Rules Agenda
October 9, 2008

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

Page 3. A. Revising SoonerCare eligibility rules to implement the Living Choice program. The Living Choice program is Oklahoma's Money Follows the Person demonstration project. **(Reference APA WF # 08-34)**

Page 11. B. Revising ambulance rules to remove specific reimbursement language and replace it with the general statement that refers providers to the Oklahoma Health Care Authority's fee schedule for SoonerCare compensable services. **(Reference APA WF # 08-14)**

Page 13. C. Revising psychologist rules to allow reimbursement for services provided by student psychologists participating in an internship or fellowship in an accredited academic clinical psychology training program. **(Reference APA WF # 08-31)**

Page 16. D. Revising inpatient behavioral health rules to clarify individual plans of care must be reviewed every five to nine calendar days in acute settings and every eleven to sixteen days in longer term treatment programs. **(Reference APA WF # 08-38)**

Page 20. E. Revising rules to add telemedicine for certain providers as a service delivery to members in rural areas, medically under served areas, or geographic areas where there is a lack of local medical or psychiatric/mental health expertise. **(Reference APA WF # 08-15)**

Page 32. F. Revising rules regarding nutritional services to permit two of the six hours allowed to be done in a group setting for pregnant members who are at risk or those who have been recently diagnosed with gestational diabetes. **(Reference APA WF # 08-32)**

Page 37. G. Revising rules to remove obsolete prior authorization contact information. **(Reference APA WF # 08-36)**

Page 40. H. Revising rules regarding the payment of Medicare Part A claims for skilled nursing facility care to limit

the SoonerCare payment to the Medicaid rate minus the total of all other payments. **(Reference APA WF # 08-28)**

Page 42. I. Revising ADvantage Waiver Services rules to add an additional exception to the cost cap provision. **(Reference APA WF # 08-30)**

A. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 113. Oklahoma Living Choice Program
OAC 317:30-5-1200. through OAC 317:30-5-1206. [NEW]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 23. Oklahoma Living Choice Program
Part 1. General Provisions
OAC 317:35-23-1. through 35-23-4. [NEW]
(Reference APA WF # 08-34)

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 implement the Oklahoma Living Choice program as authorized under Section 6071 of Public Law 109-171. The Living Choice program is designed to promote community living for individuals with disabilities or long-term illnesses. Revisions are needed to help strengthen Oklahoma's long-term services and supports for individuals who choose to transition from long-term care institutions into the community. Without the implementation of this program, many individuals who would otherwise be able to live in the community and preserve their independence will be forced to reside in an institutional setting in order to receive necessary long-term services.

SUMMARY: Agency rules are revised to implement the Oklahoma Living Choice program created to promote community living for individuals with disabilities or long-term illnesses as authorized by Section 6071 of Public Law 109-171. With grant funding from the Centers for Medicare and Medicaid Services (CMS) under the Money Follows the Person (MFP) demonstration for a five year period, the OHCA will facilitate the transition of over 2,000 individuals from institutional settings to their own homes in the community and help rebalance Oklahoma's long-term care system. The MFP demonstration offers states greater flexibility to provide community based long-term services that are not typically paid by Medicaid funds. Oklahoma will receive enhanced federal match to strengthen community based long-term care services and supports for individuals with disabilities and long-term illnesses. If this program is not implemented, many individuals who are at risk of being placed in or are currently living in an institutional setting will have no other alternative even though they could possibly be better served in their homes and communities, preserving their independence and ties to family and friends at a cost that is no greater than that of institutional care.

BUDGET IMPACT: Agency staff has determined that the revisions will cost a total of $50.8 million over the five year demonstration period with a state share of $11.6 million.

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 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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; Section 6071 of Public Law 109-171.

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 implement the Living Choice program created to promote community living for individuals with disabilities or long-term illnesses as authorized under Section 6071 of Public Law 109-171.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 113. OKLAHOMA LIVING CHOICE PROGRAM

317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses
(a) The Oklahoma Living Choice program participants may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member will begin to receive services through one of the Opportunities for Living Life home and community based services waivers.
(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.
(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services

the member is eligible to receive is limited to the amounts approved in the transition plan.
(d) Services that may be provided through the Living Choice program for older persons with disabilities or long-term illnesses are listed in paragraphs (1) through (24) of this subsection.

(1) case management;
(2) respite care;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) therapy services including physical, occupational, speech and respiratory;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs;
(12) personal care as described in Part 95 of this Chapter;
(13) Personal Emergency Response System (PERS);
(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(15) transition coordination;
(16) community transition services as described in OAC 317:30-5-1205;
(17) dental services (up to $1,000 per person annually);
(18) nutrition evaluation and education services;
(19) agency companion services;
(20) pharmacological evaluations;
(21) vision services including eye examinations and eyeglasses;
(22) non-emergency transportation;
(23) family training services; and
(24) SoonerCare compensable medical services.

