Rules Agenda
December 13, 2007

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

Page 2 A. Revising SoonerRide Non-Emergency Transportation rules to remove the exclusion of stretcher services. **(APA WF # 07-63)**

Page 4 B. Revising Pharmacy rules to comply with Section 6002 of the Deficit Reduction Act of 2005 requiring the National Drug Code (NDC) to be collected on multiple source, physician administered drugs in order to secure drug rebates. **(APA WF # 07-62)**

Page 8 C. Revising Soonercare eligibility rules to exempt the $90 VA pension when calculating the member's share of the nursing facility vendor payment. **(APA WF # 07-55)**

Page 21 D. Revising rules to limit subcontractor allowable charges for Medicaid members in PRTF facilities to the Medicaid fee schedule. **(APA WF # 07-59)**

Page 23 E. Revising rules to concur with recent changes to the ADvantage Home and Community Based Services Waiver document as approved by the Centers for Medicare and Medicaid Services. **(APA WF # 07-49)**

Page 51 F. Revising rules to: (1) limit payment for lenses and frames to one pair of glasses per 12 month period unless medically necessary or glasses are lost or damaged beyond repair; and (2) allow physicians to separate the refractive service from the medical evaluation when billing ophthalmology services. **(APA WF # 07-26)**

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

A. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 32. SoonerRide Non-Emergency Transportation
OAC 317:30-5-327.5. [AMENDED]
(Reference APA WF # 07-63)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules to add stretcher services as a covered benefit to the SoonerRide program. Existing rules exclude stretcher services under the current program. However, the agency has recently awarded a new contract which includes the broker to provide stretcher services to SoonerCare members. The rule change is needed to reflect the added benefit of stretcher services to the SoonerRide program. Without this change, current rules will not be consistent with current responsibilities of the SoonerRide broker.

SUMMARY: The purpose of this rule change is to allow stretcher services to be included as a covered benefit under the SoonerRide Program. Currently, stretcher services are excluded from the Program and provided to members through contracted ambulance providers. Generally, members are only permitted to use ambulance services in emergency situations. However, the agency has had to utilize this method because access to providers for stretcher service has been limited due to state regulations for stretcher transport. Recently, the agency issued and awarded a new Request for Proposal (RFP) for non-emergency transportation. Included in the broker responsibilities under the new RFP, the broker must now provide stretcher services based upon existing State regulations. Currently, the service is reimbursed to the ambulance provider based on an established rate per occurrence. The SoonerRide program is reimbursed based on a capitated rate for all services under the program. The added stretcher service is calculated into the base capitated rate. The added benefit will enable those members whose condition requires stretcher care to schedule and receive their non-emergency stretcher transportation through the SoonerRide program instead of through an ambulance company which generally transports in emergency situations.

BUDGET IMPACT: Agency staff have determined that these revisions are budget neutral.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revision on November 15, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administration Procedure Act, as indicated:
Revising SoonerRide Non-Emergency Transportation rules to remove the exclusion of stretcher services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-327.5. Exclusions from SoonerRide NET

SoonerRide NET excludes:
(1) transportation of members to access emergency services;
(2) transportation of members by ambulance for any reason;
~~(3) transportation of members whose medical condition requires transport by stretcher;~~
~~(4)~~ (3) transportation of members to services that are not covered by SoonerCare; and
~~(5)~~ (4) transportation of members to services that are not medically necessary.

B. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-14. through 317:30-5-15. [AMENDED]
(Reference APA WF # 07-62)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with Section 6002 of Public Law 109-171, the Deficit Reduction Act of 2005. Beginning January 1, 2008, the National Drug Code (NDC) is required to be collected on multiple source, physician administered drugs in order to secure drug rebates. Without these revisions, federal financial participation will not be available for physician administered drugs when the NDC is not collected.
SUMMARY: Agency rules are revised to comply with Section 6002 of Public Law 109-171, known as the Deficit Reduction Act of 2005 (DRA), regarding multiple source, physician administered drugs. The DRA requires the National Drug Code (NDC) to be collected on multiple source, physician administered drugs in order to secure drug rebates. Currently, these drugs are billed using only the Healthcare Common Procedure Coding System (HCPCS) code. Unlike the NDC, HCPCS codes do not specify which drug products are being dispensed and therefore drug rebates cannot be collected on these drugs. Revisions are needed to require providers to bill the appropriate NDC for physician administered drugs in addition to the Healthcare Common Procedure Coding System (HCPCS) code.

BUDGET IMPACT: Agency staff has determined that the revisions could result in additional drug rebates of approximately $5,000,000 per year of which $1,645,000 would be the state's share of the rebates.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 15, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The

Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 109-171, the Deficit Reduction Act of 2005.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Pharmacy rules to comply with Section 6002 of the Deficit Reduction Act of 2005 requiring the National Drug Code (NDC) to be collected on multiple source, physician administered drugs in order to secure drug rebates.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The ~~Authority~~ OHCA covers ~~any~~ a drug ~~for its approved purpose~~ that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1. ~~Administration of injections is paid in addition to the medication.~~

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is included in the vaccine payment. Payment will not be made for vaccines covered by the Vaccines for Children Program.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will not be made for the administration of a vaccine. The administration fee is included in the vaccine payment.

