requires states to include their 340B Drug Discount program rules in their State Plan and Medicaid policy.

(Reference APA WF # 13-11)

D. AMENDING Agency rules at OAC 317:30-5-216 to remove current Manufacturer's Suggested Retail Price (MSRP) minus 20% reimbursement from the State plan and OHCA policy. The proposed rule change will allow OHCA to reimburse manually-priced DME items at invoice cost plus 20% as opposed to using two separate methodologies.

(Reference APA WF # 13-12)

E. AMENDING Agency rules at OAC 317:30-5-47 to allow reimbursement for Long Acting Reversible Contraceptive (LARC) devices to hospitals outside of the Diagnosis Related Group (DRG) methodology.

(Reference APA WF # 13-13)

F. ADDING Agency rules at OAC 317:35-17-25 to include information on the Address Confidentiality Program (ACP). The ACP provides victims of domestic violence, sexual assault, or stalking with a substitute address and mail forwarding service that can be utilized when victims interact with state and local agencies.

(Reference APA WF # 13-24)

G. AMENDING Agency rules at OAC 317:35-17-22 to include information on rounding of billable time as per the Interactive Voice Response Authentication (IVRA) system. This change in policy will enforce compliance, clarify information for providers, and reflect practices already taking place. Additionally, minor policy revisions are made to the policy.

(Reference APA WF # 13-25)

H. AMENDING Agency rules at OAC 317:30-5-2 Policy is revised to add language that sets boundaries as to what is deemed approved genetic testing methods. Problems have recently arisen which call for more stringent policy, particularly issues regarding lab billing for expensive methods that lack sufficient evidence for their use.

(Reference APA WF # 13-26)

I. AMENDING Agency rules at OAC 317:30-5-20 to include language that explicitly addresses proper billing in regard to nucleic acid testing of single/multiple infectious organisms in a specimen.

(Reference APA WF # 13-27)

J. AMENDING Agency rules at OAC 317:2-1-7 to more accurately reflect each party's responsibilities in an audit and clarify other audit procedures in order to streamline the process.

(Reference APA WF # 13-30)

K. AMENDING Agency rules at 317:35-1-2, 317:35-5-4, 317:35-5-4.1, and 317:35-9-48.1 to change TEFRA program rules to better match current business practices and federal regulations. Changes include changing all TEFRA language regarding mental retardation or ICF/MR to individuals with intellectual disabilities or ICF/IID to match Public Law 111-256. As well, rules regarding cost effectiveness analyses being posted on MEDATS will be changed to require that the cost effectiveness analyses will be reported annually with no specification as to where that report will reside. Rules regarding TEFRA eligibility for applicants aged three years and older for the ICF/IID level of care will change the IQ requirements from 75 or less to 70 or less to match current DSM-5 and SSA guidelines regarding intellectual disabilities. Additionally, changes also include amending the current criteria to state that applicants can either have an IQ of 70 or less, or have a full-scale adaptive functional assessment indicating a functional age that does not exceed 50% of child's age to match current DSM-5 and SSA guidelines regarding intellectual disabilities. It also removes the rule that requires the assessment be either Battelle or Vineland since SSA does not specify which test is to be used. Finally, another amendment will require that one additional psychological evaluation be administered for all approved TEFRA children once they reach the age of sixteen.

(Reference APA WF # 13-34)

L. AMENDING Agency rule at OAC 317:30-3-4 to specify that providers enroll in Electronic Fund Transfers for Medicaid reimbursement via the electronic enrollment process. Language referencing the Provider Relations unit will be removed as this unit no longer exists.

(Reference APA WF # 13-35)

M. AMENDING Agency rules at 317:30-5-290.1, 317:30-5-295, 317:30-5-675, and 317:30-5-676 to add “services may be provided under the direction of a qualified provider.” The purpose of this change is to allow students and other non-qualified providers to participate in the care of SoonerCare members while under the direct supervision and guidance of a qualified provider.

(Reference APA WF # 13-43)

N. AMENDING Agency rules at OAC 317:30-5-95.29, 317:30-5-95.30, 317:30-5-95.34, 317:30-5-95.39, and 317:30-5-95.42 to establish medical necessity criteria specific for admission and continued stays in community based transitional (CBT) programs as these facilities are a lower level of care than psychiatric residential treatment facilities (PRTF) and acute residential treatment facilities. Changes are also being proposed to the rules regarding "active treatment" requirements for children under the age of 18. The change will allow providers flexibility to better tailor treatment to the individual needs of the child. Additional proposed changes include: revisions to Inspection of Care (IOC) rules, clarifying which types of facilities will be still receive on-site inspections, allowing psychosocial evaluations or admission assessments to substituted for the first therapy session, and allowing the use of mechanical restraints for children 18-20 since they are treated on the adult care unit. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V.

(Reference APA WF # 13-45)

O. AMENDING Agency rules at OAC 317:30-5-240.1, 317:30-5-240.2, 317:25-5-240.3, 317:30-5-241, 317:30-5-241.1, 317:30-5-241.2, 317:30-5-241.3, 317:30-5-241.5, 317:30-5-248, and 317:30-5-249 to remove the behavioral health rehabilitation specialist (BHRS) designation from policy since these services will only be reimbursed if provided by an LBHP, CADC, or Case Manager II (CM II) effective July 1, 2014. Changes are also made to the rules to clarify that OBH services cannot be separately billable to individuals residing in nursing facilities. Reimbursements for these services are included within the nursing facility rate, as required by federal regulation. Additionally, clarification is made that individual and group psychotherapy services cannot be provided to children ages 0-3 unless medical necessity criteria is met, and partial hospitalization (PHP) and day treatment language is amended to clarify psychosocial rehabilitation is not allowed for children ages 0-3 and prior authorization is required for children ages 4-6. Additional changes include: additional supervision requirements for paraprofessionals by licensed, master level staff that render services to members outside of an agency

setting, revising peer recovery support specialist services to include youth ages 16-18 that are transitioning into adulthood, revise behavioral health rehabilitation service documentation requirements, and clarifying when services may be rendered without a treatment plan. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V.

(Reference APA WF # 13-46)

P. AMENDING Agency rules at OAC 317:30-5-276 and 317:30-5-281 to add coverage for bio-psychosocial assessments for adults when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures. Revisions are also made to clarify that payment for behavioral health services are not separately reimbursable for members residing in a nursing facility.

(Reference APA WF # 13-47)

Q. AMENDING Agency rules at OAC 317:30-5-280 eliminate reimbursement for services provided by behavioral health professionals under supervision for licensure if they work under the direction of an individually contracted LBHP, outside of an agency setting. The additional oversight requirements imposed upon agencies provide a better training ground for individuals under supervision and afford OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) better opportunity to ensure the quality of services being provided to SoonerCare members.

(Reference APA WF # 13-48)

R. AMENDING Agency rules at OAC 317:30-5-595 and 317:30-5-596 to ensure consistency with changes in case manager provider requirements made in Title 450 of the Oklahoma Administrative Code, by the certifying agency, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). Provider qualifications are being revised in order to reflect the legislature's intent, as expressed during the 2013 legislative session. Case management reimbursement rules are also being revised in order to allow reimbursement for transitional case management provided during the last 30 days of an inpatient stay. This change will ensure successful integration back into the community upon discharge from the inpatient facility.

(Reference APA WF # 13-49)

S. AMENDING Agency rules at OAC 317:30-5-740.1, 317:30-5-741, and 317:30-5-742.2 to allow for the completion of assessments and treatment plans from 14 days to 30 days. This change aligns with current practice that mandates when provisional diagnosis documentation must be submitted. All documentation will now be due to the OHCA within 30 days of admission to a TFC facility. The Agency is also proposing rule revisions to disallow coverage of Psychosocial Rehabilitation (PSR) services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) laws. Additionally, the agency is proposing to add detail language requirements for developing and rendering assessments, service plans, and PSR services. Other revisions are also made to make minor "cleanup" changes to terminology, which include changes mandated by the Diagnostic and Statistical Manual (DSM) V.

(Reference APA WF # 13-50)

T. AMENDING Agency rules at OAC 317:30-3-65.8 to expand the age for which application of fluoride varnish during course of a well child screening is covered, from ages 12 months to 42 months to ages 6 months to 60 months.

(Reference APA WF # 13-51)

U. AMENDING Agency rules at OAC 317:30-5-640, 317:30-5-641, 317:30-5-644, 317:30-5-1020, 317:30-5-1021, 317:30-5-1022, 317:30-5-1023, 317:30-5-1025, 317:30-5-1027, 317:30-5-1030, 317:30-5-1031, 317:30-5-1032, 317:30-5-1033, and 317:30-5-1034 related to IDEA and School Based services are revised for clarity and consistency. Revisions include removing references to outdated terms and/or policy, and adding guidelines for school-based services and evaluations as it relates to the Individual Education Plan/ Individual Family Service Plan (IEP/IFSP) for clarity and consistency.

(Reference APA WF # 13-52)

V. AMENDING Agency rules at OAC 317:30-5-106 to clarify clinical laboratory services will be reimbursed in accordance with methodology approved under the State Plan.

(Reference APA WF # 13-53)

Item to be presented by Chairman McFall

10. Discussion Item – Proposed Executive Session as Recommended by the Chief 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

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
May 8, 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
February 13, 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 February 12, 2014, 10:00 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 February 10, 2014, 9:00 a.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 1:02 p.m.

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

BOARD MEMBERS ABSENT: Member McVay, Member Robison

OTHERS PRESENT:
David Dude, American Cancer Society
Becky Moore, OAHCP
Tywanda Cox, OHCA
Mary Brinkley, LeadingAge OK
Terry Cothran, OU
Charles Brodt, HP
Lori Alexander, OHCA

OTHERS PRESENT:
Brenda Teel, Chickasaw Nation
Rick, OHA
Sherris Ososanya, OHCA
Corby Thompson, OU COP/PMC
Juarez McCann, ODMHSAS
Will Widman, HP
KC Moon, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD JANUARY 9, 2014.

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 January 9, 2014 board meeting minutes as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBERS ABSENT: Member McVay, Member Robison

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Audit/Finance Committee
Member Miller stated that the committee did meet and discussed the financial report that is in good shape this month. There was a discussion of issues based on the beginning of the legislative session and noted that it is still early in the session and OHCA will continue to inform the implications of things being discussed.

Strategic Planning Committee
Vice-Chairman Armstrong stated that the committee did meet and had a discussion relating to bills about managed care Medicaid reforms. He noted that staff are engaged in the conversations taking place and he stated that he is optimistic. He commended OHCA for accomplishments of cost savings, the low per member per month and low payment error rate.

Legislative Committee
Member Bryant stated that the committee did meet and noted that OHCA will soon meet with the new Speaker. She said that Mr. Kimble will give a legislative update during the meeting.

Rules Committee
Member Nuttle stated that the committee met and discussed the rules Mrs. Roberts is bringing to the board today.

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

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

Becky Pasternik-Ikard presented the Supervisor of the Quarter – Lisa Morgan, Provider Education Manager

Cindy Roberts presented the December All Star – Demetria Bennett, Sr. Policy Specialist, Policy and Planning

Sylvia Lopez presented the January All Star – Lori Alexander, Nurse Case Manager, Quality Compliance

4b. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of December and stated that we continue to run a positive variance of $36.3 million state dollars. The variance is up $10.1 million from the previous month. We continue to be under budget in Medicaid program spending and administrative spending. She noted that drug rebate collections are over budget in that revenue category. Ms. Evans believes we will remain under budget for the month of January. For more detailed information, see Item 4b in the board packet.

4c. MEDICAID DIRECOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for December 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. Dr. Splinter gave a summary of SoonerCare traditional and choice patient-centered medical homes as well as SoonerCare enrollment low cost and high cost trends. He discussed the electronic health records (EHR) incentive statistics. For more detailed information, see Item 4c in the board packet.

4d. LEGISLATIVE UPDATE
Carter Kimble, Director of Governmental Relations

Mr. Kimble noted 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 110 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. Mr. Kimble discussed 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. For more detailed information, see Item 4d in the board packet.

ITEM 5 / OFFICE SPACE UPDATE
James Smith, Chief of Staff

Mr. Smith gave an update on the progress of the new building for OHCA. It was noted that the next board meeting will be held at the new location. For pictures, see Item 5 in the board packet.

ITEM 6 / 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 7a / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR A THERAPY MANAGEMENT VENDOR.

MOTION:	Vice-Chairman Armstrong moved for approval of Item 7a as published. Member Bryant seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Nuttle
BOARD MEMBERS ABSENT:	Member McVay, Member Robison

ITEM 7b / CONSIDERATION AND VOTE OF AUTHORITY OF FUNDS FOR THE AMENDMENT TO HEWLETT PACKARD (HP) CONTRACT TO INCREASE THE AMOUNT FOR ENROLLMENT & ELIGIBILITY.

MOTION:	Member Bryant moved for approval of Item 7b as published. Vice-Chairman Armstrong seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Nuttle
BOARD MEMBERS ABSENT:	Member McVay, Member Robison

ITEM 8A-L / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT.

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)

MOTION:	Vice-Chairman Armstrong moved for approval of Item 8A as published. Member Nuttle seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Bryant
BOARD MEMBERS ABSENT:	Member McVay, Member Robison
MOTION:	Member Bryant moved to amend approval of Item 8A to Item 8A-L as published. Member Miller seconded.
FOR THE MOTION:	Chairman McFall, Vice-Chairman Armstrong, Member Nuttle
BOARD MEMBERS ABSENT:	Member McVay, Member Robison

ITEM 9 / 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:	Vice-Chairman Armstrong moved for approval to go into Executive Session. The motion was seconded by Member Miller.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member Nuttle
BOARD MEMBERS ABSENT:	Member McVay, Member Robison

9. 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 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

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

Meeting adjourned at 2:27 p.m., 2/13/2014

NEXT BOARD MEETING
March 27, 2014
Oklahoma Health Care Authority
Board room
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Seven Months Ended January 31, 2014
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,334,770,717** or **.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,289,418,264 or 2.6% under** budget.
- The state dollar budget variance through January is **$41,200,849 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		18.4
Administration		5.0
Revenues:		
Unanticipated Revenue		15.7
Drug Rebate		4.9
Taxes and Fees		(1.2)
Overpayments/Settlements		(1.6)
Total FY 14 Variance	**$**	**41.2**

ATTACHMENTS

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

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 552,577,935	$ 552,577,935	$ -	0.0%
Federal Funds	1,212,140,131	1,167,855,939	(44,284,192)	(3.7)%
Tobacco Tax Collections	33,146,570	31,910,509	(1,236,061)	(3.7)%
Quality of Care Collections	47,278,297	47,278,297	-	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	137,972	137,972	-	0.0%
Drug Rebates	117,536,345	131,065,667	13,529,322	11.5%
Medical Refunds	28,326,236	23,795,776	(4,530,460)	(16.0)%
SHOPP	313,970,453	313,970,453	-	0.0%
Other Revenues	8,569,373	8,683,354	113,981	1.3%
TOTAL REVENUES	**$ 2,355,494,318**	**$ 2,334,770,717**	**$ (20,723,601)**	**(0.9)%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 31,135,946**	**$ 26,913,707**	**$ 4,222,239**	**13.6%**
ADMINISTRATION - CONTRACTS	**$ 66,566,534**	**$ 59,167,684**	**$ 7,398,850**	**11.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	21,906,360	21,239,424	666,935	3.0%
Acute Fee for Service Payments:				
Hospital Services	554,195,569	539,927,714	14,267,855	2.6%
Behavioral Health	12,985,014	12,525,736	459,278	3.5%
Physicians	300,723,088	288,358,698	12,364,390	4.1%
Dentists	88,490,579	84,111,681	4,378,898	4.9%
Other Practitioners	27,256,266	24,259,051	2,997,215	11.0%
Home Health Care	13,214,770	12,223,630	991,140	7.5%
Lab & Radiology	39,728,349	35,775,604	3,952,745	9.9%
Medical Supplies	30,173,481	27,701,052	2,472,429	8.2%
Ambulatory/Clinics	69,210,309	65,399,490	3,810,819	5.5%
Prescription Drugs	253,844,589	253,344,325	500,264	0.2%
OHCA TFC	1,037,998	1,111,251	(73,254)	0.0%
Other Payments:				
Nursing Facilities	343,014,073	340,347,936	2,666,137	0.8%
ICF-MR Private	35,637,395	35,188,170	449,225	1.3%
Medicare Buy-In	78,840,929	79,231,897	(390,968)	(0.5)%
Transportation	37,086,939	36,304,410	782,529	2.1%
MFP-OHCA	967,647	642,995	324,652	0.0%
EHR-Incentive Payments	8,598,312	8,598,312	-	0.0%
Part D Phase-In Contribution	45,371,917	45,778,228	(406,311)	(0.9)%
SHOPP payments	291,267,268	291,267,268	-	0.0%
Total OHCA Medical Programs	**2,253,550,852**	**2,203,336,873**	**50,213,979**	**2.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,351,342,714**	**$ 2,289,418,264**	**$ 61,924,450**	**2.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 4,151,604**	**$ 45,352,453**	**$ 41,200,849**	

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

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 21,469,872	$ 21,229,355	$ -	$ 230,448	$ -	$ 10,069	$ -
Inpatient Acute Care	467,882,465	348,164,506	283,901	6,184,127	29,599,324	1,275,570	82,375,038
Outpatient Acute Care	167,191,797	158,060,696	24,269	6,587,383	-	2,519,448	-
Behavioral Health - Inpatient	14,244,692	7,514,694	-	355,956	-		6,374,042
Behavioral Health - Psychiatrist	5,011,042	5,011,042	-	-	-	-	-
Behavioral Health - Outpatient	15,032,018	-	-	-	-	-	15,032,018
Behavioral Health Facility- Rehab	167,681,433	-	-	-	-	52,958	167,681,433
Behavioral Health - Case Management	5,742,273	-	-	-	-	-	5,742,273
Behavioral Health - PRTF	55,782,935	-	-	-	-	-	55,782,935
Residential Behavioral Management	11,958,567	-	-	-	-	-	11,958,567
Targeted Case Management	37,858,279	-	-	-	-	-	37,858,279
Therapeutic Foster Care	1,111,251	1,111,251	-	-	-	-	-
Physicians	322,548,215	245,071,778	33,892	8,473,720	39,609,324	3,643,705	25,715,797
Dentists	84,162,552	79,887,942	-	50,871	4,202,157	21,582	-
Mid Level Practitioners	2,115,435	2,067,946	-	45,466	-	2,024	-
Other Practitioners	22,364,989	21,317,869	260,379	175,908	604,220	6,613	-
Home Health Care	12,223,749	12,207,504	-	119	-	16,126	-
Lab & Radiology	37,962,002	35,373,585	-	2,186,398	-	402,019	-
Medical Supplies	28,105,274	26,090,795	1,581,729	404,223	-	28,528	-
Clinic Services	68,853,077	59,603,822	-	817,852	-	150,092	8,281,311
Ambulatory Surgery Centers	5,951,483	5,636,686	-	305,907	-	8,889	-
Personal Care Services	7,934,843	-	-	-	-	-	7,934,843
Nursing Facilities	340,347,936	191,454,836	124,904,092	-	23,980,686	8,323	-
Transportation	36,143,160	32,698,001	1,542,547	-	1,868,912	33,699	-
GME/IME/DME	62,498,835	-	-	-	-	-	62,498,835
ICF/MR Private	35,188,170	28,182,441	6,506,909	-	498,820	-	-
ICF/MR Public	25,013,501	-	-	-	-	-	25,013,501
CMS Payments	125,010,125	124,567,591	442,534	-	-	-	
Prescription Drugs	264,673,301	224,800,075	-	11,328,976	27,554,944	989,306	-
Miscellaneous Medical Payments	161,329	153,744	-	79	-	7,506	-
Home and Community Based Waiver	101,173,178	-	-	-	-	-	101,173,178
Homeward Bound Waiver	53,266,462	-	-	-	-	-	53,266,462
Money Follows the Person	5,159,502	642,995	-	-	-	-	4,516,507
In-Home Support Waiver	14,107,343	-	-	-	-	-	14,107,343
ADvantage Waiver	108,906,295	-	-	-	-	-	108,906,295
Family Planning/Family Planning Waiver	7,293,016	-	-	-	-	-	7,293,016
Premium Assistance*	26,795,720	-	-	26,795,720		-	-
EHR Incentive Payments	8,598,312	8,598,312	-	-	-	-	-
SHOPP Payments**	291,267,268	291,267,268	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,068,791,698**	**$1,639,447,465**	**$ 135,580,251**	**$ 63,943,152**	**$ 127,918,388**	**$ 9,176,458**	**$ 801,511,673**