317:30-5-1201. Benefits for members with mental retardation

(a) The Oklahoma Living Choice program participants may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member will begin to receive services through the Community waiver.
(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.
(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan. The transition plan may be amended as the member’s needs change.

(d) Services that may be provided to members with mental retardation are listed in paragraphs (1) through (28) of this subsection.

(1) assistive technology;
(2) adult day health care;
(3) architectural modifications;
(4) audiology evaluation and treatment;
(5) community transition;
(6) daily living support;
(7) dental services;
(8) family counseling;
(9) family training;
(10) group home;
(11) respite care;
(12) homemaker services;
(13) habilitation training services;
(14) home health care;
(15) intensive personal support;
(16) extended duty nursing;
(17) skilled nursing;
(18) nutrition services;
(19) therapy services including physical, occupational, and speech;
(20) psychiatry services;
(21) psychological services;
(22) agency companion services;
(23) non-emergency transportation;
(24) pre-vocational services;
(25) supported employment services;
(26) specialized foster care;
(27) specialized medical equipment and supplies; and
(28) SoonerCare compensable medical services.

317:30-5-1202. Benefits for members with physical disabilities

(a) The Oklahoma Living Choice program participants may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member will begin to receive services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided to members with physical disabilities are listed in paragraphs (1) through (31) of this subsection.

(1) case management;
(2) personal care services as described in Part 95 of this Chapter;
(3) respite care;
(4) adult day health care with personal care and therapy enhancements;
(5) architectural modifications;
(6) specialized medical equipment and supplies;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) therapy services including physical, occupational, speech and respiratory;
(11) hospice care;
(12) Personal Emergency Response System (PERS);
(13) Consumer Directed Personal Assistance Services (CD-PASS);
(14) agency companion services;
(15) extended duty nursing;
(16) psychological services;
(17) audiology treatment and evaluation;
(18) non-emergency transportation;
(19) assistive technology;
(20) dental services (up to $1,000 per person annually);
(21) vision services including eye examinations and eyeglasses;
(22) pharmacotherapy management;
(23) independent living skills training;
(24) nutrition services;
(25) family counseling;
(26) family training;
(27) transition coordination;
(28) psychiatry services;
(29) community transition services as described in OAC 317:30-5-1205;
(30) pharmacological evaluations; and
(31) SoonerCare compensable medical services.

317:30-5-1203. Billing procedures for Living Choice services

(a) The approved individual transition plan is the medical basis for the services and includes the prior authorizations, specifying:

(1) what service;
(2) which service provider;
(3) the number of units authorized; and
(4) the authorized begin and end dates of the service.

(b) As part of Living Choice quality assurance, audits are used to evaluate whether claims are consistent with individual transition

plans and services provided are documented. Claims that are not supported by individual transition plans and/or documentation of services are referred to the Surveillance Utilization Review Subsystem unit (SURS). Erroneous or invalidated claims identified through post payment reviews are recouped from the provider.
(c) Claims may not be filed until the services are rendered.

317:30-5-1204. Disclosure of information on health care providers and contractors

In accordance with the requirements of the Social Security Act and the regulations issued by the Secretary of Health and Human Services, the OHCA is responsible for disclosure of pertinent findings resulting from surveys made to determine eligibility of certain providers for home health care and contractors under SoonerCare. In Oklahoma, the Oklahoma State Department of Health (OSDH) is the agency responsible for surveying home health care providers and contractors to obtain information for use by the Federal Government in determining whether these entities meet the standards required for participation as Medicare and SoonerCare providers.

317:30-5-1205. Community transition services

(a) Community transition services are one-time set-up expenses for members transitioning from a nursing facility or public ICF/MR to a home in the community.
(b) Each member transitioning into the community is eligible for up to $2,400 per person for the purchase of essential goods and/or services authorized by a Transition Coordinator on the member's behalf.
(c) Community transition services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.
(d) Allowable expenses for community transition services include, but are not limited to:

(1) security deposits that are required to obtain a lease on a qualified residence;
(2) essential household items required for occupation and use in a community residence such as furniture, window coverings, food preparation and bed/bath linens;
(3) connection, set-up fees or deposits for utility service or access including telephone, electricity, heating and water;
(4) services necessary for the member's health, safety and welfare such as pest eradication and one-time cleaning prior to occupancy;
(5) moving expenses;
(6) fees to obtain a copy of birth certificate, identification card or driver's license; and

(7) delivery, set-up costs and removal fees for appliances, furniture, etc.