~~(b) The following drugs, classes of drugs or their medical uses are excluded from coverage:~~

~~(1) Agents used for the treatment of anorexia, weight gain, or obesity;~~

~~(2) Agents used to promote fertility;~~

(3) Agents used to promote hair growth;

~~(4) Agents used for cosmetic purposes;~~

~~(5) Agents used for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered;~~

~~(6) Agents that are experimental or whose side effects make usage controversial; and~~

~~(7) Vitamins and Minerals with the following exception:~~

~~(A) Vitamin B-12 is covered only when there is a documented occurrence of malabsorption disease;~~

~~(B) Vitamin K injections are compensable; and~~

(C) Iron injections when medically necessary and documented by objective evidence of failure to respond to oral iron.

~~(c)~~ (b) Use the appropriate ~~HCPC code when available~~ HCPCS code and National Drug Code (NDC). ~~When drugs are billed under miscellaneous codes, a paper claim must be filed. The~~ In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount~~, and National Drug Code (NDC)~~.

~~(d)~~ (c) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

~~(e)~~ (d) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

~~(f)~~ (e) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

~~(g)~~ (f) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

~~(h)~~ (g) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

~~(i)~~ (h) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit

reimbursement.

317:30-5-15. Chemotherapy injections

(a) **Outpatient.**

(1) Outpatient chemotherapy is compensable only when a malignancy is indicated or for the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). Outpatient chemotherapy treatments are unlimited. Outpatient visits in connection with chemotherapy are limited to four per month.

(2) Payment for administration of chemotherapy medication is made under the appropriate ~~HCPC Supplemental J Codes~~ National Drug Code (NDC) and HCPCS code as stated in OAC 317:30-5-14(b). Payment is made separately for office visit and administration under the appropriate CPT code.

(3) When injections exceed listed amount of medication, show units times appropriate quantity, i.e., injection code for 100 mgm but administering 300, used 100 mgm times 3 units.

(4) Glucose - fed through IV in connection with chemotherapy administered in the office ~~would be~~ is covered under the appropriate NDC and HCPCS code.

(b) **Inpatient.**

(1) Inpatient hospital supervision of chemotherapy administration is non-compensable. The hospital visit in connection with chemotherapy could be allowed within our guidelines if otherwise compensable, but must be identified by description.

(2) Hypothermia - Local hypothermia is compensable when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not compensable when used alone or in connection with chemotherapy.

(3) The following are not compensable:

(A) Chemotherapy for Multiple Sclerosis;

(B) Efudex;

(C) Oral Chemotherapy;

(D) Photochemotherapy;

(E) Scalp Hypothermia during Chemotherapy; and

(F) Strep Staph Chemotherapy.

C. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-42. [AMENDED]
(Reference APA WF # 07-55)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with federal regulations regarding the post-eligibility treatment of specific payments made by the Department of Veterans Affairs.

SUMMARY: SoonerCare eligibility rules for adults are revised to exempt the $90 Veterans Affairs (VA) pension received by certain SoonerCare members who are residing in a nursing facility. Under Section 8003 of Public Law 1001-508, VA may reduce the pension of a veteran or their surviving spouse if the veteran does not have dependents, lives in a SoonerCare approved facility, and is a SoonerCare member. Current SoonerCare rules state that the $90 pension is allowed as the individual's monthly maintenance standard; the standard for most SoonerCare nursing facility members is $50 per month. OHCA has recently received clarification from CMSthat the $90 VA pension is to be excluded when determining the member's share of the nursing facility vendor payment; therefore, the member will be entitled to the $90 reduced VA pension as well as the $50 nursing facility maintenance standard. Rule revisions are needed to comply with federal regulations.

BUDGET IMPACT: Agency staff has determined that the total annual budget impact of the rule will be $360,000 with a state share of $108,000.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 15, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2008, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016

of Title 63 of Oklahoma Statutes; 42 CFR 435.733

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising SoonerCare eligibility rules to exempt the $90 VA pension when calculating the member's share of the nursing facility vendor payment.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5.ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. 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.

(1) If it appears the applicant or ~~recipient~~ SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (14 - 494 is rounded down, and 504 - 994 is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the

nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) The coupon allotment under the Food Stamp Act of 1977;

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

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

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Loan Verification form should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Loan Verification form are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are made per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
(8) Title III benefits from State and Community Programs on Aging;
(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(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) 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 allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services 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 complementary payments;
(15) 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;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) 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.);
(20) 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;

(21) 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;
(22) Income of a sponsor to the sponsored eligible alien;
(23) The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered in determining eligibility. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as unearned income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator. When the county office is unable to resolve the situation with the BIA, the county submits a referral to the appropriate section in OKDHS Family Support Services Division (FSSD). The referral must include specific details of the situation, including the county's efforts to resolve the situation with the BIA. If FSSD cannot make a determination, a legal decision regarding availability will be obtained by FSSD, and then forwarded to the county office by FSSD. When a referral is sent to FSSD, the funds are considered as unavailable with a legal impediment until the county is notified otherwise.