* Includes $26,594,253.93 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 Seven Months Ended January 31, 2014

REVENUE		FY14 Actual YTD
Revenues from Other State Agencies	$	337,837,131
Federal Funds		515,868,177
TOTAL REVENUES	**$**	**853,705,308**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	101,173,178
Money Follows the Person		4,516,507
Homeward Bound Waiver		53,266,462
In-Home Support Waivers		14,107,343
ADvantage Waiver		108,906,295
ICF/MR Public		25,013,501
Personal Care		7,934,843
Residential Behavioral Management		8,732,200
Targeted Case Management		28,660,441
Total Department of Human Services		**352,310,770**
State Employees Physician Payment		
Physician Payments		25,715,797
Total State Employees Physician Payment		**25,715,797**
Education Payments		
Graduate Medical Education		21,633,333
Graduate Medical Education - PMTC		1,655,830
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		1,749,980
Residential Behavioral Management		3,226,366
Total Office of Juvenile Affairs		**4,976,346**
Department of Mental Health		
Case Management		5,742,273
Inpatient Psych FS		6,374,042
Outpatient		15,032,018
PRTF		55,782,935
Rehab		167,681,433
Total Department of Mental Health		**250,612,701**
State Department of Health		
Children's First		1,321,056
Sooner Start		1,510,822
Early Intervention		3,259,387
EPSDT Clinic		1,259,623
Family Planning		(131,110)
Family Planning Waiver		7,404,465
Maternity Clinic		41,869
Total Department of Health		**14,666,112**
County Health Departments		
EPSDT Clinic		510,940
Family Planning Waiver		19,661
Total County Health Departments		**530,600**
State Department of Education		**65,294**
Public Schools		**2,802,122**
Medicare DRG Limit		**75,452,312**
Native American Tribal Agreements		**4,958,057**
Department of Corrections		**1,208,991**
JD McCarty		**5,713,734**
Total OSA Medicaid Programs	**$**	**801,511,673**
OSA Non-Medicaid Programs	**$**	**45,865,691**
Accounts Receivable from OSA	**$**	**(6,327,945)**

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

REVENUES		FY 14 Revenue
SHOPP Assessment Fee	$	129,318,219
Federal Draws		184,530,370
Interest		113,698
Penalties		8,165
State Appropriations		(15,200,000)
TOTAL REVENUES	$	298,770,452

EXPENDITURES	Quarter	Quarter	*Thru Fund 340* Quarter		FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13	1/1/13 - 3/31/13		
Hospital - Inpatient Care	76,710,371	86,962,208	87,919,865	$	251,592,444
Hospital -Outpatient Care	2,748,407	2,899,948	14,433,147	$	20,081,502
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	6,540,191	$	18,808,677
Rehabilitation Facilities-Inpatient	248,410	278,398	257,838	$	784,646
Total OHCA Program Costs	85,492,242	96,623,985	109,151,041	$	291,267,268
Total Expenditures				$	291,267,268

CASH BALANCE		
	$	7,503,183

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

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 45,474,584**	**$ 45,474,584**
Interest Earned	**25,665**	**25,665**
TOTAL REVENUES	**$ 45,500,248**	**$ 45,500,248**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 122,751,680	$ 44,190,605	
Eyeglasses and Dentures	166,832	60,059	
Personal Allowance Increase	1,985,580	714,809	
Coverage for DME and supplies	1,581,729	569,422	
Coverage of QMB's	602,441	216,879	
Part D Phase-In	442,534	442,534	
ICF/MR Rate Adjustment	3,274,794	1,178,926	
Acute/MR Adjustments	3,232,115	1,163,561	
NET - Soonerride	1,542,547	555,317	
Total Program Costs	**$ 135,580,251**	**$ 49,092,112**	**$ 49,092,112**
Administration			
OHCA Administration Costs	$ 271,695	$ 135,847	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 271,695**	**$ 135,847**	**$ 135,847**
Total Quality of Care Fee Costs	**$ 135,851,946**	**$ 49,227,959**	
TOTAL STATE SHARE OF COSTS			**$ 49,227,959**

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 Seven Months Ended January 31, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,617,668
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	26,245,569	26,245,569
Interest Income	-	133,443	133,443
Federal Draws	375,153	16,286,575	16,286,575
All Kids Act	(6,825,049)	158,455	158,455
TOTAL REVENUES	$ 3,977,954	$ 42,824,041	$ 43,283,255

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 26,232,393	$ 26,232,393
	College Students		201,466	201,466
	All Kids Act		361,861	361,861
Individual Plan				
	SoonerCare Choice		$ 221,238	$ 79,646
	Inpatient Hospital		6,170,067	2,221,224
	Outpatient Hospital		6,498,538	2,339,474
	BH - Inpatient Services-DRG		342,900	123,444
	BH -Psychiatrist		-	-
	Physicians		8,398,327	3,023,398
	Dentists		34,754	12,511
	Mid Level Practitioner		44,847	16,145
	Other Practitioners		170,204	61,274
	Home Health		119	43
	Lab and Radiology		2,163,706	778,934
	Medical Supplies		400,261	144,094
	Clinic Services		801,485	288,534
	Ambulatory Surgery Center		305,049	109,818
	Prescription Drugs		11,198,124	4,031,325
	Miscellaneous Medical		78	78
	Premiums Collected		-	(929,879)
Total Individual Plan			$ 36,749,697	$ 12,300,062
	College Students-Service Costs		$ 319,745	$ 115,108
	All Kids Act- Service Costs		$ 77,989	$ 28,076
Total OHCA Program Costs			$ 63,943,151	$ 39,238,966
Administrative Costs				
	Salaries	$ 7,360	$ 605,142	$ 612,502
	Operating Costs	85,634	433,581	519,215
	Health Dept-Postponing	-	-	-
	Contract - HP	267,291	629,724	897,015
Total Administrative Costs		$ 360,286	$ 1,668,446	$ 2,028,732
Total Expenditures				$ 41,267,698
NET CASH BALANCE		$ 3,617,668		$ 2,015,557

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 Seven Months Ended January 31, 2014

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 523,749	$ 523,749
TOTAL REVENUES	**$ 523,749**	**$ 523,749**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 10,069	$ 2,537	
Inpatient Hospital	1,275,570	321,444	
Outpatient Hospital	2,519,448	634,901	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	3,643,705	918,214	
Dentists	21,582	5,439	
Mid-level Practitioner	2,024	510	
Other Practitioners	6,613	1,667	
Home Health	16,126	4,064	
Lab & Radiology	402,019	101,309	
Medical Supplies	28,528	7,189	
Clinic Services	150,092	37,823	
Ambulatory Surgery Center	8,889	2,240	
Prescription Drugs	989,306	249,305	
Transportation	33,699	8,492	
Miscellaneous Medical	7,506	1,892	
Total OHCA Program Costs	$ 9,123,500	$ 2,299,122	
OSA DMHSAS Rehab	$ 52,958	$ 13,346	
Total Medicaid Program Costs	$ 9,176,458	$ 2,312,467	
TOTAL STATE SHARE OF COSTS			**$ 2,312,467**

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

January 2014 Data for March 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2013	Enrollment January 2014	Total Expenditures January 2014	Average Dollars Per Member Per Month January 2014
SoonerCare Choice Patient-Centered Medical Home			513,315	**565,117**	**$167,732,509**	
	Lower Cost	*(Children/Parents; Other)*		518,711	$122,596,773	$236
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,406	$45,135,736	$973
SoonerCare Traditional			217,231	**197,189**	**$197,961,095**	
	Lower Cost	*(Children/Parents; Other)*		89,111	$44,384,444	$498
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,885	$153,576,651	$1,424
SoonerPlan*			48,346	**44,452**	**$676,188**	$15
Insure Oklahoma			30,202	**19,437**	**$7,964,362**	
	Employer-Sponsored Insurance		16,644	14,471	$3,172,648	$219
	*Individual Plan**		13,559	4,966	$4,791,714	$965
TOTAL			**809,094**	**826,195**	**$374,334,155**	

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 $151,356,627 are excluded.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL. This led to an increase in Insure Oklahoma IP's PMPM due to drop in member enrollment and payment of claims for these members' services that were rendered in previous months.

Net Enrollee Count Change from Previous Month Total	(2,785)

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 January 2014
Dual Enrollees		**108,514**	**109,596**
	Child	*201*	192
	Adult	*108,313*	109,404

		Monthly Average SFY2013	Enrolled January 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,674**	**15,307**	**$4,164**
	Child	64	63	
	Adult	15,610	15,244	

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

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled January 2014
Total Providers		**36,948**	**38,275**
	In-State	28,587	29,217
	Out-of-State	8,362	9,058

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	47%
SoonerCare Choice I/T/U	20%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2013	*Enrolled January 2014**	Monthly Average SFY2013	Enrolled January 2014
Physician	*7,859*	*8,396*	*12,432*	13,631
Pharmacy	*901*	*936*	*1,208*	1,266
Mental Health Provider**	*5,811*	*4,887*	*5,880*	4,927
Dentist**	*1,205*	*993*	*1,380*	1,105
Hospital**	*194*	*183*	*923*	695
Optometrist	*578*	*571*	*612*	600
Extended Care Facility	*362*	*356*	362	356

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

Total Primary Care Providers	*4,997*	*5,282*	6,541	6,804
Patient-Centered Medical Home	*1,935*	*2,030*	1,985	2,119

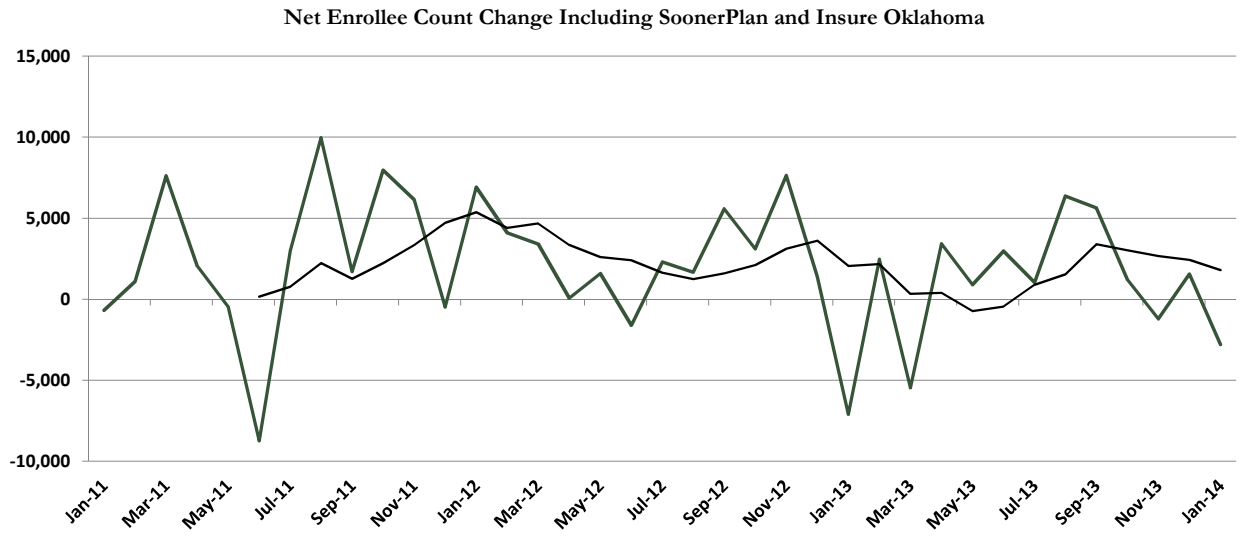
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*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

SOONERCARE NET ENROLLEE COUNT CHANGE FROM MONTH TO MONTH



Net Enrollee Count Change includes SoonerCare, SoonerPlan and Insure Oklahoma. Trendline is 6 month rolling average. In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of federal poverty level (FPL) and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

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 3/5/2014	February 2014		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	68	$799,001	1,934	$45,829,169
Eligible Hospitals	14*	$3,627,832	93	$84,464,130
Totals	82	$4,426,833	2,027	$130,293,299

*Current Eligible Hospitals Paid

ADAIR COUNTY HC INC
CHEROKEE NATION - WW HASTINGS
CHOCTAW MEMORIAL HOSPITAL
CLAREMORE IND HSP
LAWTON IND HSP
MEMORIAL HOSPITAL & PHYSICIAN GROUP
OK CENTER FOR ORTHOPAEDIC & MULTI SPECIALTY
OKMULGEE MEMORIAL HSP
PERRY MEM HSP AUTH
PURCELL MUNICIPAL HOSPITAL
SEQUOYAH COUNTY CITY OF SALLISAW HOSPITAL AUTHORITY
ST ANTHONY HSP
STILLWATER MEDICAL CENTER
STROUD REGIONAL MEDICAL CENTER
WEATHERFORD HOSPITAL AUTHORITY

SOONERCARE PROVIDER CAPACITY ANALYSIS

MARCH 2014
OHCA BOARD REPORT

Oklahoma HealthCare Authority

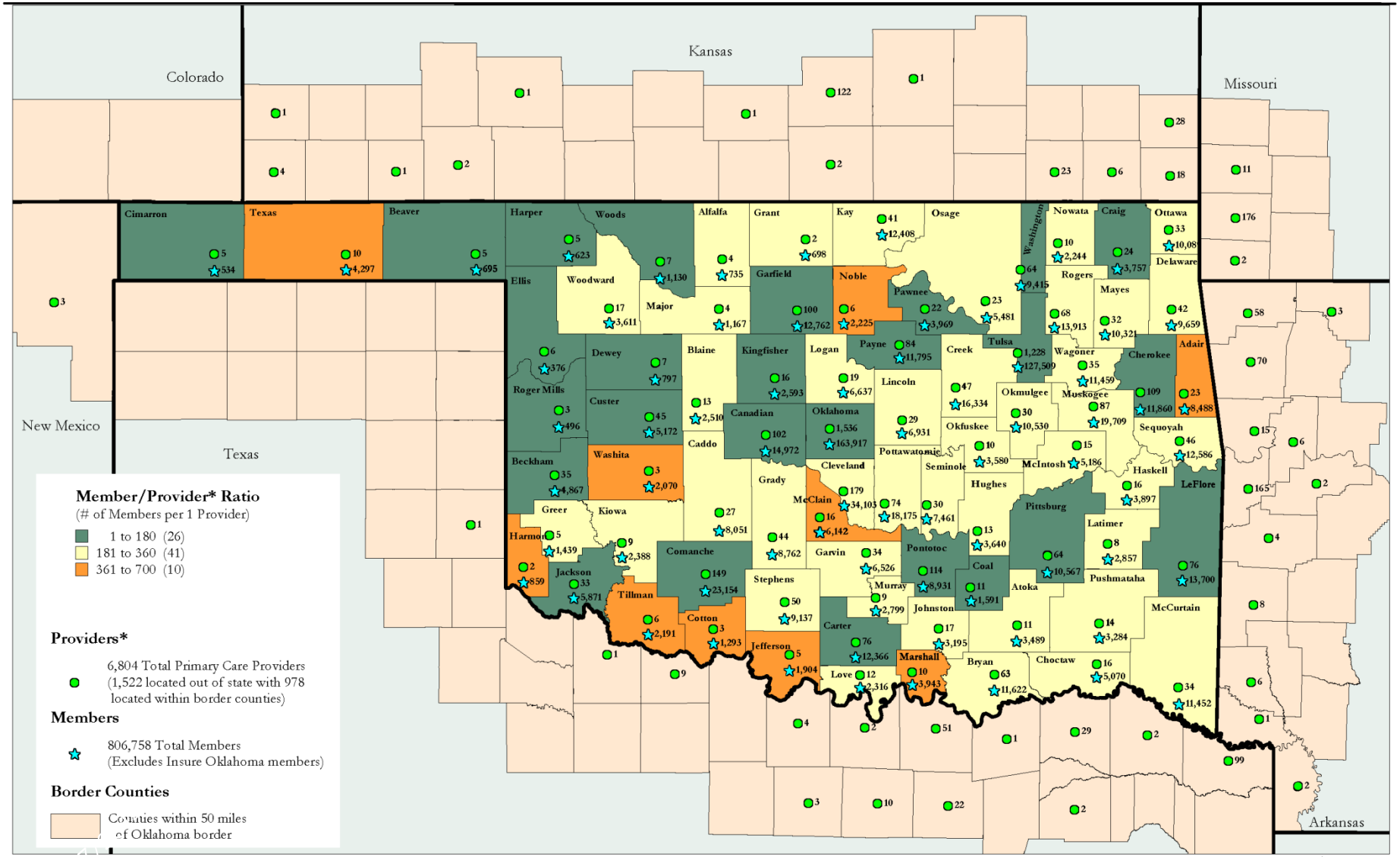
INTRODUCTION

Analysis project was completed by OHCA to:

- ❑ Look at the SoonerCare “primary care” type provider-to-member ratio overall.
- ❑ Examine the SoonerCare Choice capacity on a county level.
- ❑ Identify areas of need and find out what measures are being taken for improvement.

ALL SOONERCARE MEMBER TO PROVIDER* RATIO

JANUARY 2014



Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice/Medical Home Provider. Data is valid as of the report date and is subject to change.

02/21/2014

PATIENT-CENTERED MEDICAL HOME
A TEAM APPROACH

- According to America's Health Ranking, Oklahoma ranks 48th in the number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics and internal medicine) with 82.7 per 100,000 population.[1] Note these figures do not include Nurse Practitioners or Physician Assistants.
- SoonerCare primary care providers are: all providers contracted as Family Practitioners, General Pediatricians, General Practitioners, Internists, General Internists, Nurse Practitioners, and Physician Assistants.
- Oklahoma's Patient-Centered Medical Home model is team-based care. Because Oklahoma has large rural zones and areas lacking adequate physician coverage, the PCMH is a workforce mix that includes various levels of medical staff, office personnel, care coordinators and specialists.
- The PCMH concept encompasses the medical home partnership, facilitated access to specialty care, educational services, out-of-home care, family support, and other public and private community services important to the overall health of the patient.