(e) Non-allowable expenses for community transition services include, but are not limited to:

(1) monthly rental or mortgage expenses;

(2) monthly utility charges;

(3) household items that are purely recreational purposes; and

(4) services or items that are available through other Living Choice services such as homemaker services, environmental modifications and adaptations, or specialized supplies and equipment.

317:30-5-1206. Transition coordinator services

Transition coordinators must meet the requirements in paragraphs (1) and (2) of this subsection.

(1) Transition coordinators must:

(A) complete case management training with the ADvantage waiver; or

(B) complete the curriculum requirements for a bachelor's degree and one year paid professional experience in aging or disability populations; or

(C) complete a degree program as a registered nurse or licensed practice nurse and one year paid professional experience; or

(D) have at least two years paid work experience as an independent living specialist or transition specialist at one of the five federally recognized Centers for Independent Living organizations in Oklahoma.

(2) Transition coordinators must successfully complete the Living Choice program transition coordinator training.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 23. OKLAHOMA LIVING CHOICE PROGRAM

PART 1. GENERAL PROVISIONS

317:35-23-1. Oklahoma Living Choice program

The Oklahoma Living Choice program is created to promote community living for members with disabilities or long-term illnesses and is authorized by Section 6071 of Public Law 109-171, the Deficit Reduction Act of 2005.

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with mental retardation and members with physical disabilities are eligible to transition into the community through the Oklahoma Living Choice program if they meet all of the criteria in

paragraphs (1) through (6) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least six months prior to the proposed transition date.

(3) He/she must have at least one month of SoonerCare paid long-term care services prior to transition.

(4) He/she requires at least the same level of care that necessitated admission to the institution.

(5) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

(6) His/her needs can be met by the Living Choice program while living in the community.

317:35-23-3. Participant disenrollment

Members are disenrolled from the program if:

(1) he/she is admitted to a nursing facility, ICF/MR, residential care facility or behavioral health facility for more than 30 consecutive days;

(2) he/she is incarcerated;

(3) he/she is determined to no longer meet SoonerCare financial eligibility for home and community based services;

(4) he/she is determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or

(5) he/she moves out of state.

317:35-23-4. Re-enrollment

(a) A member may re-enroll in the program without residing in an institution for the six months prior if:

(1) the necessity for the institutionalization is documented in the revised individual transition plan; and

(2) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.

(b) The member remains eligible during hospitalization and convalescent care periods as long as the stay does not exceed six months.

B. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 33. Transportation by Ambulance
OAC 317:30-5-336.5. [AMENDED]
(Reference APA WF # 08-14)

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 that remove current reimbursement language in the transportation by ambulance rules and replace it with a general statement that refers providers to the Oklahoma Health Care Authority's fee schedule for SoonerCare compensable services. Replacing specific reimbursement language with a general statement allows the Agency the flexibility of adjusting rates without continually revising policy and is necessary to keep policy consistent with State plan changes.

SUMMARY: Ambulance rules are revised to remove the Medicare Ambulance Fee Schedule (AFS) and replace it with a general statement that refers providers to the Oklahoma Health Care Authority's fee schedule for SoonerCare compensable services. Effective October 1, 2005, OHCA adopted Medicare's AFS and began reimbursing most ambulance providers at 97%. Air ambulance services were the exception. OHCA reimbursement for air ambulance services were and still are 61% of Medicare's AFS. In order to retain fixed wing providers and ensure SoonerCare members have access to this service, the rates for fixed wing aircraft have been increased to 100% of Medicare's AFS. This increase has required changes to the reimbursement language for fixed wing aircraft in the State plan and consequently, revisions to policy language as well to remain consistent with State plan language. In an effort to avoid the lengthy and labor intensive process that occurs each time agency rules are revised, OHCA is replacing specific reimbursement language with a general statement referencing the State plan or OHCA fee schedule. This practice allows the Agency the flexibility of adjusting rates to meet market demands without continually revising the reimbursement language in agency rules. This also makes the transportation by ambulance reimbursement section consistent with other reimbursement sections in rules.

BUDGET IMPACT: Agency staff has determined that the cost to increase the rates for fixed wing aircraft to 100% of the Medicare Ambulance Fee Schedule is $130,593.03. The State's share is $42,965.11.