(C) At each reapplication or redetermination, the worker is to contact BIA to obtain information regarding any changes as to the availability of the funds and any information regarding modifications to the IIM account. Information regarding prior disbursements is also obtained at this time. All of this information is reviewed for the previous six or twelve-month period, or since the last contact if the contact was within the last certification or redetermination period.

(D) When disbursements have been made, the worker determines whether such disbursements were made to the member or to a

third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers should obtain documentation to verify services rendered and payment made by BIA.

(E) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received;

(24) Income up to $2,000 per year received by individual Indians, which are derived from leases or other uses of individually-owned trust or restricted lands;

(25) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(26) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(27) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;

(28) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

(29) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

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

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

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income, (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of medical assistance and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the medical assistance and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Appendix C-2-A.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or

Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. ~~The $90 payment becomes the monthly maintenance standard for the veteran.~~ In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers'

Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) 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. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits

received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. 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 his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month they are received.

(ii) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(iii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expense and appropriate earned income disregards.

(iv) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's 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.

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

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must

be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and 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 given in OAC 340:10-3-33(1)).

(v) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** 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:

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

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

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

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

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages,

allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

(3) **Countable income.** The countable income is the sum of the earned income after exclusions and the total gross unearned income.

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A mentally retarded child living in the home who is ineligible for SSP due to the deeming process may be approved for Medical Assistance under the Home and Community Based Waiver (HCBW) Program as outlined in OAC 317:35-9-5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents income are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(6) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Appendix C-1, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

D. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-96.8. [NEW]
(Reference APA WF # 07-59)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of new rules which add language to policy that protects Psychiatric Residential Treatment Facilities (PRTFs) from having to pay billed charges when they must use other providers. PRTFs are paid a bundled per diem that includes physician, pharmacy and hospital services. The rate was established on the premise that these additional services, provided by a subcontractor, would be reimbursed according to the Medicaid fee schedule, not the billed amount which is often times much higher. If new rules are not issued, these facilities may be liable for charges for which they have not been adequately compensated. Revisions are needed to limit subcontractor allowable charges for SoonerCare members in PRTF facilities to the Medicaid fee schedule.

SUMMARY: Agency rules are issued to add language to policy that protects Psychiatric Residential Treatment Facilities (PRTFs) from having to pay billed charges when they must use other providers. As of October 2005, PRTFs are paid a bundled per diem that includes, but is not limited to physician services, pharmacy and hospital services. If a child requires one of these services while living and receiving care at the facility, the PRTF is responsible for the payment of these additional services. The payment methodology on which the per diem is based was established on the premise that these additional services would be paid at the Medicaid allowable. These other providers or "subcontractors" may currently charge the PRTF their billed rate rather than the Medicaid allowable which is often times much higher. New rules are needed to keep the PRTFs from being charged more for services they must provide than what they are being compensated for by the SoonerCare program for SoonerCare members. Rules are revised to limit subcontractor allowable charges for SoonerCare members in PRTF facilities to the Medicaid fee schedule.

BUDGET IMPACT: Agency staff has determined that the issuance of these rules is budget neutral to the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rules on November 15, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2008, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.15

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to limit subcontractor allowable charges for SoonerCare members in PRTF facilities to the Medicaid fee schedule.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.8. Psychiatric Residential Treatment Facility Payments to Subcontractors

(a) Psychiatric Residential Treatment Facilities (PRTFs) that receive a pre-determined all-inclusive per diem payment must provide routine, ancillary and professional services. In the event the member receives an ancillary service, the PRTF is responsible for making timely payment to the subcontractor or other provider.

(b) For purposes of subsection (a) of this Section, timely payment or adjudication means payment or denial of a clean claim within 45 days of presentation to the PRTF.

(c) No subcontractor of the PRTF may charge more than the OHCA fee schedule for SoonerCare compensable services.

(d) The subcontractor may not bill the SoonerCare member until the PRTF has refused payment and the subcontractor/medical provider has appealed under OAC 317:2-1-2.1 and the OHCA permits the subcontractor to bill the member.

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-760. through 30-5-764.[AMENDED]
(Reference APA WF # 07-49)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to facilitate consistency with the ADvantage Home and Community-Based Services Waiver which was approved by the Centers for Medicare and Medicaid effective July 1, 2007. The United States Supreme Court's decision in Olmstead vs. L. C. requires that Oklahoma provide service options to enable individuals with disabilities to live in the community rather than receiving services in an institution. These revisions will allow more individuals the opportunity and means to make that transition.