[1]*America's Health Ranking published by the United Health Foundation* http://www.americashealthrankings.org/OK/PCP/2013

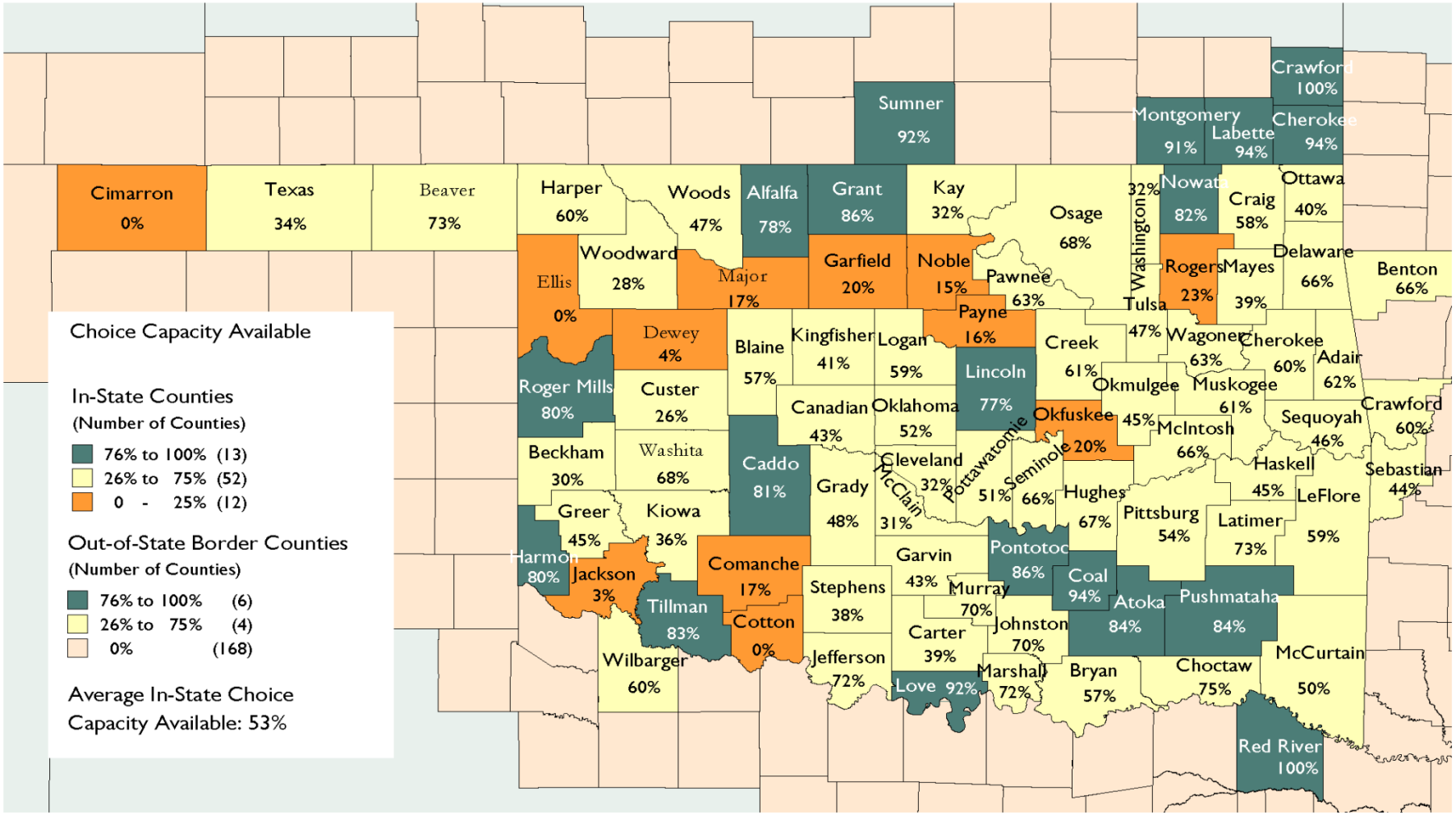
SOONERCARE CHOICE MEDICAL HOMES

SoonerCare Choice Medical Homes - January 2014		
Primary Care Provider Specialty	Total Contracted	Total PCMH
Family Practitioner	2,024	803
General Internist	65	29
General Pediatrician	956	376
General Practitioner	344	73
Internist	1,315	220
Nurse Practitioner *	1,077	395
Physician Assistant *	1,238	294
Total (Unduplicated)**	**6,804**	**2,119**
*Not included in Primary Care Healthcare Professional Shortage Area (HPSA) definition of PCP		
**PCPs can have multiple specialty code descriptions.		

SOONERCARE CHOICE CAPACITY

- Patient-Centered Medical Home providers declare their panel size upon enrollment and can change at any time.
- There are limits on panel capacity. No more than 2,500 members per provider and 1,250 for mid-level providers
- SoonerCare Choice members select their Medical Homes. Now they are on the Medical Home's panel.
- Panel hold – The provider can contact us and request this status, this is usually due to changes in their practice (providers leaving, etc.). OHCA can also place a provider on panel hold while reviewing quality of care issues or non-compliance with their medical home contract.
- Other panel impacts - Medical licensure issues, non-compliance with the Health Department related to Vaccines For Children program.

SoonerCare Choice Capacity Available – January 2014



Border counties are within 50 miles of the Oklahoma border. Choice providers were counted if they had an active panel size that was not on hold. Providers include but were not limited to clinics (FQHCs and RHCs) and PCPs (Advanced Registered Nurse Practitioners, Family Practitioners, General Pediatricians, General Practitioners, Internists, General Internists, and Physician Assistants).

2/18/2014

CAPACITY ANALYSIS HIGH POINTS

- There are 12 counties that have 25 percent or less capacity available. By majority these providers are in the Northwest part of the state.
- Except for Cimarron County, all other lower capacity counties border a county with more than 50 percent capacity available.
- The SoonerCare enrollees in the shortage areas comprise 9 percent of the SoonerCare Choice enrollees.
- In the areas with the highest percent of population enrolled in SoonerCare, the provider network appears to be robust and there is more than 50 percent capacity available.

ANALYSIS CONCLUSION

- SoonerCare implemented Patient-Centered Medical Home, and recognizes Physician Assistants and Nurse Practitioners as part of the "primary care team" thus providing members an increased access to appropriate levels of care.
- Oklahoma's SoonerCare provider network appears to provide access in most areas. According to the Patient-Centered Medical Homes self-reported capacity, the in-state network has 53 percent unused capacity.
- Ongoing efforts are being made to retain and bolster the current provider network within the OHCA. Additionally, there are various state and federal efforts to address the potential physician shortage.

PROVIDER RECRUITMENT

- If there are areas of low/no medical homes. OHCA will talk to the PCP provider types contracted.

- If there are no contracted PCP-types in the area or they are not willing to become medical homes, OHCA checks other sources for recruitment leads, such as the medical licensure board or the yellow pages.

- Typically providers do not know what is involved with being a medical home and how much support OHCA delivers. Provider Services are in the process of talking to all of the contracted PCP-type providers. It takes resources and face-to-face meetings to educate potential medical homes on the Patient-Center Medical Home delivery model.

RECRUITMENT STRATEGIES

- Previously Contracted Providers
- Internet/Social Media
- Medical Licensure Boards
- OU OSU Residency Programs
- State Medical Association Meeting
- ARNP, PA State Association Meetings
- Current PCMH Providers
- Community and Advocacy Outreach
- Medical education payments for residency programs

RETENTION STRATEGIES

- Care coordination fees
- SoonerExcel payments
- Enhanced payments to most PCPs until January 2015 (except OU and OSU)
- Practice facilitators
- Continuing provider education
- Dedicated provider support staff
- Competitive payment rates
- Provider led advisory groups

OHCA BOARD MEETING

MARCH 27TH, 2014 OHCA BOARD MEETING

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. This bill passed the House 74-15 and has been referred to Senate Health & Human Services committee.
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A major bill we have been tracking, **SB1495**, by Sen. Kim David was originally intended to have OHCA implement a private managed care program. A floor amendment was submitted by Sen. David for OHCA to develop and implement a private managed care pilot program under the Oklahoma Medicaid program. It passed the Senate 25-21 with the pilot to begin no later than January 1, 2016**.** **HB2788**, Rep. Mark McCullough's private managed care program legislation for OHCA failed the March 13th deadline in the House.

HB 2384 by Rep. Doug Cox creates the Medicaid Sustainability & Cost Containment Act. This bill requires rules concerning provider rates, prior authorizations for non-generic pharmaceuticals, limits ER visits and requests a study on durable medical equipment and diabetic supplies. It passed the House 58-25 with the title off and has been referred to Senate Health & Human Services committee.

After the February and March deadlines, and as of March 19, 2014, the Oklahoma Legislature is tracking a total of 1,015 legislative bills for the remainder of session. OHCA is currently tracking 33 bills.

The following are the remaining Senate and House deadlines for 2014:

SENATE AND HOUSE DEADLINES
Remaining Deadlines

March 27, 2014	Deadline for Double-Assigned House Bills from lst Senate Committee
April 03, 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; Senate Bills & Senate Joint Resolutions to be heard in House 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.

Recommendation 1: Prior Authorize Procysbi™ (Cysteamine Bitartrate)

The Drug Utilization Review Board recommends the prior authorization of Procysbi™ (cysteamine bitartrate) with the following criteria:

Procysbi™ (Cysteamine Bitartrate) Approval Criteria:

1. An FDA approved diagnosis of nephropathic cystinosis; and
2. A patient specific, clinically significant reason why member cannot use the short-acting formulation Cystagon® (cysteamine bitartrate).

Recommendation 2: Prior Authorize Ravicti® (Glycerol Phenylbutyrate)

The DUR Board recommends prior authorization of Ravicti® (glycerol phenylbutyrate) with the following criteria:

Ravicti® (Glycerol Phenylbutyrate) Approval Criteria:

1. An FDA approved diagnosis of urea cycle disorder (UCD); and
2. Active management with protein restricted diet; and
3. A patient specific, clinically significant reason why member cannot use Buphenyl® (sodium phenylbutyrate).

Recommendation 3: Prior Authorize Sirturo™ (Bedaquiline)

The DUR Board recommends the prior authorization of Sirturo™ (bedaquiline fumarate) with the following criteria:

Sirturo™ (Bedaquiline Fumarate) Approval Criteria:

1. An FDA approved diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB); and
2. Member must be 18 years of age or older; and
3. An alternative, effective treatment regimen cannot otherwise be provided; and
4. Medical supervision by an infectious disease specialist; and
5. Sirturo™ must be used in combination with at least three other drugs to which the patient's MDR-TB isolate has been shown to be susceptible; and
6. Sirturo™ must be administered under direct observation; and
7. Baseline ECG should be obtained and repeated 2, 12, and 24 weeks after starting treatment; and
8. Liver enzymes should be obtained at baseline and monitored monthly.
9. Sirturo™ will not be approved for the treatment of latent, extra-pulmonary or drug-sensitive tuberculosis. MDR-TB must be confirmed by sensitivity cultures indicating resistance to at least isoniazid and rifampin.
10. A maximum quantity of 188 tablets for the entire course of treatment will apply.
11. Approvals will be for the duration of 24 weeks.

Recommendation 4: Prior Authorize Inhaled Tobramycin Products and Pulmozyme® (Dornase Alfa)

The DUR Board recommends the following:

1. Reserve use of inhaled tobramycin products and Pulmozyme® (dornase alfa) for members who have a diagnosis of cystic fibrosis. These medications will not require a prior authorization and claims will pay at the point of sale if member has a reported diagnosis of cystic fibrosis within the past 24 months of claims history. If the member does not have a reported diagnosis, a manual prior authorization will be required for coverage consideration.
2. Restrict use of inhaled tobramycin products to 28 days of therapy per every 56 days to ensure cycles of 28 days on therapy followed by 28 days off therapy. Use outside of this recommended regimen may be considered for coverage via a manual petition.
3. Access to Tobi® Podhaler™ will remain similar to Tobi® at this time. A study will be conducted over the course of the next year to evaluate and compare the impact of the two products on overall healthcare outcomes including hospitalizations and pharmacy costs. The results of this study may contribute to further recommendations regarding Tobi® Podhaler™.

Recommendation 5: Prior Authorize Adempas® (Riociguat) and Opsumit® (Macitentan)

The DUR Board recommends prior authorization of the following medications:

Adempas® (Riociguat) Approval Criteria:

1. FDA approved diagnosis of pulmonary arterial hypertension or chronic thromboembolic pulmonary hypertension
    a. Members with a diagnosis of pulmonary arterial hypertension must have previous failed trials of at least one of each of the following categories:
        i. Revatio® (sildenafil) or Adcirca® (tadalafil); and
        ii. Letairis® (ambrisentan) or Tracleer® (bosentan); and
    b. Members with a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) must currently be on anticoagulation therapy; and
2. Medical supervision by a pulmonary specialist and/or cardiologist; and
3. Member must not be on concurrent PDE-5 inhibitor therapy; and
4. Female members and all healthcare professionals (prescribers and dispensing pharmacies) must be enrolled in the Adempas® REMS program.
5. A quantity limit of 90 tablets per 30 days will apply.

Opsumit® (Macitentan) Approval Criteria:

1. FDA approved diagnosis of pulmonary arterial hypertension; and
2. Previous failed trials of at least one of each of the following categories:
    a. Revatio® (sildenafil) or Adcirca® (tadalafil); and
    b. Letairis® (ambrisentan), or Tracleer® (bosentan); and

3. Medical supervision by a pulmonary specialist and/or cardiologist; and
4. Female members and all healthcare professionals (prescribers and dispensing pharmacies) must be enrolled in the Opsumit® REMS program.
5. A quantity limit of 30 tablets per 30 days will apply.

Recommendation 6: Prior Authorize Select Cephalosporins (cefixime, ceftibuten, and cefditoren)

The DUR Board recommends prior authorization of cefixime (Suprax®), ceftibuten (Cedax®), and cefditoren (Spectracef®) with the criteria below.

Suprax® (Cefixime), Cedax® (Ceftibuten), and Spectracef® (Cefditoren) Approval Criteria:

1. Indicated diagnosis or infection known to be susceptible to requested agent; and
2. Patient specific, clinically significant reason why member cannot use cephalexin and cefdinir, or other cost effective therapeutic equivalent medication(s).

State Plan Amendment Rate Committe (SPARC)
March 5th, 2014
Anesthesia Payment Rate Change – Modification for CPT 01996

1. Is this a "Rate Change" or a "Method Change"?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Increase

2. Presentation of issue – Why is change being made?
   During the last SPARC we inadvertently included procedure code 01996 as one of the codes that should be updated as part of the formula involving base units and time units multiplied by a conversion factor. However during the update process we discovered that procedure code 01996 was actually paid through a flat fee methodology. We are asking take this code back to the flat fee methodology. CPT code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) will pay at a flat fee; the flat fee will increase from the budget reduction max fee of $91.44 ($94.50 default) to $117.00

3. Current methodology and/or rate structure.
   The methodology for the flat fee involves the base units assigned by Medicare multiplied by the current conversion factor. Medicare limits the time unit on this code to 1 unit.

4. New methodology or rate.
   The change is to revert to the previous methodology; to go back to the flat fee methodology rather than a base multiplied by time multiplied by conversion factor.

5. Budget estimate.
   This is budget neutral. The budget impact of this code was included in the previous budget impact.

6. Agency estimated impact on access to care.
   This rate increase will encourage providers to participate in the Medicaid program and thus have a positive impact on access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve a methodology change for procedure code 01996.

8. Effective date of change.
   January 1, 2014

State Plan Amendment Rate Committee (SPARC)
March 5th, 2014
Long-Acting Reversible Contraception (LARC)

1. Is this a "Rate Change" or a "Method Change"?
   Method change – This request is to move the long-acting reversible contraception (LARC) payment out of the DRG bundled payment (if done as part of an inpatient stay) and pay for it separately.

1b. Is this change an increase, decrease, or no impact?
   No impact – this payment is currently being made in the outpatient physician office setting; this change would move the payment from the physician office to the hospital.

2. Presentation of issue – Why is change being made?
   Providing LARC placement while the member is in the hospital immediately after delivery is desirable because the member is there and eligibility is assured. Further, some women do not make their physician postpartum follow-up visit or have lost eligibility by the time they do, which leads to costly unplanned pregnancies. ACOG has also endorsed the placement of LARC during this immediate postpartum period as safe, effective and desirable.
   Currently if a hospital were to provide this expensive implantable during the inpatient stay it would be bundled into the DRG payment and hospitals would be unwilling to supply it. This change seeks to reimburse for the LARC separately, at the same rate as is currently reimbursed in the physician's office.

3. Current methodology and/or rate structure.
   Currently all services provided during an inpatient stay are bundled into the inpatient DRG payment

4. New methodology or rate.
   The change is a change in methodology; we will allow an exception to the DRG methodology and reimburse this implantable outside of the DRG bundled methodology.

5. Budget estimate.
   This is budget neutral. This service is currently being provided in the physician's office.

6. Agency estimated impact on access to care.
   This change will encourage hospitals to provide this service which will have a positive impact on a woman's access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve a methodology change for the DRG bundled payment methodology and allow an exception for reimbursement of LARC in addition to the DRG payment.

8. Effective date of change.
   July 1, 2014

A.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-7 [AMENDED]

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43 [AMENDED]

317:35-5-44 [AMENDED]

317:35-5-45 [AMENDED]

317:35-5-46 [AMENDED]

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1 [AMENDED]

PART 3. APPLICATION PROCEDURES

317:35-6-15 [AMENDED]

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-35 [AMENDED]

317:35-6-36 [AMENDED]

317:35-6-37 [AMENDED]

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60.1 [AMENDED]

317:35-6-61 [AMENDED]

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48 [AMENDED]

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

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-67 [AMENDED]

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 3. RESOURCES

317:35-10-10 [AMENDED]

PART 5. INCOME

317:35-10-25 [AMENDED]

317:35-10-26 [AMENDED]

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-6 [AMENDED]

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-20 [AMENDED]

(REFERENCE APA WF # 13-08)

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) **Categorical relationship.** All individuals under age 19 are automatically related to the children's group and further determination is not required. Adults age 19 or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) **Grandfathered CHIP children.** As provided in OAC 317:35-6-1, the MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013 until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later.

(1) The MAGI methodology eliminates the following income disregards, which are subtracted from gross income under the TANF methodology prior to ~~January~~October 1, ~~2014~~2013:

(A) The $240 work related expense deduction from earned income per employed household member;

(B) The disregard of the first $50 of child support received by a household; and

(C) The deduction for child support expenses paid by an employed parent or caretaker who needs child care in order to work, in the amount of the actual expense paid up to a maximum of $200 per month for children under 2 years of age and up to a maximum of $175 per month for children 2 years of age or older.

(2) If the elimination of the disregards listed in (1) when the MAGI methodology is applied to a child who was enrolled in SoonerCare on December 31, 2013 makes the child financially ineligible, the child is related to the Grandfathered CHIP children group.

(3) The following children are not eligible for the Grandfathered CHIP Children group:

(A) Children who are eligible for SoonerCare through another eligibility group;

(B) Children who have other creditable health insurance coverage;

(C) Children who are inmates of public institutions or are patients in institutions for mental disease; or

(D) Children who are eligible for coverage under a health plan offered to employees of the State of Oklahoma.

(4) If a child's eligibility in this group is redetermined during his/her certification period and the child is financially ineligible without regard to elimination of the

disregards in (1), the child's benefits are closed using normal procedures.

(5) Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.

(c) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be considered as a possibly liable third party, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, the member must assist OHCA with the subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit the appropriate information.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant

did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind, or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility if it is counted under the financial eligibility methodology used for the group for which eligibility is being determined. The rules in OAC ~~317:10~~317:35-10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(ii) Prior to ~~January~~October 1, ~~2014~~2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CFSD or retained by the member. Effective ~~January~~October 1, ~~2014~~2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child/spousal support is counted as income.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or

less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights. These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(2) Prior to ~~January~~October 1, ~~2014~~2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective ~~January~~October 1, ~~2014~~2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.