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

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

PROPOSED EFFECTIVE DATE: December 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 447.201; 42 CFR 447.204

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising ambulance rules to remove specific reimbursement language and replace it with the general statement that refers providers to the Oklahoma Health Care Authority's fee schedule for SoonerCare compensable services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-336.5 Levels of ambulance service, ambulance fee schedule and base rate
(a) In accordance with the Oklahoma Emergency Response System Development Act of 2005, §63 OS 1-2503, a license may be issued for basic life support, intermediate life support, paramedic life support, specialized mobile intensive care units, or stretcher aid vans.
(b) ~~Effective October 1, 2005, the OHCA adopted the Medicare Ambulance Fee Schedule (AFS).~~ Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for SoonerCare compensable services.
(1) The ambulance provider bills one base rate procedure. Levels of service base rates are defined at 42 CFR 414.605.
(2) The base rate must reflect the level of service rendered, not the type of vehicle in which the member was transported, except in those localities where local ordinance requires Advanced Life Support (ALS) as the minimum standard of service.

C. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 25. Psychologists
OAC 317:30-5-275. [AMENDED]
(Reference APA WF # 08-31)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow for reimbursement for services provided by clinical psychology interns completing required internships and post doctoral fellows completing required supervision for licensure. The change is needed to increase the OHCA provider network of psychologists thereby increasing the access to desperately needed mental health services for SoonerCare members.

SUMMARY: Agency rules are revised to allow for reimbursement for services provided by clinical psychology interns completing required internships and post doctoral fellows completing required supervision for licensure. These individuals are considered to be qualified to provide services by the state licensing board and are currently providing much needed psychiatric services in the academic training setting, without reimbursement. Payment will be made to the licensed practitioner responsible for the SoonerCare member’s care who is directly supervising the intern or post doctoral fellow. The revisions also require active participation and oversight by the licensed practitioner as well as specific documentation requirements.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

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

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Section 5003 through 5016 of Title 63 of Oklahoma Statutes.

RESOLUTION:

Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising psychologist rules to allow for reimbursement for services provided by clinical psychology interns completing required internships and post doctoral fellows completing required supervision for licensure.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 25. PSYCHOLOGISTS

317:30-5-275. Eligible providers

(a) Payment is made for compensable services to psychologists licensed in the state in which face to face services are delivered. ~~Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.~~ ~~Each psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).~~ Payment is also made to practitioners who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical psychology academic training program and are under current board approved supervision toward licensure. Each psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA). Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.

(b) In order for services provided by clinical psychology interns completing required internships and post-doctoral fellows completing required supervision for licensure to be reimbursed, the following conditions must be met:

(1) The practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or post doctoral fellowship;

(2) The psychology intern or post-doctoral fellow must be under the direct supervision of the licensed psychologist responsible for the member's care;

(3) The licensed psychologist responsible for the member's care must:

(i) Staff the member's case with the intern or fellow,

(ii) actively direct the services,

(iii) be available to the intern or fellow for in-person consultation while they are providing services,

(iv) agree with the current plan for the member, and

(v) confirm that the service provided by the intern or fellow was appropriate; and

(4) The member’s medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the member’s care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the member’s care.

D. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-95.33. [AMENDED]
(Reference APA WF # 08-38)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow for review of individual plans of care for children in an inpatient setting every five to nine calendar days in acute care situations and every eleven to sixteen calendar days in the longer term treatment program or specialty psychiatric residential treatment facility. The previous wording was not easily understood by providers and could potentially lead to confusion and erroneous and/or untimely submissions which could result in unnecessary sanctions and recoupments.

SUMMARY: Agency rules are revised to create a more lenient time frame within which a provider of inpatient behavioral health services must review an individual plan of care (IPC) for children residing in their facility. The rule was recently revised to address this issue but the language used led to confusion and the interpretation that more strenuous constraints had been placed on the providers, which was not the intent. The revisions herein establish a clearly defined time frame within which the providers have to submit their plans of care.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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 and 42 CFR 440.160.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does

hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising inpatient psychiatric hospital rules to allow for review of individual plans of care for children in an inpatient setting every five to nine calendar days in acute care situations and every eleven to sixteen calendar days in the longer term treatment program or specialty psychiatric residential treatment facility.

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

317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional (LBPH)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;
(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;
(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;
(7) must be reviewed ~~no less than~~ every five to nine calendar days when in acute care and a regular PRTF and ~~no less than~~ every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,
(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are

not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.

E. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
OAC 317:30-3-27. [NEW]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-11. [REVISED]
Part 3. Hospitals
OAC 317:30-5-47. [REVISED]
Part 35. Rural Health Clinics
OAC 317:30-5-361. [REVISED]
Part 75. Federally Qualified Health Centers
OAC 317:30-5-664.10. [REVISED]
Part 110. Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us)
OAC 317:30-5-1090. [REVISED]
(Reference APA WF # 08-15)

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 that add telemedicine as a service delivery option for certain provider types and specialties. Approximately twenty percent of our SoonerCare members live in rural or medically underserved areas. The addition of telelmedicine as a service delivery option provides member's with increased access to quality care. Moreover, members will have the option of staying in their community and will no longer have to travel long distances which may put their health at further risk.