SUMMARY: Rules are revised to concur with recent changes to the ADvantage Home and Community Based Services Waiver document as approved by the Centers for Medicare and Medicaid Services. Agency rules are amended to: (1) update the methodology for approval of a spouse or legal guardian to provide personal care services; (2) update the covered localities for the Consumer-Directed Personal Assistance Services and Supports (CD-PASS) program to allow for state wide expansion; (3) remove the requirement that the member receive State Plan or ADvantage personal care for one year before being considered for the CD-PASS program; (4) expand on the requirement for Specialized Medical Equipment and supplies to require that providers of reoccurring services which are mailed verify that the member is still eligible and needs the supply; (5) eliminate Comprehensive Home Care (CHC) and CHC Personal Care; (6) update the nutritional requirement for Home Delivered Meals and add the requirement that the provider obtain a signature from the member or member's representative; (7) update the requirement and definitions for Financial Management Services for the CD-PASS program; (8) revise the service definition, scope and requirements for Institutional Transitions Services for the CD-PASS program; (9) revise the reimbursement methodology requirements for Advanced Supportive/Restorative Assistance to reflect current practices; and (10) revise the CD-PASS budget allocation requirement process.

BUDGET IMPACT: Agency staff has determined that the revisions

are budget neutral to the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 20, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2008, or immediately upon Governor's approval, whichever is later.

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to concur with recent changes to the ADvantage Home and Community Based Services Waiver document as approved by the Centers for Medicare and Medicaid Services.

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

317:30-5-760. ADvantage program

The ADvantage Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for elderly and disabled individuals. To receive ADvantage Program services, individuals must meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability. ADvantage Program recipients must be Medicaid eligible. The number of recipients of ADvantage services is limited.

317:30-5-761. Eligible providers

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

Health Care Authority).

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

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

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

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

(5) The AA relies upon the Oklahoma Department of Human Services ~~DHS/Aging~~ (OKDHS)/Aging Services Division (ASD) for ongoing programmatic evaluation of Adult Day Care and Home Delivered Meal providers for continued programmatic certification. Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite services do not have a programmatic evaluation after the initial certification.

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

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

~~(I)~~ (i) either no other provider is available; or

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

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

~~(ii) The Director of OKDHS approves a request for spouse or legal guardian to be the provider under one of the aforementioned documented circumstances.~~

(B) The service must:

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

(ii) be necessary to avoid institutionalization;
(iii) be a service/support that is specified in the individual service plan;
(iv) be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;
(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;
(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the ~~client~~ member; or
(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the ~~client~~ member; or
(III) spouse or guardian has taken a leave of absence without pay to provide care for the ~~client~~ member; or
(IV) spouse or guardian provides assistance/care for the ~~client~~ member ~~thirty-five~~ 35 or more hours per week without pay and the ~~client~~ member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the ~~client~~ member.

(C) The spouse or legal guardian who is a service provider will comply with the following:
(i) not provide more than 40 hours of services in a seven day period;
(ii) planned work schedules must be available ~~two weeks~~ in advance to the member's Case Manager, and variations to the schedule must be noted and supplied ~~to the fiscal agent when billing~~ two weeks in advance to the Case Manager unless change is due to an emergency;
(iii) maintain and submit time sheets and other required documentation for hours paid; and
(iv) be documented in the service plan as the ~~client's~~ member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is

obligated to ~~the following~~ additional monitoring requirements when ~~clients~~ members elect to use a spouse or legal guardian as a paid service provider. The AA will monitor through documentation submitted by the Case Manager the following:

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

(ii) face-to-face visits with the recipient by ~~AA representative~~ the Case Manager on at least a semi annual basis~~; and~~

~~(iii) monthly reviews by the AA of hours billed for spouse or legal guardian providing care~~.

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

317:30-5-762. Coverage

Individuals receiving ADvantage Program services must have been determined to be eligible for the program and must have an approved plan of care. Any ADvantage Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the ~~recipient~~ member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the ~~recipient~~ member has exhausted these services available under the State Plan.

(1) To allow for development of administrative structures and provider capacity to adequately deliver Consumer-Directed Personal Assistance Services and Supports (CD-PASS), availability of CD-PASS is limited to ADvantage Program ~~clients~~ members that reside in ~~the following~~ counties ~~and zip codes:~~ that have sufficient provider capacity to offer the CD-PASS service option as determined by OKDHS/ASD.

~~(A) Tulsa;~~

~~(B) Creek;~~

~~(C) Rogers;~~

~~(D) Wagoner; and~~

~~(E) Osage County zip codes of 74126, 74127, 74106, and 74063.~~

(2) ADvantage Case Managers within the CD-PASS ~~geographic target~~

approved area will provide information and materials that explain the CD-PASS service option to their ~~clients~~ members. The AA provides information and material on CD-PASS to Case Managers for distribution to ~~clients~~ members.

(3) The ~~client~~ member may request CD-PASS services from their Case Manager or call an AA maintained toll-free number to request CD-PASS services.