(3) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

317:35-5-45. Determination of income and resources for children and parents and caretaker relatives

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with OAC 317:35-10 for individuals categorically related to AFDC. Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. Individuals categorically related to AFDC are excluded from the AFDC resource test. Certain AFDC rules are specific to money payment cases and are not applicable when only SoonerCare services are requested. Exceptions to the AFDC rules are:

(1) the deeming of the parent(s)' income to the minor parent;

(2) the deeming of the sponsor's income to the sponsored alien;

(3) the deeming of stepparent income to the stepchildren. The income of the stepparent who is not included for SoonerCare in a family case is not deemed according to the stepparent liability. Only the amount of the stepparent's contribution to the individual is considered as income. The amount of contribution is determined according to OAC 317:35-10-26(a)(8), Person acting in the role of a spouse;

(4) the AFDC lump sum income rule. For purposes of SoonerCare eligibility, a period of ineligibility is not computed;

(5) mandatory inclusion of minor blood-related siblings or minor dependent children. For SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children;

(6) the disregard of one half of the earned income;

(7) dependent care expense. For SoonerCare only, dependent care expenses may be deducted for an in-home provider who, though not approved, would have qualified had the qualification process been followed;

(8) AFDC trust rule. The availability of trusts for all SoonerCare only cases is determined according to OAC 317:35-5-41.6;

(9) AFDC Striker rules. Striker status has no bearing on SoonerCare eligibility;

(10) ET&E Sanction rule. The ET&E status has no bearing on SoonerCare eligibility. However, a new SoonerCare application is required.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the children and parent and caretaker relatives groups. See Subchapter 6 of this Chapter for MAGI rules.

317:35-5-46. Determination of income and resources for categorical relationship to pregnancy-related services

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Countable income for an individual categorically related to pregnancy-related services is determined in the same manner as for an individual categorically related to AFDC. (See OAC 317:35-5-45). Eligibility is based on the income received in the first month of certification with changes in income not considered after certification. Individuals categorically related to pregnancy-related services are excluded from a resource test.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the pregnancy group. See Subchapter 6 of this Chapter for MAGI rules. Eligibility is based on the income received in the first month of certification with changes in income not considered after certification, and there is no resource test.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare Health Benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children,
(2) Grandfathered CHIP children,
(3) Pregnant women,
(4) Pregnancy-related services under Title XXI,
(5) Parents and caretaker relatives,
(6) SoonerPlan Family Planning program,
(7) Independent foster care adolescents,
(8) Inpatients in public psychiatric facilities under 21, and
(9) Tuberculosis.

(b) See 42 CFR 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) ~~MAGI rules are not applied to members enrolled in SoonerCare on December 31, 2013 until March 31, 2014, or the date of their next regularly scheduled renewal, whichever is later.~~MAGI rules take effect on October 1, 2013.

~~(d) For new applicants or individuals who have had a break in eligibility and are not enrolled on December 31, 2013, MAGI rules take effect on January 1, 2014.~~

PART 3. APPLICATION PROCEDURES

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

(a) **Application**. An application for pregnant women and families with children consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. Effective October 1, 2013, individuals who wish to use a paper application form to apply for coverage under a MAGI eligibility group must submit the federal Single Streamlined Application to apply for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, in the county OKDHS office, or online. A face to face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. Effective October 1, 2013, an application for SoonerCare may also be submitted through the Health Insurance Exchange.

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

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

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

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

not guarantee coverage and if a completed application is not submitted within fifteen days, the NODOS is void.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

(c) **Other application and signature requirements.** For additional rules regarding other application and eligibility determination procedures, see Part 7 of Subchapter 5 of this Chapter.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-35. General eligibility consideration

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Financial eligibility for SoonerCare Health Benefits for Pregnant Women and Families with Children is determined using the rules on income according to the category to which the individual is related. (See Part 5, Subchapter 5 of this Chapter.) Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. There is not a resource test for individuals categorically related to AFDC or pregnancy related services.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Financial eligibility for SoonerCare Health Benefits for MAGI eligibility groups is determined using the MAGI methodology. Unless questionable, the income of individuals who are related to a MAGI eligibility group does not require verification. There is no resource test for individuals related to any of the MAGI groups (see Part 1 of this Subchapter for a list of the MAGI groups).

(c) When medical assistance is requested on behalf of any individual, eligibility is determined for that individual as well as all other individuals in the family unit who meet basic criteria for a SoonerCare eligibility group.

(d) Income is evaluated on a monthly basis for all individuals included in the case for Health Benefits.

317:35-6-36. Financial eligibility of individuals categorically related to AFDC or pregnancy-related services

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(1) the individual;

(2) the spouse of the individual;

(3) the biological or adoptive parent(s) of the individual who is a minor dependent child. For Health Benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;

(4) minor dependent children of the individual if the children are being included in the case for Health Benefits. If the individual is 19 years or older and not pregnant, at least one minor dependent child must be living in the home and included in the case for the individual to be related to AFDC;

(5) blood related siblings, of the individual who is a minor child, if they are included in the case for Health Benefits;

(6) a caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(b) **Prior to ~~January~~October 1, ~~2014~~2013.** The family has the option to exclude minor dependent children or blood related siblings [OAC 317:35-6-36(a)(4) and (5)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income must be included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.

(c) **Effective ~~January~~October 1, ~~2014~~2013.** The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through OAC 317:35-6-54.

(d) **Effective ~~January~~October 1, ~~2014~~2013.** Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.

(e) When determining financial eligibility for an individual related to the children, parent or caretaker relative, or pregnancy_groups, consideration is not given to income of any person who is aged, blind or disabled and receives SSI or is determined to be categorically needy.

317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services

Individuals whose income is less than the standards on DHS Appendix C-1 for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically needy standards/categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on DHS Appendix C-1. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically needy standards/categorically related to children's and parent/caretakers' groups.**

(A) **Categorical relationship.** For the individual related to AFDC to be considered categorically needy, the standards on DHS Appendix C-1 schedules must be used.

(i) **DHS Appendix C-1, Schedule X.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically Needy Standard, according to the family size. ~~Income standards are 73.1% of the AFDC Need Standard.~~

(ii) **DHS Appendix C-1, Schedule I.A.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family. ~~Income standards are 185% of Federal Poverty Level.~~

(B) **Families with children.** Individuals who meet financial eligibility criteria for the children's and parent/caretakers' groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the children's or parent/caretakers' groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in Work Supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of

the assistance unit, or the new or increased earnings of the caretaker relative.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60.1 Changes in circumstances

(a) **Reporting changes.** Members are required to report changes in their circumstances within 10 days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances**. When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

(d) **Exception January to March, 2014.** During the period January to March, 2014, redeterminations due to changes in circumstances will be processed, but the effective date of any termination action taken as a result of changes in household composition or income for individuals in MAGI eligibility groups will be April 1, 2014, or later.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within 90 days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

(d) Periodic redeterminations scheduled for January to March, 2014 will be rescheduled for April, 2014.

SUBCHAPTER 7. MEDICAL SERVICES
PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48. Eligibility for the SoonerPlan Family Planning Program

(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for

SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below the applicable standard on the OKDHS Appendix C-1. Prior to ~~January~~October 1, ~~2014~~2013, the standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1). Effective ~~January~~October 1, ~~2014~~2013, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to ~~January~~October 1, ~~2014~~2013, in determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. ~~January~~October 1, ~~2014~~2013, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for the SoonerPlan Family Planning Program.

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

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-67. Determining financial eligibility of categorically needy individuals

Financial eligibility for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals medical care for categorically needy individuals is determined as follows:

(1) **Prior to ~~January~~October 1, ~~2014~~2013, financial eligibility/categorically related to AFDC**. In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

(B) parent(s) and minor children of their own. Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

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

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

(2) **Effective ~~January~~October 1, ~~2014~~2013, financial eligibility in a Modified Adjusted Gross Income (MAGI) eligibility group.** In determining financial eligibility for an individual related to a group for whom the MAGI methodology is used, rules in Subchapter 6 of this Chapter are followed.

(3) **Financial eligibility/categorically related to ABD**. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the individual's countable income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule VI. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering an ICF/MR, see OAC 317:35-9-68 (a)(3) to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI, is applicable for individuals related to ABD. If the individual is in an ICF/MR and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard on OKDHS Appendix C-1, Schedule VI, is used. The rules on determination of income and resources are applicable only when an individual has entered an ICF/MR and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends [Refer to OAC 317:35-9-68 (a)(3)(B)(x)]. An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(B) In determining eligibility for HCBW/MR services, refer to OAC 317:35-9-68(b).

(C) In determining eligibility for individuals age 65 or older in mental health hospitals, refer to OAC 317:35-9-68(c).

(4) **Transfer of capital resources on or before August 10, 1993**. Individuals who have transferred capital resources on or before August 10, 1993 and are applying for or receiving NF, ICF/MR or HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this rule. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value

of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's child who is under 21 or who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office, FSSD, Health Related and Medical Services, for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF services and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual. The cost of care during the penalty period cannot be used to shorten or end the penalty period.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look-back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months dropping any leftover portion) determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization;

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer;

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance;

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child;

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value;

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65; or

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this

paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such

individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purpose of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services or HCBW for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to

this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN
PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Prior to ~~January~~October 1, ~~2014~~2013, the countable income generated from any resource is considered in accordance with Part 5 of this Subchapter. Effective ~~January~~October 1, ~~2014~~2013, countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-25. Income defined

Prior to ~~January~~October 1, ~~2014~~2013, income is defined as that gain, payment or proceed from labor, business, property, retirement and other benefits. Effective ~~January~~October 1,

~~2014~~2013, for MAGI eligibility groups as defined in OAC 317:35-6-1, income is defined by the Internal Revenue Code.

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to the children, parent or caretaker relative, SoonerPlan, or Title XIX and XXI pregnancy eligibility groups does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Health Care Authority (OHCA). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 10 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member

who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. Effective ~~January~~October 1, ~~2014~~2013, the MAGI methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in OAC 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within 10 days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Prior to ~~January~~October 1, ~~2014~~2013, a nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security

lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to a member of the children, parent or caretaker relative, or pregnancy groups who is not currently eligible for SSI, is not counted as income. Effective ~~January~~October 1, ~~2014~~2013, whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Prior to ~~January~~October 1, ~~2014~~2013, lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award. Effective ~~January~~October 1, ~~2014~~2013, whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Effective ~~January~~October 1, ~~2014~~2013, income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months,

will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Effective ~~January~~October 1, ~~2014~~2013, whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) Prior to ~~January~~October 1, ~~2014~~2013, a caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. Effective ~~January~~October 1, ~~2014~~2013, MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) Prior to ~~January~~October 1, ~~2014~~2013, consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children. However, if that person is the stepparent, the policy on stepparent liability is applicable. Effective ~~January~~October 1, ~~2014~~2013, MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) Prior to ~~January~~October 1, ~~2014~~2013, if a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month. Effective ~~January~~October 1, ~~2014~~2013, MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse,

if living with him/her, is also related to the parent or caretaker relative group.

(7) Prior to ~~January~~October 1, ~~2014~~2013, a stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included. Effective ~~January~~October 1, ~~2014~~2013, a stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) Prior to ~~January~~October 1, ~~2014~~2013, when there is a stepparent or person living in the home with the biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind. Effective ~~January~~October 1, ~~2014~~2013, MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Prior to ~~January~~October 1, ~~2014~~2013, payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment

in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings. Effective ~~January~~October 1, ~~2014~~2013, whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment prior to ~~January~~October 1, ~~2014~~2013.** If the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered**. The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from self-employment effective ~~January~~October 1, ~~2014~~2013.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from wages, salary or commission.** Prior to ~~January~~October 1, ~~2014~~2013, if the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income. Effective ~~January~~October 1, ~~2014~~2013, countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **Earned income from work and training programs.** Prior to ~~January~~October 1, ~~2014~~2013,earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year. Effective ~~January~~October 1, ~~2014~~2013, countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(5) **Individual earned income exemptions prior to ~~January~~October 1, ~~2014~~2013.** Exemptions from each individual's earned income include a monthly standard work

related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) The actual amount paid for child care per month, up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted.

(iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider.

(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(6) **No individual earned income exemptions effective ~~January~~October 1, ~~2014~~2013.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of 5% of the FPL for the individual's household size as defined in OAC 317:35-6-39.

(7) **Formula for determining the individual's net earned income prior to ~~January~~October 1, ~~2014~~2013.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(8) **Formula for determining the individual's net earned income effective ~~January~~October 1, ~~2014~~2013 for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income prior to ~~January~~October 1, ~~2014~~2013.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under

consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(d) **Unearned income effective ~~January~~October 1, ~~2014~~2013.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(e) **Income disregards prior to ~~January~~October 1, ~~2014~~2013.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of the loan. When copies of written agreements or OKDHS Form 08AD103E are not

available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;
(5) Indian payments (including judgment funds or funds held in trust) which are distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;
(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;
(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;
(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;
(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;

(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(15) Earnings of a child who is a full-time student are disregarded;
(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
(24) Interests of individual Indians in trust or restricted lands;
(25) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
(26) Any payments made directly to a third party for the benefit of a member of the benefit group;
(27) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;

(28) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complimentary payments;

(29) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(30) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);

(31) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(32) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(33) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(34) Wages paid by the Census Bureau for temporary employment related to Census activities.

(f) **Income disregards effective ~~January~~October 1, ~~2014~~2013.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(g) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by 2.

(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

SUBCHAPTER 15. PERSONAL CARE SERVICES

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

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

(1) **Financial eligibility/categorically related to AFDC prior to ~~January~~October 1, ~~2014~~2013.** In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

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

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

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

(2) **Financial eligibility for MAGI eligibility groups effective ~~January~~October 1, ~~2014~~2013.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

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

(4) **Determining financial eligibility for Personal Care**. For individuals determined categorically needy for Personal Care, the member will not pay a vendor payment for Personal Care services.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-20. Determining financial eligibility of categorically needy individuals

Financial eligibility for NF medical care is determined as follows:

(1) **Financial eligibility/categorically related to AFDC prior to ~~January~~October 1, ~~2014~~2013.**

(A) In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(i) spouse; and

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

(I) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.

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

(B) Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

(2) **Financial eligibility for MAGI eligibility groups effective ~~January~~October 1, ~~2014~~2013.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(3) **Financial eligibility/categorically related to ABD**. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering a nursing facility, see paragraph (3) of OAC 317:35-19-21 to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy

standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used. The rules on determination of income and resources are applicable only when an individual has entered a NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

(B) An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(4) **Transfer of capital resources on or before August 10, 1993**. Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving NF, ICF/MR, or receiving HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this policy. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's minor child who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon

the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this

Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon

the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes

institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

B.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3 [AMENDED]

SUBCHAPTER 11. INSURE OKLAHOMA IP

PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. [AMENDED]

317:45-11-11. [AMENDED]

317:45-11-12. [REVOKED]

317:45-11-13. [REVOKED]

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. [AMENDED]

317:45-11-21. [AMENDED]

317:45-11-21.1. [REVOKED]

317:45-11-24. [AMENDED]

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. [REVOKED]

(REFERENCE APA WF # 13-16)

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before

March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver~~ and/or state plan using rules found in OAC 317:35~~.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.

"In-network" means providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma IP" means the Individual Plan program.

"Insure Oklahoma ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract with the Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

"Qualified Health Plan(QHP)" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

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

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

(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services~~,~~ and limits~~, and applicable co-payments~~ are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. ~~Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit.~~ Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).
(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation Therapy. Covered for heavy metal poisoning only.
(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required. ~~Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.~~
(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95~~; $50 co-pay per admission~~.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year ~~with a $10 co-pay~~. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are

covered per month; PCP referral required for specialist visits~~; $10 co-pay per visit~~.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures~~; $25 co-pay per visit~~.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections~~; $10 co-pay per visit~~.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year~~; $10 co-pay per visit~~.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. ~~Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.~~

(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20~~; $0 co-pay~~.

(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901~~; $0 co-pay~~.

(13) Immunizations. Covered in accordance with 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility~~; $0 co-pay~~.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts~~; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies~~.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1~~; $50 co-pay per admission~~.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.

(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596~~; $10 co-pay per visit~~.

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

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

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician

if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 Okla. Stat. § 1353(4) and (5), 59 § 1903(C) and (D), 59 § 1925.3(B) and (C), and 59 § 1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

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

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

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

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

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

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy~~; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment~~.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit~~; $5 co-pay per prescription~~.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit~~; $5 co-pay per month~~.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits~~; $5/$10 co-pay per prescription~~.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1~~; $5/$10 co-pay per product~~.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076~~; $10 co-pay per visit~~.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13~~; $25 co-pay per prosthesis~~.
(26) Surgery. Covered in accordance with 317:30-5-8~~; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit~~.
(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit~~; $0 co-pay~~.
(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit~~; $25 co-pay per month~~.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57~~; $0 co-pay~~.
(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Fundus photography.
(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696~~; $0 co-pay~~.

317:45-11-11. Insure Oklahoma IP adult non-covered services

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in 317:45-11-10. These services include, but are not limited to:
(1) services not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;

(12) physical medicine including chiropractic and acupuncture therapy;
(13) hearing services;
(14) transportation [emergency or non-emergency (air or ground)];
~~(15) rehabilitation (inpatient);~~
~~(16) cardiac rehabilitation;~~
~~(17)~~(15) allergy testing and treatment;
~~(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;~~
~~(19)~~(16) hospice regardless of location;
~~(20)~~(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
~~(21)~~(18) genetic counseling;
~~(22)~~(19) fertility evaluation/treatment/and services;
~~(23)~~(20) sterilization reversal;
~~(24)~~(21) Christian Science Nurse;
~~(25)~~(22) Christian Science Practitioner;
~~(26)~~(23) skilled nursing facility;
~~(27)~~(24) long-term care;
~~(28)~~(25) stand by services;
~~(29)~~(26) thermograms;
~~(30)~~(27) abortions (for exceptions, refer to 317:30-5-6);
~~(31)~~(28) services of a Lactation Consultant;
~~(32)~~(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
~~(33)~~(30) enhanced services for medically high risk pregnancies as found in 317:30-5-22.1;
~~(34)~~(31) ultraviolet treatment-actinotherapy; and
~~(35)~~(32) private duty nursing.

317:45-11-12. Insure Oklahoma IP children benefits [REVOKED]

~~(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3- 1 (f) . The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45- 11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Native American children providing documentation of ethnicity are exempt from co-payments.~~
~~Coverage includes:~~
~~(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.~~
~~(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.~~

~~(3) Chelation therapy. Covered for heavy metal poisoning only.~~
~~(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.~~
~~(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.~~
~~(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.~~
~~(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.~~
~~(8) Dialysis. Covered as medically necessary.~~
~~(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.~~
~~(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.~~
~~(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.~~
~~(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.~~
~~(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.~~
~~(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.~~
~~(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.~~
~~(16) Laboratory services. Covered as medically necessary.~~
~~(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments not to exceed eight units/hours per testing set; $0 co-pay.~~
~~(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.~~
~~(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC~~

~~treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.~~
~~(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.~~
~~(21) Nutrition services. Covered as medically necessary; $10 co-pay.~~
~~(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.~~
~~(23) Other medically necessary services. Covered as medically necessary.~~
~~(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.~~
~~(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.~~
~~(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.~~
~~(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.~~
~~(28) Physical, occupational, and speech therapy. Covered as medically necessary. $10 co-pay per visit.~~
~~(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.~~
~~(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.~~
~~(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.~~
~~(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.~~
~~(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.~~

(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.
(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.
(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:
(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

317:45-11-13. Insure Oklahoma IP children non-covered services [REVOKED]

Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in 317:45-11-12. These services include, but are not limited to:
(1) services not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) transportation [non-emergency (air or ground)];
(11) rehabilitation (inpatient);

~~(12) cardiac rehabilitation;~~
~~(13) allergy testing and treatment;~~
~~(14) Temporomandibular Joint Dysfunction (TMD) (TMJ);~~
~~(15) genetic counseling;~~
~~(16) fertility evaluation/treatment/and services;~~
~~(17) sterilization reversal;~~
~~(18) Christian Science Nurse;~~
~~(19) Christian Science Practitioner;~~
~~(20) skilled nursing facility;~~
~~(21) long-term care;~~
~~(22) stand by services;~~
~~(23) thermograms;~~
~~(24) abortions (for exceptions, refer to 317:30-5-6);~~
~~(25) donor transplant expenses;~~
~~(26) tubal ligations and vasectomies; and~~
~~(27) private duty nursing.~~

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements

(a) ~~Working~~Oklahoma employed working adults not eligible to participate in an employer's qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.