SUMMARY: Agency rules are revised to add telemedicine as a service delivery option for certain provider types and specialties. Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient and for the purpose of improving patient care. Telemedicine includes consultive, diagnostic and treatment services. The addition of telemedicine as a service delivery option provides members with increased access to specialists and provisions of care not previously deliverable, better continuity of care and eliminates the hardship caused by traveling extended distances. Oklahoma, like many other states, has a provider distribution problem. Specialists are concentrated in metropolitan centers, such as Oklahoma City and Tulsa, and few, if any are in rural areas. Not only will telemedicine improve the quality of care SoonerCare members receive by extending specialty care to rural and underserved areas; it also offers rural providers enhanced

clinical support.

BUDGET IMPACT: Agency staff as determined that the cost to add telemedicine as a service delivery method is $500,000. The State's share is $169,000.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: January 1, 2009.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Telemedicine Act of 1997; 42 CFR 410.78.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Agency rules to add telemedicine as a service delivery option for certain provider types and specialties.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telemedicine

(a) **Applicability and Scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural or underserved areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member’s understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery.

(b) **Definitions.** The following words and terms, when used in this

Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Distant site"** means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(2) **"Certified or licensed health care professional"** means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(3) **"Originating site"** means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(4) **"Telehealth"** means the use of telecommunication technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(5) **"Telemedicine"** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(6) **"Store and forward"** means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) **"Interactive telecommunications"** means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(8) **"Rural area"** means a county with a population of less than 50,000 people.

(9) **"Underserved area"** means an area that meets the definition of a medically underserved area (MUA) or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

(10) **"Telemedicine network"** means a network infrastructure,

consisting of computer systems, software and communications equipment to support telemedicine services.

(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments and pharmacologic management.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas, underserved areas, or geographic areas where there is a lack of medical/psychiatric/mental health expertise locally.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;

(B) A hospital;

(C) A school;

(D) An outpatient behavioral health clinic;

(E) A critical access hospital;

(F) A rural health clinic (RHC);

(G) A federally qualified health center (FQHC); or

(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty physicians and practitioners are contracted:

(A) Physicians;

(B) Advanced Registered Nurse Practitioners;

(C) Physicians Assistants;

(D) Genetic Counselors;

(E) Licensed Behavioral Health Professionals; and

(F) Dieticians.

(d) **Non-covered services.** Non-covered services include:

(1) Telephone conversation;

(2) Electronic mail message; and

(3) Facsimile.

(e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.

(f) **Conditions.** The following conditions apply to all services rendered via telemedicine.

(1) Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the SoonerCare member. As a condition of payment the member must be present and participating in the telemedicine visit.

(2) Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.

(3) For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.

(4) The telemedicine equipment and transmission speed must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.

(5) An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.

(6) The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.

(7) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

(8) The member retains the right to withdraw at any time.

(9) All existing confidentiality protections apply.

(10) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(11) There will be no dissemination of any member images or information to other entities without written consent from the member.

(g) **Reimbursement.**

(1) A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.

(A) Hospital outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.

(B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.

(C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.

(D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.

(E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.

(2) Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine service rendered from the distant site is billed with the modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.

(4) Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.

(5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(h) **Documentation.**

(1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.

(2) Documentation must indicate the services were rendered via telemedicine, the location of the originating and distant sites, and which OHCA approved network was used.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(i) **Telemedicine Network Standards.** In order to be an approved

telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include a Diagnostic and Statistical Manual (DSM) multi axial diagnosis completed for all five axes from the most recent version of the DSM.

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed. ~~For general physicians (M.D. or D.O.), physician assistants, or nurse practitioners, payment is made for the appropriate medical procedure code(s) and not for psychiatric procedure codes.~~

~~(d) No services in the psychiatry series of the CPT manual may be provided via telemedicine or other electronic medium, with the exception of "pharmacologic management". Pharmacological management may be performed via telemedicine under the following circumstances:~~

~~(1) A healthcare professional with knowledge of the patient must accompany and attend the patient during the performance of the service.~~

~~(2) The psychiatrist performing the service or in the case of a group practice or agency, another psychiatrist within that~~

~~practice or agency must have seen the patient receiving the service during either a psychiatric exam or previous pharmacologic management session or other face-to-face psychiatric service.~~

~~(3) The patient must understand the procedure including the technologic aspects of the process and agree, in writing, to having his/her pharmacological management session via electronic equipment.~~

~~(e) The telecommunications equipment must provide clear images of the psychiatrist to the patient. The psychiatrist must have a clear visual field to effectively evaluate the physical condition of the patient, including but not limited to extrapyramidal symptoms, injuries and changes in weight. Audio reception must be sufficient for the patient and physician to clearly hear one another's conversation.~~

(d) Psychiatric services performed via telemedicine are subject to the requirements found in OAC 317:30-3-27.