(4) The AA uses the following criteria to determine an ADvantage ~~client's~~ member's service eligibility to participate in CD-PASS:

(A) residence in the CD-PASS ~~geographic target~~ approved area;

~~(B) client's receipt of State Plan or ADvantage Personal Care services for 12 months or more;~~

~~(C)~~ (B) ~~client's~~ member's health and safety with CD-PASS services can ~~reasonable~~ reasonably be assured based on a review of service history records and a review of ~~client~~ member capacity and readiness to assume Employer responsibilities under CD-PASS with any one of the following findings as basis to deny a request for CD-PASS due to inability to assure ~~client~~ member health and safety;

(i) the ~~client~~ member does not have the ability to make decisions about his/her care of service planning and the ~~client's~~ member's "authorized representative" is not willing to assume CD-PASS responsibilities, or

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

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

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

(5) The AA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate

in CD-PASS:

(A) the ~~client~~ member does not have the ability to make decisions about his/her care or service planning and the ~~client's~~ member's "authorized representative" is not willing to assume CD-PASS responsibilities; or

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

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

(D) ~~participant~~ the member abuses or exploits their employee; or

(E) ~~participant~~ the member falsifies time-sheets or other work records; or

~~(F) based on documented experience of being abusive and/or uncooperative, no Employer Support Services Provider will agree to assist the person, or~~

~~(G)~~ (F) ~~participant~~ the member, even with ~~Employer Support Services Provider~~ CM/CDA and Financial Management Services assistance, is unable to operate within their Individual Budget Allocation; or

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

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

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

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

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

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

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

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

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

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

(iii) The United States 2000 Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

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

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

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

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

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

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

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

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

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

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

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

~~(6) **Comprehensive Home Care**. Comprehensive Home Care is an~~

~~integrated service-delivery package which includes case management, personal care, skilled nursing, in-home respite and advanced supportive/restorative assistance.~~

~~(A) Comprehensive Home Care is provided by an agency which has been trained and certified by the Long Term Care Authority to provide an integrated service delivery system. Comprehensive Home Care is case management in combination with one or more of the following services:~~

~~(i) personal care,~~

~~(ii) in-home respite,~~

~~(iii) skilled nursing, and/or~~

~~(iv) advanced supportive/restorative services.~~

~~(B) All services must be provided in the home and must be sufficient to achieve, maintain or improve the member's ability to carry out daily living activities. However, with OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan. The sub-component services of Comprehensive Home Care are the same as described in (A) of this paragraph (see subparagraph (1)(A) of this section for Case Management services, OAC 317:35-15-2 for Personal Care service, subparagraph (8)(A) of this section for Skilled Nursing, subparagraph (2)(A) of this section for In-Home Respite, and subparagraph (7)(A) of this section for Advanced Supportive/Restorative Assistance).~~

~~(C) CHC services are billed using the appropriate HCPC procedure code along with the CHC provider location code on the claim.~~

~~(7)~~ (6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. The service assists with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

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

~~(8)~~ (7) **Skilled Nursing.**

(A) Skilled Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to be treatment for an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily

provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide, assessment of the member's health and assessment of services to meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services for participation in interdisciplinary team planning of service plan and/or assessment/evaluation of:

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

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

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

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

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

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

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

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of

the chronic condition. Provide skills training (including return skills demonstration to establish competency) for preventive and rehabilitative care procedures to the member, family and/or other informal caregivers as specified in the service plan.

(B) Skilled Nursing service is billed for service plan development and/or assessment/evaluation services or, for non-assessment services. Skilled Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure code is used to bill for all other authorized skilled nursing services. A ~~minimum of three and a~~ maximum of ~~seven~~ eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to produce a nurse evaluation is an agreement, as well, to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted.

~~(9)~~ (8) **Home Delivered Meals.**

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

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

~~(10)~~ (9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and

are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

~~(11)~~ (10) **Physical Therapy services.**

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

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

reports or record documentation.

~~(12) **Comprehensive Home Care (CHC) Personal Care.**~~

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

~~(B) CHC Case Manager and Skilled Nursing staff are responsible for development and monitoring of the member's CHC Personal Care plan.~~

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

~~(13)~~ (11) **Speech and Language Therapy Services.**

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

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

~~(14)~~ (12) **Respiratory Therapy Services.**

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

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

~~(15)~~ (13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal

illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

~~(16)~~ (14) **ADvantage Personal Care.**

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

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

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

~~(17)~~ (15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from

getting up from a fall unassisted;
(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
(iii) demonstrates capability to comprehend the purpose of and activate the PERS;
(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
(vi) the service avoids premature or unnecessary institutionalization of the member.

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

~~(18)~~ (16) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance~~,~~ and Advanced Personal Services Assistance ~~and Employer Support Services~~ that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ~~the Employer Support~~ ADvantage Program Administrative Financial Management Services (FMS) ~~provider~~, for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:
(i) recruits, hires and, as necessary, discharges the PSA or APSA;
(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the ~~SPSA~~ APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the

attendant's competency in performing each task in the ASPA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies

with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

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

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

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

(v) use lift for transfers;

(vi) manually assist with oral medications;

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

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

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

~~(D) The service Employer Support Services is assistance with employer related cognitive tasks, decision-making and specialized skills that may include:~~

~~(i) assistance with Individual Budget Allocation planning and support for making decisions, including training, reference material and consultation, regarding employee management tasks such as recruiting, hiring, training and supervising the Personal Service Assistant or Advanced Personal Service Assistant;~~

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

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

~~(iv) for performing Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:~~

~~(I) employer payroll, at a minimum of semi monthly, and associated mandatory withholding for taxes, Unemployment Insurance and Workers' Compensation Insurance performed on behalf of the member as employer of the PSA or APSA; and~~