(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide social security numbers for all household members;

(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;

(6) be age 19 through 64 or an emancipated minor;

(7) make premium payments by the due date on the invoice;

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);

(9) be not currently covered by a private health insurance policy or plan; and

(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(2) be ineligible for participation in their employer's qualified health plan due to number of hours worked.

(3) have received notification from Insure Oklahoma indicating their employer has applied for Insure Oklahoma and has been approved.

(e) If employed and working for an employer who does not offer a qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ No standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work may be made for self-employed individuals. Allowable Deductions for work related expenses for self-employed individuals, with the exception of the standard deduction, are found at 317:35-10-26(b)(1);

(2) verify self-employment and income by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; and

(3) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicant must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) Applicant must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level based on a family size of one. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(2) Applicant must verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.

(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.
(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.
(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.
~~(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.~~
~~(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.~~
~~(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.~~
~~(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:~~
~~(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;~~
~~(B) loss of employment by a parent which made coverage available;~~
~~(C) affordable ESI is not available; "affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or~~
~~(D) loss of medical benefits under SoonerCare.~~
(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might

impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma IP and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible through the last day of the month the child attains the age of one year.~~

~~(b) The newborn child's eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~

~~(c) The newborn child's certification period is shortened only in the event the child:~~

~~(1) loses Oklahoma residence; or~~

~~(2) expires.~~

~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent of their monthly gross household income, based on a family size of one and capped at ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(3) Native Americans providing documentation of ethnicity are exempt from premium payments.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but

are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits [REVOKED]

~~The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Native Americans children providing documentation of their ethnicity are exempt from dental co-pay requirements. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.~~

~~(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.~~

~~(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.~~

~~(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.~~

~~(4) Class C services are covered as medically necessary and include major, prosthodontics care such as crowns, bridges and dentures, $25 co-pay is required.~~

~~(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.~~

~~(6) Emergency dental services are covered as medically necessary, no co-pay is required.~~

C.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS
317:30-5-42.19. [NEW]
PART 5. PHARMACIES
317:30-5-87. [NEW]
PART 35. RURAL HEALTH CLINICS
317:30-5-363. [NEW]
PART 75. FEDERALLY QUALIFIED HEALTH CENTERS
317:30-5-664.6. [AMENDED]
(REFERENCE APA WF # 13-11)

317:30-5-42.19. 340B Drug Discount Program
(a) For 340B Drug Discount Program guidelines refer to section 317:30-5-87.

PART 5. PHARMACIES

317:30-5-87. 340B Drug Discount Program
(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).
(b) Covered Entities.
(1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.
(2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.
(3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.
(4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the Unit Rebate Amount multiplied by the quantity submitted. All drugs shall be adjusted by the URA whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the Unit Rebate Amount applicable to the quarter in which the claim is submitted to OHCA for payment.

(c) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between OHCA, the contract pharmacy and the Covered Entity.

PART 35. RURAL HEALTH CLINICS

317:30-5-363. 340B Drug Discount Program

(a) For 340B Drug Discount Program guidelines, refer to section 317:30-5-87.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.6. ~~Prescription drugs provided by Health Centers~~ Prescription drugs purchased under the 340B Drug Discount Program provided by Health Centers

~~(a) Eligible Health Centers may elect to participate in the 340B prescription drug program which limits the purchase cost of covered outpatient drugs.~~

~~(b) Centers that are eligible for participation in the 340B program must submit a request to participate to the Office of Pharmacy Affairs which includes their SoonerCare billing information. On an annual basis, a copy of the completed 340B participation form from the Office of Pharmacy Affairs must also be submitted to OHCA's Pharmacy Unit. Additionally, the Center must notify OHCA in writing of any changes in participation as well as any changes in name, address, or the addition of any satellite facilities.~~

~~(c) For purposes of SoonerCare reimbursement, Health Centers participating in the 340B program may only dispense 340B drugs to the members who meet the definition of patient as defined by the Office of Pharmacy Affairs and outlined in this subsection:~~

~~(1) The Health Center has established a relationship with the member, such that the Center maintains records of the individual's health care; and~~

~~(2) The individual receives health care services from a health care professional who is either employed by the Center or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility of the care provided remains with the Center; and~~

~~(3) The individual receives a health care service or range of services from the Center which is consistent with the service or range of services for Health Centers.~~

~~(d) An individual will not be considered a "patient" of the Center for purposes of 340B funding if the only health care service received by the individual from the Center is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting.~~
~~(e) If the Center subcontracts for pharmacy services, the Center must have a written contract which includes the reimbursement methodology for the subcontractor. The Health Center must be the entity purchasing any 340B drugs and must be the entity billing SoonerCare for any 340B drugs.~~
~~(f) Health Centers participating in the 340B program must maintain a separate accounting system for their 340B drugs and any other drugs which were not purchased through the 340B program.~~
~~(g) On an annual basis, the Center must submit to OHCA a description of their inventory system and accounting system for both their 340B drugs and any drugs purchased and dispensed outside the 340B program.~~
~~(h) Health Centers participating in the 340B prescription drug program can only bill SoonerCare for their acquisition cost plus dispensing fee for drugs purchased through the 340B program.~~
~~(i) Health Centers that purchase drugs outside of the 340B program can bill SoonerCare at the SoonerCare fee schedule for those drugs.~~
(a) For 340B Drug Discount Program guidelines, refer to section 317:30-5-87.

D.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS
317:30-5-216. [AMENDED]
(REFERENCE APA WF # 13-12)

317:30-5-216. Prior authorization requests

(a) **Prior authorization requirements**. Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.

(1) **Required forms**. ~~Form HCA-12A may be obtained at local county OKDHS offices and is~~All required forms are available on the OHCA web site at www.okhca.org.

(2) **Certificate of medical necessity**. The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.

(b) **Submitting prior authorization requests**. Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.

(c) **Prior authorization review**. Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) **Prior authorization decisions**. After the ~~HCA-12A~~PA request is processed, a notice will be issued ~~advising whether or not the item is authorized~~regarding the outcome of the review. If ~~authorization is issued,~~the request is approved the notice will include an authorization number, ~~the time period for which the device is being authorized and~~ the appropriate ~~procedure code~~date span and procedure codes approved.

(e) **Prior authorization does not guarantee reimbursement**. Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(f) **Prior authorization of manually-priced items.**

~~Manually-priced items must include documentation showing the supplier's Manufacturer's Suggested Retail Price (MSRP) of the item with the request for prior authorization. The MSRP must be listed for each item in the "billed charges" box on the HCA-12A. If an item does not have an MSRP, the provider must include a copy of the current invoice indicating the cost to the provider and a statement from the manufacturer that there is no MSRP available. Reimbursement will be determined as per OAC 317:30-5-218.~~Manually-priced items must be prior authorized. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of two. OHCA may establish a fair market price through claims review and analysis.

E.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS
317:30-5-47 [AMENDED]
(REFERENCE APA WF # 13-13)

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay. In addition to the DRG payment, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if the DRG payment is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The DRG payment and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-

state hospitals will be reimbursed in the same manner as in-state hospitals.
(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.
(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
(7) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(8) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(9) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.
(10) All inpatient services are reimbursed per the DRG methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

F.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES
317:35-17-25 [NEW]
(REFERENCE APA WF # 13-24)

317:35-17-25. Address Confidentiality Program

(a) ADvantage members who are victims of domestic violence, sexual assault, or stalking can enroll in the Address Confidentiality Program (ACP). The ACP maintains a confidential location by providing a substitute address and mail forwarding service when victims interact with state and local agencies as per Section 60.14 of Title 22 of the Oklahoma Statutes.

(b) The ADvantage Administration (AA), when appropriately notified by a currently enrolled ADvantage member or by their case manager of enrollment in the ACP, will:

(1) Confirm the member's ACP enrollment;

(2) Remove the member's physical address from the waiver management database;

(3) Notify the county worker and LTC RN of address change;

(4) Maintain a confidential file with the physical address of the member; and

(5) Provide the physical address to contracted providers when services must be provided to or in the home of the member.

G.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 17. ADvantage Waiver Services
317:35-17-22 [AMENDED]
(Reference APA WF # 13-25)

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the Oklahoma Health Care Authority (OHCA).

(b) The ~~OKDHS/ASD~~Department of Human Services Aging Services (DHS/AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying:

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

(c) As part of ADvantage quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision ~~will be~~are turned over to the OHCA Provider Audit Unit for follow-up investigation.

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

(e) The provider must document the amount of time spent for each service, per OAC 317:30-5-763. For service codes that specify a time segment in their description, such as 15 minutes, each timed segment equals one unit. Only time spent

fulfilling the service for which the provider is authorized, per OAC 317:30-5-763, shall be authorized for timed based services. Providers shall not bill for a unit of time when not more than one-half of a timed unit is performed. For example, if a unit is defined as 15 minutes, providers should not bill for services performed for less than 8 minutes. The rounding rules utilized by the IVRA and web-based billing system to calculate the billable amount of a unit are:

(A) services provided for a duration of less than 8 minutes cannot be rounded up and do not constitute a billable 15 minute unit; and

(B) services provided for a duration of 8 to 15 minutes are rounded up and do constitute a billable 15 minute unit.

H.
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]
(REFERENCE APA WF # 13-26)

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~~may be 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~~Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is ~~considered~~proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; 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.

I.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS
317:30-5-20 [AMENDED]
(REFERENCE APA WF # 13-27)

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Covered lab services.** Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

(B) Reimbursement rate for laboratory procedures is the lesser of the CMS National 60% fee or the local carrier's allowable (whichever is lower).

(C) Medically necessary laboratory services are covered.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.

(3) **Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(C) Billing multiple units of nucleic acid detection, whether using the direct probe or amplified probe technique, for single infectious organisms when testing for more than one infectious organism in a specimen is

not permissible.

~~(C)~~(D) Laboratory services not considered medically necessary are not covered.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

J.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
317:2-1-7 [AMENDED]
(Reference APA WF # 13-30)

317:2-1-7. ~~Oklahoma Health Care Authority Audit~~Program Integrity Audit Appeals

All appeals related to audits ~~and/or reviews~~originating from Program Integrity resulting in overpayments are heard by an ~~OHCA~~ Administrative Law Judge per 56 Okla. Stat. § 1011.9.

(1) If a provider disagrees with a decision of an OHCA audit, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision by submitting an LD-2 form to OHCA's docket clerk.

(2) The appeal will be commenced by the receipt of an LD-2 form from the appellant provider. The form must set out with specificity~~,~~ the overpayment ~~decision~~finding to which the provider objects along with the grounds for the appeal. The provider ~~should~~shall explain in detail~~,~~ the factual and/or legal basis for disagreement with the ~~allegedly~~alledged erroneous decision. ~~All~~The provider shall attach to the LD-2 form all relevant exhibits the provider believes necessary to decide the appeal ~~should be attached to the LD-2 form~~, including the following:

(A) Citations for any statute or rule that the provider ~~feels~~contends has been violated;

(B) The provider's name, address and telephone number;

(C) The name, address, and phone number of the provider's representative, if any; and

(D) The LD-2 must be signed by the provider or provider's representative.

(i) For purposes of this section, "provider" means the person or entity against which the overpayment is sought.

(ii) If someone other than an individual provider or entity's authorized representative is representing the provider, he/she must be licensed to practice law within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 Okla. Stat. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(3) The burden of proof during the hearing will be upon the provider and the Administrative Law Judge will decide the case based upon a preponderance of evidence standard as

defined by the Oklahoma Supreme Court.

~~(3)~~(4) ~~Upon receipt of the appeal by the docket clerk, the matter will be docketed for a hearing before an OHCA Administrative Law Judge.~~Within approximately 45 days of receiving the LD-2, the docket clerk will schedule a pre-hearing conference before an Administrative Law Judge. This period of time is intended to allow parties an opportunity to settle the dispute prior to the pre-hearing. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's legal division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed with prejudice.

~~(4)~~(5) Any change in contact information during the course of the appeal should be immediately reported to the OHCA docket clerk.

~~(5)~~(6) The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

~~(6) Within 45 days of the LD-2 being received and filed by the OHCA, any settlement discussions being held by the parties must be finalized. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's Legal Division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed.~~

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned administrative law judge as follows:

(A) At the conference the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(B) Each party shall be present, on time and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown.

(C) ~~Prior~~Within fifteen days prior to the prehearing conference, the Appellant~~ each party~~ shall file a prehearing conference statement with the ~~OHCA~~docket clerk and provide a copy to the other party; and within 10 days prior to the prehearing conference, OHCA shall file a prehearing conference statement with the docket clerk and provide a copy to the other party. Each party's

prehearing conference statement shall include:

(i) A brief statement of his or her case, to include a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of any documents and exhibits and the original, or a copy, of each document or exhibit to be offered into evidence or presented at the hearing; and

(iv) Any requirements or requests for discovery.

~~(D) Administrative Law Judge shall:~~

~~(i) hear and rule on pending requests or motions;~~

~~(ii) rule on whether or not witnesses have knowledge of the facts at issue;~~

~~(iii) rule on whether or not documents and exhibits are relevant;~~

~~(iv) rule on whether or not discovery requests and other motions and requests are relevant;~~

~~(v) strike or deny witnesses, documents, exhibits, discovery requests and other requests or motions which are cumulative, not relevant or not material, used as a means of harassment, unduly burdensome or not timely filed; and~~

~~(vi) identify and rule on errors being appealed and issues to be heard at the administrative hearing.~~

(E) The prehearing conference shall be informal, structured by the administrative law judge, and not open to the public. The administrative law judge shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least ~~10~~20 calendar days prior to the scheduled prehearing conference.

(ii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness ~~or present~~ testimony be presented at the prehearing conference.

(F) A request for continuance of a prehearing conference can be made up to three days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The administrative judge shall rule on the request and in no case shall a combination of continuances exceed a total of 30 calendar days except for good cause shown.

(G) ~~The~~Following the prehearing conference, the

administrative judge shall issue ~~a prehearing conference statement~~an Order setting out the witnesses, exhibits, documents, and issues to be presented at the hearing; the hearing date; the decisions reviewed and made during the prehearing conference; other scheduling deadlines as may be needed; and any stipulations agreed to by the parties. The administrative judge should attempt to issue the Order within two weeks of the prehearing conference.

(8) Administrative Law Judge shall:

(A) Hear and rule on pending requests or motions;

(B) Rule on whether witnesses have knowledge of the facts at issue;

(C) Rule on whether a witness shall produce a report to detail proposed testimony as described in Rule 26 of the Federal Rules of Procedure;

(D) Rule on whether discovery requests and other motions and requests are relevant;

(F) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed; and

(G) Identify and rule on errors being appealed and issues to be heard at the administrative hearing.

~~(8)~~(9) The hearing shall be digitally recorded and closed to the public.

~~(9)~~(10) The administrative law judge should attempt to make the final hearing decision within 180 days from the date of the prehearing conference. The final order shall be the entire record of the appeal. Pursuant to Administrative Procedures Act, the Order does not need to contain findings of fact or conclusions of law. The final order is the final decision and is not appealable to the CEO.

K.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 1. GENERAL PROVISIONS
317:35-1-2 [AMENDED]
SUBCHAPTER 5. COUNTABLE INCOME AND RESOURCES
317:35-5-4 [AMENDED]
317:35-5-4.1 [AMENDED]
SUBCHAPTER 9. ICF/MRIID, HCBW/MRIID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
317:35-9-48.1 [AMENDED]
(Reference APA WF # 13-34)

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as 65 years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Effective January 1, 2014, children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative

group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which

the individual is related.

"Categorically related" or "related" means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for ~~in-patient~~inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human

Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 CFR 435.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care

received in a nursing facility, an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the Oklahoma Health Care Authority that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services.

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-

month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/~~MRs~~IIDs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. COUNTABLE INCOME AND RESOURCES

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) **Determination of categorical relationship to the disabled by SSA.** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSI on disability.** If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has

been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the

same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because

the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ABCDM-80-D 08MA022E with pertinent medical information

substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form 08MA016E, Authorization for Examination and Billing. The OKDHS worker sends the 08MA016E and OKDHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.

(V) Setting a date for re-examination, if needed.

(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as

outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/~~MRs~~IIDs, or inpatient acute care hospital stays expected to last not less than 60 days. In addition to disability LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TB infection.** Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60 days), nursing facility or intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

317:35-5-4.1. Special level of care and cost effectiveness application procedures for TEFRA

(a) In order for a child to be eligible for TEFRA, he/she must

require a level of care provided in an acute care hospital for a minimum of 60 days, or a nursing facility or intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities for a minimum of 30 days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the OKDHS worker, the ~~Assessment~~assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/~~MR~~IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form, OKDHS worker, and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are ~~posted~~reported by LOCEU ~~on MEDATS~~annually.

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

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

In order to determine level of care for TEFRA children:

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

(A) Applicants under age three must:

(i) have a diagnosis of a developmental disability; and (ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two developmental areas.

(B) Applicants age three years and older must:

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

(ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/~~MR~~IID level of institutional care requires an IQ of ~~75~~70 or less, ~~and~~or a full-scale functional assessment ~~(Vineland or~~

~~Battelle)~~ indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations are required for children who are approved for TEFRA under ICF/~~MR~~IID level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three, ~~and~~ ~~again at~~age six, and again at age sixteen to ascertain continued eligibility for TEFRA under the ICF/~~MR~~IID level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third, ~~and~~sixth, and sixteenth birthday.

L.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION
317:30-3-4 [AMENDED]
(Reference APA WF # 13-35)

317:30-3-4. ~~Electronic fund transfer or direct deposit~~Electronic fund transfer/direct deposit

~~To comply with the Cash Management Act of 1990, the Medicaid agency and the Office of State Treasurer offer a service of~~Providers must accept Medicaid reimbursement via Electronic Fund Transfer/Direct Deposit~~ or Direct Deposit of Medicaid provider payments~~. These payments are deposited electronically by the State Treasurer to the~~ provider's~~ financial institution the provider designates during the electronic enrollment process. ~~Provider authorizations are mailed to new providers after initial enrollment in the Medicaid program. Additional Electronic Funds Transfer Authorization forms may be requested from Provider Relations.~~Providers may change the designated financial institution by submitting an update through the electronic enrollment process, subject to OHCA acceptance.

M.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS
317:30-5-290.1 [AMENDED]
PART 28. OCCUPATIONAL THERAPY SERVICES
317:30-5-295 [AMENDED]
PART 77. SPEECH AND HEARING SERVICES
317:30-5-675 [AMENDED]
317:30-5-676 [AMENDED]
(Reference APA WF # 13-43)

317:30-5-290.1. Eligible providers
(a) Physical therapy means services prescribed by a treating physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and may be provided to a member by or under the direct guidance and supervision of a qualified physical therapist.
~~(a)~~(b) Eligible physical therapists must be appropriately licensed in the state in which they practice.
~~(b)~~(c) All eligible providers of physical therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform physical therapy services.
(d) A licensed physical therapy assistant may perform services within the scope of his or her practice under state law under the immediate supervision of a physical therapist.
(1) The physical therapist must be present in the area where the assistant is performing services; and
(2) The physical therapist must be immediately available to assist the assistant being supervised with the services being performed.
(3) The member's record must be signed by the physical therapist following the treatment rendered by a physical therapy assistant to certify the treatment was performed under his or her supervision.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-295. Eligible providers
(a) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and may be provided to a member under the direct guidance and supervision of a qualified occupational therapist.
~~(a)~~(b) Eligible occupational therapists must be appropriately licensed in the state in which they practice.