PART 3. HOSPITALS

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

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

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

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

(A) laboratory services;

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

(C) technical component on radiology services;

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

(E) pre-admission diagnostic testing performed within 72

hours of admission; and
(F) organ transplants.

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

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(7) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(8) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(9) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.

PART 35. RURAL HEALTH CLINICS

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one type of encounter per member per day. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is

required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services which are not included in the all-inclusive rate must be itemized separately using the appropriate CPT or HCPCS code.(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

(B) Insertion and implantation of a subdermal contraceptive device.

(C) Removal, implantable contraceptive devices.

(D) Removal, with reinsertion, implantable contraceptive device.

(E) Insertion of intrauterine device (IUD).

(F) Removal of intrauterine device.

(G) ParaGard IUD.

(H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code.

(6) **Telemedicine.** The originating site facility fee for

When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2002, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in OAC 317:30-5-664.12.

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care services (that are not included in the SoonerCare capitation payment, if applicable) and other health services at the current rate for that CPT/HCPCS code.

(c) As claims are filed, reimbursement for SoonerCare Traditional members is made for all medically necessary covered primary care and other health services at the PPS rate.

(d) The originating site facility fee for telemedicine services is not a Federally Qualified Health Center (FQHC) service. When a FQHC serves as the originating site, the originating site facility fee is paid separately from the center's all-inclusive rate.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) An I/T/U outpatient facility may provide other items and services which are not part of an encounter. If covered, these services are separately billable to the SoonerCare program. Coverage of services will be based upon medical necessity and the scope of coverage under the SoonerCare program and subject to any limitations, restrictions or prior authorization requirements.

(b) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service rate. Examples of these services include but are not limited to:

(1) pharmaceuticals/drugs;
(2) durable medical equipment;
(3) glasses;

(4) ambulance;
(5) home health;
(6) inpatient practitioner services;
(7) non-emergency transportation [refer to OAC 317:35-3-2];
(8) behavioral health case management [refer to OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599];
(9) psychosocial rehabilitative services [refer to OAC 317:30-5-240 through 317:30-5-248]; and
(10) psychiatric residential treatment facility services [refer to OAC 317:30-5-96.3].

(c) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

(d) The originating site facility fee for telemedicine services is not an I/T/U service. When an I/T/U serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

F. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-22. [REVISED]
Part 108. Nutritional Services
OAC 317:30-5-1076. [REVISED]
(Reference APA WF # 08-32)

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 that allow nutritional counseling in a group setting for women at risk for or recently diagnosed with gestational diabetes. Current SoonerCare rules only allow nutritional counseling on an individual basis and often members must wait several weeks for an appointment. Therefore, to increase access to this service for our SoonerCare members, rules are revised to allow two of the six hours of nutritional counseling to be done in a class setting.

SUMMARY: Agency rules are revised to allow nutritional counseling in a group setting for women at risk for or recently diagnosed with gestational diabetes. Gestational diabetes mellitus is a glucose intolerance that begins, or is first recognized, during pregnancy. A wide range of complications is associated with the disorder. For the mother, gestational diabetes increases the risk of preeclampsia, cesarean delivery, and future type two diabetes. In the fetus or neonate, the disorder is associated with higher rates of perinatal mortality, macrosomia, birth trauma, hyperbilirubinemia and neonatal hypoglycemia. Integral to the treatment and management of gestational diabetes is proper nutrition. Current SoonerCare rules only allow nutritional counseling on an individual basis. This is causing a delay in care for SoonerCare members who must wait several weeks for their initial appointment. Although medical nutrition therapy must be individualized with consideration given to maternal weight and height, eating habits, etc., it is customary for the first session to focus on explaining the basic pathophysiology of gestational diabetes, why monitoring and treatment are important and the complications of the disease. Allowing two of the six hours of nutritional counseling to be done in a group setting improves quality of care by decreasing the delay in providing this service and increases SoonerCare member’s access.

BUDGET IMPACT: Agency staff as determined that the cost to allow nutritional counseling in a group setting for women at

risk for or recently diagnosed with gestational diabetes is budget neutral. The reimbursement rate for the group therapy code is approximately one-third the individual rate; however we anticipate by decreasing the delay in providing this service, we will see an increase in access.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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 440.130

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Agency rules to allow nutritional counseling in a group setting for women at risk for or recently diagnosed with gestational diabetes.