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

(D) The service Financial Management Services are program

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

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

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

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

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

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

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

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

~~(G) The service of Employer Support Services is billed per month unit of service. The Level of service and number of units of Employer Support Services a member may receive is limited to the Level and number of units approved on the Service Plan.~~

~~(19)~~ (17) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community. ~~Institution Transition Services may include, as necessary, any one or a combination of the following:~~

~~(i) Case Management;~~
~~(ii) Nursing Assessment and Evaluation for in-home service planning;~~
~~(iii) Environmental Modifications including Assessment for Transition Environmental Modification Services; and/or,~~
~~(iv) Medical Equipment and Supplies.~~

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

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

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

~~(C) Institution Transition Skilled Nursing Services are nursing services, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Institutional Transition Skilled Nursing services are solely for assessment/evaluation and service planning for in-home assistance services.~~

(i) Institution Transition Skilled Nursing services are prior authorized and billed per assessment/evaluation visit using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Skilled Nursing Services from regular Skilled Nursing Services.

(D) Institution Transition Environmental Modifications are those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Such adaptations are the same as described under OAC 317:30-5-763(4)(A) and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Services may include accessibility evaluation of the member's home and follow-up evaluation of the adequacy of installed environmental modifications to meet the member's accessibility and environmental adaptive needs. Accessibility evaluation services must be performed by an Accessibility Specialist who is trained and certified through a Federal or State agency approved program for Americans with Disabilities Act (ADA) Accessibility Guidelines - Title III (Public Accommodations) or by a physical or occupational therapist. Accessibility evaluation services do not include evaluations of the need for modifications or equipment that serve a therapeutic or rehabilitative function for which a therapist evaluation is necessary.

(i) Institution Transition Environmental Modification services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Environmental Modification Services and Assessments from regular Environmental Modification Services and Assessments.

(E) Institution Transition Specialized medical equipment and supplies are those devices, controls, or appliances,

~~specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Item reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.~~

~~(i) Institution Transition Medical Equipment and Supply services are prior authorized and billed using the appropriate HCPC.~~

~~(ii) A unique modifier code is used to distinguish Institution Transition Medical Equipment and Supply Services from regular Medical Equipment and Supply services.~~

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

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

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

(iii) Institutional Transition Services are provided to the individual within ~~120~~ 180 days of discharge from the institution;

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

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

317:30-5-763.1. Medicaid agency monitoring of the ADvantage program

The Medicaid Agency will monitor the eligibility process and the ADvantage plan of care approval process by reviewing annually a minimum of three ~~(3)~~ percent of ADvantage ~~client~~ member service plans and associated ~~client~~ member eligibility documents for ~~clients~~ members selected at random from the total number of ~~clients~~

members having new, reassessed or closed plans during the most recent ~~twelve (12)~~ 12 month audit period.

(1) The Medicaid Agency monitoring of the ADvantage Program is a quality assurance activity. The monitoring evaluates whether program medical and financial eligibility determinations and plans of care authorizations have been done in accordance with Medicaid Agency policy and requirements specified in the approved waiver document. The areas evaluated include:

(A) ~~Client~~ Member eligibility determination;

(B) ~~Client~~ Member "freedom of choice";

(C) ADvantage certified and Medicaid contracted providers on the plan;

(D) ~~Client~~ Member acceptance of the plan;

(E) Qualified case managers;

(F) Plan services are goal-oriented services; and,

(G) Plan of care costs are within cost cap guidelines.

(2) At the discretion of the Medicaid Agency, the random selection of ~~clients~~ members for audit shall be done by the MMIS or the AA Waiver Management Information System using an algorithm approved by the Medicaid Agency.

(3) At the discretion of the Medicaid Agency, the Medicaid Agency auditor may review records at the AA place of business or have the AA mail or transport copied file documents to the Medicaid Agency place of business.

(4) Missing documents and/or deficiencies found by the Medicaid Agency are reported to the AA for correction and/or explanation. Periodic reports of deficiencies are provided to the ~~DHS/ASD~~ OKDHS/ASD and the AA.

317:30-5-764. Reimbursement

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

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

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

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

(4) The rates for units of ADvantage Personal Care and In-Home Respite~~, CHC Personal Care, and CHC In-Home Respite~~ are set

equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for ~~a unit of Skilled Nursing and CHC Skilled Nursing are set equivalent to the ADvantage Case Management Standard rate.~~ Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

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

(A) ~~Authorized PSA and APSA units (determined from CDA/CM and member planning);~~ The individual Budget Allocation (IBA) expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) ~~Total CD-PASS IBA (annualized authorized units X the rate for comparable agency personal assistance services). The Total CD-PASS IBA (TIBA) is the annualized budget amount calculated to cover reimbursement for all CD-PASS services - Personal Services Assistance (PSA), Advanced Personal Services Assistance (APSA) and Employer Support Services (ESS). The TIBA is equal to that portion of the annualized cost for Personal Care services and Advanced Supportive/Restorative assistance under the member's existing service plan that CD-PASS services replace;~~ The PSA and APSA service unit rates are calculated by the AA during the CD-PASS service eligibility determination process. The AA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