~~(b)~~(c) All eligible providers of occupational therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform occupational therapy services.
(d) A licensed occupational therapy assistant may perform services within the scope of his or her practice under state law under the immediate supervision of an occupational therapist.

(1) The occupational therapist must be present in the area where the assistant is performing services; and

(2) The occupational therapist must be immediately available to assist the assistant being supervised with the services being performed.

(3) The member's record must be signed by the occupational therapist following the treatment rendered by an occupational therapy assistant to certify the treatment was performed under his or her supervision.

PART 77. SPEECH AND HEARING SERVICES

317:30-5-675. Eligible providers

(a) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direct guidance and supervision of a speech pathologist or audiologist, for which a member has been referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.
~~(a)~~(b) Eligible speech and hearing providers must be either state licensed speech/language pathologists or state licensed audiologists who:

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

(2) have completed the equivalent educational requirements and work experience necessary for the certificate; or

(3) have completed the academic program and are acquiring supervised work experience to qualify for the certificate.

~~(b)~~(c) All eligible providers of speech and hearing services must have entered into a contract with the Oklahoma Health Care Authority to perform speech and hearing services.

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the

therapist must have on file a signed and dated prescription or referral for the therapy services from the member's treating physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible ~~recipients~~members are filed directly with the fiscal agent.

N.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.29 [AMENDED]
317:30-5-95.30 [AMENDED]
317:30-5-95.34 [AMENDED]
317:30-5-95.39 [AMENDED]
317:30-5-95.42 [AMENDED]
(Reference APA WF # 13-45)

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

(a) Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1), (2), (3), (4), (6) and one of (5)(A) through (5)(D) of this subsection.

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

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

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

(4) Child must be medically stable.

(5) Within the past 14 calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (~~i.e.~~e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

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

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

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

(A) Intensive behavioral management.

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

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

(b) Community Based Transitional Residential Treatment (CBT) facility admissions for children must meet the terms and conditions in (1) through (6) of this subsection.

(1) A primary diagnosis from the most recent edition of the DSM with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.

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

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

(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.

(B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, or intensive outpatient services.

(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.

(i) Personal safety.

(ii) Cognitive functioning.

(iii) Family relations.

(iv) Interpersonal relations.

(v) Educational/vocational performance.

(4) Child must be medically stable and not require 24 hour on-site nursing or medical care.

(5) Within the past 14 calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the 14 day requirement may be made

in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).

(6)Within the past 14 calendar days, the patient's behaviors have created significant functional impairment.

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Intensive behavioral management.

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

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

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

(b) For continued stay Community Based Transitional Residential Treatment (CBT), children must meet the terms and conditions found in (1) through (5) of this subsection.

(1) A primary diagnosis from the most recent DSM with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.

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

(3) There is documented continued need for 24 hour observation and treatment as evidenced by:

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

(B) Clinical documentation clearly indicates continued significant functional impairment in two of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors:

(i) Personal safety.

(ii) Cognitive functioning.

(iii) Family relations.

(iv) Interpersonal relations.

(v) Educational/vocational performance.

(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.

(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.

317:30-5-95.34. Active treatment for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all

involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the Wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

~~(1)~~(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

~~(2)~~(3) **"Family therapy"** means interaction between a LBHP, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

~~(3)~~(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

~~(4)~~(5) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

~~(5)~~(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between a LBPH and a member to promote emotional or psychological change to alleviate disorders.

~~(6)~~(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between a LBHP as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons

for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Core Services.

~~(1)~~(A) Individual treatment provided by the physician. Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

~~(2)~~(B) Individual therapy. LBHPs performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a LBHP as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

~~(3)~~(C) Family therapy. The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a LBHP as described in OAC 317:30-5-240.3.

~~(4)~~(D) Process group therapy. The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in

acute care and two hours per week in residential treatment by a LBHP as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by a LBHP or Licensed Therapeutic Recreation Specialist may be substituted.

(E) Transition/Discharge Planning. Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) Elective services.

~~(5)~~(A) Expressive group therapy. Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. ~~Expressive group therapy must be provided four hours per week in acute care, three hours per week in residential treatment and twice a week in CBT. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.~~

~~(6)~~(B) Group rehabilitative treatment. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. ~~Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care with the exception of CBT. Individuals in CBT must receive a total of 6 hours of group rehabilitative treatment per week provided at a frequency of no less than 6 times a week. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.~~

~~(7)~~(C) Individual rehabilitative treatment. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent

with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis. ~~One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.~~

(D) Recreation therapy. Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

(E) Occupational therapy. Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and activities of daily living (ADL) functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) Wellness resource skills development. Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical

wellness plan development, implementation assistance and support.

~~(8)~~(3) Modifications to active treatment. When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components do not include assessments/evaluations. Active treatment begins the day of admission. Days noted are calendar days.

(1) Individual treatment provided by the physician.

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. These visits do not include the Psychiatric Evaluation or History and Physical unless personally rendered by the physician. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) Individual therapy.

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented.

Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP.

(3) Family therapy.

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP and the assessments/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

~~(4) Process group therapy.~~

~~(A) In acute, by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning day 7, 3 hours of treatment are required each week.~~

~~(B) In residential treatment (including PRTF and CBT) by day 5, 1 hour of treatment must be documented. Beginning on day 7, 2 hours of treatment are required each week.~~

~~(5) Expressive group therapy.~~

~~(A) In acute by day 2, 1 hour of treatment is required. By day 4, 2 hours of treatment are required. By day 6, 3 hours of treatment are required. Beginning day 7, 4 hours of treatment are required each week.~~

~~(B) In residential treatment (including PRTF) by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning day 7, 3 hours of treatment are required each week.~~

~~(C) In CBT, by day 4, 1 hour of treatment is required. Beginning day 7, 2 hours of treatment are required each week.~~

~~(6) Rehabilitative treatment.~~

~~(A) In acute and RTC (including PRTF and specialty) on day 1, safety and unit orientation are required. Beginning day 2, 2 hours of Group Rehabilitation or 1 hour of Individual Rehabilitation is required.~~

~~(B) In CBT, by day 7, 6 hours of treatment are required.~~

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-95.39. Seclusion, restraint, and serious incident reporting requirements for children

(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age 18.

(1) Each facility must have policies and procedure to describe the conditions, in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) four hours for children 18 to 20 years of age;

(B) two hours for children and adolescents nine to 17 years of age; or

(C) one hour for children under nine years of age.

(2) The documentation required to ~~insure~~ ensure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) an order for seclusion/restraint including the name of the LIP, date and time of order;

(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;
(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;
(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:
(i) member's immediate situation;
(ii) member's reaction to intervention;
(iii) member's medical and behavioral conditions; and
(iv) need to continue or terminate the restraint or seclusion.
(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;
(H) debriefing of the child within 24 hours by a LBHP;
(I) debriefing of staff within 48 hours; and
(J) notification of the parent/guardian.

(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the member population in at least the following:

(1) techniques to identify staff and member behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;
(2) the use of nonphysical intervention skills;
(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;
(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;
(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

(6) monitoring the physical and psychological well-being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and

(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.

(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.

(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to member outcome, staff debriefing and programmatic changes implemented (if applicable).

(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).

(4) Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.

(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.

317:30-5-95.42. ~~Inspection of care~~Service quality review of psychiatric facilities providing services to children

(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.

~~(a)~~(b) There will be an ~~on site~~on-site ~~Inspection of Care (IOC)~~Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent.

Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the provider manual. The Oklahoma Health Care Authority will designate the members of the ~~Inspection of Care~~Service Quality Review team.

~~(b)~~(c) The ~~IOC~~SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.

~~(c)~~(d) The ~~inspection~~review will include observation and contact with members. The ~~Inspection of Care~~Service Quality Review will consist of members present or listed as facility residents at the beginning of the ~~Inspection of Care~~Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.

~~(d)~~(e) Following the on-site inspection, the ~~Inspection of Care~~SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the ~~inspection of care~~review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.

~~(e)~~(f) Deficiencies found during the ~~IOC~~SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:

(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.

~~(f)~~(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a ~~full~~partial per-diem recoupment ~~of the compensation received. Full per-diem recoupment will only occur for those documents~~. The total recoupment, however, will not exceed 10 percent of the total compensation received for the episode of care.

~~(g)~~(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem

or partial per diem, the facility will be required to refund the amount.

~~(h)~~(i)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

O.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES IN AN AGENCY SETTING
317:30-5-240.1 [AMENDED]
317:30-5-240.2 [AMENDED]
317:25-5-240.3 [AMENDED]
317:30-5-241 [AMENDED]
317:30-5-241.1 [AMENDED]
317:30-5-241.2 [AMENDED]
317:30-5-241.3 [AMENDED]
317:30-5-241.5 [AMENDED]
317:30-5-248 [AMENDED]
317:30-5-249 [AMENDED]
(REFERENCE APA WF # 13-46)

317:30-5-240.1. Definitions
The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Accrediting body" means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM Patient Placement Criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral Health (BH) Services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means Behavioral Health Aides.

~~**"BHRS"** means Behavioral Health Rehabilitation Specialist.~~

"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"Child" means an individual younger than 21, unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member.

"CM" means case management.

"CMHCs" means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with serious mental illnesses, and youth with serious emotional disturbances.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means Facility Based Crisis Stabilization.

"FSPs" means Family Support Providers.

~~**"ICF/MR"**~~**"ICF/IID"** means Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities.

"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).

"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section

1905(a)(24)(B)].

"Level of Functioning Rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a Licensed Behavioral Health Professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance ~~abuse~~use disorder treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"Provider Manual" means the OHCA BH Provider Billing Manual.

"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

~~"RSS"~~"PRSS" means Peer Recovery Support Specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Serious Emotional Disturbance (SED)" means a condition experienced by persons from birth to 18 that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD)

equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either ~~(A) or (B)~~i or ii below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious Mental Illness (SMI)" means a condition experienced by persons age 18 and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six months and be

expected to persist for a year or longer.
(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.
(C) The adult must exhibit either ~~(A) or (B)~~(i) or (ii) below:
(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):
(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.
(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.
(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).
(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-240.2. Provider participation standards

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

provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1, or 3-415 of Title 43A of the Oklahoma Statutes;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statues;

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

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

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

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

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

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with Section(s) 3-317—, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:

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

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

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

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

(C) Peer Support/Community Recovery Support;

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

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

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

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

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

(8) Partial Hospitalization/Intensive Outpatient CARF,

JCAHO, or COA will be required as of December 31, 2009.

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

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 or Title 43A of the Oklahoma Statutes will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

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

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and ~~OAC 317:30-5-280~~317:30-5-240.3.

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

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

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

(A) One of the LBHPs;

(B) A ~~BHRS~~Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) on the team will not be providing rehabilitative services;

(C) An AODTP, if treatment of ~~alcohol and other~~

~~drug~~substance use disorders is provided;

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

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

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

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

(A) Assessments and ~~Treatment~~Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and

(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable Federal and State Regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-240.3. Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board

eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided, issued by one of the licensing boards listed in (A) through (F) ~~or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) of this paragraph~~. The exemptions from licensure under 59 '1353(4) (Supp. 2000) and (5), 59 '1903(C) and (D) (Supp. 2000), 59 '1925.3(B) (Supp. 2000) and (C), and 59 '1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

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

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

(5) Licensure candidates actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (2)(A) through (F) above. The supervising licensed professional responsible for the member's care must:

(A) staff the member's case with the candidate,
(B) be personally available, or ensure the availability of a fully licensed LBHP to the candidate for consultation while they are providing services,
(C) agree with the current plan for the member, and
(D) confirm that the service provided by the candidate was appropriate; and
(E) The member's medical record must show that the requirements for reimbursement were met and the licensed professional responsible for the member's care has reviewed, countersigned, and dated the service plan and

any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(b) **Certified Alcohol and Drug Counselors (CADC's).** CADC's are defined as having a current certification as a CADC in the state in which services are provided.

~~(c) **Behavioral Health Rehabilitation Specialists (BHRS).** BHRSs are defined as follows:~~

~~(1) After 7/01/10:~~

~~(A) Bachelor degree earned from a regionally accredited college or university recognized by the United States Department of Education and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or~~

~~(B) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or~~

~~(C) Certification as an Alcohol and Drug Counselor; or~~

~~(D) A current license as a registered nurse in the state where services are provided and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or~~

~~(E) If qualified as a BHRS prior to 07/01/10 and have a ODMHSAS letter on file confirming that the individual meets BHRS qualifications.~~

~~(2) BHRS designations made between July 1, 2010 through June 30, 2013 will continue to be recognized until June 30, 2014 at which time 7/1/13 criteria must be met. Unless otherwise specified in rules, on or after 7/01/13, BHRS will be required to meet one of the following criteria:~~

~~(A) LBHP;~~

~~(B) CADC; or~~

~~(C) Current certification by ODMHSAS as a Behavioral Health Case Manager II as described in OAC 317:30-5-595(2).~~

~~(d)~~(c) **Multi-Systemic Therapy (MST) Provider**. Masters level who work on a team established by OJA which may include Bachelor level staff.

~~(e)~~(d) **~~Community~~Peer Recovery Support Specialist ~~(RSS)~~(PRSS)**. The ~~community/recovery support worker~~Peer Recovery Support Specialist must ~~meet the following criteria:~~be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(1) High School diploma or GED;~~

~~(2) Minimum one year participation in local or national member advocacy or knowledge in the area of behavioral health recovery;~~

~~(3) current or former member of behavioral health services;~~

~~and~~

~~(4) successful completion of the ODMHSAS Recovery Support Provider Training and Test.~~

~~(f)~~(e) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;

(4) pass background checks; and

(5) ~~treatment~~service plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

~~(g)~~(f) **Behavioral Health Aide (BHA)**. BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or

(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and

(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and

(5) ~~treatment~~service plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP and/or systems of care team, with a LBHP available at all times to provide back up, support, and/or consultation.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section ~~unless specified otherwise, and~~ when provided in accordance with a

documented individualized service plan, developed to treat the identified behavioral health and/or substance ~~abuse~~use disorder(s), unless specified otherwise.
(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and ~~treatment~~service plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.
(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.
(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.
(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.

317:30-5-241.1. Screening, assessment and service plan
All providers must comply with the requirements as set forth in this Section.
(1) **Screening**.
(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

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

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

(2) **Assessment**.

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

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

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

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

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

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

(ii) Source of information;

(iii) Member's first name, middle initial and last name;
(iv) Gender;
(v) Birth Date;
(vi) Home address;
(vii) Telephone number;
(viii) Referral source;
(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Signature of parent of guardian participating in face-to-face assessment. Signature required for members over the age of 14;
(xiv) Bio-Psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (~~i.e.~~e.g., attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.
(xv) Mental status and Level of Functioning information, including questions regarding:

(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and
(IV) Full ~~Five Axes~~ DSM diagnosis.
(xvi) Pharmaceutical information to include the following for both current and past medications;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.
(xvii) LBHP's interpretation of findings and diagnosis;
(xviii) Signature and credentials of LBHP who performed the face-to-face behavioral assessment;
(xix) Client Data Core Elements reported into designated OHCA representative.

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

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

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

including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

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

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

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

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the ~~treatment~~service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present (signatures are required from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP; and

(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP.

(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.

(xiii) Service plan updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the ~~treatment~~service plan, and his/her signature and date; and

(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP.

(E) **Service limitations**:

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

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

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

(A) **Definition**. Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be

reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

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

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

(i) date;

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

(iii) signature of the provider;

(iv) credentials of provider;

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

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

(vii) progress made toward goals and objectives;

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

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

(D) **Service Limitations**. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of two, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient

setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either ~~an~~ a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy**.

(1) **Definition**. Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) ~~**Definition**~~**Interactive Complexity**. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with

guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the ~~treatment~~service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified professionals**. Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) in a setting that protects and assures confidentiality. ~~Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.~~

(4) **Limitations**. A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the Licensed Behavioral Health Professional (LBHP) should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(b) **Group Psychotherapy**.

(1) **Definition**. Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP and two or more individuals to promote positive emotional or

behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

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

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

(4) **Qualified professionals**. Group psychotherapy will be provided by a LBHP. Group Psychotherapy must take place in a confidential setting limited to the LBHP, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations**. A maximum of 12 units per day per member is compensable. Group Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(c) **Family Psychotherapy**.

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

(2) **Qualified professionals**. Family Psychotherapy must be provided by a LBHP.

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

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

(1) **Definition**. MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

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

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

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

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

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

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

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

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

(D) Drugs and biologicals furnished for therapeutic purposes.

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

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

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

(2) **Qualified professionals**.

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

(i) A licensed physician;

(ii) Registered nurse; and

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

(B) The clinical team may also include ~~any of the following paraprofessionals:~~a Certified Behavioral Health Case Manager.

~~(i) Behavioral Health Rehabilitation Specialist; or~~

~~(ii) Certified Behavioral Health Case Manager.~~

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

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

(4) **Limitations**. Services are limited to children 0-20 only. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements**.

(A) Therapeutic Services are to include the following:

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

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

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

(i) Individual therapy - a minimum of 1 session per week;
(ii) Family therapy - a minimum of 1 session per week; and
(iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable services which include the following:
(i) Behavioral Health Case Management (face-to-face);
(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);
(iii) Medication Training and Support; and
(iv) Expressive therapy.

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

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

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.
(B) Medical director must be a licensed psychiatrist.
(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

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

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

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

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

(4) **Limitations**. Services must be offered at a minimum of 4 days per week at least 3 hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity.

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

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

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

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

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

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

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

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if clinically necessary and appropriate (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Behavioral health case management as needed and part of weekly hours for member;
(iv) Occupational therapy as needed and part of weekly hours for member; and
(v) Expressive therapy as needed and part of weekly hours for the member.

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

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

(a) **Definition**. Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Clinical restrictions**. This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system ~~group~~when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery ~~based curriculum~~. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(3) **Qualified providers**. A ~~BHRS~~Certified Behavioral Health Case Manager II (CM II), CADC, and LBHP may perform PSR,

following development of a service plan and treatment curriculum approved by a LBHP. ~~PSR staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology~~. The ~~BHRS~~CM II and CADC must have immediate access to a fully licensed LBHP who can provide clinical oversight ~~of the BHRS~~ and collaborate with the ~~BHRS~~qualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a fully licensed LBHP is required for PSR providers regularly rendering services in an agency setting. A minimum of one face-to-face consultation per week with a fully licensed LBHP is required for PSR providers regularly rendering services away from the outpatient behavioral health agency site.

(4) **Group sizes**. The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation**. Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

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

(C) **Location**. In order to develop and improve the member's community and interpersonal functioning and self care abilities, PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. The following members are not eligible for PSR services:

(i) Residents of ~~ICF/MR~~ICF/IID facilities, unless authorized by OHCA or its designated agent;

(ii) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity;

(iii) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;
(iv) inmates of public institutions;
(v) members residing in inpatient hospitals or IMDs; and
(vi) members residing in nursing facilities.

(E) **Billing limits**. PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR**. The maximum is 24 units per day for adults and 16 units per day for children.
(ii) **Individual PSR**. The maximum is six units per day.
(iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved. ~~There are no limits on PSR services for individuals determined to be Level 4.~~
(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has

produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for ~~intensive and skills training mental health, substance abuse or integrated~~PSR day programs may be in the form of daily summary or weekly summary notes. Progress notes for all Behavioral Health Rehabilitation services ~~and~~ must include the following:

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

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

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

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

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

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

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

(viii) Signature of the lead qualified provider; and

(ix) Credentials of the lead qualified provider;

(G) **Additional documentation requirements.**

(i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and

(ii) Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.

(H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:

(i) Room and board;

(ii) educational costs;
(iii) supported employment; and
(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations**. Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** ~~BHRS~~CM II, CADC or LBHP.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements**. Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

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

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

the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations**.