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

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except

major illness distinctly unrelated to the pregnancy.(b) Procedures paid separately from total obstetrical care are listed in (1) - ~~(7)~~(8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies, must be performed by an active candidate or Board Certified diplomate in Maternal-Fetal Medicine.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-

section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.

(8) Nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.

(1) Additional non stress tests, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

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

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Coverage for children is in accordance with OAC 317:30-3-47.

(3) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the Mentally Retarded program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

G. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
OAC 317:30-5-216. [AMENDED]
(Reference APA WF # 08-36)

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 remove obsolete prior authorization contact information. The change ensures that agency rules reflect accurate mailing information and it expedites prior authorization requests so that members may access needed care in a timely manner.

SUMMARY: Agency rules are revised to remove obsolete prior authorization contact information. The current policy directs healthcare providers to send prior authorization requests to OHCA. As of April 7, 2008, providers were notified to send all prior authorization requests directly to OHCA's contracted fiscal agent. Any prior authorization requests that are sent to OHCA in error are delayed since OHCA must forward all requests to the contracted fiscal agent for processing. Without this revision, members may experience unnecessary delays in access to healthcare services.

BUDGET IMPACT: Agency staff has determined that the rule revision is budget neutral.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising medical providers rules to remove obsolete prior

authorization contact information.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-216. Prior authorization requests

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

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

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

(3) **DIF**. The requesting supplier must complete and submit a DIF as indicated by Medicare standards unless OHCA policy indicates that a CMN or other documentation is required. By signing the DIF, the supplier is validating the information provided is complete and accurate. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the information given in the DIF.

(b) **Submitting prior authorization requests**. ~~All requests for PA are submitted to OHCA, Attention: Medical Authorization Unit, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, OK 73105, or faxed to (405)530-3496 or submitted on-line via Secured Website followed by fax. All requests for prior authorization should be submitted in the same manner regardless of the age of the member.~~Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.

(c) **Prior authorization review**. Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets

SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(d) **Prior authorization decisions**. After the HCA-12A is processed, a notice will be issued advising whether or not the item is authorized. If authorization is issued, the notice will include an authorization number, the time period for which the device is being authorized and the appropriate procedure code.

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

(f) **Prior authorization of manually-priced items.** Manually-priced items must include documentation showing the supplier's estimated cost of the item with the request for prior authorization. Reimbursement will be determined as per OAC 317:30-5-218.

H. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope And Administration
OAC 317:30-5-25. [AMENDED]
(Reference APA WF # 08-15)

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 of Medicare Part A to the Medicaid allowable for services in a skilled nursing facility. The change is needed to maximize the use of state funding and support the ongoing quality of care initiatives undertaken by the industry and the OHCA.

SUMMARY: SoonerCare rules are revised to limit payment of Medicare Part A to the Medicaid allowable for services in a skilled nursing facility. The change will pay only up to the Medicaid rate for Medicare crossover claims for Skilled Nursing care, which in effect will reduce these payments by approximately $21 million. The state share for these payments will be used in support of the Medicaid rate components for regular nursing home care. Alternatively, the denied claim amounts for the crossovers are reimbursable by the Medicare program to the facilities as bad debt expense.

BUDGET IMPACT: Agency staff has determined an estimated total savings of $14,996,390 for FFY2009 and $17,834,578 for FFY 2010. The estimated savings for the State’s share is $5,113,769 for FFY 2009 and $6,343,759 for FFY 2010.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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 USC 1902(a)(10) and 1905(p)(3) of the Social Security Act.

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 rules to limit payment of Medicare Part A to the Medicaid allowable for services in a skilled nursing facility.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-25. Crossovers (coinsurance and deductible)
(a) **Medicare ~~Parts A and~~ Part B**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals.
(b) **Medicare Part A**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals limited to the Medicaid allowable reimbursement for services in a skilled nursing facility.
~~(b)~~ (c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.

317:30-5-122. Levels of care
The level of care provided by a long term care facility to a patient is based on the nature of the health problem requiring care and the degree of involvement in nursing services/care needed from personnel qualified to give this care.
(1) **Skilled Nursing facility.** ~~Payment~~ When total payments from all other payers are less than the Medicaid rate, payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.
(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.
(3) **Intermediate Care Facility for the Mentally Retarded.** Care provided by a nursing facility to patients who require care and active treatment due to mental retardation or developmental disability combined with one or more handicaps. The mental retardation or developmental disability must have originated during the patient's developmental years (prior to 22 years of chronological age).

I. CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-3. [AMENDED]
(Reference APA WF # 08-30)

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 add an additional exception to the ADvantage cost cap provision. Rules are in need of revision to accommodate unusual circumstances in which the member's health and safety can be assured and the Director of Aging Services Division determines that it is in the state's best interest to service the member in ADvantage.