~~(C) Authorized Employer Support Service level (based on AA assessment of member's level of need for Employer Supportive Services from review of Consumer Readiness assessment for those new to CD-PASS or performance if existing CD-PASS participant);~~

~~(D) Total Annual ESS budget allocation (annualized ESS authorized units X the ESS level rate) and~~

~~(E) Client IBA (CIBA) which is equal to the Total CD-PASS IBA minus Total ESS allocation (E=B-D).~~

~~(F) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid~~

~~reimbursement for CD-PASS to be equal to or less than expenditures for equivalent services using agency providers. The TIBA and service unit rates are calculated by the AA during the CD-PASS service eligibility determination process. Based upon the member record review, member "Self-assessment of Readiness" to assume employer role and responsibilities and other available information, the AA authorizes a level of support to cover Employer Support Service needs. This process establishes the monthly rate for Employer Support Services. Thereafter, as part of the service planning authorization process at a minimum of annually, the AA, in consultation with the member reviews and updates the authorized level of Employer Support Services.~~

~~(G) The PSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Personal Care (PC) services under the member's existing service plan and the result is divided by the total number of PC units authorized per month.~~

~~(i) The allocation of portions of PSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;~~

~~(ii) If both APSA and PSA units are being authorized the ESS monthly rate amount employed in the PSA rate determination is in proportion to the units of PSA to combined PSA plus APSA units;~~

~~(H) The APSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Advanced Supportive/Restorative (ASR) assistance services under the member's existing service plan and the result divided by the total number of ASR units authorized per month.~~

~~(i) The allocation of portions of APSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;~~

~~(ii) If both APSA and PSA units are being authorized, the ESS monthly rate amount employed in the APSA rate determination is in proportion to the units of APSA to combined PSA plus APSA units.~~

~~(I)~~ (C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in

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

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

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

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

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-10. [AMENDED]
Part 45. Optometrists
OAC 317:30-5-431. through 317:30-5-432. [AMENDED]
OAC 317:30-5-432.1. [NEW]
Part 47. Optical Companies
OAC 317:30-5-451. [AMENDED]
OAC 317:30-5-452. [REVOKED]
(Reference APA WF # 07-26)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to limit payment for lenses and frames to one pair of glasses per 12 month period and to allow physicians to separate the refractive service from the medical evaluation when billing ophthalmology services. Current OHCA policy does not address repairs or frequency of replacement for glasses. Rule revisions would save the agency the cost of supplying member(s) with multiple pairs of eyeglasses when not medically necessary as well as promote efficient use of state and federal dollars. In addition, proposed rule revisions would allow physicians performing ophthalmology services to bill based on current CPT guidelines and update policy to be consistent with Medicare and other third party payors. Current rules are inconsistent with CPT guidelines which have separated the refraction from the medical exam. Rule revisions are needed to clarify and update rules to comply with current coding guidelines.

SUMMARY: Agency rules are revised to limit payment for lenses and frames to one pair of glasses per 12 month period and to allow physicians to separate the refractive service from the medical evaluation when billing ophthalmology services. There is no provision in the SoonerCare program for the coverage of glasses for adults; however, for children, payment is made for lenses and frames required to correct visual defects or to protect children with monocular vision. Current policy does not address repairs or frequency of replacement. Based upon several recent audits, some providers have been dispensing multiple sets of glasses at each exam. Rule revisions would save the agency the cost of supplying member(s) with multiple pairs of eyeglasses when not medically necessary as well as encourage providers to repair frames rather than dispensing both new frames and

lenses when only frames are broken. Proposed rule revisions would also allow physicians performing ophthalmology services to bill based on current CPT guidelines and update policy to be consistent with Medicare and other third party payors. Current OHCA policy requires providers to bill routine checkups and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses and eye refractions using the CPT code for the Intermediate exam. This is inconsistent with current coding guidelines which have separated the refraction from the medical exam. Rule revisions are needed to clarify and update rules to comply with current CPT guidelines.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency. The staff anticipates a savings due to the limit on eyeglasses; however, this will be offset by an increase due to the separation of the eye refraction from the medical exam.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 15, 2007, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2008, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.230(d)

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to: (1) limit payment for lenses and frames to one pair of glasses per 12 month period unless medically necessary or glasses are lost or damaged beyond repair; and (2) allow physicians to separate the refractive service from the medical evaluation when billing ophthalmology services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-10. Ophthalmology services

(a) **Covered services for adults.**

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.

(2) ~~Payment is made for treatment of eye disease not related to refractive errors.~~ There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids ~~treatment of refractive errors~~, determination of refractive state or treatment of refractive errors, or purchase of lenses, frames, ~~eye examinations for the purpose of prescribing glasses or for the purchase of~~ or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered service may be billed to the patient if properly notified.

(3) The global surgery fee ~~schedule~~ allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. ~~Postoperative care~~ Co-management for cataract surgery should be filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the optometrist's information must be in the referring provider's section of the claim.