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

(B) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

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

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

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

317:30-5-241.5. Support services

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

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

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

be provided only for persons most clearly in need of intensive ongoing services.

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

(4) **Limitations**. PACT services are billable in 15 minute units. A maximum of 105 hours per member per year in the aggregate is allowed. All PACT compensable SoonerCare services are required to be face-to-face. ~~SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for FBCS and CM.~~The following services are separately billable: Case management, facility-based crisis stabilization, physician and medical services.

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

(A) PACT assessments (initial and comprehensive);

(i) **Initial assessment**- is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

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

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

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

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

(K) Blood draws and /or other lab sample collection services performed by the nurse.

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

(1) **Definition**. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral health aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing

interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

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

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

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

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

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

(1) **Definition**. This service provides the training and support necessary to ensure engagement and active participation of the family in the ~~treatment planning~~service plan development process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the ~~treatment planning~~service plan development process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

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

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

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

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

(d) **~~Community~~Peer Recovery Support Services ~~(CRS)~~(PRSS)**.

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

(2) **Target population**. ~~Adults~~Children 16 and over with SED and/or substance use disorders and adults 18 and over with SMI and/or ~~AOD~~ substance use disorder(s).

(3) **Qualified professionals**. Peer Recovery Support Specialists ~~(RSS)~~ PRSS must be ~~trained/credentialed~~certified through ODMHSAS pursuant to OAC 450:53.

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

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

(6) **Service requirements**.

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

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

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

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

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

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

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

(ii) facilitate peer support groups;

(iii)assist in setting up and sustaining self-help (mutual support) groups;
(iv) support members in using a Wellness Recovery Action Plan (WRAP);
(v) assist in creating a crisis plan/Psychiatric Advanced Directive;
(vi) utilize and teach problem solving techniques with members;
(vii) teach members how to identify and combat negative self-talk and fears;
(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(x) assist other staff in identifying program and service environments that are conducive to recovery; and
(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

317:30-5-248. Documentation of records

All outpatient behavioral health services must be reflected by documentation in the member's records.

(1) For Behavioral Health Assessments (see OAC 317:30-5-241), no progress notes are required.

(2) For Behavioral Health Services Plan (see OAC 317:30-5-241), no progress notes are required.

(3) Treatment Services must be documented by progress notes.

(A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack of, in treatment and must include the following:

(i) Date;
(ii) Person(s) to whom services were rendered;
(iii) Start and stop time for each timed treatment session or service;
(iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or photocopied signatures are

allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;
(v) Credentials of therapist/service provider;
(vi)Specific service plan need(s), goals and/or objectives addressed;
(vii) Services provided to address need(s), goals and/or objectives;
(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
(ix) Member (and family, when applicable) response to the session or intervention;
(x) Any new need(s), goals and/or objectives identified during the session or service.

(4) In addition to the items listed above in this subsection:

(A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;
(B) a list/log/sign in sheet of participants for each Group rehabilitative or psychotherapy session and facilitating qualified provider must be maintained; and
(C) for medication training and support, vital signs must be recorded in the medical record, but are not required on the behavioral health services plan;

(5) Progress notes for ~~intensive and skills training behavioral health, substance abuse, or integrated BHR~~PSR day programs may be in the form of daily or weekly summary notes and must include the following:

(A) Curriculum sessions attended each day and/or dates attended during the week;
(B) Start and stop times for each day attended;
(C) Specific goal(s) and/or objectives addressed during the week;
(D) Type of Skills Training provided each day and/or during the week including the specific curriculum used with the member;
(E) Member satisfaction with staff intervention(s);
(F) Progress or barriers made toward goals, objectives;
(G) New goal(s) or objective(s) identified;
(H) Signature of the lead qualified provider; and
(I) Credentials of the lead qualified provider.

(6) Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes ~~and signed by the member (or note if the member is unable/refuses to sign)~~.

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

(1) Talking about the past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.

(2) Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.

(3) Work/school specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following ~~317:30-5-285~~317:30-5-595 through ~~317:30-5-285~~317:30-5-599.

(4) Job specific supports such as teaching/coaching a job task.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 25. PSYCHOLOGISTS
317:30-5-276 [AMENDED]
PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS
317:30-5-281 [AMENDED]
(Reference APA WF # 13-47)

317:30-5-276. Coverage by category

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

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

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

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** ~~There is no coverage for adults for services by a psychologist.~~Coverage for adults by a psychologist is limited to Bio-Psycho-Social Assessments when required by OHCA as part

of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: Depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

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

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the

psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

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

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals.

Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.
(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.
(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill children.
(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.
(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.
(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.
(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological

testing unless allowed by the OHCA or its designated agent.
(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.
(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

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

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

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

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final

administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** ~~There is no coverage for adults for services by a LBHP.~~Coverage for adults by a LBHP is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

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

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

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

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services

may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

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

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.
(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.
(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.
(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.
(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a

child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

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

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

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

Q.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 25. LICENSED BEHAVIORAL HEALTH PROVIDERS
317:30-5-280 [AMENDED]
(Reference APA WF # 13-48)

317:30-5-280 Eligible Providers

~~(a)~~ Licensed Behavioral Health Professionals (LBHP) are defined as follows:

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

(2) Practitioners with a license to practice in the state in which services are provided.

~~(A) Psychologist,~~

~~(B)~~(A) Social Worker (clinical specialty only),

~~(C)~~(B) Professional Counselor,

~~(D)~~(C) Marriage and Family Therapist,

~~(E)~~(D) Behavioral Practitioner, or

~~(F)~~(E) Alcohol and Drug Counselor.

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

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

~~(b) Practitioners who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical academic training program and are under current board approved supervision toward licensure. Each supervising LBHP must have a current contract with the Oklahoma Health Care Authority (OHCA).~~

~~(c) For those LBHP candidates who are actively and regularly receiving a LBHP board approved supervision, or extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in 2 (A) through (F) above.~~

~~(d) In order for services provided by clinical academic interns completing required internships and LBHP candidates completing~~

~~required supervision for licensure to be reimbursed, the following conditions must be met:~~

~~(1) The licensed LBHP practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or LBHP board approved supervision;~~

~~(2) The academic intern or LBHP candidate must be under the direct supervision of the licensed professional responsible for the member's care;~~

~~(3) The supervising licensed professional responsible for the member's care must:~~

~~(A) staff the member's case with the academic intern or LBHP candidate,~~

~~(B) actively direct the services,~~

~~(C) be available to the intern or LBHP candidate for in-person consultation while they are providing services,~~

~~(D) agree with the current plan for the member, and~~

~~(E) confirm that the service provided by the intern or LBHP candidate was appropriate; and~~

~~(4) The member's medical record must show that the requirements for reimbursement were met and the licensed professional responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed professional is responsible for the member's care.~~

R.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES
317:30-5-595 [AMENDED]
317:30-5-596 [AMENDED]
(Reference APA WF # 13-49)

317:30-5-595. Eligible providers

Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(B) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.

(C) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(D) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(F) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.

(2) **Provider Qualifications.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the service must be a LBHP, CADC, or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from the ODMHSAS. ~~Case Manager Certifications issued prior to July 1, 2013 will continue to be recognized in addition to the certifications~~

~~noted above until June 30, 2014.~~ The requirements for obtaining these certifications are as follows:

(A) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (i), (ii) or (iii) below:

(i) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education ~~with at least nine (9) hours of college credit in a behavioral health field~~; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification ~~as a Certified Psychiatric Rehabilitation Practitioner (CPRP)~~or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(iv) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE.

(B) Certified Behavioral Health Case Manager I meets the requirements in either(i) or (ii), and(iii):

(i) completed 60 college credit hours; or

(ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(iii)Completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(C) **Wraparound Facilitator Case Manager.** LBHP, CADC, or meets the qualifications for CM II and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(D) **Intensive Case Manager**. LBHP, CADC or meets the provider qualifications of a Case Manager II and has the following:

(i) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(ii) must have attended the ODMHSAS six hours Intensive case management training.

(E) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

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

(1) Payment is made for services rendered to SoonerCare members as follows:

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

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to

home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs.

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

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

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

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

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

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

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

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

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

(VIII) Transitioning from institutions to the community. ~~Individuals~~Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) ~~may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term,~~

~~institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge~~.Individuals are considered to be transitioning to the community during the last 30 consecutive days of a covered institutional stay. ~~These~~This time ~~requirements~~ ~~are~~is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(B) ~~Levels of Case Management~~**Levels of Case Management.**

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

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have

attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

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

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

(ii) Managing finances; or

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

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

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

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

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

(viii) Mentoring or tutoring;

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

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

(xi) monitoring financial goals;

(xii) services to nursing home residents;

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

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

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

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

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

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

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

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

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

(i) date;

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

(iii) start and stop times for each service;

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

(v) credentials of the service provider;

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

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

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

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

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

(xi) member satisfaction with staff intervention.

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

S.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS
317:30-5-740.1 [AMENDED]
317:30-5-741 [AMENDED]
317:30-5-742.2 [AMENDED]
(Reference APA WF # 13-50)

317:30-5-740.1. Provider qualifications and requirements

(a) **Therapeutic foster care model**. Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) ~~**Behavioral Health Rehabilitation Specialist (BHRS)**~~**Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the ~~BHRS~~ CM must have:

(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and

(B) have access to weekly consultation with a licensed behavioral health professional.

(C)CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.

(2) **Licensed Behavioral Health Professional (LBHP)**. A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in a TFC setting must demonstrate a general processional or educational background in the following areas:

(A) case management, assessment and treatment planning;
(B) treatment of victims of physical, emotional, and sexual abuse;
(C) treatment of children with attachment disorders;
(D) treatment of children with hyperactivity or attention deficit disorders;
(E) treatment methodologies for emotionally disturbed children and youth;
(F) normal childhood development and the effect of abuse and/or neglect on childhood development;
(G) anger management;
(H) crisis intervention; and
(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist**. TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS)**. The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;
(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;
(C) completion of therapeutic foster parent training outlined in this section;
(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;
(E) have weekly contact with the foster care agency professional staff; and
(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for

direct enrollment must have a contract on file with the Oklahoma Health Care Authority.

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) treatment of victims of physical, emotional, and sexual abuse;

(3) treatment of children with attachment disorders;

(4) treatment of children with hyperactive or attention deficit disorders;

(5) normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) treatment of children and families with substance ~~abuse and chemical dependency~~use disorders;

(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) anger management;

(9) inpatient authorization procedures;

(10) crisis intervention;

(11) grief and loss issues for children in foster care;

(12) the significance/value of birth families to children receiving outpatient behavioral health services in a foster care setting; and

(13) trauma informed methodology.

317:30-5-741. Coverage by category

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

(b) **Children.** Outpatient behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.

(c) **Medical necessity criteria**. Medical necessity criteria is delineated as follows:

(1) ~~An Axis I primary~~A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and

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

(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.

(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.

(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

317:30-5-742.2. Individual plan of care and prior authorization of services

(a) All outpatient behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) All outpatient behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1)**Assessment**.

(A) Definition. Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's

family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

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

(C) Time requirements. The minimum face-to-face time spent in assessment session(s) with the member and others for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.

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

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

(ii) Source of information;

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

(iv) Gender;

(v) Birth Date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

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

(xi) Presenting reason for seeking services;

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

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

(xiv) Bio-Psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding:

(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and
(IV)All related diagnoses from the most recent addition of the DSM.

(xvi) Pharmaceutical information to include the following for both current and past medications;

(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;

(xviii) Signature and credentials of LBHP who performed the face-to-face behavioral assessment.

~~(1)~~(2) **Individual plan of care requirement.**

(A) A written individual plan of care following a comprehensive evaluation for each member must be

formulated by the provider agency staff within ~~14~~ 30 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or photocopied signatures are allowed. This plan must be revised and updated each 90 days with documented involvement of the legal guardian and resident.

(B) The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented ~~full five-axis DSM-IV~~ diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

(C) Requests for outpatient behavioral services in a foster care setting will be approved for a maximum of three months.

(D) Qualified professional. This service is performed by a LBHP.

(E) Time requirements. Individual plan of care updates must be conducted face-to-face and are required every three months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the LBHP and member.

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

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(x) updates to goals, objectives, service provider, services, and service frequency, must be documented within the individual plan of care until the review/update is due.
(xi) individual plan of care updates must address the following:
(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;
(II) progress, or lack of, on previous individual plan of care goals and/or objectives;
(III) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

~~(2)~~(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy**. See OAC 317:30-5-241.2(a), (b), and (c).

~~(B) **Substance abuse/chemical dependency therapy.** Substance abuse/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug~~

dependency addiction or nicotine use and addiction.

(C) **Psychosocial rehabilitation (PSR).**

(i) **Basic living skills redevelopment.** Daily activities that are age appropriate and relevant to the goals of the individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills.

(ii) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development.

(iii) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption.

(iv) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive

~~setting within the community.~~

(B) **Crisis/behavior management and redirection**. The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by a LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) **Substance use /chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by a LBHP.

(E) **Substance Use Rehabilitation Services**.

Definition. Covered outpatient substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more

intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

(i) Definition. PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) Clinical restrictions. This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) Qualified providers. CM II and LBHP may perform PSR, following development of an individual plan of care curriculum approved by a LBHP. PSR staff must be appropriately and currently trained in a recognized behavioral/ management intervention program such as MANDT or CAPE or trauma informed methodology. The CM II must have immediate access to a fully licensed LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one monthly face-to-face

consultation with a fully licensed LBHP is required.
(iv) Group sizes. The maximum staffing ratio is eight to one for children under the age of eighteen.
(v) Limitations.
(I) Location. In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.
(II) Eligibility for PSR services. PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.
(III) Billing limits. PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.
(vi) Progress Notes. In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must

address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

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

(II) Specific goal(s) and objectives addressed during the session/group;

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

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

(V) Progress, or barriers made towards goals, objectives;

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

(VII) Signature of the qualified provider; and

(VIII) Credentials of the qualified provider;

(vii)Additional documentation requirements.

(I)Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.

(viii) Non-Covered Services. The following services are not considered PSR and are not reimbursable:

(I) room and board;

(II) educational costs;

(III) supported employment; and

(IV) respite.

G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS).

T.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES
317:30-3-65.8 [AMENDED]
(Reference APA WF # 13-51)

317:30-3-65.8. Dental services

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every 184 days. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, amalgam composites and posterior amalgam restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized (refer to OAC 317:30-5-696(3) for amount, duration and scope).

(b) Dental screens should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the child needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin before the age of two(unless otherwise indicated) and once yearly thereafter. Additionally, children should be seen for prophylaxis once every 184 days, if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a well child screening for members ages ~~12~~6 months to ~~42~~60 months. Reimbursement is limited to two applications per year by eligible providers who have attended an OHCA-approved training course related to the application of fluoride varnish.

U.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 73. EARLY INTERVENTION SERVICES
317:30-5-640 [AMENDED]
317:30-5-641 [AMENDED]
317:30-5-644 [AMENDED]
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES
317:30-5-1020 [AMENDED]
317:30-5-1021 [AMENDED]
317:30-5-1022 [AMENDED]
317:30-5-1023 [AMENDED]
317:30-5-1025 [AMENDED]
317:30-5-1027 [AMENDED]
PART 104. SCHOOL-BASED CASE MANAGEMENT SERVICES
317:30-5-1030 [AMENDED]
317:30-5-1031 [AMENDED]
317:30-5-1032 [AMENDED]
317:30-5-1033 [AMENDED]
317:30-5-1034 [AMENDED]
(Reference APA WF # 13-52)

317:30-5-640. General provisions and eligible providers

(a) **General provisions**.

(1) Payment is made to eligible providers certified by the Oklahoma State Department of Education (OSDE) or the Oklahoma State Department of Health (OSDH) for the delivery of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to infants and toddlers from birth up to their third birthday with developmental disabilities, pursuant to the requirements of the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004, Public Law 108-446 Part C, and subsequent amendments.

(2) EPSDT services are comprehensive child-health services, designed to ensure the availability of, and access to, required health care resources and to help parents and guardians of ~~Medicaid~~SoonerCare eligible children use these resources. Effective EPSDT services assure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The OSDE and the OSDH play a significant role in educating parents about EPSDT services.

(3) An Individualized Family Services Plan (IFSP) entitles the ~~Medicaid~~SoonerCare eligible child to medically necessary and appropriate health related EPSDT treatment services.

Such services must be allowable under federal Medicaid regulations and must be necessary to ameliorate or correct defects of physical or mental illnesses or conditions.

(4) Federal regulations require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals that meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical and mental illnesses or conditions. ~~Medicaid~~SoonerCare providers who offer EPSDT screenings must assure that the screenings they provide meet the minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

(b) **Eligible providers.** Eligible providers are state education and health departments and their contract agencies as designated in the State's Plan for Early Intervention Services, developed in response to the requirements of Part C of the IDEIA and who are enrolled as eligible ~~Medicaid~~SoonerCare providers. A completed contract to provide EPSDT health related services must be submitted to the Oklahoma Health Care Authority (OHCA). Providers must have a ~~Medicaid~~SoonerCare provider agreement in order to receive ~~Medicaid~~ reimbursement.

317:30-5-641. Coverage by category

Payment is made for early intervention services as set forth in this Section.

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

(2) **Children.** Payment is made for compensable services rendered by the OSDH and its contractors, pursuant to the State's plan for Early Intervention services required under Part C of the IDEIA.

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

(B) **Child health encounter (EPSDT partial screen).** The child health encounter (the EPSDT partial screen) may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child health encounter may include:

(i) child health history,
(ii) physical examination,
(iii) developmental assessment,
(iv) nutrition assessment and counseling,
(v) social assessment and counseling,
(vi)indicated laboratory and screening tests,
(vii) screening for appropriate immunizations,
(viii) health counseling, and
(ix) treatment of common childhood illness and conditions.

(C) **Hearing and Hearing Aid evaluation.** Hearing evaluations must meet guidelines found at OAC 317:30-5-675 and OAC 317:30-5-676.

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

(i) holds a certificate of clinical competence from the American Speech-Language Hearing Association ~~ASHA~~(ASHA); or
(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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

(i) holds a certificate of clinical competence from ASHA; or
(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) **Speech language evaluation.** Speech language evaluation must be provided by a ~~state-licensed~~State licensed speech language pathologist~~ who meets the guidelines found at OAC 317:30-5-675~~.

(G) **Physical therapy evaluation.** Physical therapy evaluation must be provided by a State licensed physical therapist.

(H) **Occupational therapy evaluation.** Occupational therapy evaluation must be provided by a State licensed occupational therapist.

(I) **Psychological evaluation and testing.** Psychological evaluation and testing must be provided by State-licensed, board certified, psychologists.

(J) **Vision testing.** Vision ~~**testing**~~testing examination must be provided by a State licensed Doctor of Optometry (O.D.) or licensed physician specializing in ~~**ophthalmology**~~ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(K) **Treatment encounter.** A treatment encounter may occur through the provision of individual, family or group treatment services to infants and toddlers who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, vision, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of the Individual Family Services Plan (IFSP), and may include the following:

(i) **Hearing and Vision Services.** These services include assisting the family in managing the child's vision and/or hearing disorder such as auditory training, habilitation training, communication management, orientation and mobility, and counseling the family. This encounter is designed to assist children and families with management issues that arise as a result of hearing and/or vision loss. These services are usually provided by vision impairment teachers or specialists and orientation specialists, and mobility specialists. These services may be provided in the home or community setting, such as a specialized day care center. Hearing services must be provided by:

(I) a State licensed, Master's Degree, ASHA certified audiologist; or

(II) a State licensed, Master's degree, ASHA certified speech language pathologist; or

~~(III) a speech therapist working under the direction of a State licensed ASHA certified speech language pathologist; or~~

~~(IV)~~(III) an audiologist or speech language pathologist who has completed the equivalent educational requirements and work experience necessary for the certificate~~;~~ or has completed the

academic program and is acquiring supervised work experience to qualify for the certificate.