SUMMARY: ADvantage Waiver Services rules are revised to add an additional exception to the cost cap exception. The ADvantage program allows a specified number of persons to receive home and community based long-term care services who without such services would be institutionalized. Generally, the estimated annual cost of providing the individual's care in their home cannot exceed the annual cost of caring for that person in a nursing facility; however, the waiver regulations permit certain exceptions to the 100% nursing facility cost cap policy. Currently, policy lists five instances that might allow the individual to be approved for ADvantage services, even though the estimated services cost exceeds the expense of nursing facility care. Revisions would add an exception that would allow services only if approved by the OKDHS/Aging Services Division Director based on specific criteria as outlined in policy. Rules are also revised to replace the Administrative Agent with the OKDHS Aging Service Division as the approval source for ADvantage cost cap exceptions and replace or remove outdated language.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the Oklahoma Health Care Authority. The State's share of additional costs incurred due to this exception to the cost cap will be paid by the Oklahoma Department of Human Services and is expected to be minimal.

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 18, 2008,

and recommended Board approval.

PROPOSED EFFECTIVE DATE: December 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 441.302

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising ADvantage Waiver Services rules to add an additional exception to the cost cap provision.

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

317:35-17-3. ADvantage program services
(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program ~~clients~~ members must be ~~Medicaid~~ SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility. The number of ~~clients~~ individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following

criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of ~~state plan~~ Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable ~~Medicaid~~ SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate ~~Medicaid~~ SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. To meet program cost effectiveness eligibility criteria, the annualized cost of a ~~client's~~ individual's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the ~~Administrative Agent (AA) under one of~~ Oklahoma DHS Aging Services Division (OKDHS/ASD) in accordance with the exceptions listed in (1)- ~~(5)~~ (6) of this subsection. The cost of the service plan furnished to ~~a client~~ an individual may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:

(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or

(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or

(3) expenditures are for ADvantage Hospice services;

(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by ~~Medicaid~~ SoonerCare if the individual were receiving services in a nursing home; and/or

(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to ~~a client~~ an individual under any combination of ~~these~~ circumstances described under exceptions (1) through (5) can reasonably be expected to be no more than 200% of the individual cap; or

(6) the OKDHS/ASD Director:

(A) determines that providing ADvantage services to the member would benefit the member and be in the best interests

of the state;
(B) specifically authorizes a service plan that is not more than 250% of the cost cap prior to taking into account exception costs;
(C) determines that the service plan is less than 175% of the cost cap after taking into account any combination of circumstances described under cost exceptions (1) through (5); and
(D) determines that fewer than 150 members are already receiving services under this cost cap exception.

(c) Services provided through the ADvantage waiver are:

(1) case management ~~or Comprehensive Home Care (CHC) case management~~;

(2) respite ~~or CHC in-home respite~~;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/respiratory therapy/speech therapy or consultation;

(7) advanced supportive/restorative assistance ~~or CHC advanced supportive/restorative assistance~~;

(8) skilled nursing ~~or CHC skilled nursing~~;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan)~~,~~ or ADvantage personal care~~, or CHC personal care~~;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services; and

(16) ~~Medicaid~~ SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the ~~client~~ individual. If the ~~AA~~ OKDHS/ASD determines all ADvantage waiver slots are filled, the ~~client~~ individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the ~~client's~~ individual's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for

persons that have a developmental disability and those that do not have a developmental disability.

(2) the ~~client~~ individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the ~~client~~ individual does not pose a physical threat to self or others as supported by professional documentation.

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

(e) The ~~AA~~ OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that ~~a client~~ an individual is not eligible:

(1) if the ~~client's~~ individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver ~~client's~~ individual's health, safety, or welfare can be maintained in their home. If a ~~client's~~ member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the ~~client's~~ individual's health, safety or welfare in their home cannot be assured.

(2) if the ~~client~~ individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the ~~client~~ individual or other household visitors.

(4) if the ~~client's~~ individual's needs are being met, or do not require ADvantage services to be met, or if the ~~client~~ individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to ~~client~~ individual's health and safety is not acceptable to the ~~client~~ individual, or to the interdisciplinary service plan team, or to the ~~AA~~ OKDHS/ASD.

(f) The case manager provides the ~~AA~~ OKDHS/ASD with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the ~~client~~ individual is removed from the ADvantage program.

As a part of the procedures requesting redetermination of program eligibility, the ~~AA~~ OKDHS/ASD will provide technical assistance to the Provider for transitioning the ~~client~~ individual to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

~~(h) The AA provides OKDHS with notification that the client is no longer program eligible.~~