(b) **Covered services for children.**

(1) ~~Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia, and significant refractive errors or strabismus.~~ Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

~~(2) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment will be made for periodic visual screenings as set forth in the periodicity schedule adopted by the Oklahoma Health Care Authority (OHCA) in accordance with the American Academy of Pediatrics. Payment will be made for lenses and frames required to correct visual defects or to protect children with monocular vision. In addition to periodic visual screenings, payment will be made for interperiodic visual screenings when medically necessary.~~

(2) Payment is made for certain corrective lenses and optical supplies when medically necessary. Refer to OAC 317:30-5-432.1. for specific guidelines.

(c) **Individuals eligible for Part B of Medicare.** Payment is made

utilizing the Medicaid allowable for comparable services.

(d) **Procedure codes.**

(1) ~~Routine checkups and eye examinations for the purpose of prescribing, fitting or changing eyeglasses and eye refractions are billed using the General Ophthalmological Services CPT codes for the Intermediate exam. CPT manual guidelines are the basis for this policy and coverage of services is dependent on the purpose of the examination rather than on the ultimate diagnosis. A routine examination is still routine even if a pathologic condition is identified.~~ The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

~~(2) Evaluation and Management codes should be used when the primary purpose of the examination is examination and treatment of a medical or surgical condition.~~

~~(3) Frames are billed using the appropriate HCPC code. Payment includes the dispensing fee.~~

~~(4)~~ (2) ~~Visual~~ Vision screening~~,~~ is a component of ~~the EPSDT exam~~ all eye exams performed by ophthalmologists or optometrists ~~of an asymptomatic child, is included in a routine exam~~ and is not billed separately. ~~Use the appropriate visual acuity screening test CPT code (see CPT section A Other Services and Procedures) when billing visual screening separately from a routine eye exam.~~

~~(d) **Payment.** The Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~

~~(e) **Non-covered items.** Non-covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.~~

~~(f) **Prior authorization.** Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. The appropriate HCPC code should be used. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.~~

PART 45. OPTOMETRISTS

317:30-5-431. Coverage by category

Payment is made to optometrists as set forth in this Section.

(1) **Adults.** Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.

(A) ~~Payment is made for treatment of eye disease not related to refractive errors.~~ There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, ~~eye examinations for the purpose of prescribing glasses~~ or ~~for the purchase of~~ visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered services may be billed to the patient if properly notified.

(B) The global surgery fee ~~schedule~~ allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. ~~Postoperative care~~ Co-management for cataract surgery should be filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the ~~optometrist's~~ surgeon's information must be in the referring provider's section of the claim.

(C) Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery.

(2) **Children.** Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

~~(A) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia and significant refractive errors or strabismus.~~

~~(B) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment will be made for periodic visual screenings as set forth in the periodicity schedule found at OAC 317:30-3-65.7. Payment will be made for lenses and frames required to correct visual defects or to protect children with monocular vision. In addition to periodic visual screenings, payment will be made for interperiodic visual screenings medically necessary.~~

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

317:30-5-432. Procedure Codes

(a) ~~Routine checkups and eye examinations for the purpose of prescribing, fitting or changing eyeglasses and eye refractions are billed using the General Ophthalmological Services CPT codes for the Intermediate exam. CPT manual guidelines are the basis for this policy and coverage of services is dependent on the purpose of~~

~~the examination rather than on the ultimate diagnosis. A routine examination is still routine even if a pathologic condition is identified.~~ The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.
~~(b) Evaluation and Management codes should be used when the primary purpose of the examination is examination and treatment of a medical or surgery condition.~~
~~(c) Payment for frames includes the dispensing fee.~~
~~(d)~~ (b) ~~Visual~~ Vision screening~~,~~ is a component of ~~the EPSDT exam~~ all eye exams performed by ophthalmologists or optometrists ~~of an asymptomatic child, is included in a routine exam~~ and is not billed separately. ~~Use the appropriate visual acuity screening test CPT code when billing visual screening separately from a routine eye exam.~~
~~(e) Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~
~~(f) Non-covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.~~
~~(g) Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.~~

317:30-5-432.1 Corrective Lenses and Optical Supplies
(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year.
(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.
(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.
(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.
(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required; however, the provider must document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to

ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.
(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.
(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.
(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.
(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.

PART 47. OPTICAL COMPANIES

317:30-5-451. Coverage by category

Payment is made to optical suppliers as set forth in this Section.

(1) **Adults.** There is no provision for the coverage of glasses for adults, or for the purchase of visual aids.

(2) **Children.** Payment ~~will be~~ is made for medically necessary lenses and frames ~~required to correct visual defects or to protect children with monocular vision~~. Refer to OAC 317:30-5-432.1. for specific guidelines.

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

~~**317:30-5-452. Procedure codes**~~ **[REVOKED]**

~~(a) **Claims.** Payment for frames includes the dispensing fee.~~

~~(b) **Payment.** Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~

~~(c) **Non-covered items.** Non-covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.~~

~~(d) **Prior authorization.** Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children~~

~~when medically necessary.~~