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

(ii) **Speech language therapy services.** Speech language therapy services must be provided by a State licensed, speech language pathologist who:

(I) holds a certificate of clinical competence from ASHA; or

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

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

(iii) **Physical therapy services.** Physical therapy services must be provided by a State licensed physical therapist.

(iv) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a State licensed occupational therapist.

(v) **Nursing services.** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(vi) **Psychological services.** Psychological and counseling services are planning and managing a program of psychological services, including the provision of counseling or consultation to the family of the infant or toddler, when the service is for the direct benefit of the child and assists the family to better understand and manage the child's disabilities. Psychological services must be provided by a State-licensed psychologist.

(vii) **Psychotherapy counseling services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a State licensed Social Worker, a State Licensed Professional Counselor, a

State licensed Psychologist, State licensed Marriage and Family Therapist, or a State licensed Behavioral Practitioner, or under Board Supervision to be licensed in one of the above stated areas.

(viii) **Family Training and Counseling for Child Development.** Family Training and Counseling for Child Development services are the provision of training and counseling regarding concerns and problems in development. Services integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay. All services must be for the direct benefit of the child. Family Training and Counseling for Child Development services must be provided by a Certified Child Development Specialist.

(L) **Immunizations.** Immunizations must be coordinated with the Primary Care Physician for those infants and toddlers enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the OSDH.

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

(i) State licensed Speech Language Pathologist who:

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

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

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

(ii) State licensed Physical Therapist; or

(iii) State licensed Occupational Therapist.

317:30-5-644. Documentation of records

All early intervention services rendered must be reflected by documentation in the records. Documentation of records must include the provider's signature or identifiable initials for every prescription or treatment. Documentation of records may be completed manually or electronically in accordance with guidelines found at OAC 317:30-3-15. Each required element of the age specific screening must be documented with a description

of any noted problem anomaly or concern. In addition, a plan for following necessary diagnostic evaluations, procedures and treatments, must be documented. ~~The OHCA Child Health Provider Manual contains forms that may be used for this purpose.~~

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1020. General provisions

(a) Payment is made to eligible qualified school providers for delivery of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to eligible individuals under the age of 21. School-based services must be medically necessary and have supporting documentation to be considered for reimbursement. In addition, services provided in the school setting are only compensable when provided to eligible SoonerCare members pursuant to an Individual Education Plan (IEP).

(b) EPSDT services are comprehensive child-health services, designed to ensure the availability of, and access to, required health care resources and to help parents and guardians of ~~Medicaid~~SoonerCare eligible children use these resources. Effective EPSDT services assure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The Schools play a significant role in educating parents and guardians about all services available through the EPSDT program.

(c) The receipt of an identified EPSDT screening makes the ~~Medicaid~~SoonerCare child eligible for all necessary follow-up care that is within the scope of the ~~Medicaid~~SoonerCare Program. An Individualized Education Program (IEP) or Individual Family Services Plan (IFSP) entitles the ~~Medicaid~~SoonerCare eligible child to medically necessary and appropriate health related EPSDT treatment services. For reimbursement purposes, prior to rendering a medically related evaluation and/or service pursuant to an eligible SoonerCare child's IEP or IFSP, either through an IEP/IFSP addendum or a new IEP/IFSP, parental consent must be obtained. An IEP or IFSP serves as the plan of care for consideration of reimbursement for health related EPSDT treatment services. The IEP or IFSP may not serve as an evaluation. Services that require prior authorization will need to be authorized prior to the development of the IEP or IFSP. The IEP/IFSP must be completed and signed during the meeting by all required providers and individuals and must include the type, frequency, and duration of the service(s) provided, the signatures including credentials of the provider(s), including

the direct care staff delivering services under the supervision of the professional, and the specific place of services if other than the school, e.g., field trip, home. The IEP/IFSP must also contain measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare. In order to bill SoonerCare for services rendered in the school including evaluations, these services must result in or be identified in the IEP. Federal regulations require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under federal Medicaid regulations and must be necessary to ameliorate or correct defects of physical or mental illnesses/conditions.

(d) Federal regulations require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical and mental illnesses or conditions. ~~Medicaid~~SoonerCare providers who offer EPSDT screenings must assure that the screenings they provide meet the minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

(e) To assure full payment for the EPSDT screening, providers must perform and document all necessary components of the screening examination~~ as defined under Child Health Centers at OAC 317:30-5-198~~. Documentation of screening services performed must be retained for future review.

(f) Evaluations must be prior authorized when medically necessary and/or required, and prescribed or referred by a treating physician or other practitioner of the healing arts with supporting medical documentation. Initial evaluations (e.g. initial physical therapy evaluation) that do not require a prior authorization and that are performed as part of the IEP development process are compensable when the appropriate documented referral and supporting medical documentation are in place. Evaluations completed for educational purposes only are not compensable. All evaluations must be medically necessary and support the services billed to SoonerCare. The evaluations must be included in the IEP for reimbursement consideration. A diagnosis alone is not sufficient documentation to support the medical necessity of services. The child's diagnosis must clearly establish and support that the prescribed therapy is medically necessary. Evaluations must be completed annually, and updated to accurately reflect the participant's current status.

Evaluations include but are not limited to hearing and speech services, physical therapy, occupational therapy, and psychological evaluations and must include the following information:

(1) Medical documentation that supports why the member was referred for evaluation;

(2) Diagnosis;

(3) Member's strengths, needs, and interests;

(4) Recommended interventions for identified needs, including outcomes and goals;

(5) Recommended units and frequency of services; and

(6) Dated signature and credentials of professional completing the evaluation.

(g) Annual evaluations/re-evaluations are required prior to each annual IEP. No more than five SoonerCare members can be present during a group therapy session. A daily log/list must be maintained and must identify the participants for each group session.

317:30-5-1021. Eligible providers

(a) Eligible providers are local, regional, and state educational services agencies as defined by State law and the Individuals with Disabilities Education Act (IDEA), as amended in 1997. A completed contract to provide EPSDT services through the schools must be submitted to the Oklahoma Health Care Authority (OHCA). The OHCA must approve the contract in order for eligible school providers to receive reimbursement.

(b) Qualified Schools must notify OHCA of all subcontractors performing IEP related evaluations and services in the school setting prior to services being rendered. The notification must include a copy of the agreement between the school and subcontractor and must reflect the start and ending dates of the agreement for services. OHCA may request that schools enroll with SoonerCare all entities and individuals that provide SoonerCare services in the school setting and may require that the rendering provider be included on any claim for payment by the school.

317:30-5-1022. Periodicity schedule

(a) The Oklahoma ~~Medicaid~~SoonerCare Program adopted the recommendations of the American Academy of Pediatrics for services, which include at least the following:

(1) Six screenings during the first year of life;

(2) Two screenings in the second year;

(3) One screening yearly for ages two through five years;

(4) One screening every other year for ages six through 20 years.

(b) ~~Medicaid eligible children enrolled in~~Children enrolled in ~~***SoonerCare***~~SoonerCare are referred to their ~~***SoonerCare***~~SoonerCare provider for services. In cases where the ~~***SoonerCare***~~SoonerCare provider authorizes the School to perform the screen or fails to schedule an appointment within three weeks and a request has been made and documented by the School, the School may then furnish the EPSDT child health screening and bill it as a fee-for-service activity. Results of the child health screening are forwarded to the child's ~~***SoonerCare***~~SoonerCare provider.

317:30-5-1023. Coverage by category

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

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

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

(A) Children enrolled in SoonerCare must be referred to their SoonerCare provider for child health screenings. In cases where the SoonerCare provider authorizes the school to perform this screen or fails to schedule an appointment within three weeks and a request has been made and documented by the school, the school may then furnish the EPSDT child health screening. Written notification must be mailed to the Soonercare member's PCP prior to the school's intent to furnish and bill for the screen. Results of this screening must be forwarded to the child's SoonerCare provider.

(B) Child health screenings must be provided by a state licensed physician (M.D. or D.O.), state licensed nurse practitioner with prescriptive authority, or state licensed physician assistant. Screening services must include the following:

(i) Comprehensive health and developmental history, including assessment of both physical and mental health development;

(ii) Comprehensive unclothed physical exam;

(iii) Appropriate immunizations according to the age and health history;

(iv) Laboratory test, including blood level assessment; and

(v) Health education, including anticipatory guidance.

(C) Mass screenings for any school-based service are not billable to SoonerCare, nor are screenings that are performed as a child find activity pursuant to an IDEA requirement. There must be a documented referral in place that indicates the child has an individualized need that warrants a screening to be performed.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include any of the following:

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

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

(A) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry. Hearing evaluations must adhere to guidelines found at OAC 317:30-5-676 and must be provided by a state licensed audiologist who:

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

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

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

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when

appropriate) provided by a state licensed audiologist who:

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

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

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

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

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

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

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

(D) **Vision Screening**. Vision screening in school children includes application of tests and examinations to identify visual defects or vision disorders and must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN, or State Certified Vision Impairment Teacher.

(E) **Speech Language evaluation.** Speech Language evaluation is for the purpose of identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech Language evaluations must adhere to guidelines found at OAC 317:30-5-676 and must be provided by state licensed speech language pathologist who:

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

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

(iii) has completed the academic program and is

acquiring supervised work experience to qualify for the certificate.

(F) **Physical Therapy evaluation**. Physical Therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems and must be provided by a state licensed physical therapist. Physical Therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational Therapy evaluation**. Occupational Therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state licensed occupational therapist. Occupational Therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.

(H) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE). Psychological evaluations and testing services must adhere to guidelines found at OAC 317:30-5-241.1 and 317:30-5-241.2.

(4) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services must adhere to guidelines found at OAC 317:30-5-676 and may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by

or under the direct guidance of one of the following individuals practicing within the scope of his or her practice under State law:

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

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

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

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

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

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

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

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

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

~~(iv)~~(iii) state certified deaf education teacher;

~~(v)~~(iv) certified orientation and mobility specialists; and

~~(vi)~~(v) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech Language Therapy services must adhere to guidelines found at OAC 317:30-5-676 and must be provided by or under the direct guidance and supervision of a state licensed Speech Language Pathologist within the scope of his or her practice under State law who:

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

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

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

~~(iv) a Speech Therapy Assistant who has been authorized~~

~~by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more than two Speech Therapy assistants, and must be on site.~~

(C) **Physical Therapy Services.** Physical Therapy Services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the child's education. Physical Therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a state licensed physical therapist ~~or~~;services may also be provided by a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services**. Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently. Occupational Therapy services must adhere to guidelines found at OAC 317:30-5-296 and must be provided by or under the direct guidance and supervision of a state licensed Occupational Therapist ~~or~~;services may also be provided by an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

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

(F) **Psychotherapy Services.** Psychotherapy services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas. Psychotherapy services must adhere to guidelines found at OAC 317:30-5-

241.1 and 317:30-5-241.2.

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

(i) state licensed, Speech Language Pathologist who:

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

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

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

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

(H) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, oral feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants that have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties. Personal Care services do not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a registered nurse or licensed practical nurse. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a registered nurse or licensed practical nurse.

(I) **Therapeutic Behavioral Services**. Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and ~~evaluation.~~annual evaluations/re-evaluations. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has

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

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

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

317:30-5-1025. Interperiodic screening examination

Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. They may include physical, mental or dental conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system. ~~Medicaid eligible children enrolled in ***SoonerCare***~~Children enrolled in SoonerCare are referred to their ~~***SoonerCare***~~SoonerCare provider for these services. In cases where the ~~***SoonerCare***~~SoonerCare provider authorizes the School to perform the screen or fails to schedule an appointment within three weeks and a request has been made and documented by the School, the School may then furnish the EPSDT child health screening and bill it as a fee-for-services activity. Results of this interperiodic screening are forwarded to the child's ~~***SoonerCare***~~SoonerCare provider.

317:30-5-1027. Billing

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

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

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

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

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

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

(3) Service: Child Health Encounter; Unit: per encounter; limited to 3 encounters per day.

(4) Service: Individual Treatment Encounter; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services.

(B) Speech Language Therapy; Unit: per session, limited to one per day.

(C) Physical Therapy.

(D) Occupational Therapy.

(E) Nursing Services; Unit: up to 15 minutes; maximum 32 units per day.

(F) Psychotherapy Services; maximum 8 units per day.

(G) Assistive Technology.

(H) Therapeutic Behavioral Services.

(5) Service: Group Treatment Encounter; ~~No~~no more than 5 members per group, Unit: 15 minutes, unless otherwise specified. A daily log/list must be maintained and must identify the SoonerCare participants for each group therapy session.

(A) Hearing and Vision Services.

(B) Speech Language Therapy; Unit: per session, limited to one per day.

(C) Physical Therapy.

(D) Occupational Therapy.

(E) Psychotherapy Services; maximum 8 units per day.

(6) Service: Administration only, Immunization; Unit: one administration.

(7) Service: Hearing Evaluation; Unit: Completed Evaluation.

(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.

(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).

(10) Service: Tympanometry and acoustic reflexes.

(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).

(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.

(13) Service: Speech Language Evaluation; Unit: one evaluation.
(14) Service: Physical Therapy Evaluation; Unit: one evaluation.
(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.
(16) Service: Psychological Evaluation and Testing; Unit: one hour.
(17) Service: Personal Care Services; Unit: 10 minutes, 32 units yearly.
(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.
(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.

PART 104. SCHOOL-BASED CASE MANAGEMENT SERVICES

317:30-5-1030. Eligible providers

(a) **Case management providers.** Services are provided by case managers certified by the State Department of Education as meeting the requirements for providing case management. ~~Medicaid~~SoonerCare School-Based Targeted Case Management (SBTCM) services must be made available to all eligible ~~recipients~~members and must be delivered on a statewide basis with procedures that ensure continuity of service without duplication and in compliance with federal and state mandates and regulations related to servicing the targeted population in a uniform and consistent manner. The case managers must be certified by the single state Medicaid agency as meeting the following:

(1) a minimum of five (5) years experience in meeting the case management and service needs of the target population.
(2) a minimum of five (5) years experience in providing all core elements of case management services, including:
(A) individualized strengths and needs assessment;
(B) needs-based service planning;
(C) service coordination, monitoring and advocacy;
(D) service plan review; and
(E) crisis assistance planning.
(3) a minimum of five (5) years experience in developing and implementing Individualized Education Programs (IEP) and/or Individualized Family Service Plans (IFSP) and in meeting the requirements of the IDEA, in accordance with State and Federal law. Each IEP and/or IFSP is ~~dependant~~dependent upon the needs of the individual student as determined by consultation that may include any or all of the professions in (A) through (F) of this paragraph. Those providing input

must meet state or national licensure, registration or certification requirements of the profession in which they practice and include:

(A) special education,

(B) school psychologist,

(C) occupational therapist,

(D) physical therapist,

(E) speech language specialist, or

(F) school counselor and other specialists as identified.

(4) a demonstrated ability to collaborate with public and private services providers.

(5) experience in providing and coordinating education support services, including but not limited to Student Assistance, Special Education, Psychology and Counseling Services.

(6) adequate administrative capacity to fulfill state and federal requirements.

(7) a financial management capacity and system that provides documentation of services and costs.

(8) a capacity to document and maintain individual case records in accordance with state and federal requirements.

(9) a demonstrated ability to meet all state and federal laws governing participation of providers in the ~~State Medicaid~~SoonerCare program including, but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

(b) **Provider agreement**. A Provider Agreement between the Oklahoma Health Care Authority and the providers for case management services must be in effect before reimbursement can be made for compensable services.

(c) **Qualifications of individual case managers.** A targeted case manager for the SBTCM program must:

(1) be employed by the school or their contractor;

(2) possess an appropriate certificate, or meet other comparable requirements as applicable to the profession or discipline in which a person is providing special education, early intervention or related services, in accordance with the requirements of the Oklahoma State Department of Education; or

(3) be licensed, certified or registered as a health care professional in the State, and meet the qualifications for related services staff under the most current provisions of Part B or Part C of the Individuals with Disabilities Education Act.

(d) **Provider selection.** Provision of case management services must not restrict an individual's free choice of providers.

Eligible ~~recipients~~members must have free choice of the providers of other medical care under the plan.

317:30-5-1031. Coverage by category

(a) Payment is made for case management services to children as set forth in this Section.

(1) **Description of case management services.** The target group for case management services is individuals 0-21 who are receiving services pursuant to an Individualized Education Program (IEP), an Individualized Family Service Plan (IFSP), a Section 504 Accommodation Plan, or an Individualized Health Service Plan (IHSP), and who have a disability or are medically at risk. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. Medically at risk refers to individuals who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social or physical development.

(A) Services are provided to assist the target population in gaining access to needed medical, social, educational, and other services. Major components of the service include:

(i) Individualized needs assessment

(ii) Needs-based service planning;

(iii) Service coordination, monitoring and advocacy;

(iv) Services plan review; and

(v) Crisis assistance planning.

(B) Case record documentation of the service components listed in (1) of this subsection is included as a case management activity. The client has the right to refuse case management and cannot be restricted from services because of a refusal for Case Management Services.

(C) Case management does not include:

(i) Program activities of the agency itself that do not meet the definition of case management.

(ii) Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to targeted case management.

(iii) Diagnostic, treatment or instructional services, including academic testing.

(iv) Services that are an integral part of another service already reimbursed by ~~Medicaid~~SoonerCare.

(v) Activities that are an essential part of ~~Medicaid~~SoonerCare administration, such as outreach, intake processing, eligibility determination or claims processing.

(2) **Non-duplication of services.** To the extent any eligible ~~recipients~~members in the identified targeted population are receiving TCM services from another provider agency as a result of being members of other covered targeted groups, the providers assures that case management activities are coordinated to avoid unnecessary duplication of service. To the extent any of the services required by the ~~client~~member are a ~~Medicaid~~SoonerCare covered benefit of a managed care organization of which the client is a member, the provider will assure that timely referrals are made and that coordination of care occurs.

(3) **Providers.** Case management services must be provided by the schools or their contractors.

(b) **Individuals eligible for Part B of Medicare**. Case Management Services provided to Medicare eligible ~~recipients~~members are filed directly with the fiscal agent.

317:30-5-1032. Reimbursement

(a) Reimbursement for SBTCM services is a unit rate based on the analysis of the average annual costs of providing case management services by participating providers. A unit of service is defined as each completed 10 minute increment that meets the description of case management activity with, or on behalf of the individual, his or her parent(s) or legal guardian.

(b) Payment will be made on the basis of claims submitted for payment. The provider will bill for the unit rate for each documented unit of ~~Medicaid~~SoonerCare SBTCM service provided to each ~~Medicaid~~SoonerCare eligible individual.

317:30-5-1033. Billing

Claims should not be submitted until ~~Medicaid~~SoonerCare eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after 10 months from the date of service, a claim should be submitted in order to assure that the claim is filed and reimbursement ~~from Medicaid funds~~ can be made should the individual be determined eligible at a later date.

317:30-5-1034. Documentation of records

All case management services rendered must be reflected ~~by~~documentationby documentation in the records. The case manager documents all units of ~~Medicaid~~SoonerCare SBTCM services provided on the service record form.

V.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 7. CERTIFIED LABORATORIES
317:30-5-106 [AMENDED]
(Reference APA WF # 13-53)

317:30-5-106. Payment rates
Payment will be made for covered clinical laboratory services ~~at 95 percent of the HCFA National Laboratory Fee Schedule, or 95 percent of the local Medicare Carrier's allowable charge for procedures not included in the National Laboratory Fee Schedule, or in instances where no national or local fee has been established, an interim fee will be established by the Procedure Rate Review Committee of the Oklahoma Health Care Authority.~~in accordance with methodology approved under the Oklahoma Medicaid State Plan.